

Liverpool Community Health NHS Trust

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Community health services for children, young people and families

Quality Report

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

Summary of findings

Ratings

Overall rating for Community Health Services for Children, Young People and Families

Requires Improvement



Are Community Health Services for Children, Young People and Families safe?

Requires Improvement



Are Community Health Services for Children, Young People and Families caring?

Good



Are Community Health Services for Children, Young People and Families effective?

Requires Improvement



Are Community Health Services for Children, Young People and Families responsive?

Requires Improvement



Are Community Health Services for Children, Young People and Families well-led?

Requires Improvement



Summary of findings

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Summary of findings

Overall summary

We found that children's and families services were caring but required improvement to be safe, effective and responsive to the needs of the local population.

There were systems in place for reporting and investigating incidents and there was evidence that learning from incidents occurred at a local level within teams. However, there was an inconsistent approach to reporting incidents and varied understanding of what constituted a reportable incident and near miss across the division. Safeguarding arrangements were embedded in practice and staff were well supported with regular safeguarding supervision. Risk assessments were carried out at a local level in order to provide safe care. However, recent restructuring of teams and records management systems had led to a potential increased risk in the safe management of caseloads.

The division provided a range of services both in the community and in schools, and teams aimed to provide a flexible service where possible. Teams worked well locally and had developed processes and effective ways of working. There was some evidence of shared learning across teams in pockets throughout the division. However the approach to shared learning across the division was not consistent.

The clinics we visited were clean and well maintained and staff followed infection control procedures. Staff were passionate about providing person centred care and understood the importance of engaging with families in order to understand their situation and the support they required. Patient experience surveys showed a high level of satisfaction with the services provided. Staff understood the needs of the local communities and there were several examples of local initiatives and joint working to promote care that would meet the needs of children and young people. The trust had tried to plan services to meet the needs of different children and young people through a redesign of the health visiting service and proposed restructuring of the speech and language service. However, staff did not feel engaged in the redesign process and as a result the trust did not fully appreciate the impact the changes would have. There

was little evidence that children, young people and their families who used the service had been involved in decisions about the service redesigns. In some cases, staff reported this had led to a loss of engagement.

Outcomes for children, young people and their families using the service varied when compared with other services and national targets; though there was evidence that performance was reviewed and actions were in place to improve outcomes across the different teams. There was good evidence of multidisciplinary team working and inter-agency working within the service but this was not consistent across all teams.

Staff aimed to assess and deliver treatment in line with current legislation, standards and recognised evidence-based guidance. However increased capacity, staffing issues, changes in commissioning contracts and service redesign had led to challenges in delivering the Healthy Child Programme and ability to meet waiting time targets for speech and language, occupational therapy and physiotherapy. We found there were insufficient numbers of staff to ensure the health, safety and welfare of people who used services.

Staff awareness of the trust's visions and values varied throughout the service. The managers and staff we spoke with were clear on the management structures within the division and staff reported they received good support from their direct line managers and team leaders. However, staff were not clear how the information was escalated to senior managers and taken into consideration.

We found mixed evidence of staff engagement with the trust board. There were some good examples of local engagement initiatives but very few of the staff we spoke with had attended one of the 'Big Conversation' meetings. The main reason given for non-attendance was not having the time due to work pressures. Throughout the division we found staff who were involved in initiatives and projects to develop and improve care for children, young people and their families. Staff showed they had a good understanding of the challenges faced by the local community and used a variety of methods to support learning, engagement and involvement.

Summary of findings

Background to the service

The children's and families division provides services across all geographical areas served by the Trust and include the following;

- Health visiting and social inclusion health visiting
- Children's complex needs and community matrons
- Children's dietetics
- School nursing
- Children's continence care
- Children's audiology
- Child protection and safeguarding
- Children's therapists (Speech and language, physiotherapy, occupational therapy)
- Family Nurse Partnership
- Youth Offending Teams
- Children's Walk in Centre

- Children's diabetes services
- Care of Next Infant
- Children's Liaison (based within acute hospitals)

The inspection of children's and families services was undertaken by 2 inspectors from CQC, a nurse (with experience in school nursing), a paediatric speech and language therapist, a clinical governance consultant (with experience in paediatric nursing) and a health visitor. We visited 18 services across 9 locations, went on 3 home visits, 2 school visits, and observed clinics. During our inspection we spoke to approximately 138 people, including families and children, and reviewed the information from comment cards received during the inspection.

Our inspection team

Our inspection team was led by:

Chair: Fiona Stephens, Clinical Quality Director, Medway Community Healthcare

Head of Inspection: Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; School Nurse, Health Visitor, GP, Nurse, Therapists, Senior Managers, and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

Liverpool Community Health NHS Trust was inspected as part of the second pilot phase of the new inspection process we are introducing for community health

services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

To get to the heart of patients' experiences 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?

The inspection team always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.

Summary of findings

2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

Before visiting, we reviewed a range of information we hold about Liverpool Community Health NHS Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between

13 and 15 May 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We visited 23 locations including three community inpatient facilities ward35 Aintree Hospital, and wards 9 and 11 in the Alexandra Wing, Broadgreen Hospital. The remaining locations included three walk-in centres and various community facilities. We carried out an unannounced visit on 13 May to the evening district nursing services.

What people who use the provider say

During our inspection we spoke with children, young people and their families. Overwhelmingly feedback on services was positive with patients indicating that they were listened to by their health professional and were involved in decisions about their care. Where negative comment was made this tended to be with regard to waiting times. People spoke highly of the staff and their caring and supportive approach.

