Central Manchester University Hospitals NHS Foundation Trust

RW3

Community health services for children, young people and families

Quality Report

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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)
RW3LP	Longsight Health Centre	Community Children's services	M13 0RR
RW3X4	Newton Heath Health Centre	Community Children's services	M40 2JF
RW3CL	Chorlton Health Centre	Community Children's services	M21 9NJ
RW3MH	Moss Side Health Centre	Community Children's services	M14 4GP

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated community health services for children, young people and families as 'requires improvement' overall because;

Staff were familiar with the safeguarding policy and procedures and had an effective working relationship with the trust's safeguarding team.

A daily child protection clinic was held by community paediatricians who would see any child where a professional had raised safeguarding concerns.

Records were stored securely and were accessible to health visitors and health professionals as appropriate. We observed contemporaneous record keeping that reflected national guidance. However documentation audits were requested from the trust but not received in order to provide assurance on the standard of the records.

Although 57% of the school age population in the Manchester area were from ethnic minority groups, appointment letters were only sent out in the English language. Staff had not raised this as a concern. Staff did have access to a translation service, which included telephone services. However, staff told us they did not utilise this to arrange initial appointments.

The environment and some equipment used by health visitors at Longsight Health Centre was not fit for purpose. There was evidence of rodent infestation within the building, a ripped baby changing mat, visible dust on service tops and window shutters, and baby weighing scales balanced unsafely on a stand. Risk assessments completed prior to the clinics did not identify the main risks. Also at Longsight Health Centre we observed a poor level of hygiene in respect of dirty stairwells, clinical and storage areas. We observed two out of five vaccination fridges, at Alexandra Park, that were visibly dirty. The fridge temperatures were not checked daily as per the trust policy and we found one fridge that was only checked on seven occasions throughout October 2015 which was against trust policy.

Patients received care in line with current evidence-based guidance and standards. Policies and procedures were in place and staff were aware of how to access them. Frequent audits were completed and subsequent action plans implemented.

Incidents were reported via an electronic reporting system within community children and young people's services. The incidents reported were predominantly in relation to personal accident or injury, which resulted in no harm. However, other incidents staff told us about, such as delays in the completion of development checks, dirty clinical rooms and difficulties with IT, were not reported on the system. Staff gave examples of where positive changes had been implemented in practice.

The services were delivered by caring, committed and compassionate staff who treated people with dignity and respect. Staff actively involved young people and those close to them in all aspects of their care. The service met the needs of the children, young people and their families. Services were planned and delivered in a way that met the needs of the local population. However, the heath visiting service were only compliant with the trust target of 95% completion for the new birth visit. They were not compliant with the trust target of 95 % completion for antenatal contacts (maximum compliance of 20%, July 2015) and two year developmental reviews (average 50% compliance). The service as a whole was meeting their key performance indicators for referral to assessment times. For all services we inspected, the referral to assessment time was less than 12 weeks.

The strategy for the services was aligned with the trust's operational strategy and staff were aware of the trust's vision and values. However, there was no clear strategy for the engagement of the diverse population including those form a BME background. Regular team meetings were held in each community children's team where governance and risk were standard agenda items. There was an overarching risk register and local risk registers held by each service.

However we found not all identified risks were on the risk register, such as non-compliance of antenatal contacts and development reviews, lack of IT connectivity and a lack of cleanliness at Longsight health centre. Risk

Summary of findings

assessments were completed prior to well-baby clinics but these did not identify all the risks. We found some equipment used by health visitors at Longsight health centre was not fit for purpose. Risk assessments completed prior to the clinics did not identify the main risks.

Summary of findings

Background to the service

Central Manchester University Hospitals NHS Foundation Trust provides city wide services across the Manchester area for children, young people and families. Approximately 129, 700 children from antenatal to 18 years of age are provided with care and treatment by the children's community services.

Services provided by the trust include health visiting, school nursing, healthy schools, paediatric continence service, family nurse partnership, speech and language therapy, orthoptists, and a homeless families' service. Specialist services are provided in the areas of special needs school nursing, physiotherapy, occupational therapy, community paediatric consultants, community children's nursing and palliative care.

The health visiting service visits families with children from birth to school age and school nursing services support children from school entry until 16 years of age. Services are provided in clinic settings, as drop-in sessions, and within the school environment. A large number of children and families are seen in their own homes or temporary accommodation.

The Family Nurse Partnership programme provides intensive support to young mothers and their children up to two years of age.

Community health services for children, young people and their families provide services in both the community and in schools, and teams aim to provide a flexible service where possible.

Our inspection team

Our inspection team was led by:

Chair: Nick Hulme, Chief Executive, The Ipswich Hospital NHS Trust

Team Leader: Ann Ford, Care Quality Commission

The team inspecting community health services for children, young people and their families included a CQC inspector (with previous experience of working in community children's services), a school nurse and a health visitor (specialist advisors).

Why we carried out this inspection

We carried out this inspection as part of our comprehensive inspection of Central Manchester University Hospitals NHS Foundation Trust.

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 the trust, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit between 11 November 2015 and 13 November 2015.

We spoke with a large number of staff including the children and families clinical services managers and professional leads. We also spoke with health visitors, school nurses, clerical officers, practice teachers, sexual health practitioners, school health care assistants,

Summary of findings

healthy schools staff, homeless families health visitors, family nurse practitioners, children's continence team, team leaders, speech and language therapists, physiotherapist, occupational therapists, orthoptists and infant feeding coordinators.

