Leeds Community Healthcare NHS Trust

RY6

Community health services for children, young people and families

Quality Report

CQC Registered Location	CQC Location ID
Head Quarters	RY6X6
Hannah House	RY6X3

Tel: 0113 220 8500
Website: www.leedscommunityhealthcare.nhs.uk

Date of inspection visit: 24-27 November 2014
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This report describes our judgement of the quality of care provided within this core service by Leeds Community Healthcare 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 Leeds Community Healthcare NHS Trust and these are brought together to inform our overall judgement of Leeds Community Healthcare NHS Trust

Summary of findings

Ratings

Overall rating for Community health services for children, young people and families	Good
Are Community health services for children, young people and families safe?	Good
Are Community health services for children, young people and families effective?	Good
Are Community health services for children, young people and families caring?	Good
Are Community health services for children, young people and families responsive?	Good
Are Community health services for children, young people and families well-led?	Good

Summary of findings

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Overall summary

Overall rating for this core service Good

Community health services for children, young people and families included a range of services. During our inspection we reviewed the health visiting service, the school nursing service, children's audiology, community paediatrics, the children looked after team, the family nurse partnership service, therapy services, Hannah House, sickle cell and Thalassemia service and the stammering centre.

We spoke with 105 members of staff across children's services and reviewed 24 health care records. We spoke with 33 parents who were either accessing services during our inspection or by telephone. We accompanied staff on three home visits. We received 4 CQC comment cards which had been completed by parents prior to or during the inspection.

We rated children's and young people's services as good for safety. There were systems in place to report incidents. Staff reported they knew how to report incidents and usually received feedback from these. However we found learning and actions from a serious case review were not shared with other relevant services. The school nursing service was working within the DH recommendations from Choosing Health or CPHVA guidance of one qualified school nurse for every secondary school and their cluster of primary schools. Maximum health visitor caseloads were within the trust's caseload weighting tool but did not meet the recommendations of Lord Laming or the CPHVA. Medical staff within the Child Development Unit (CDC) told us they were concerned that the community paediatric service had been partially staffed over a number of years by locum medical staff.

Overall children's and young people's services were rated good for providing effective services. The Healthy Child Programme was delivered through skill mixed child health teams. The teams consisted of health visitors, school nurses, community staff nurses, nursery nurses, assistant practitioners and health care assistants. Initiatives such as UNICEF baby friendly were in operation. We reviewed evidence which demonstrated patient outcomes and performance information was closely monitored and reported by children's services in the trust. For example we saw performance data which monitored compliance with the key contacts within the Healthy Child Programme for the 0-5 age group. Although managers and staff told us supervision occurred on a three monthly basis the trust's systems were unable to demonstrate this happened. This meant the trust did not have an effective system to record supervision.

Overall we rated children's and young people's services good for the quality of care. As part of our inspection we observed care in patient's homes, clinic settings and observed staff speaking to clients on the telephone. In order to gain an understanding of people's experiences of care we talked to 33 people who used services within children's services. Throughout our inspection we found members of staff treated children, young people and families with dignity and respect. Staff we spoke with told us they were passionate about delivering a quality service. People who used services told us they were happy with the care they and their child received.

Overall we rated children's and young people's services as good for providing responsive services. The trust had a range of specialist services to meet the different needs of people which included the stammering centre, sickle cell and thalassemia service and Hannah house. Children's services were provided in a number of settings including the patient's home, health centres, children centres and the child or young person's school. Children's services within the trust followed the trust's NHS complaints processes. The main themes from the complaints were communication, staff attitude and treatment. Staff within children's services told us themes from complaints were shared at monthly team meetings.

Overall we rated children's and young people's services as good for being well-led. Staff within the different children's services were clear about the vision of their individual service and the trust's vision and values. However a strategy between health visiting and school nursing which supported how both services worked together to support children, young people and their families needed to be developed.

Summary of findings

Governance arrangements were in place and learning took place, however some medical staff in CDC did not always receive timely feedback from clinical incidents or concerns they had raised.

There was an open culture, and whilst not all staff had regular formal meetings with their managers outside of their appraisals, they told us they felt well supported and could access their managers when they needed to.

Staff across services told us they felt the service reviews had not been well communicated and they did not feel listened to. They told us the trust had held consultation events and meetings but the information provided had not been sufficient. The majority of staff we spoke with told us they understood the reasons for the reviews but felt the communication of change was not always as good as it could be.