Experience surveys showed a high level of satisfaction with the services provided. We looked at the experience

survey results for health visiting (February 2014), community matrons (April 2013), Sefton occupational therapy (February 2014) and Sefton physiotherapy (February 2014); 99% of respondents to the health visiting survey and 100% of respondents to the community matrons, physiotherapy and occupational therapy surveys said they had confidence and trust in the staff supporting them. In all four of the patient experience surveys we reviewed 100% of all respondents said they had been treated with dignity and respect.

Good practice

- The North Sefton Complex Care Team had good systems in place for ensuring staff were competent to carry out their roles, for example the development of evidence based competency training and assessment for non-professionals to enable them to carry out interventions, such as gastrostomy feeds, in either school or home settings.
- Drop in clinics were provided by health visitors and speech and language therapy teams to offer advice, support and a more flexible service.
- Speech and language therapists used Skype to carry out therapy sessions in schools. Teams across the division used iPads to access public health education information via a range of apps and the internet
- The continence team had been involved in the development and pilot of a catheter care passport to

promote patient understanding and self-care. The continence team also used self-help packs where relevant to support children and their families to manage their own treatment and care needs.

- The complex care team at North Sefton used a transition pathway to ensure all involved parties were aware of their responsibilities when supporting a young adult to move from child to adult services. A 'moving on' meeting was held when the child was 14 years old with all relevant multidisciplinary professionals in order to agree the transition plan. The team also aimed to coordinate review meetings with school reviews to ensure clear communication between health, social care and education.

Summary of findings

Areas for improvement

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

- The trust must ensure there are sufficient numbers of staff to provide safe, effective and responsive services. (Note – action a provider must take is associated with the issuing of a compliance action. In this case a compliance action against regulation 22 was still in force at the time of the inspection and further inspection activity will take place to assess compliance).
- The trust should take steps to address the issue that it is not currently meeting key areas of the Healthy Child Programme and waiting times for therapy services.
- The trust should ensure that health visitors have full oversight of their caseloads and ensure the relevant appropriate systems are in place to support this.
- The trust should ensure staff and people who use services are meaningfully engaged with cost improvement plans/service redesign plans to allow clear trust oversight of potential issues and impact of changes.
- The trust should ensure there is clear, effective leadership so that teams don't work in isolation of each other and there is shared learning to drive improvement and sharing of staff and resources.

- The trust should ensure there are effective mechanisms in place to share practice innovations across the division.
- In conjunction with commissioners the trust should ensure there are clear commissioning intentions and agreements for all services.
- The trust should continue to develop its integrated information technology systems to enable full integration and connectivity across the trust ensuring clear communication with and involvement of staff.
- The trust should ensure that all staff, including managers are aware of the organisations risk management policies and guidance including knowledge of incident reporting and management.
- The trust should take measures to protect the safety of all staff, and in particular lone working staff, in a consistent way.
- The trust should ensure newly qualified staff receive the time and support they require to be confident and competent to undertake relevant tasks such as immunisation and vaccination clinics.

Action the provider **COULD** take to improve

- Improve communication with staff regarding concerns raised, identified risks, management of staffing vacancies and management of change to ensure staff anxiety is reduced.

Liverpool Community Health NHS Trust

Community health services for children, young people and families

Detailed findings from this inspection

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

Requires Improvement



Are Community Health Services for Children, Young People and Families safe?

By safe, we mean that people are protected from abuse

Summary

There were systems in place for reporting and investigating incidents and there was evidence that learning from incidents occurred at a local level within teams. However, we found the reporting of incidents was inconsistent across services and there was limited evidence to demonstrate that learning was shared between teams and across the division. Systems were in place to protect people from abuse and staff were well supported with regular safeguarding supervision. However, recent restructuring of teams and records management systems had led to a potential increased risk in the safe management of caseloads and identification and monitoring of “at risk” children.

There had been a recruitment drive across all teams particularly in relation to health visiting services. Staffing

establishments had been reviewed to meet the needs of children, young people and their families using the service and ensure newly employed staff were evenly placed with more experienced members of staff. However, teams throughout the division were still carrying vacancies and we found there had been a high turnover of new staff in some of the health visiting teams. Risk assessments were carried out at a local level in order to provide safe care. Services had plans in place to manage and mitigate anticipated risks and major incidents. However as described, the provider did not always anticipate the possible risks associated with cost improvement plans or service redesign.

Incidents, reporting and learning

We found there were systems in place for reporting incidents. Staff told us they were aware of how to report

Are Community Health Services for Children, Young People and Families safe?

incidents and felt they were encouraged to report. However there were inconsistencies in reporting across services and understanding of what constituted a reportable incident or near miss. For example, the family nurse partnership (FNP) team would report serious incidents via Datix (i.e. an incident that did or may have resulted in harm) but did not report all minor or moderate incidents in a child or young person's home; instead these were recorded on a separate paper log sheet that was stored in the client's file. This meant there was a potential that reporting mechanisms did not always provide a complete and accurate picture of safety across the division.

Any serious untoward incidents (SUIs) including 'never events' was subject to a full root cause analysis investigation and a strategy meeting was held to determine the key facts, manage any immediate risks and make decisions to confirm the level of investigations required. This ensured there was a consistent approach to investigations using recognised best practice. No 'never events' had been reported in 2013 for the children's and families division. However there had been two child deaths reported, both of which occurred in the family home. The trust was awaiting the coroner's report for one of the incidents. For the second incident, the child was found to have died of natural causes. Both incidents had been fully investigated in line with the trust's policy.