We visited clinics in different areas of Manchester. These included the Newton Heath Health Centre, Newton Silk Mill, Moss Side Health Centre, Staincliffe Road Offices, Chorlton Health Centre, Clayton Health Centre, Gorton Clinic Therapy Centre, Charleston Road Health Centre, Longsight Health Centre and New Moston library.

During the inspection, we also held focus groups with health visitors and school nurses who worked within the service. We reviewed over 13 sets of records and used information provided by the trust and information we had requested to inform our inspection.

We spoke with children, young people, their families, relatives and representatives. We observed a well- baby clinic.

What people who use the provider say

People who use the service told us they were treated with respect and dignity and that they had been communicated with in a clear and friendly manner.

Comments we received via comments boxes that were left in each community location were extremely positive about the care and support received. Some comments noted that the environments in some clinics (Longsight Health Centre in particular) were poor and required improvement

Good practice

- The special needs nursing team had developed a multiple health needs training package that was delivered to the local authority and education to educate all staff, including transport, youth group workers and any local initiatives, who came into contact with a child with complex health needs. This ensured they knew the signs to look for if a child's condition deteriorated and what immediate support the child or young person would need. At the time of the inspection several hundred people had gone through this training.
- The healthy schools team delivered bespoke training packages in school dependent on the identified need of the school. Training was also delivered to teachers in the form of staff workshops.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider must:

- Ensure all clinics and services are provided in suitably maintained environments and that monitoring systems are robust and highlight any issues and risks in a timely manner.

The provider should:

- Take action to ensure the health visiting service is meeting all key targets of the healthy child programme.
- Ensure the departmental risk register reflects all identified risks.
- Take action to ensure all clinical incidents are reported appropriately via the electronic reporting system.
- Take action to reduce delays in children's treatment within the continence service.
- Consider providing all staff with a lone worker device when conducting visits in the community.
- Ensure that there is adequate access to handheld devices across children and young people's services to ensure equity of the services being delivered.

Summary of findings

- Review the appointment system to ensure it reflects the black and ethnic minority diversity of the local population.
- Consider developing a clear strategy that identifies how services will effectively engage with the diverse population using services, including those form a BME background.

Central Manchester University Hospitals 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

We rated community children, young people and families services as 'requires improvement' for Safe because;

Staff were familiar with the safeguarding policy and procedures and had an effective working relationship with the trust's safeguarding team.

A child protection clinic was held daily by community paediatricians who would see any child where a professional had raised safeguarding concerns. Safeguarding supervision was offered to all caseload holders on a quarterly basis or more frequently if required. However there was no requirement for health professionals to discuss all their ongoing families with safeguarding concerns at these sessions which meant there was a risk that some families would never be discussed. Records were stored securely and were accessible to health visitors and health professionals as appropriate. We observed contemporaneous record keeping that reflected national guidance.

The environment and some equipment used by health visitors at Longsight Health Centre was not fit for purpose. There was evidence of rodent infestation within the building, a ripped baby changing mat, visible dust on service tops and window shutters, and baby weighing scales balanced unsafely on a stand. Risk assessments completed prior to the clinics did not identify the main risks. Also at Longsight Health Centre we observed a poor level of hygiene in respect of dirty stairwells, clinical and storage areas. We observed two out of five vaccination fridges at Alexandra Parkwere visibly dirty. The fridge

temperatures were not checked daily as per the trust policy and we found one fridge that was only checked on seven occasions throughout October 2015 which was against trust policy.

Incidents were reported via an electronic reporting system within community children and young people's services. Leaders raised concerns there was a low number of clinical incidents being reported. The incidents reported were predominantly in relation to personal accident or injury, which resulted in no harm. However, other incidents staff told us about, such as delays in the completion of development checks, dirty clinical rooms and difficulties with IT, were not reported on the system.

Caseload numbers for health visitors was requested from the trust but information was not supplied in a format that gave assurance of caseload sizes. Therefore assurance was not received in terms of whether health visitor caseload numbers met national standards.

There had been a recent school nursing review which had seen a 40% reduction in school nurses. Special needs services, including special school nursing, physiotherapy, and occupational therapy had experienced an increase in the number of referrals they received. Staff felt this was caused by the increasing population of Manchester and an increase in babies born with complex medical complications.

Safety performance

- Safety performance was monitored through monthly divisional integrated clinical effectiveness meetings, including incidents, complaints and identified risks. Safety performance was a standard agenda item at team meetings and the information discussed at the monthly divisional integrated clinical effectiveness meetings was fed back to staff.
- There were no serious incidents reported on the Strategic Executive Information System (**STEIS)** between 1 July 2014 and 30 June 2015 for the service.

Incident reporting, learning and improvement

- Incidents were reported via an electronic incident reporting system. A policy was in place to support this that staff were familiar with.
- Out of 723 incidents reported within physical health services between 1 September 2014 and 31 August 2015, 170 were reported in children and young people's services. The incidents reported were predominantly in relation to personal accident or injury, which resulted in no harm. However, other incidents staff told us about, such as delays in the completion of development checks and difficulties with IT, were not reported on the system. This meant that the number of incidents reported by this service may not be accurate and lessons may not be learnt from systemic issues that required further investigation.
- Service leads identified that incident reporting in terms of clinical incidents was low within the community children and young people's services. A risk matrix had recently been given to staff to raise awareness of reporting clinical incidents and to identify what incidents should be reported.
- Staff gave some examples of where positive changes had been implemented in practice as a result of incidents being reported. These included changes in using the interpreter services and improvements in the supply of equipment to children with complex needs.