Summary of findings

Background to the service

Children and young people under the age of 20 years make up 24.1% of the population of Leeds. The health and wellbeing of children in Leeds is mixed compared with the England average. Infant and child mortality rates are similar to the England average. The level of child poverty is worse than the England average with 22.5% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average. 26.8% of school children are from a minority ethnic group. Children in Leeds have average levels of obesity: 8.7% of children aged 4-5 years and 19.6% of children aged 10-11 years are classified as obese.

Community health services for children, young people and families included a range of services delivered in the Leeds area. Core services included health visiting, school nursing and therapy services. These services were complemented by specialist teams such as Family Nurse partnership team, Hannah House, Child development centre and the stammering centre.

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, nurses, 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

Leeds Community Healthcare NHS Trust was inspected as part of CQC's inspection programme. The trust is also seeking to become a foundation trust. 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.
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

Before visiting, we reviewed a range of information we hold about Leeds Community Healthcare NHS Trust and

Summary of findings

asked other organisations to share what they knew about the provider. We carried out an announced visit between 24 and 27 November 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 29 locations which included 3 community inpatient facilities. We carried out unannounced visits on 26 November to the twilight service and child development services.

What people who use the provider say

We received a number of comment cards, and spoke with children, young people and their families during the inspection. They told us that they felt well cared for, that their dignity and privacy were respected, and that staff included them when planning their care.

Good practice

- The trust had a member's zone which encouraged children and young people to become involved and influence how services were delivered. The trust provided information which showed there were 134 public members aged 14-16 years and 69 aged 17-18 years of the member's zone.
- The stammering centre promoted self-help we saw an after school teens group for young people aged 12-17 years old which provided young people with an opportunity to meet other young people who stammer and fun activities to practice fluency.
- The trust has started to engage with children and young people to develop web based applications to support children and young people with their health needs.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure school nursing staff are aware of how to access archived health visiting records if they identified safeguarding concerns of school aged children.
- The trust should ensure they have an effective system to record safeguarding supervision.
- The trust should review how health visiting and school nursing services work together to support children, young people and their families.
- The trust should ensure investigations into clinical incidents are undertaken in an appropriate timescale to ensure sufficient measures are put in place to prevent a reoccurrence.

Leeds Community Healthcare 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

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

Summary

We rated children's and young people's services as good for safety. There were systems in place to report incidents. Staff reported they knew how to report incidents and usually received feedback from these.

The trust had a named doctor for safeguarding children. We were told the current doctor's designated time equated to one session per week (one half day) which was low in comparison with other trusts. The usual number of sessions were at least 4 sessions per week. However, the trust had a number of roles in place to support the named doctor's role, including 3 band 7 nurses, and 2.6 WTE administration staff.

The current named doctor had been employed via a locum consultant contract since October 2013. The designated doctor role was currently covered by the trust's board level medical director who was also a paediatrician and lead for the service.

We found records were stored safely and appropriately.

The school nursing service was working within the DH recommendations from Choosing Health or CPHVA guidance of one qualified school nurse for every secondary school and their cluster of primary schools. Maximum Health visitor caseloads were within the trust's caseload weighting tool but did not meet the recommendations of Lord Laming or the CPHVA. Medical staff within the Child Development Unit (CDC) told us they were concerned that the community paediatric service had been partially staffed over a number of years by locum medical staff.

Detailed findings

Incidents, reporting and learning

We found there were systems in place to report incidents. Across services staff we spoke with told us they knew how

Good

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to report incidents and generally received feedback from these. Senior staff told us any incidents which needed sharing with the teams were cascaded through a monthly professional issues and cascade briefing.

There had been 486 incidents within children's community services between May 2014 and October 2014. We saw information that showed the categories of incidents within each service. This allowed the trust to identify themes and trends in services. For example we saw across children's services there had been 42 incidents relating to communication.

We saw information which showed the trust had undertaken a root cause analysis for a serious incident case which highlighted lessons learnt and contributing factors. A root cause analysis (RCA) is a method of problem solving that tries to identify the root causes of incidents. When incidents do happen, it is important that lessons are learned to prevent the same incident occurring again. An action plan had been developed as a result of the incident; actions were on going at the time of inspection.

We found the trust had one action plan following a serious case review. A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. The review looked at lessons than can help prevent similar incidents from happening again in the future. We saw the action plan was monitored to ensure the actions were delivered.