The process for providing staff with feedback following an investigation varied between the different teams and locations. In the FNP written feedback, usually via email was given to the person who submitted the incident but in the majority of teams feedback was generally given via team meetings.

Minutes from team meetings, risk assessments and action plans showed learning from incidents took place within teams. Staff were able to describe where prompt action had been taken or lessons had been learned to improve practice. For example, we found there had been an incident reported on 29 October 2013 at one clinic where a baby had fallen from a clinic bed. A risk assessment was completed as a result and staff described the measures that had been put in place to avoid reoccurrence including ensuring a member of staff is always present and signage to remind parents not to leave their babies unattended when using the scales or clinic bed.

However, it was not clear if learning from this incident was shared between teams across the children and families

division. We found that two further similar incidents resulting in babies falling from weighing scales/off the clinic bed occurred at another clinic on 22 November 2013 and 27 January 2014. Again risk assessments had been completed following the events but this showed that the risk to children had increased through a lack of shared learning.

Cleanliness, infection control and hygiene

We found the clinics we visited were clean, tidy and in a good state of repair. Staff were seen to be adhering to the "bare below the elbows" policy and used personal protective equipment such as gloves and aprons appropriately. Staff washed their hands in line with best practice guidance and hand gel was available which staff used regularly. An annual audit completed at the Smithdown Children's Walk In Centre (WiC) for 2013/2014 showed the centre had good levels of compliance with infection prevention and control standards. An action plan was in place for identified areas of improvement which demonstrated that the provider was taking steps to address the issues.

Staff who worked remotely such as health visitors, school nurses and the complex care teams all had access to personal protective equipment and hand gel to take with them on visits. Staff we spoke with confirmed there was always enough stock available.

Medicines

Where the management of medicines was the responsibility of the trust, procedures were in place, but for the majority of children, young people and their families the medicines were held in their home and accessed by staff, from the child's supply. Medicines at the children's walk in centre were stored safely and appropriately in line with best practice guidance.

Medicines required for immunisation and vaccination clinics were transported to schools and clinics in line with the trust's medicine management policies. During our inspection we found there had been three incidents relating to issues with the cold chain storage of medicines. All three incidents were unrelated and had been fully investigated with local learning shared within the teams. One investigation report also stated that changes had been made to the Trust's cold chain policy as a result of learning from the incident.

Are Community Health Services for Children, Young People and Families safe?

Safeguarding

Staff were confident about safeguarding children; they were aware of the local authority procedures and were well supported with regular safeguarding supervision every three months. Staff reported that they were able to access additional support when it was needed from the safeguarding leads both within the organisation and the local authority. Staff received training in safeguarding children, 100% of staff had completed level 4 safeguarding children training, 88% had completed level 3, 77% level 2 and 66% had level 1.

Health visitors routinely attended serious case reviews. However staff told us that following the restructure the safeguarding team no longer attended the meetings routinely but would only attend to support a new health visitor. They reported this had put additional pressure on them and reduced the oversight the safeguarding team had of ongoing issues.

At the children's walk in centre, the central administration system (CAS) was updated monthly to include new looked after children and child protection plan cases with a flag alert and remove closed cases so that all staff were aware if any known vulnerable children attended the clinic.

Records

In September 2013 the health visiting service was redesigned. As part of the redesign certain nurses moved from health visiting to school nursing for line management and caseload duties. Staff told us this had been a difficult change to manage as there had been little transition period to allow for a robust handover.

We found that the electronic record systems were not fully in place to support these changes. At the same time the filing of paper records was changed in line with best practice guidance so that records were stored in date of birth order rather than under each caseload holder. This was to aid clerical and administration staff who would be supporting the teams but meant that staff did not have clear oversight of their portfolios and this had led to some children being 'lost' in the system.

For example, one member of staff told us they had gone to perform a home visit for one child only to discover there was a second child also living at the home. The children's services manager explained that this issue had been identified and data analysts had been recruited to rectify

the situation so that EMIS (an electronic medical records system) would allow staff to view their caseloads. In the meantime, the manager told us that staff should be able to identify their caseloads by using their 'birth book'.

The changes had also led to a delay in the transfer of records from health visitors to school nurses. In turn school nurses reported they were faced with a backlog of records to review which meant delays in reviews of potentially 'at risk' children. Staff also reported that records were not arriving on time for children going into special schools and due to the changes in caseloads they could not track down the health visitor who had been previously responsible. However we found that any children going into special schools who were potential safeguarding risks were identified beforehand and their records were sent separately to ensure they weren't missed.

Lone and remote working

Lone and remote working arrangements varied across the division. Staff told us they did not always feel safe when performing home visits. For example, one person told us couldn't get in contact with their base following a home visit incident as there was no formal buddying system or end of day process. Staff also reported that recent changes to caseloads meant that there was a lack of knowledge of where potential joint visits may be required.

Assessing and responding to patient risk

Individual teams demonstrated ways they assessed and responded to risk in order to provide a safe service for children, young people and their families. For example, staff at the children's walk in centre used the Manchester triage system to assess and prioritise patients' needs.

Staffing levels and caseload

Staffing establishments had been reviewed to meet the needs of children, young people and their families using the service and ensure newly employed staff were evenly placed with more experienced members of staff. However staff were unhappy that they had not been fully consulted in the process. They reported that changes to caseloads had led to a loss of local knowledge that in many cases had been built over a sustained period of time.