Safeguarding

- Staff were familiar with the safeguarding policy and procedures and had an effective working relationship with the trust's safeguarding team.
- Safeguarding training formed part of the trust's mandatory training programme. Data provided by the trust showed in March 2015 only 67% of staff had completed level two, 77% of staff had completed level one. By November 2015, 91% of staff in the Children's division had completed level two training. Eighty-six percent had completed level three safeguarding training. This was slightly below the trust's target 90%.
- Safeguarding supervision was offered to all caseload holders on a quarterly basis or more frequently if required. Group safeguarding supervision was also available for practitioners to access, if required. We saw evidence that supervision sessions were recorded in the child's records. However there was no requirement for health professionals to discuss all their ongoing families with safeguarding concerns at these sessions which meant there was a risk that some families would never be discussed. A primary purpose of safeguarding supervision is to enable health professionals to reflect on practice and management of cases in order to enhance best practice. There

Requires improvement

Are services safe?

- Each referral form to allied health professionals contained a section for the referrer to identify if there were any safeguarding concerns at the time of the referral.
- All staff had received 'Prevent' training, which is the government's response to help counter the extreme ideologies that recruit vulnerable people and to offer guidance and support to those who are drawn to them.
- A daily child protection clinic was delivered by community paediatricians between Monday and Friday, where all children were seen the same day as a safeguarding concern was raised. This involved a paediatrician who was first on call who had responsibility for running the clinic and a second on call who took telephone calls and offered advice. Out of those hours, children were seen at the children's hospital.
- The vulnerable babies' team had specialist care planners who chaired strategic partnership meetings and led on safeguarding cases. If neglect was suspected by the health visitor, the team would facilitate support. Once the family's needs had been met, the care was transferred back to the family health visitor.
- All staff spoken with were aware of child sexual exploitation and there was a policy in place to support staff in this area. Within the healthy schools team there was a sexual relationship lead, who delivered training within local schools, for both teaching staff and students, on child sexual exploitation.

Medicines

- All the vaccination fridges had recently been moved to Alexandra Park health centre. We observed two out of five of these fridges were visibly dirty. The fridges were not checked daily as per the trust policy and we found one fridge that was only checked on seven occasions throughout October 2015.
- The immunisation team worked to patient group directions in relation to the school immunisation programme. These allow a nurse to give prescription-only medicines to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. Appropriate systems were in place for the management of this.
- Childhood vaccinations were mainly given by the immunisation team. However school nurses expressed a wish to continue in the delivery of some immunisation sessions for their named school as a way of maintaining their skills in this area.

Environment and equipment

- Medical device alerts were sent out via email and also discussed at team meetings to ensure that all staff were aware of what the alert was and the required action. Medical device alerts are the prime means of communicating safety information to health and social care organizations and the wider healthcare environment on medical devices. They are prepared and distributed nationally by the Medicines & Healthcare products Regulatory Agency (MHRA)and are distributed nationally for each healthcare setting to implement any requirements.
- Staff informed us they had the necessary equipment they needed to perform their roles effectively.
- Scales were calibrated yearly and stickers that had been placed on them to identify they had been calibrated were observed on the scales in use.
- Some equipment at Longsight health centre was not clean or not fit for purpose, including a ripped baby changing mat, visible dust on service tops and window shutters, and baby weighing scales balanced unsafely on a stand. There was also evidence of a rodent infestation. We reviewed risk assessments completed by health visitors prior to the clinics and found these risks were not identified. Additionally the pillows in clinic rooms used for baby clinic had thin plastic covers on them which were a potential risk to babies and toddlers who were undressed on the couch where the pillows were kept. We found in all other clinics we visited that the equipment and environment was satisfactory. We raised these matters with the trust at the time of our inspection and immediate action was taken to address our concerns.
- There was insufficient storage in some of the community bases. An example of this was at Charleston Road Health Centre where two large boxes containing height measures fell off the filing cabinets during our visit. These had been balanced on top of other equipment.

Requires improvement

Are services safe?

Quality of records

- The community children and young people's services predominantly used paper-based records to record the treatment and care given to patients. Records were stored securely and were accessible to health visitors and health professionals as appropriate.
- We reviewed 13 sets of children and young people's records. The sample was taken from the health visiting, school nursing and family nurse partnership teams and included records and parent held red books. We observed contemporaneous record keeping that reflected national guidance in all of the records reviewed. Record audits were completed by the trust and a subsequent action plan developed. These audits identified key challenging in terms of designation being written and errors being signed, dated and timed.
- The health visiting service was using new templates for each contact and developmental review. Although health visitors had been consulted in the development of these templates, they raised some concerns in respect of them not being user friendly and there not being enough space to include personal notes. In all the records we reviewed, we saw the templates had been completed differently, which showed there was no standardised approach in place.
- School health records were stored in various locations across Manchester due to limited space within the health centres. There was a robust system in place to ensure information was accessible to the school nurses when it was required. Some school nursing records were kept in boxes rather than filing cabinets due to space issues. These boxes were held in locked rooms.
- Records were used by all health professionals involved in the care of the child to ensure continuity of care.