Cleanliness, infection control and hygiene

There were policies and procedures for infection prevention and control. Staff reported they had received infection control training. Health centres and clinics we visited appeared visibly clean. Throughout our inspection we observed good infection control practices such as hand hygiene and cleaning equipment between uses. We found all staff had access to personal protective equipment and hand gel to take with them on visits.

Maintenance of environment and equipment

The clinics we visited were well maintained and were decorated in a suitable manner to meet the needs of children. Staff told us they had the equipment they needed to perform their roles effectively. We found equipment had been serviced and checked appropriately.

Medicines management

We reviewed the management and administration of immunisations by school nursing teams and found these were managed safely. School nurses we talked with explained they had received training and demonstrated an awareness of the 'cold chain' to ensure the correct temperature of immunisations were maintained.

We found within children's services there were some school nurse and health visitor trained prescribers who could prescribe medicines, such as lotions and creams, along with analgesia, such as paracetamol.

Safeguarding

Teams were able to identify the number of children subject to child protection plans, child in need or common assessment framework (CAF) plans. This meant there were systems in place to enable the service to identify the most vulnerable children in their care.

All staff we spoke with were able to explain how safeguarding referrals were identified, referred and followed up. The Safeguarding Children and Young people: roles and competencies for health care staff Intercollegiate document March 2014 stated all clinical staff such as health visitors, school nurses and paediatric allied health professionals require level three safeguarding training.

The trust had a safeguarding team which included named nurses and nurse advisors who gave members of staff advice, training and planned supervision. The trust had a named doctor for safeguarding children. We were told the current doctor's designated time equated to one session per week (one half day) which was low in comparison with other trusts. The usual number of sessions were at least 4 sessions per week. However, the trust had a number of roles in place to support the named doctor's role, including 3 band 7 nurses, and 2.6 WTE administration staff.

The current named doctor had been employed via a locum consultant contract since October 2013. The designated doctor role was currently covered by the trust's board level medical director who was also a paediatrician and lead for the service.

Records systems and management

We reviewed a sample of health records within children's services and found detailed and accurate records. We found the health visiting service had undertaken an audit in

Good

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March 2014 which demonstrated an overall compliance rate for documentation of 94%. This result had showed an improvement year on year. Within all the health centres we visited we found records were stored safely and securely.

When we reviewed records within the health visiting service we found the records contained information on all members of the family and were not separated into individual records. We asked senior staff how they maintained confidentiality if a patient asked to see their record. They told us there was a process where information which did not relate to that person would be removed or redacted before the record would be shared with the person who had requested it.

One of the actions from a serious case review was that health visitors would be able to retrieve archived health visitor records if safeguarding concerns had been identified at the primary health visitor contact. We were told by senior staff a process had been developed to facilitate this. However, during our inspection we found that some staff were unaware of the retrieval process for archived health visitor records, when they had identified safeguarding concerns of school aged children. For example we found some staff in school nursing were unaware of how to retrieve archived health visiting records where there had been historic safeguarding concerns. These concerns may not have been routinely handed over if they had resolved at the time the child had transferred from health visiting to school nursing. This indicated the trust had not shared lessons learnt between children's services to ensure that any significant information in archived records was used to inform a more comprehensive and accurate assessment.

Lone and remote working

We found the trust had a policy for lone-working. We talked with a number of staff across children's services who all demonstrated a clear awareness of the trust's lone working policy and procedure. We saw there were systems in place to record the whereabouts of staff and staff were provided with mobile phones. For example staff in health visiting told us each day there was a duty health visitor who was the contact for staff to report to if they would not be returning to the office at the end of the day.

Assessing and responding to patient risk

Staff within the safeguarding team told us there were policies and procedures to support staff with safeguarding concerns. For example there was a child sexual exploitation matrix which staff could use as a risk assessment to identify vulnerability or risk factors with children and young people.

We found there were systems in place to respond to risk for example if there were concerns about staff visiting a family by themselves staff would visit with a colleague or use an alternative venue to the patient's home. Staff reported they were able to put a note in the care record so this would alert other staff members to the risk. Staff throughout children's services told us they would use this system to alert colleagues.

Staffing levels and caseload

Health visiting teams consisted of health visitors supported by community nursery nurses and administration staff. Health visitors had overall responsibility for the caseloads but would allocate packages of care to nursery nurses to undertake. For example a package of care may be undertaken with a child and family by the nursery nurse on sleep management.