There had been a recruitment drive across all teams particularly in relation to the Call to Action plan. Call to Action is a government initiative to expand and strengthen health visiting services. However, teams throughout the division were still carrying vacancies and some health

Are Community Health Services for Children, Young People and Families safe?

visiting teams reported there had been a high turnover of new staff. Managers explained that where possible, caseloads were weighted and allocated depending on the level of need of the patients and the demand on staff.

We found risk assessments had been carried out at local level in relation to staff shortages due to staff leaving and planned staff sickness. However it was not clear how the information was then used effectively to avoid staffing issues. For example, the physiotherapy team was short staffed due to retirement and long term sickness. Staff felt that with better forward planning the situation could have been avoided. We found that a risk assessment had been completed, though it was not dated so it wasn't clear when it had been written; the issue had been escalated to the area manager in January 2014.

The children's and families' division monthly performance report March – April 2014 also indicated there was a high level of staff sickness. The trust's overall sickness absence

rate was 5.8% (target was 4.6% with a benchmark of 5.6%). The children's and families division's sickness absence rate was 5.4% and the rate for health visitors and school nurses specifically was 6.7%.

Managing anticipated risks

Services had plans in place to manage and mitigate anticipated risks including changes in demand, disruptions to facilities or period incidents such as bad weather. For example the children's walk in centre had access to bank staff that were familiar with the service in the event of busy periods or staff sickness. The complex care team had plans in place to cope in the event of bad weather.

Major incident awareness and training

Services had identified possible major incident risks and plans were in place to manage these. For example there was an emergency evacuation plan in place at the children's walk in centre. Records showed staff participated in an emergency evacuation drill twice a year.

Are Community Health Services for Children, Young People and Families 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

Staff assessed and delivered treatment in line with current legislation, standards and recognised evidence-based guidance. Outcomes for children, young people and their families using the service varied when compared with other services and national targets; though there was evidence that performance was reviewed and actions were in place to improve outcomes across the different teams. There was good evidence of multidisciplinary team working and inter-agency working within the service but this was not consistent across all teams. Care pathways were used by different teams to ensure a standardised approach to care.

There were systems in place to ensure that staff, equipment and facilities enabled the effective delivery of care and treatment. All staff received mandatory training in a range of areas. The trust had recently moved to a new programme for providing mandatory training which staff reported would be more efficient in the long term and would improve mandatory training attendance. However, some new health visiting staff told us they felt they had to 'step up' very quickly to undertake immunisation and vaccination clinics. We found staff received a formal annual appraisal though clinical supervision processes were informal and varied from team to team.

Evidence based care and treatment

In most cases children and young people's needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence-based guidance. For example, the trust had a family nurse partnership (FNP) team in Liverpool. The FNP is a voluntary health visiting programme for first time mothers that are underpinned by internationally recognised evidence based guidelines. The speech and language team (SALT) used a risk assessment tool based on the Malcolmss Care Aims philosophy in order to triage patients and identify their needs. The model aims to provide a standardised way of capturing and communicating clinical reasoning and an ability to focus resources effectively by being outcomes driven and not demand led.

Health visiting and school nursing teams aimed to work in accordance with the Healthy Child Programme. The

Healthy Child Programme is an early intervention and prevention public health programme that offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices. The Healthy Child Programme identifies key opportunities for undertaking developmental reviews that services should aim to perform.

All health visitors, midwives and nurses we spoke with were aware of the guidelines relevant to their sphere of practice and were working to support their success.

Patient outcomes

Outcomes for children, families and young adults using the service varied when compared with other services and national targets. For example, the FNP annual audit report 2013 found the Liverpool FNP team had met three out of five targets in the pregnancy stage, four out of five targets in the infancy stage (improvement on 2012) and one out of five targets in toddlerhood stage. The report showed performance had been reviewed and actions were in place to improve outcomes. For example, network meetings had been established with young parents' workers from children's centres and Connexions to support partnership working, strengthen referral pathways and manage transition from FNP to universal services.

An assessment of one of the health visiting teams against the UNICEF UK Baby Friendly Initiative standards in January 2014 found the team had met 42 out of the 44 specified criteria. However, the trust's quarterly report for the Healthy Child Programme (Quarter 4, 2013) indicated that new birth visits were not being undertaken consistently in line with the requirements of the programme. Only 24% of infants in Liverpool and 48% in Sefton received a face-to-face new birth visit within 14 days from birth. The report also stated that 72% (Liverpool) and 43% (Sefton) of new parents received a face-to-face new birth visit after 14 days from birth but it did not specify how long after the 14 days. The Healthy Child Programme stipulates that a new baby review should take place by 14

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days with mother and father in order to assess maternal mental health and discuss issues such as infant feeding (to increase the uptake of breast feeding) and how to reduce the risks of sudden infant death syndrome.

Health visiting teams provided a service to children from 0-4 years at which stage children would then move to the school nursing teams from 4-19 years. From speaking with staff it was clear that they were committed to providing a good service with a smooth transition between teams. However, as previously described, the service redesign and changes to the records management systems had impacted on their ability to deliver this service.

There had been initiatives to improve support to parents in a number of areas which had resulted in positive outcomes. For example, due to increased demand and extended waiting times, the SALT team had set up drop in sessions to try and support parents and children who were on the waiting list. The aim was to reduce parental anxiety and provide faster access to advice possibly reducing the need for SALT referral or reduced length of SALT input. Feedback from parents using the service after a three month pilot was positive.