Cleanliness, infection control and hygiene

- Staff were aware of infection prevention and control guidelines and where this guidance could be accessed.
- We observed that equipment was cleaned in line with the trust's protocols and that equipment such as weighing scales and changing mats was cleaned between each baby-weighing at the clinic we observed.
- Good hand washing techniques were observed and alcohol hand wash was used by staff to decontaminate their hands. Hand wash posters were displayed in prominent positions to act as a reminder for people to wash their hands thoroughly. There were also posters to advice on the correct method of hand washing.
- Hand hygiene audits were completed and data supplied by the trust showed that compliance ranged between 84% (speech and language therapy) and 100% within the service between June 2015 and November 2015.
- At Longsight health centre we observed a poor level of hygiene in respect of dirty stairwells, clinical and storage areas. We were told by staff that there had been an ongoing problem with rodent infestation and staff had observed mice in the building. Measures had been taken to resolve this problem.
- The clinic rooms used by community children staff at Longsight health centre were visibly dirty with thick layers of dust on window sills and shutters. Fabric pillows were on the examination couches with no cleaning schedule in place and no evidence of any cleaning that had taken place. We were also told by a paediatrician that she had recently had to clean a clinic room prior to using it.
- The offices for paediatricians at Longsight health centre had a kitchen area directly next to the toilet area. Staff raised concerns with us in relation to their privacy and dignity.
- We raised these matters with the trust at the time of our inspection and immediate action was taken to address our concerns. A full review of the service and assurance systems in place was also undertaken to ensure robust monitoring of the service going forward.

Mandatory training

- The organisation used an electronic monitoring system to manage staff mandatory training. Staff received mandatory training in areas such as safeguarding children, fire awareness, equality and diversity, and moving and handling. Data supplied by the trust showed that 87% of staff in community children and young people's services had completed mandatory training. This was slightly below the trust's target of 90%.
- Training was delivered centrally either face to face or online through the intranet. There was an expectation that staff were to keep up to date with their own mandatory training and reminders were given to staff at team meetings.
- Staff reported that they were supported to complete their mandatory training and felt they had enough time

to complete it. However they told us that mandatory training was more focused on the acute setting rather than community staff. An example of this was community staff had to cover training in blood transfusions when there was no possibility of them undertaking this task.

Assessing and responding to patient risk

- Staff accessed, and referred directly, to specialist services for children when needed. We were told of incidences across these services when medical advice was sought and delivered in a timely manner, for example health visitors referred directly for paediatric, speech and language and occupational therapy reviews.
- Health visitors used an evidence based assessment tool to inform discussions with parents regarding their child's development. Any areas of need were identified and referrals were completed to appropriate professionals. We saw evidence of this documented in patient records.
- New health screening tools were due to be implemented in the school nursing service to look at areas where young people were at risk, for example female genital mutilation and self-harm.

Staffing levels and caseload

- The service had recently appointed three new midwifery specialist health visitors. A focus of their role was to improve relationships with midwifery services.
- There had been a recent school nursing review which had reduced the number of school nurses by 40%. However there had been a high turnover of school nursing staff during the review as staff had been concerned about their job security. This meant that the service had reduced by 50% over the six months prior to the inspection. The trust was undergoing a recruitment campaign to recruit to the vacant posts as per national guidance each Secondary school had a linked school nurse.
- In addition to the school nursing, the trust had a healthy schools team, who delivered the majority of the Healthy Child Programme health agenda within the school setting; this relieved the school nursing team to undertake bespoke health promotion with individual children and young people and to focus on safeguarding work.
- Caseload numbers for health visitors was requested from the trust but information was not supplied in a format that gave assurance of caseload sizes. Therefore assurance was not received in terms of whether health visitor caseload numbers met national standards.
- We were told that the population of Manchester had been gradually increasing and there had also been an increase in babies born before their due date, which had subsequently increased the number of children with complex medical complications. This had put additional pressure on the special needs teams including physiotherapy, special needs nursing and occupational therapy. The services had experienced an increase in referrals but no increase in staffing numbers to accommodate this. A meeting had been set up with commissioners to discuss this.
- The homeless families' team had seen an increase in their caseloads due to an increase in the number of homeless families in the area. This reflected the national picture of homelessness. We were told there was a planned review of caseloads due to take place early 2016.

Managing anticipated risks

- Lone working policies were in place and staff followed them. Staff had mobile phones and also used a buddy system. Lone worker devices had been distributed to each team but there were not enough devices for each lone worker to have their own. This meant it was difficult for teams to decide which professionals would have a device on a daily basis.
- Central Alerting Systems (CAS) alerts were sent directly to all relevant staff via email. These were also followed up by discussion at the team meetings. CAS is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

Major incident awareness and training

- The service had plans to manage and mitigate anticipated major incident risks, including seasonal incidents such as bad weather or a flu pandemic.

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

We rated community children, young people and families services as 'good' for effective because;

Children and young people's needs were assessed appropriately with care and treatment delivered in line with current legislation and evidence based guidance. Policies and procedures were in place and staff were aware of how to access them. Staff had a good understanding of how to obtain consent. Gillick competencies and Fraser guidelines were followed to ensure that people who used the services were appropriately protected.

The healthy child programme was delivered through health visiting services including health visitors, staff nurses, nursery nurses, and school nurses, in line with current legislation, standards and recognised evidence based guidelines. For example, the trust had introduced two family nurse partnership teams across the Manchester area.

There were ample desktop computers within clinic bases. However staff experienced difficulties with connectivity whilst in the school setting and as a result, were frequently unable to access relevant information such as policies and procedures. This had been highlighted on the departmental risk register.

Evidence based care and treatment

- The healthy child programme (an early intervention and prevention public health programme) was delivered across the 0-19 age range by health visitors, specialist health visitors, school nursing, community children's staff nurses, nursery nurses and community support workers.
- Evidence based tools were used by health visiting and family nurse partnership teams to assess a child's development. For example, the tool used to complete developmental assessments was the Ages and Stages Questionnaire (ASQ), which is a nationally recognised, evidence-based tool and is used within the family nurse partnership programme nationally.
- Speech and language therapy used Royal College of Speech and Language Therapy competencies in addition to trust wide competencies.
- The trust had two family nurse partnership teams working across the Manchester area. The family nurse partnership was a voluntary health visiting programme for first-time young mothers, underpinned by internationally recognised evidence-based guidelines.
- Regular audits were completed across the children and young people's services, including hand hygiene, use of epilepsy NICE guidelines pathway and a hip audit. These audits demonstrated overall good compliance.