In 2011 the health visitor implementation plan (DH) identified the government's commitment to increase the number of health visitor's nationally by 4,200, to be reached by March 2015. For Leeds Community Healthcare Services this meant there would be an increase to 166 whole time equivalent (WTE) health visitors by March 2015 working in the trust. This overall number of health visitors would include health visiting staff in the trust working in other roles and who may not have face to face contact with children. At the time of our inspection the trust had 155.9 wte health visitors working within the service. We spoke with the service manager who told us they were confident they would meet the trajectory by March 2015. They also told us they provided monthly reports on the health visitor numbers and the trusts performance to the Department of Health (DH).

Lord Laming (2009) in his report on the protection of children in England stated health visitor caseloads should be no more than 400 children. The community practitioner and health visitor association (CPHVA 2009) made further recommendations that 400 should be a maximum caseload and 250 was the ideal caseload number for any health visitor. Senior managers told us a caseload weighting tool had been developed to help establish health

Good

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visiting caseloads determined on level of need by using Indices of Multiple Deprivation (IMD) and local authority areas. As such we found health visiting caseloads had been matched to the local authority areas. For example the tool identified that for caseloads in the 10% most deprived areas health visitors would have a caseload of 250 children. Operational leads within health visiting told us the largest caseloads per health visitor were 500 in a low deprivation area. This meant the trust were working within their caseload weighting tool but did not meet the recommendations of Lord Laming or the CPHVA.

The trust had sufficient specialist community public health nurse (SCPHN) who specialised in school nursing.

In 2004 the Department of Health (DH) in their white paper Choosing health: making health choices easier committed to the provision of 'at least one full time, year round, qualified school nurse for each secondary school and its cluster of primary schools' (school pyramids).The CPHVA (2013) further recommended there should be one full time public health qualified school nurse (SCPHN) for every secondary school and its cluster of primary schools with additional qualified school nurses or community staff nurses according to health need. Within the Leeds area there were 25 school clusters/ pyramids. This meant the school nursing service were working within the DH recommendations from Choosing Health or CPHVA guidance of one qualified school nurse for every secondary school and their cluster of pyramids.

The family nurse partnership (FNP) team had 10.6 wte nurses which managed to offer the programme to 17% of the eligible mothers. Additional funding had been secured to enable the team to offer the programme to 20% of eligible mothers. At the time of our inspection further recruitment was planned.

Managing anticipated risks

Before our inspection we requested the children's unit risk registers and were provided with these. We found there were four risks which related to children's community services. For all the risks we saw the risk was identified and actions had been put in place to reduce the risk. For example pre-planned maintenance was not commissioned for children's equipment. This caused a potential risk that equipment which was not maintained may not be fit for purpose and may present a risk by using it. The service had put measures in place which included the equipment being serviced externally and discussions were taking place with commissioners to look at regular maintenance programmes.

Are Community health services for children, young people and families effective?

Good

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

Overall children's and young people's services were rated good for providing effective services. The Healthy Child Programme was delivered through skill mixed child health teams. The teams consisted of health visitors, school nurses, community staff nurses, nursery nurses, assistant practitioners and health care assistants. Initiatives such as UNICEF baby friendly were in operation.

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.

We reviewed evidence which demonstrated patient outcomes and performance information was closely monitored and reported by children's services in the trust. For example we saw performance data which monitored compliance with the key contacts within the Healthy Child Programme for the 0-5 age group.

Although managers and staff told us supervision occurred on a three monthly basis the trust's systems were unable to demonstrate this happened. This meant the trust did not have an effective system to record supervision.

Detailed findings

Evidence based care and treatment

The Healthy Child Programme (HCP) is an early intervention and prevention public health programme that offers every family a programme of screening tests, immunisations, developmental reviews, information and guidance to support parenting and healthy choices. The trust provided this service through teams that consisted of health visitors, school nurses, community staff nurses, nursery nurses and health care assistants. We found the health visiting service delivered the whole of the HCP and were looking to introduce an additional contact at three-four months.

Initiatives such as UNICEF baby friendly initiative were in operation. The UK Baby Friendly Initiative was based on a global accreditation programme of UNICEF and the World Health Organization. It was designed to support breastfeeding and parent/ infant relationships by working with public services to improve standards of care. The health visiting service was currently accredited to stage three. This meant the service had demonstrated they were meeting the standards required for staff training, education and support to parents.