Competent staff

There were systems in place to ensure that staff, equipment and facilities enabled the effective delivery of care and treatment.

All staff received mandatory training in a range of areas including infection control, safeguarding and record keeping. Overall the children's division had an 80% compliance rate with completion of mandatory training. The trust had recently moved to a new programme for providing mandatory training which meant there had been some delays in renewing training. All staff were however booked to attend in the next 12 months. Staff and managers reported the new process would be more efficient in the long term and would make it easier for them to attend mandatory training.

All newly qualified staff were offered a preceptorship. However concerns were identified that the presence of newly qualified staff whilst good for the long term, did put additional pressure on more experienced staff who were also acting as preceptors. We spoke with some of the newly qualified health visitors and they told us they were aware of this and felt they had to 'step up' very quickly to undertake

immunisation and vaccination clinics. We found staff received a formal annual appraisal though clinical supervision processes were informal and varied from team to team.

We identified good practice for ensuring staff were competent to carry out their roles, for example the development of evidence based competency training and assessment for non-professionals to enable them to carry out interventions, such as gastrostomy feeds, in either school or home settings.

Use of equipment and facilities

The clinics we visited were well maintained and were decorated in a suitable manner to meet the needs of children. For example, Smithdown Walk in Centre was decorated with brightly coloured posters and information leaflets were displayed along with pictures that children had painted in order to make the environment more welcoming for children and young people.

The complex care team in North Sefton reported they had good access to equipment from the local acute hospital which was readily available and delivered promptly. However we found that equipment for one of the teams was being ordered by a member of administration staff who did not have the adequate knowledge of the items required (e.g. tracheostomies). When items were requested the order had to be approved by a manager in order to ensure they were correct. However, managers were not always able to access the electronic ordering system when working remotely and this had led to delays in obtaining the right equipment. In some cases this meant staff had to go back to the local acute hospital in order to obtain equipment in time to meet people's needs.

We found equipment such as weighing scales were maintained and calibrated in line with manufacturer's guidance. The children's walk in centre had clear environment and equipment maintenance records in place which supported this. Their records also showed that estates requests were handled quickly and efficiently to ensure the property was well maintained.

Multi-disciplinary working and working with others

There was good evidence of multidisciplinary team working and inter-agency working within the service though this was not consistent across all teams. For example, we found the complex care team in North Sefton had clear processes

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in place for transition from child to adult services. However, the trust's NICE update report identified that there was a "significant gap in current practice" to ensure that the multidisciplinary team had a central role in transition to prepare young people and their parents or carers for transfer to adult services. An action plan was in place which identified that the occupational therapy team had developed complex needs pathways that were awaiting approval. The physiotherapy team also planned to develop a pathway and the trust aimed to implement a transition in to adult services educational healthcare system. However there was no date provided for the completion of these actions.

Co-ordinated integrated care pathways

Care pathways were used by different teams across the service to ensure a standardised approach to care. For example, the speech and language therapy team were developing a neurodevelopment pathway to address the increase in demand for the service.

Health visitors used a perinatal mental health pathway to identify mothers at risk of developing post natal depression. The pathway was based on NICE guidance and was followed from the initial birth visit through to the 12 month visit. A clear flowchart and guidance document were in place to support staff in how to complete the pathway and identify appropriate interventions that may be required.

We found the complex care team at North Sefton used a transition pathway to ensure all involved parties were aware of their responsibilities when supporting a young adult to move from child to adult services. A 'moving on' meeting was held when the child was 14 years old with all relevant multidisciplinary professionals in order to agree the transition plan. The team also aimed to coordinate review meetings with school reviews to ensure clear communication between health, social care and education.

Are Community Health Services for Children, Young People and Families caring?

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

Summary

Staff were passionate about providing care centred on the needs of children, young people and their families and recognised the importance of engaging with families in order to understand their situation and the support they required. Patient experience surveys showed a high level of satisfaction with the services provided. Children, young people and their families who used the service felt they had been treated with dignity and respect, and received support to cope emotionally with their treatment and care. We found all the staff we spoke with were child and family focused and they looked at the family unit when completing their assessments.

Compassionate care

All the staff we spoke with were passionate about providing good quality, person centred care. Staff were clear about the importance of engaging with families in order to understand their situation and the support they required.

We looked at the patient experience survey results for health visiting (February 2014), community matrons (April 2013), Sefton occupational therapy (February 2014) and Sefton physiotherapy (February 2014). All the surveys showed high levels of patient satisfaction with the services provided. 99% of respondents to the health visiting survey and 100% of respondents to the community matrons, physiotherapy and occupational therapy surveys said they had confidence and trust in the staff supporting them.

During our inspection we spoke with children and young people who used the service and their families. All the people we spoke with were happy with the service they received. People spoke highly of the staff and their caring and supportive approach. For example, one parent told us they had received a: "Brilliant service, very helpful." Another person told us they were: "We're very happy with the service."

Dignity and respect

During our inspection we observed staff to be polite, supportive and respectful in their approach when speaking with children, young people and their families. We spoke with a school nurse team leader who clearly illustrated where their responsibilities lay in supporting young adults

and the need to assess competence and respect confidentiality. They also described how they were able to have the right conversation with young people when there were matters disclosed that could not remain confidential.

In all four of the patient experience surveys we reviewed 100% of all respondents said they had been treated with dignity and respect.

Patient understanding and involvement

It was clear from discussions with families and professionals that children, young people and families were involved in the decisions about the care they received. The assessment processes and on going assessments included goal setting and were revisited on a regular basis to ensure progress was being made. All staff discussed the use of multi-disciplinary team working to identify and assist in developing children to their potential.