Technology and telemedicine

- Ample computers were available to all teams of staff within their bases. Additionally some staff, including school nurses, had laptop computers. However staff told us they had frequent difficulties with connectivity whilst in the school environment, which subsequently prevented them from accessing relevant information, such as policies and procedures. This had been raised as a concern on the risk register and service leads were working with schools to resolve the issue.
- Health visitors told us they did not have access to laptops as, when they had previously had them, they had not found them useful so had given them back. This meant that health visitors did not have information, such as policies and procedures readily available when out of the office.
- Staff, including health visitors and the homeless families' team, told us they frequently had difficulties with inputting their completed work onto the computer system as they could only input children that were registered in the area. Subsequently they were unable to fully demonstrate their workload to commissioners.
- Some staff had been given handheld computer devices which they told us were an asset to the role. These were being used for a variety of reasons, for example, physiotherapists used them for children to improve hand mobility and for young people to share their views of the service. However as only some staff had been given these devices, there was inequity in relation to the tools that could be used with patients across the region.

Good

Are services effective?

Patient outcomes

- The family nurse partnership had annual reviews and was meeting all the fidelity goals. The fidelity goals cover four main areas which are recruitment, retention of clients (measured by attrition rates), amount of programme received and programme content received.
- The delivery of the healthy child programme was monitored for the service. Data from 1 February 2015 to 31 July 2015 showed that between 89% (July) and 93% (February to May) of births were visited by a health visitor within 14 days, which was worse than the national average of 98%.
- Data showed that between 46% (February) and 54% (July) of children received a development assessment between the required ages of two and two and a half (healthy child programme). This was significantly worse than the national average of 98%. Managers told us this low figure was because only one appointment was offered, which was sent out through the child health system. Appointment letters were only sent out in English. At the time of the inspection 57% of school children in Manchester were from a minority ethnic group. Health visitors used their own discretion as to whether the child would be appointed a further date. However, data supplied by the trust, showed the 'did not attend' (DNA) rate for the health visiting service for 2014/15 was only 4%.
- There were discrepancies in the data that was captured for patient outcomes. An example of this was the 6-8 week review was completed at the same contact as the mental health assessment; however the data for these differed each month. In July 2015, whilst 100% of mental health assessments were completed, only 74% of 6-8 weeks reviews were showing as completed on the trust data. This discrepancy was raised with managers, who were looking into the accuracy of data collected.
- The trust had an infant feeding team who provided one to one support to breastfeeding mothers in their own home. The team had the capacity to spend up to a day with a breastfeeding mother, however visits ordinarily lasted up to an hour. They also provided training and support to the health visiting teams and all the health visitors had completed additional breastfeeding training.
- The trust was working towards stage three status of the baby friendly initiative in December 2015. The baby friendly initiative is a worldwide programme of the World Health Organization and UNICEF. It is designed to support breastfeeding and parent-infant relationships by working with public services to improve standards of care.
- Each health visitor team had a breast feeding champion to cascade information and offer support to the team.

Competent staff

- Data supplied by the trust showed that 88% of staff within children's community services had received an appraisal between 1 December 2014 and 30 November 2015, which was slightly below the trust target of 90%.
- Community paediatricians each took a lead role in key areas such as adoption and fostering, education, safeguarding and children looked after. Health visitors also had lead roles within each base to cascade information and offer support, for example breastfeeding and healthy child programme leads.
- Community paediatricians held monthly peer review meetings where they provided challenge and debate to each other and brought recent cases they had worked with to discuss.
- Newly qualified speech and language therapists received supervision for the first year in post and then could subsequently choose if they wanted to extend this supervision.
- Additional complementary training was also offered to staff, for example occupational therapy staff had recently undertaken a post graduate sensory training module.

Multi-disciplinary working and coordinated care pathways

- Good multi-disciplinary working was evident within the family nurse partnership and how the families were integrated with universal services (healthy child programme). There was a graduation pathway into universal services when the child reached two years of age. However, staff told us about some communication difficulties between the family nurse partnership and heath visiting teams. This was specifically in relation to health visitors only getting involved with the families once the transition period had started. Additionally health visitors started a new child record rather than continue with the existing one. This meant there was no continuity of care within the child's records and there was a potential for information to be missed.

Good

Are services effective?

- We saw evidence in records of integrated care involving other health professionals including speech and language, physiotherapy and paediatric consultant services. For example, joint assessments were completed with community paediatricians and therapists or special needs nurses. Occupational therapy and physiotherapy offered joint assessments for splinting.
- External multi-disciplinary team working took place with the local authority, social care, hospitals and schools where applicable. There was a vulnerable babies and vulnerable families team who took overall responsibility for communicating with the local authority for families where additional support was required or were safeguarding concerns had been identified. The trust had a safeguarding team who provided 24 hour support. This team had good links to the Local Authority. The team reported they had a good working relationship with local authorities and worked very closely with them.
- Due to the transformation of school nursing services, school nurses told us they now had a much better working relationship with schools. The change in their service meant that each school had a named school nurse who spent a significant amount of time working in the school. This new approach had been welcomed by the schools and had improved working relationships.