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. The FNP programme was a voluntary health visiting programme for first-time mothers that was underpinned by internationally recognised evidence based guidelines.

The trust monitored and identified whether they followed appropriate NICE Guidance relevant to services they provided. For example we saw the children's community nursing team were compliant with NICE guidance on pressure ulcers. Health visitors also told us they shared best practice with other professionals and agencies. One health visitor told us they had shared NICE guidance on postnatal care with the GP practice in relation to the 6-8 week health check for babies.

We looked at a number of health care records and found in the majority of records a full assessment of the person's needs had been undertaken. In one health visiting record we looked at we found an assessment of the mother's maternal health including postnatal depression had been undertaken. We saw within the care plan the practitioner had used NICE guidance questions to assess the mother's mood and then used a more specific tool (Edinburgh postnatal depression tool) to aid the assessment. The Edinburgh postnatal depression tool was used as an assessment of the symptoms and difficulties the person was experiencing.

Nutrition and hydration

The health visiting service had infant feeding co-ordinators to support parents and staff with feeding concerns. We saw throughout the Leeds area there were a number of baby cafes and breastfeeding support groups to support

Are Community health services for children, young people and families effective?

Good

breastfeeding mothers with any concerns or worries. The trust also offered specialist feeding clinics for more complex feeding concerns. Staff reported this clinic was well attended and evaluated by parents.

Approach to monitoring quality and people's outcomes

We reviewed evidence which demonstrated patient outcomes and performance information was closely monitored and reported by children's services in the trust. For example we saw performance data which monitored compliance with the key contacts within the Healthy Child Programme for the 0-5 age group; for example 54% of parents received a primary birth visit within 14 days.

The overall rate of babies who were breastfeeding in quarter one of 2014/ 2015 was 50.4% which was better than the target of 44%. We found the service were using a range of initiatives to improve breastfeeding rates which included information at antenatal contacts, peer support groups and baby cafes.

We saw the school nursing service achieved their key performance indicators for height and weight measurements for the national childhood measurement programme (NCMP) were within expected targets.

Specialised services such as the children looked after team (CLA) and the FNP team also monitored indicators to ensure they were meeting their respective targets. For example we saw in the CLA for the year 2013/ 201414 100% of health needs assessments had been undertaken within 20 days which met the CQUIN target.

Competent staff

There were formal processes in place to ensure staff had received training, supervision and an annual appraisal. We talked with a number of health visitors, school nurses, therapists and specialist teams such as the CLA team and FNP team. All staff we talked with told us they undertook a variety of mandatory training and received an annual appraisal. For example we saw information that 85% of staff within children's services had received an annual appraisal.

Health visitors and school nurses received a minimum of quarterly safeguarding supervision of their work with their most vulnerable babies, children and young people. We were told safeguarding supervision was provided by the safeguarding team. Staff told us they could request this more frequently if required. The designated doctor for children looked after told us how child protection cases were subject to regular and ongoing supervision and review with medical staff.

We were told by workforce services the trust had introduced a central recording system for safeguarding supervision in April 2014. This information showed 770 staff across from across the trust were required to undertake child protection supervision. The information showed that from 1 August 2014 378 members had recorded supervision which was a recording rate of 49.9%. Although managers and staff told us supervision occurred on a three monthly basis the trust's systems were unable to demonstrate this happened. This meant the trust did not have an effective system to record supervision.

Multi-disciplinary working and coordination of care pathways

We were provided with and observed a range of evidence which showed how services worked with other agencies to meet the needs of children and young people. For example we spoke with health visiting teams who told us they worked closely with local children's centres to meet the needs of children and their families. They did this through joint allocation meetings with children centre staff to identify the support the family needed and the most appropriate person to do this.

Within health visiting and school nursing we found staff worked less closely together to meet the needs of children and young people. Staff reported they were involved in child protection cases at the same time but did not routinely undertake joint working with a family. We found the service had developed a standard operating procedure for staff to follow when children transferred from the health visiting teams to the school nursing service. Standards had also been developed for communication between midwifery and health visiting. We found links with midwifery teams were more developed in some areas than others though work was underway to improve this.