The trust provided a range of information to support children and families. All professionals we spoke with were clear that time must be spent with parents and children to assist them in understanding the choices available to them. Staff showed they had a good understanding of the challenges faced by the local community and used a variety of methods to support learning, engagement and involvement. For example, the FNP team used a range of visual aids to support parents to understand the benefits of breast feeding, staff across the service used iPads to access public health education information via a range of apps and the internet and the SALT team used Skype to carry out therapy sessions remotely.

The service had good access to a range of interpreters via global access and language line. Health visitors and the FNP team explained that they would always try to keep the same interpreter where possible in order to build relationships with families.

Of the 201 respondents to the health visiting survey, 99% said they had been involved in decisions relating to care and treatment; 90% said the health visitor had explained treatment in a way they completely understood and 9% in way they mostly understood.

Are Community Health Services for Children, Young People and Families caring?

Emotional support

Children, young people and their families received support to cope emotionally with their treatment and care. We found all the staff we spoke with were child and family focused and they looked at the family unit when completing their assessments. In some cases it was clear that staff worked with families as well as the children and young people. Families were referred for emotional and mental health support to help them develop their relationships. For example, we saw one example of extensive support provided to a mother who had suffered from post-natal depression. The family told us they

appreciated the support and guidance the health visitor had offered to enable the family to cope during such a difficult time. We found perinatal and post natal maternal mental health assessments were undertaken at key stages throughout pregnancy and after birth.

Promotion of self-care

Where possible children and their families were supported to manage their own treatment and care needs. For example, the continence team used self-help packs where relevant and staff reported that in some cases this had resulted in patients not requiring the service.

Are Community Health Services for Children, Young People and Families responsive to people's needs?

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

Summary

Staff understood the needs of the local communities and there were several examples of local initiatives and joint working to promote care that would meet the needs of children, young people and their families. The trust had tried to plan services to meet the needs of different children and young people through a redesign of the health visiting service and proposed restructuring of the speech and language service. However, we found that staff did not feel engaged in the redesign process and as a result the trust did not fully appreciate the impact the changes would have. Changes to the commissioning contract along with the redesign of the health visiting service had greatly impacted on the service's ability to deliver key areas of the Healthy Child Programme. Similarly, a lack of staff and changes to the children's surgical pathway had led to increased waiting times in the physiotherapy service.

The division provided a range of services both in the community and in schools and teams aimed to provide a flexible service where possible. Teams worked well locally and had developed processes and effective ways of working. There was some evidence of shared learning across teams in pockets throughout the division. However the approach to shared learning across the division was not consistent. There were systems in place to support children's discharge from hospital though again this varied between areas. There was evidence that services actively encouraged feedback from people who used services and responded to complaints appropriately.

Service planning and delivery to meet the needs of different people

There was evidence that the trust had endeavoured to plan services to meet the needs of children, young people and families through a redesign of the health visiting service and proposed restructuring of the speech and language service. For example, the aim of the health visiting service redesign was to ensure a universal ante-natal programme could be provided across Liverpool and Sefton and recognised the different challenges faced in the two areas.

We found that staff did not feel engaged in the redesign process and as a result the trust did not fully appreciate the impact the changes had had. At the same time there had been a change in the commissioning contract to continue

to deliver the 0-5 years immunisations for a further 2 years. As a result this had greatly impacted on the ability of the health visitor service to deliver against key areas of the Healthy Child Programme and staff told us they did not have as much time to spend on health promotion. For example, one of the health visiting teams told us they had to cancel new birth visits in order to undertake immunisation and vaccination clinics. While another reported they were not meeting requirements for ante-natal visits; although a pathway had been developed which they planned to pilot in the near future.

Staff understood the needs of the local communities and there were several examples of local initiatives and joint working to promote care that would meet the needs of children, young people and families. For example, health visiting teams worked closely with children's centres that provided a variety of classes and services such as ante-natal classes, adult education, baby massage classes and breakfast clubs. The centres also signposted parents to other trust services including baby clinics, health visitor drop in clinics and immunisation clinics. The continence team worked closely with the local acute trust and other providers to ensure pathways were followed consistently across all areas.

We found there were inconsistencies in approach across the different teams and most notably there were differences between the Liverpool and Sefton areas. We found the complex care team in North Sefton worked well with the local acute trust to ensure effective discharge from hospital but the same processes were not in place in Liverpool. There was some evidence of shared learning across teams in pockets throughout the division. For example, the manager of the family nurse partnership (FNP) reported that health visitors had adopted the "ages and stages" development review tools to aid their assessments. However the approach to shared learning across the division was not consistent.

Access to care as close to home as possible

The division provided a range of services both in the community and in schools. In addition to home visits, clinics and drop in sessions were held by health visitors throughout Liverpool and Sefton in GP practices, health centres and children's centres. Therapy services were

Are Community Health Services for Children, Young People and Families responsive to people's needs?

provided in schools (mainstream and special schools). The trust also has the only children's walk in centre in the United Kingdom. Smithdown Children's Walk in Centre is specifically designed for the care of children 0 - 15 years with minor injuries and minor ailments, and is an open access service (no appointment required).

Access to the right care at the right time

Staff aimed to provide a flexible approach to the provision of their service and ensure people had access to the right care at the right time. For example, in 2011 the FNP team had identified that they needed to refine their service to offer support for more vulnerable individuals such as young adults aged 17 years and under. The service had adapted to meet these needs.