Referral, transfer, discharge and transition

- There were clear processes for assessing new referrals within each of the community children and young people's services. Referrals were managed effectively, evidenced by the meeting of key performance indicators relating to time frames from referral to assessment and first contact.
- Health professionals actively took part in education, health and care plans (EHC) for children and young people. These ensured plans were in place for the young person's ongoing health needs to be met. The EHC plan contained a transition summary to assist with planning for transition. This process was very well embedded within children and young people's services.
- Community paediatricians told us there was no adult service that took over their specific role when the young person reached 18 years old. However young people were referred to appropriate specialists if required.
- Staff told us there had been some inappropriate discharges for children with complex needs from the children's hospital and neighbouring trusts. This had involved discharge planning meetings not taking place with community staff and incomplete discharge letters to enable them to have a full understanding of the child's needs. The process was that a discharge planning meeting, involving all professionals involved in the plan of care should take place prior to discharge from hospital for children with complex medical needs. As a response to these concerns, a member of staff had recently completed a secondment at the hospital to raise awareness of the community teams and look at more effective joined up working.

Access to information

- Some community staff, including school nurses, had access to laptops but due to the connectivity issues in some community locations they were unable to access information in a timely way. This issue had been reported but had not been rectified. Health visitors did not have laptops so could not access information, such as policies and procedures whilst conducting home visits or working in some community settings.
- A number of professionals across the community children's services had been issued with handheld computer devices but not all staff had access to them. The devices were not interchangeable as they were attached to the professional's profile so could not be used by other members of the team. These devices enabled information to be accessed very quickly when required.
- There was a public health library service that staff could access for resources to assist them with delivering public health initiatives. We were told this library was well stocked and staff had access to all the public health information they needed.
- The healthy schools team told us of difficulties they had with accessing training packages when delivering teaching sessions in schools due to IT issues. This was because of the differences in IT systems between health and education and the two systems were not always compatible. Staff told us they had raised their concerns with management and reported this to the IT department, who were looking into a resolution.

Good

Are services effective?

Consent

- Consent forms for vaccinations within school health were sent out to parents and carers prior to the vaccination sessions to inform them of the appropriate details and to obtain the relevant consent.
- Staff used the Gillick competency and Fraser guidelines (used to decide whether a young person is mature enough to make decisions), where appropriate, for example with consent for vaccinations to balance young people's rights and wishes with the responsibility to keep children safe from harm.
- Staff informed us that the health visiting service used implied consent.
- Within the family nurse partnership, consent was obtained formally as patients signed an agreement to join the programme. Parents were given clear information prior to giving their consent.

Good

Are services caring?

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

Summary

We rated community children, young people and families services as 'good' for Caring because;

Children, young people, families and carers told us they received compassionate care with good emotional support. Parents told us they felt informed and involved in their child's healthcare.

Staff were child and family focused and they looked at the family unit when completing their assessments. Good interactions were observed between staff and children, young people and their families

Compassionate care

- Children, young people and those close to them were positive about the care and treatment provided by staff. Parents at a baby clinic described positive experiences with the health visitors and explained how they handled babies with compassion and care. Children, young people and those close to them were happy and relaxed in the department and staff interacted well with them.
- All parents and children we spoke with were very happy with the service they received. They found the staff to be very approachable and knowledgeable.
- Staff were passionate about the care they provided and were very clear on the importance of engaging the families with all interventions that were offered to them.
- There were separate rooms in the clinics we visited to allow for parents to speak confidentially with members of staff if required.
- Feedback was sought from patients and their families and this was discussed at staff meetings. We saw evidence of compliments for staff including 'thank you' cards and letters.

Understanding and involvement of patients and those close to them

- Parents and carers of children told us staff focused on their needs and those of their children.
- Parents and carers felt involved in discussions about care and treatment options and told us they felt confident to ask questions about the care and treatment they received and make informed decisions.
- Whenever possible, staff supported children and their parents and carers to manage their own treatment needs. Staff told us they would discuss goals with families and give them advice about how they could make progress to achieve these goals.
- Parents of children with behavioural difficulties were invited to attend a 'Riding the Rapids' initiative, which was an initiative to support parents to manage the child's challenging behaviours.

Emotional support

- Parents were encouraged to continue working with children at home for their speech and language development.
- Health visitors offered support to mothers who suffered from postnatal depression. This was well documented within the child's records.
- Young people could choose to have a patient held health action plan as part of their transition. This was a multidisciplinary document to prevent the child or young person having to continually explain their health needs to each professional who cared for them. It contained wishes and dreams, medical history, contact numbers and focused on introducing the young person as an individual.

Good

Are services responsive to people's needs?

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

Summary

We rated community children, young people and families services as 'good' for Responsive because;

Care was provided in a variety of locations, including to people in their home and also in local clinics, treatment centres, through drop in sessions and also timed appointments as and when required. New initiatives were being used to meet people's needs, such as social media apps and bespoke public health work delivered in schools.

The service as a whole was meeting their key performance indicators for referral to assessment times. For all services we inspected, the referral to assessment time was less than 12 weeks. The healthy child programme was managed between the health visiting and school nursing services. The health visiting service were compliant with the trust target of 95% completion for the new birth visit.

Staff were aware of how to deal with complaints and escalate them as required. Learning from complaints was shared locally at team meetings and via emails.

However;

Although 57% of the school age population in the Manchester area were from ethnic minority groups, appointment letters were only sent out in the English language. Staff had not raised this as a concern. Staff did have access to a translation service, which included telephone services. However, staff told us they did not utilise this to arrange initial appointments.

The children's continence service did not have a bladder scanner which caused a significant delay in children receiving treatment.

The community children and young people's services were not providing a seven day service for children and young people and there were no plans to move towards this with the exception of the children's community nursing service.

The health visiting service were not compliant with the trust target of 95 % completion for antenatal contacts (maximum compliance of 20%, July 2015) and two year developmental reviews (average 50% compliance).