Within the sickle cell and thalassemia service we found the service worked closely with a range of other professionals including hospital consultants, GP's, health visitors, school nurses and staff in education facilities. For example staff told us how they worked with hospital consultants to meet children and young people for three monthly reviews of their care and treatment.

Are Community health services for children, young people and families caring?

Good

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

Summary

Overall we rated children's and young people's services good for the quality of care. As part of our inspection we observed care in patient's homes, clinic settings and observed staff speaking to clients on the telephone. In order to gain an understanding of people's experiences of care we talked to 33 people who used services within children's services.

Throughout our inspection we found members of staff treated children, young people and families with dignity and respect. Staff we spoke with told us they were passionate about delivering a quality service. People who used services told us they were happy with the care they and their child received.

Detailed findings

Compassionate care

As part of our inspection we observed care in patient's homes, clinic settings and observed staff speaking to clients on the telephone. In order to gain an understanding of people's experiences of care we talked to 33 people who used services in children's services. Staff we spoke with told us they were passionate about delivering a quality service. People who used services told us they were happy with the care they and their child received. One parent told us "I'm very happy with the care my daughter receives."

We received four comment cards from parents who accessed children's services at the trust. All the comments we received were very positive. One person wrote "I've been really pleased with the care we have received. Care has been excellent."

Dignity and respect

Throughout our inspection we found members of staff treated children, young people and families with dignity and respect. On one of the comment cards the person wrote "I have felt okay to ask questions and have felt treated as an individual." People we spoke with told us staff were caring, friendly and helpful in the contacts they had with children and their families.

We saw on one home visit with a health visitor to a family how they treated the person with dignity and respect. On another home visit we observed the member of staff engaging with the children whilst discussing care and support with the parents.

Patient understanding and involvement

People we spoke with during the inspection told us they had been involved in the planning of their care. We saw trust comment cards were used within the community children's physiotherapy service so patients and their relatives could share their comments, compliments or concerns. On one card the person wrote "little learners is an excellent service, my child has benefitted lots from it. They really enjoyed it thank you."

Within the children's occupational therapy team feedback had been sought on the bike therapy group from both parents and children. We saw all five of the parents who had responded felt the sessions had helped their child.

On the trust website we found there was a member's zone which encouraged children and young people to become involved and influence how services were delivered. The trust provided information which showed there were 134 public members aged 14-16 years and 69 aged 17-18 years of the member's zone. We saw information which showed the school nursing service had sought views from young people and parents on the development of app and website based information for people to access. This information was publicly available on the trust's website for people to access.

Emotional support

Staff we spoke with were child and family focused and offered support to help children and parents cope with their care and treatment. Within health visiting services staff assessed mothers for signs of postnatal depression and offered support to the mother if this was needed. For example we saw in one record where the mother had indicated they felt low in mood listening visits had been offered. Listening visits are associated with a reduction in depression/ low mood, and an improvement in life satisfaction. This demonstrated the service followed best practice guidance in supporting women with low mood.

Are Community health services for children, young people and families caring?

Good

During our inspection we visited the stammering centre and observed a child who attended for their visit. We found the speech therapist involved both the child and parent in the assessment and planning of their care.

Promotion of self-care

We saw examples of courses and information in the stammering centre which promoted self-help. For example we saw an after school teens group for young people aged 12-17 years old which provided young people with an opportunity to meet other young people who stammer and fun activities to practice fluency. This demonstrated how the trust promoted self-care, peer support and independence.

Are Community health services for children, young people and families responsive to people's needs?

Good

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

Summary

Overall we rated children's and young people's services as good for providing responsive services. The trust had a range of specialist services to meet the different needs of people which included the stammering centre, sickle cell and thalassaemia service and Hannah house.

Children's services were provided in a number of settings including the patient's home, health centres, children centres and the child or young person's school. Health visiting staff reported they offered out of hour's clinics in the early evening and on a Saturday morning. We found within health visiting and school nursing 'drop in' clinics were offered so patients could access the service without an appointment which meant the service was accessible.

Children's services within the trust followed the trust's NHS complaints processes. The main themes form the complaints were communication, staff attitude and treatment. Staff within children's services told us themes from complaints were shared at monthly team meetings.

Detailed findings

Service planning and delivery to meet the needs of different people

The stammering support centre offered specialist services to patients of all ages from childhood through to adulthood. The centre offered specialist speech and language therapy assessment and support for children, young people and adults who stammer in the Leeds, Yorkshire and Humber region. We found the service tailored services to different age groups for example we saw a five day course had taken place in October 2014 aimed at developing confidence, develop positive thinking and problem solving skills. The course was aimed and young people aged 12-16 years old.