We found that waiting times for speech and language therapy services had increased to 26 weeks (against a target of 18 weeks) mainly due to an increase in sensory assessment referrals. In response to increased demands and waiting times, we found the speech and language therapy (SALT) team had set up drop in sessions to try and support parents and children who were on the waiting list. The aim was to reduce parental anxiety and provide faster access to advice possibly reducing the need for SALT referral or reduced length of SALT input. A review of the impact of the drop in centres after the first three months was undertaken and parents' feedback was positive. Similarly the physiotherapy service reported a waiting time of approximately 24 weeks. We found that new pathways in children's surgery had had a significant impact on physiotherapists' caseloads. Staff reported that work was on going with the clinical commissioning group and the acute trusts to try and address concerns.

Meeting the needs of individuals

Staff we spoke with demonstrated an awareness of the cultural diversity and issues within their local communities and explained how this could be taken into consideration when assessing and planning treatment and care needs. The service had good access to a range of interpreters via global access and language line. Health visitors and the FNP team explained that they would always try to keep the same interpreter where possible in order to build relationships with families.

Support for children with long term conditions was shared with other agencies to ensure a multidisciplinary approach that was based on individual needs. In addition, systems were in place to ensure non-professionals were

appropriately trained to provide specialist interventions such as evidence based competency training and assessment for as gastrostomy feeds, in either school or home settings.

We also found that the continence service saw palliative care referrals within one day and all other referrals within three days; this was in line with local targets. A triage process was in place to ensure individual needs could be prioritised and met.

Moving between services

When a child reaches school age, the management of their health care needs moves from the health visitor to the school nurse. A health assessment for all children is carried out when they start school. Following the service re-design, delays in the transfer of records between the health visiting service and the school nursing service had led to a backlog of assessments for the children moving into the school nursing service. This also meant there had been delays in reviews of potentially 'at risk' children.

There were systems in place to support children's discharge from hospital though this varied across areas. The complex care team in North Sefton worked well with the local acute trust to ensure effective discharge from hospital but the community matron's team reported that the same processes were not in place in Liverpool which meant children were often discharged with limited notice beforehand.

We found the complex care team at North Sefton used a transition pathway to ensure all involved parties were aware of their responsibilities when supporting a young adult to move from child to adult services. A 'moving on' meeting was held when the child was 14 years old with all relevant multidisciplinary professionals in order to agree the transition plan. The team also aimed to coordinate review meetings with school reviews to ensure clear communication between health, social care and education.

Complaints handling (for this service) and learning from feedback

There were posters displayed and leaflets available about how to make a complaint in the children's walk in centre and all the various health centres we visited. However, staff recognised that children, young people and families they supported may not be inclined to make formal complaints and so the emphasis was on local resolution at the time

Are Community Health Services for Children, Young People and Families responsive to people's needs?

dissatisfaction was expressed or issues were raised. Staff were able to describe how they managed verbal complaints including offering to arrange a meeting between the complainant and the team manager.

We saw examples of formal complaints that had been received and fully investigated in line with the trust's complaints policy. This included one complaint that was taken to a Board review. The complainant was invited to attend a board meeting to discuss their complaint and the manager of the service was asked to explain what action had been taken. The complaint was resolved to the person's satisfaction and learning from the complaint was evident.

Whilst local management and learning from complaints was evident, staff also told us that it was not always clear what action had been taken by the trust when issues had

been escalated for further investigation and action. For example, the continence team had received complaints from patients who had been unable to get through to the service as it only had one telephone line. Staff emphasised that telephone access was an important part of their service. At the time of our inspection the risk had been escalated but staff hadn't received any feedback.

There was evidence that services actively encouraged feedback from people. We found services had undertaken patient satisfaction surveys all of which showed high levels of satisfaction and positive feedback from people who used the service. Where areas for improvement had been highlighted, an action plan was in place to address the issues. The FNP also invited someone who had used the service to the annual review in order to share their experiences.

Are Community Health Services for Children, Young People and Families 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

Staff awareness of the trust's visions and values varied through the service. The managers and staff we spoke with were clear on the management structures within the division and staff reported they received good support from their direct line managers and team leaders. However, staff were not clear on how decisions were taken corporately.

Throughout the division we found staff who were involved in initiatives and projects to develop and improve care. We found the division had undertaken patient surveys across different teams. Surveys we reviewed demonstrated high levels of patient satisfaction with the services provided. However, staff reported there had been little, if any, patient involvement with the health visiting service redesign and so some families did not know they would get a new health visitor; in some cases this has led to loss of engagement. We found mixed evidence of staff engagement. There were some good examples of local engagement initiatives but very few of the staff we spoke with had attended one of the 'Listening into Action' meetings due to work pressures.

Vision and strategy for this service

Staff awareness of the trust's visions and values varied throughout the service. Some staff told us that the visibility of the board had improved in the last 12 months. For example, we found that one of the non-executive directors had attended a North Sefton complex care team meeting. Other staff told us the board's main focus seemed to be on achieving foundation trust status but felt they would have more chance of achieving it if the board listened to staff more.

Staff recognised the trust's vision for the health visiting service was to ensure a universal ante-natal programme could be provided across Liverpool and Sefton. However, they told us the decision had been made to change the service without meaningful consultation with them or people who used the service. We found staff had been offered one to one meetings to discuss their concerns but there was a perception amongst staff that the "decision had already been made".