Planning and delivering services which meet people's needs

- School nurses had recently undergone a service transformation. As part of this transformation school nurses had gone back into wearing uniforms, when they had previously worn their own clothes. School nurses felt this was much better received by the young people as they stood out and the young people could see them as health professionals.
- The healthy schools team worked with local schools to provide health promotion activities and training dependent on the needs of the local area. An example of this was in relation to bespoke training given on sex and relationships at a local catholic school.
- The infant feeding team used a social media app for mothers to ask for advice and support which complemented the service they provided.
- Most staff had a good knowledge of the people they had on their caseload, or who attended the schools they looked after. They were aware of the needs of the population and the type of support they needed.
- Health professionals, including physiotherapists, occupational therapists, ophthalmologists, speech and language therapists and community paediatricians completed assessments and ongoing treatments for children with complex needs within the school environment. This meant that these children and young people were given treatment in a timely way with minimal disruption to their schooling.

Equality and diversity

- All locations were accessible for people with physical disabilities.
- A translation service was used for families whose first language was not English. However, staff told us of some difficulties they had experienced with using this service, in relation to interpreters not attending as planned or the interpreter not being appropriate for the person's needs/situation.
- The service was engaged in an initiative named 'I am Manchester' which looked at preventing extremism and bringing people together from different cultural backgrounds.

Good

Are services responsive to people's needs?

- The children and young people's service had a homeless families team, who worked with all homeless families and travelling communities where there was a preschool children. A high proportion of the team's work, involved families from a black and minority ethnic population. The team engaged well with these families and supported integration with families of a similar ethnic background at various support groups in the community.
- Appointment letters were only sent out in the English language; however 57% of school age population in the Manchester area were from ethnic minority groups. Staff had not raised this as a concern. Staff did have access to a translation service, which included telephone services. However, staff told us they did not utilise this to arrange initial appointments.
- Ten percent of trust employees were from a black and minority ethnic background.

Meeting the needs of people in vulnerable circumstances

- Public health initiatives were targeted to meet specific needs that had been identified to the school nursing and healthy schools team, such as sex and relationships and bullying and harassment. This team delivered bespoke training to all schools dependent on the identified health needs of the local area.
- There were very good networks of support in place for looked after children. Staff worked closely with young people and built up close working relationships with them.
- There was a vulnerable children's team who delivered intense work with children and their families who were identified as 'child in need' or children subject to a child protection. This team liaised with other professional agencies, including the Local Authority to ensure the family received the correct level of support.
- The homeless families' team visited all homeless families within the Manchester area where there was a child under school age, to address the health needs of the family and to provide the family with ongoing support. This team supported families to access suitable healthcare, education and housing provisions. The team regularly visited families and supported them to access community activities and appropriate professionals.

Access to the right care at the right time

- The health visiting and school nursing services were not providing a seven day service for children and young people and there were no plans to move towards this. However the Children's Community Nursing Service provided a 365 day, 8am to 10pm, city-wide acute service including specialist nursing services and services for children with complex need
- The healthy child programme was managed between the health visiting and school nursing services. However, the heath visiting service were only compliant with the trust target of 95% completion for the new birth visit. They were not compliant with the trust target of 95 % completion for antenatal contacts (maximum compliance of 20%, July 2015) and two year developmental reviews (average 50% compliance).
- The service, as a whole, was meeting their key performance indicators for referral to assessment times. For all services we inspected, the referral to assessment time was less than 12 weeks and some services had no waiting lists (audiology and children's continuing care team). More urgent cases were identified and prioritised accordingly.
- Orthoptists told us that their waiting lists were high at certain times of the year. This was because the routine eye tests completed for all 4-5 year olds were completed for all eligible children at the end of the academic year. This subsequently generated a lot of referrals at one time which led to a rise in the waiting lists.
- The children's continence service did not have a bladder scanner which caused a significant delay in children receiving treatment. This was because once the children were seen in clinic, a referral had to be completed to the GP, who then referred the child to the hospital services and then subsequently back to the GP. The continence team then needed to actively seek out the results of the scan from the GP. This frequently delayed treatment by a minimum of six weeks. Staff told us that if the service had its own bladder scanner the procedure would be completed as part of the initial assessment and therefore treatment would not be delayed.
- Data supplied by the trust showed the 'did not attend' (DNA) rate for the health visiting service for 2014/15 was low at 4%.

Good

Are services responsive to people's needs?

Learning from complaints and concerns

- Patients and those close to them knew how to raise concerns or make a complaint. The trust encouraged people who used services, those close to them or their representatives to provide feedback about their care.
- Staff were aware of the complaints process. Staff told us they would always try to resolve any issues immediately. If issues could not be resolved, the family was directed to the complaints process. Staff were aware of any complaints made about their own service and any subsequent learning.

Requires improvement

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated community children, young people and families services as 'requires improvement' for well-led because;

There was no robust checking of safeguarding processes and training records within community children and young people's services. Although there was a safeguarding supervision policy it did not fully ensure the safety of vulnerable children in terms of the safeguarding supervision within the service. This was because there was no requirement for all safeguarding families to be discussed at supervision sessions.

There was an overarching risk register for the division and local risk registers held by each service. The risks on the risk register had good control measures in place and a review date set. All risks were reviewed monthly at the divisional integrated clinical effectiveness meetings. However not all identified risks were on the risk register, such as non-compliance with antenatal contacts and development reviews and a lack of cleanliness at Longsight health centre. Risk assessments were completed prior to well-baby clinics but these did not identify all the risks.

The concerns around the environment at Longsight health centre had not been addressed by senior leaders, although incident reports had been submitted to alert them to it.