We found Hannah House offered a short break service for children with complex health needs who required nursing care up to the age of 19. Short break services allow parents or carers to have a break from caring 24 hours a day.

Parents told us if there was a bed cancellation at short notice staff at Hannah House would offer this to another child and family so they would benefit from respite instead of the bed being empty.

The trust had a team of school nurses who worked in specialist inclusive learning centres to support children and young people with their complex health needs whilst they attended school. Staff told us children and young people could access them at any time and this helped build positive therapeutic relationships. For example staff told us one young person who had been self-harming had felt confident enough to speak to the nursing team so they could get support.

Within early years services the trust had a well-established FNP team. The FNP programme was a voluntary home visiting programme for first time young mums and dads, aged 19 or under. A specially trained family nurse visits the young parents regularly, from early in pregnancy until the child was two. The Family Nurse Partnership programme was underpinned by an internationally recognised evidence base, which demonstrated it can improve health, social and educational outcomes in the short, medium and long term.

Access to the right care at the right time

Children's services were provided in a number of settings including the patient's home, health centres, children centres and the child or young person's school. Health visiting staff reported they offered out of hour's clinics in the early evening and on a Saturday morning. We found within health visiting and school nursing 'drop in' clinics were offered so patients could access the service without an appointment which meant the service was accessible. For example school nurses offered drop in clinics in schools each week.

Within health visiting, school nursing and the FNP team we found they delivered services in line with recognised programmes of care however there was flexibility to provide additional support outside of these programmes. For example in health visiting we saw additional support was offered outside of the healthy child programme contacts to support a mother who was experiencing low mood.

Are Community health services for children, young people and families responsive to people's needs?

Good

The trust was responsible for the designated child protection unit which was a stand-alone facility located at the St James's Hospital campus. We found the unit was located adjacent to the Thackeray Medical Museum and not close to other clinical services in the hospital. The designated doctor for looked after children explained that all children's acute services (including inpatient services and investigations) were located at the Leeds General Infirmary site. This meant children sometimes required ambulance transportation when investigations were required.

Discharge, referral and transition arrangements

There was a standard operating procedure in place to handover children's care from the health visiting service to school nursing. We asked managers and staff how information on individual children was transferred between health visiting services and school nursing. Staff told us for children with complex needs for example child protection a form was completed for the school nurse with the relevant information. However if at the time of transfer the child did not have complex needs but had previously this information may not be highlighted to the school nursing service. This meant the school nursing service may not have access to all the relevant information about the child or young person which was relevant to their care and support.

In 2012 the DH developed a school nursing and health visiting partnership pathway for supporting children and their families. The overarching rationale for the pathway was to achieve consistent, seamless support and care and this was best achieved by partnership working between the services. When we spoke with staff in both services they told us they tended to work with each other on child protection cases but did not routinely undertake joint work with children and their families.

The CLA team offered support to young people who were about to or had left care. The team continued to support young people by reviewing their health needs up to a maximum age of 25. This meant the trust had processes in place to support young people with their health needs while they moved from local authority care to independent living.

Complaints handling (for this service) and learning from feedback

Children's services within the trust followed the trust's NHS complaints processes. We saw there were complaints leaflets available within the areas we visited**.** Staff told us they knew how to manage complaints locally and how to escalate where appropriate. We saw in the period of May-October 2014 children's services had received nine complaints. The main themes form the complaints were communication, staff attitude and treatment. Staff within children's services told us themes from complaints were shared at monthly team meetings.

Are Community health services for children, young people and families well-led?

Good

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

Summary

Overall we rated children's and young people's services as good for being well-led. Staff within the different children's services were clear about the vision of their individual service and the trust's vision and values. However a strategy between health visiting and school nursing which supported how both services worked together to support children, young people and their families needed to be developed.

Governance arrangements were in place and learning took place, however some medical staff in CDC did not always receive timely feedback from clinical incidents or concerns they had raised.

There was an open culture, and whilst not all staff had regular formal meetings with their managers outside of their appraisals, they told us they felt well supported and could access their managers when they needed to.