Governance, risk management and quality measurement

The managers and staff we spoke with were clear on the management structures within the division, the responsibilities of their individual role, who they reported to and when they should escalate decisions or concerns. Staff were not clear about the decision making process by the board. However we found the division maintained a risk register which in the main reflected the issues we found during our inspection.

The children's division performance report was produced monthly which highlighted service performance against targets and there was some evidence of this information being used to target service improvements. For example, the therapies and continence teams had targeted DNA rates (Did not attend) and as a result had seen a reduction in the overall rate of DNA incidences.

Whilst staff could describe the management structure within the division up to divisional senior management level, they were not as aware of the governance structure within the trust and how groups such as the clinical effectiveness group or the patient safety group fitted into that structure. However, we did find that learning and actions were cascaded via senior management meetings, team leader meetings and local team meetings and minutes from these meetings confirmed this.

Leadership of this service

Staff reported they received good support from their direct line managers and team leaders but several comments were made that suggested a disconnect or breakdown in communication between middle management and the board. For example, one member of staff told us: "Things seem to get above band 8 but then disappear in to the ether and nothing ever happens."

Interviews with senior divisional management staff indicated that there was a lack of full understanding of the depth of the issues and the serious impact it was having on staff. For example, one senior manager told us that newly appointed health visitors were leaving because they had jobs closer to home but health visitors told us it was due to the poor systems and lack of support.

Are Community Health Services for Children, Young People and Families well-led?

Culture within this service

During our inspection we asked staff about the culture within the children's division. We found that there had been an improvement in the culture and the majority of staff told us they felt comfortable raising concerns and reporting incidents. In the 2013 NHS staff survey the trust were rated better than average in six out of 28 areas. Areas where the trust was performing well included: Percentage of staff able to contribute towards improvements at work, work pressure felt by staff and percentage of staff working extra hours.

The trust were rated worse than average in 11 out of the 28 areas including: Percentage of staff experiencing harassment, bullying or abuse from staff in the 12 months leading to the survey; Percentage of staff feeling pressure to attend work when feeling unwell in the 3 months leading to the survey and Staff motivation at work. However due to staff shortages, staff across the different teams including physiotherapy, speech and language therapy, occupational therapy, health visiting and school nursing reported feeling pressurised due to work commitments.

There was a high level of anxiety amongst staff regarding the changes that had and were occurring either as part of individual service redesign or as part of more generic changes such as the move into hubs. During one focus group staff told us: "[We] dread going on leave because [we] dread what [we] will find on return."

Public and staff engagement

We found the division had undertaken surveys across the different teams. We looked at the survey results for health visiting (February 2014), community matrons (April 2013), Sefton occupational therapy (February 2014) and Sefton physiotherapy (February 2014). All the surveys showed high levels of satisfaction with the services provided. However, staff reported there had been little, if any, involvement with the health visiting service redesign and so some families did not know they would get a new health visitor; in some cases this has led to loss of engagement.

We found mixed evidence of staff engagement. There were some good examples of staff engagement initiatives at a local level. For example, one of the school nursing teams utilised the trust "Team talk" monthly newsletter to discuss issues and on going work in the trust as part of team meetings. The majority of staff we spoke with knew about the "Listening into Action" meetings that had been held by the trust. However, very few of the staff we spoke with had

actually attended one of the meetings. The main reason given for non-attendance was not having the time due to work pressures. Overall, discussions with staff either in interviews or focus groups indicated that staff felt they had not been fully involved in the changes that had occurred within the division.

Innovation, improvement and sustainability

Throughout the division we found staff who were involved in initiatives and projects to develop and improve care. Examples of this were the development of drop in clinics provided by health visitors and therapies teams to offer advice, support and a more flexible service, the use of Skype by therapists to carry out therapy sessions in schools and the development and pilot of a catheter care passport to promote understanding and self-care.

The trust was one of three in the country participating in a pilot run by the Royal College of Paediatrics and Child Health for the e-Redbook. The eRedbook is an online personal child health record based on the existing, paper-based, Redbook. It is designed to allow parents/carers to maintain records of their child's health online. Although not fully rolled out across the division, staff were being provided with iPads that enabled remote access to information such as NICE guidelines and the British National Formulary. We saw how staff were using iPads to engage patients and improve learning and health promotion during home visits.

At the time of our inspection the trust was in the process of moving teams from locations based within health centres to centralised 'hubs' with better facilities in order to promote flexible and integrated working. However, there was a concern amongst staff that the hubs were not in accessible locations and as result teams would be less visible in the community. Similarly staff told us that due to the location of some of the hubs, they had to travel further meaning they had reduced the amount of home visits they could perform.

The trust recognised that the children's and families division needed to change in order to provide a sustainable, fair and integrated service across Liverpool and Sefton and had taken action in the form of service redesigns to address this. However the provider did not always anticipate the possible risks associated with cost improvement plans. For example, a quality impact assessment was completed 7 May 2013 to anticipate the potential impact the health visiting service redesign would

Are Community Health Services for Children, Young People and Families well-led?

have. However, staff told us they were not involved with the initial assessment and as a result the trust did not have clear sight of the potential impact on patient safety that the restructuring could have. Following staff feedback, the assessment was reviewed on 3 October 2013 and one to one meetings were held with staff to discuss concerns. Similarly, speech and language therapy staff told us there

had been a lack of engagement and trust understanding of the potential impact that proposed cost improvement plans to their service may have. In response, the service had submitted an alternative proposal which was being reviewed. It was felt that earlier consultation with the service could have avoided this.