The strategy for community children's and young people's services was aligned with the trust's operational strategy and staff were aware of the trust's vision and values. Regular team meetings were held in each community children's team where governance and risk were standard agenda items. However, despite having 57% of children from a black, minority ethnic background within the school population, there was no clear strategy describing how services would engage and communicate with the diverse population including those from a BME background.

Service leads were visible and approachable and fostered supportive relationships not only within the individual teams but within the wider service. We observed some innovative practice, including a social media app for breastfeeding mothers to access advice and a bespoke healthy schools programme delivery.

Service vision and strategy

- The strategy for community children and young people's services was based on the needs of the local population. A robust approach was taken to strategic planning and service plans identified the needs of the children and young people living in Central Manchester. The service strategy was aligned with the trust's operational strategy and staff were aware of the trust's vision and values.
- However, despite having 57% of children from a black, minority ethnic background within the school population, there was no clear strategy describing how services would engage and communicate with the diverse population including those from a BME background.
- School nursing had recently undergone a service transformation. All staff were very clear of the service vision and valued the weekly update meetings in relation to this.

Governance, risk management and quality measurement

- Regular team meetings were held in each of the children and young people's services. Governance matters, including identified risks and lessons learned from incidents and complaints, were standard agenda items on all meetings.
- There was an overarching risk register for the division and local risk registers were held by each service. The risks on the risk register had good control measures in place and a review date set. All risks were reviewed monthly at the divisional integrated clinical effectiveness meetings. However we found some risks identified by staff and leaders were not on the risk register, such as non-compliance of antenatal contacts and development reviews, IT connectivity issues and also the cleanliness and environmental issues at Longsight health centre.
- The concerns around the environment at Longsight health centre had not been addressed by senior leaders, although incident reports had been submitted to alert them to it.

Requires improvement

Are services well-led?

- Each office base had a 'patient safety at a glance' board that identified governance and risk management matters, such as staff survey results, lessons learned from incidents and complaints and patient feedback.
- Monthly directorate integrated clinical effectiveness (DICE) meetings were held where all areas of governance were discussed at a divisional level. Information from this meeting was subsequently fed up to board level and fed back to staff within team meetings.
- Audit and clinical effectiveness (ACE) days were held quarterly where all staff from community children and young people's services were invited. The agenda for these meetings was led by requests from staff and the format of the day was a seminar in the morning and group work in the afternoon.
- Health visitors completed risk assessments prior to well-baby clinics. However we reviewed a sample of these for Longsight health centre and found they did not identify the risks we identified, including the lack of cleanliness, ripped baby changing mats, plastic covers on pillows and sockets hanging off the wall.

Leadership of this service

- Staff within children and young people's community services were clear about the management structure and felt the team leaders were very visible and approachable. Staff told us they felt managers fostered supportive relationships not only within the individual teams but within the wider service.

Culture within this service

- New staff felt included and supported as they began their employment with the teams and said that more experienced staff were open and willing to teach and advise in a manner that was not patronising. The services were focused on providing high quality care.
- Staff worked well together and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of children and young people's services.
- There was a positive culture around improving the health outcomes of the population which was embedded within service delivery. Staff were passionate about delivering public health strategies both on an individual basis and within community and school settings.

Public engagement

- Despite having a population of 57% of school age children from black and ethnic minority backgrounds, the community children's service was not responding to their needs, particularly in respect of public engagement and information being only available in the English language.
- The services sought feedback from children and young people who used the services via an app on handheld computer devices. However only staff that had been issued with these devices could use this.
- Letters had been sent out to parents to inform them of the changes to the school nursing service, including the role of the school nurse, and what the changes meant in practice for them and their child.

Staff engagement

- Staff received communications from an organisational level such as newsletters and attended team meetings. Overall staff felt they were listened to and felt supported.
- School nurses told us they felt they were well engaged with whilst going through the recent school nursing review in that they had weekly update meetings with their manager.
- Staff well-being was measured using an app on either a handheld computer device or laptop. This was subsequently printed off monthly and displayed on staff notice boards. Team leaders worked on the area of most concern within each team.
- One head of service, who was reasonably new in post asked all staff in her team to complete a 'getting to know you' questionnaire, which asked staff what they liked and disliked about their roles and also any good practice to share and concerns they had. The information gathered was being used to help shape future development.

Innovation, improvement and sustainability

- The special needs nursing team had developed a multiple health needs training package that was delivered to the local authority and education to educate all staff, including transport, youth group workers and any local initiatives, who came into contact with a child with complex health needs. This ensured

Requires improvement

Are services well-led?

they knew the signs to look for if a child's condition deteriorated and what immediate support the child or young person would need. At the time of the inspection several hundred people had gone through this training.

- The healthy schools team delivered bespoke training packages in school dependent on the identified need of the school. Training was also delivered to teachers in the form of staff workshops.
- The Infant feeding team won the chief nurse award this year for the 'most improved divisional area'.
- The infant feeding team had set up a social media page to offer mothers ad hoc and timely advice. This service was open to all mothers who were known to the service.

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 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15: Premises and equipment (1) (a), (2).** We found that the environment at Longsight Health Centre was not fit for purpose with evidence of rodent infestation and dirty clinical areas. Equipment at Longsight Health Centre was not fit for purpose, including a ripped baby changing mat and baby weighing scales balanced unsafely on an unsuitable stand. Additionally there were pillows in clinic rooms that had thin plastic covers on them which were a potential risk to babies and toddlers who were undressed on the couch. 15(1(a)), 15(2),

This section is primarily information for the provider

Enforcement actions

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.