Staff across services told us they felt the service reviews had not been well communicated and they did not feel listened to. They told us the trust had held consultation events and meetings but the information provided had not been sufficient. The majority of staff we spoke with told us they understood the reasons for the reviews but felt the communication of change was not always as good as it could be.

Detailed findings

Vision and strategy for this service

Health visiting services were on trajectory to ensure the local population's needs were met in line with the health visitor implementation plan which was monitored by NHS England. Staff demonstrated knowledge and understanding of the health visitor implementation plan and its aim to expand and develop the service and were able to articulate how the service were implementing this and when this would be achieved by.

When we spoke to staff within the different children's services they were clear about the vision of their individual service and the trust's vision and values. For example staff in the health visiting service were able to articulate the need for early intervention and working closely with children's centres to support children and their families. However we found there was no strategy between health visiting and school nursing which supported how both services worked together to support children, young people and their families. Senior staff told us there had been discussions about developing a 0-19 service but no firm plans had been put in place at the time of our inspection.

Governance, risk management and quality measurement

We saw minutes of meetings we showed the children's management team met monthly to review quality and risk issues. For example we saw the last six months of minutes for the performance meeting and areas such as recruitment, performance, staffing and sickness were discussed at each meeting.

Just before our inspection a concern had been raised regarding respite care and the short break service at Hannah House. Senior managers told us what immediate actions they had put in place and staff we spoke with told us they felt supported while the investigation was being undertaken.

We found action plans were developed following serious incidents with children and young people the actions and progress had been monitored. However we found learning was not necessarily shared across other services within the trust for example an incident regarding health visiting records was not shared with school nursing.

We found some medical staff in CDC had not always received timely feedback from clinical incidents or concerns they had raised. For example we were told by staff of an incident/ near miss which had occurred in August 2013. Staff told us that the investigation into this was only about to take place in November 2014, over a year after the original incident had occurred. In another incident we reviewed we identified that the incident had been reported in December 2013 but the investigation was not completed until September 2014. It was unclear whether the service put any immediate actions in place to stop a reoccurrence

Are Community health services for children, young people and families well-led?

Good

however the delay in the investigation and identification of any learning points meant the service could not be assured that there were sufficient measures in place to prevent a reoccurrence of the incident.

Leadership of this service

The majority of staff we spoke with spoke positively about their line managers and the management of the services they worked for. Staff within therapy services told us they felt valued and well supported by their direct line management team. However staff in some services felt less positive about leadership within the trust particularly in relation to the service reviews and how they were managed/ handled.

Across all the services staff we spoke with told us outside of their appraisals they did not have regular meetings with their line manager. All staff told us they were confident they could request a meeting if they needed this and their line manager would facilitate this.

Band 6 staff within health visiting teams told us they were encouraged to self manage in their teams. Each band 6 took on a lead responsibility for example liaison with a GP practice or management of another member of the team.

Culture within this service

We found there was a positive culture among all the staff and teams we met. Staff spoke positively about the services they provided and told us they endeavoured to provide high quality care to children and young people. We observed staff working well together and they reported good relationships with other multi-agency partners such as children's centres and schools.

Public and staff engagement

We saw examples of public and patient involvement within services. In the children's occupational therapy we saw results from a survey in which parents had described staff "as a positive influence in terms of the support and encouragement they offered and their ability to develop the child's skills."

We talked with staff across a number of services who told us they felt the service review had not been well communicated or well led and they did not feel listened to. They told us the trust had held consultation events and meetings but the information provided had not been sufficient. The majority of staff we spoke with told us they understood the reasons for the reviews but felt the communication of change was not always as good as it could be. Staff told us when they had asked questions regarding the reviews these had not always been answered fully and in some instances answers to their questions had not been given. One member of therapy staff told us "they tell us about the changes but don't listen to what we say in return." Another member of staff said they felt there was "an apparent lack of care for the feelings of staff in a prolonged period of change."

The medical director had requested an invited review of the trusts medical child protection service in January 2014 by the Royal College Paediatrics and Child Health (RCPCH). We found this had been completed and a report recently shared with the medical director and community paediatricians. The report made a number of recommendations. We were told the trust was now working with the community paediatric team to develop measures to address the recommendations made in the RCPCH report.

Innovation, improvement and sustainability

In the CLA team staff were working with young people to develop a web based application which would allow the young person to have access to their health history. The school nursing service had also sought views from young people and parents on the initial development of app and website based information for people to access and this was on the next stage of development.