East Cheshire NHS Trust

RJN

Community health services for children, young people and families

Quality Report

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

Summary of findings

Ratings

Overall rating for Community health services for children, young people and families	Requires Improvement 
Are Community health services for children, young people and families safe?	Good 
Are Community health services for children, young people and families effective?	Requires Improvement 
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?	Requires Improvement 

Summary of findings

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Overall summary

We found mixed evidence of staff engagement with the trust board. We were told by community staff that the trust was focused on Macclesfield District General Hospital and they felt separate from the acute trust. We were told that senior managers were not visible.

Management and team leader posts had been condensed, making visibility across the whole district challenging.

The trust had restructured services in order to meet the needs of the population, but the changed structures had not been embedded at the time of the inspection. There was little evidence that children, young people and families had been involved in decisions about the service redesign.

There were systems in place for reporting and investigating incidents and there was evidence that learning from incidents occurred. Safeguarding arrangements were embedded in practice and staff were well supported with regular safeguarding supervision.

The clinics we visited were clean and well maintained and staff followed infection control procedures. Staff were passionate about providing person-centred care and understood the importance of engaging with families in order to understand their situation and the support they required.

Staff aimed to assess and deliver treatment in line with current legislation, standards and evidence-based practice. We found that staff numbers were sufficient to deliver the Healthy Child Programme but this was new to teams as they were becoming fully staffed following significant recruitment.

Summary of findings

Background to the service

East Cheshire NHS Trust community health services for children, young people and families provided a range of services delivered to people across East, Central and South Cheshire and Vale Royal. Core services included:

- Health visiting
- Continuing healthcare for children
- School nursing
- Children's therapy services (physiotherapy, speech and language therapy and occupational therapy)
- Community sexual health services for people of all ages
- Specialist nurse services such as the children's diabetes nurse specialist
- the Family Nurse Partnership (FNP).

The FNP 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 provided services in both the community and schools, and teams aimed to provide a flexible service where possible.

Children and young people under the age of 20 years make up 23% of the population of East Cheshire, and 9% of schoolchildren are from a minority ethnic group. The health and wellbeing of children in East Cheshire are mixed compared with the England average.

Infant and child mortality rates are similar to the England average. The level of child poverty is better than the England average with 13% of children aged under 16 years living in poverty.

Children in East Cheshire have better than average levels of obesity: 8% of children aged 4–5 years and 15% of children aged 10–11 years are classified as obese.

The MMR (measles, mumps and rubella) immunisation rate is better than the England average. The immunisation rate for diphtheria, tetanus, polio, pertussis and Hib (Haemophilus influenza type b) in children aged two is also better than the England average.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Director of EJ Consulting Ltd: Bradford Hospitals NHS Foundation Trust.

Head of Inspection: Helen Richardson, Care Quality Commission

The team inspecting community health services for children, young people and their families included a CQC inspector, a school nurse, a health visitor, a paediatric nurse and a sexual health nurse.

Why we carried out this inspection

We carried out this inspection as part of our comprehensive inspection of East Cheshire NHS 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, we reviewed a range of information we hold about the core service and asked other

Summary of findings

organisations to share what they knew. We held a listening event in Macclesfield on 9 December 2014 when people shared their views and experiences of community health services for children, young people and their families. Some people also shared their experiences by email or telephone.

We carried out an announced visit from 9 to 12 December 2014.

During the inspection, we held focus groups with staff who worked within the service, such as school nurses and health visitors. We observed how people were being cared for and reviewed care or treatment records of people who use the services.

We visited six locations including the sexual health centre at Macclesfield District General Hospital, went on one home visit and two school visits, and observed various clinics. During our inspection we spoke with 103 people, including families and children, who shared their views and experiences of the services. We spoke with members of staff at all levels. These staff included school nurses, health visitors, speech and language therapists, physiotherapists and occupational therapists. We spoke with service managers in children's and young people's services and with therapy and support staff.

What people who use the provider say

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

We spoke to eight young people following human papilloma virus (HPV) immunisation and seven of them told us that they were familiar with the role of the school nurse as she had spoken to them at a school assembly. All eight pupils told us that they would rate the service between nine and 10 out of 10.

We saw that patient surveys had been undertaken in therapies (in 2014) and that the responses demonstrated a high level of satisfaction. For example, 93% of paediatric therapy patients said that they definitely felt involved in decisions about their child's care and treatment. In speech and language therapy, 92% said that they received a full explanation of why their child had been referred, and 97% said that they were given sufficient time to discuss any concerns.

Good practice

Our inspection team highlighted the following areas of good practice:

- Hebden Green Community School had implemented a model of shared leadership between the head teacher, lead therapist and lead nurse to ensure that the needs of the child were central, with the aim of keeping children in school to improve individual outcomes.
- School nurses at Eaglebridge Clinic in Crewe had developed the duty nurse rota to access and respond to all enquiries on a daily basis on behalf of the team. This ensured that prompt, responsive care could be provided.
- Eaglebridge Clinic school nurses also had a weekly allocation meeting to ensure that all safeguarding commitments were covered by the team, ensuring consistency where possible.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider should ensure that services for children, young people and their families are consistently meeting key areas of the Healthy Child Programme.

The provider should ensure that there is clear, effective leadership and integration of services so that teams do not work in isolation from the rest of the trust.

Summary of findings

The provider should ensure that all staff, including managers, are aware of the identified risks within community health services for children, young people and their families.

The provider should consider performing population health needs assessments in order to identify the needs particular to a school or location.

East Cheshire 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 Community health services for children, young people and families safe?

By safe, we mean that people are protected from abuse

Summary

Staff knew how to manage and report incidents. Staff received feedback on incidents reported to the trust and we saw that there had been learning and development from incident investigations.

Clinics and health centres were clean and in a good state of repair. Staff followed the 'bare below the elbow' policy in clinical areas and hand hygiene standards were met. Staff used appropriate hand-washing techniques and personal protective equipment (PPE). There were safeguarding processes in place and staff understood the need to prioritise safeguarding. Staff understood the process for escalating safeguarding concerns.

Overall, there were adequate numbers of staff to deliver the service. However, we found that staff shortages had had an impact on the health visitors' ability to undertake antenatal visits to some families. Following a successful recruitment campaign, staff were confident that this issue would be addressed by January 2015.

Detailed findings

Incidents, reporting and learning

- From 1 November 2013 to 31 October 2014, a total of 49 incidents were reported that were relevant to children, young people and families in the community; of these, 96% were rated as 'low harm' or 'no harm'.
- The trust had systems in place for reporting incidents. Staff used the electronic incident-reporting system and they were encouraged to report all incidents and near

misses. Staff confirmed that incidents of all levels of harm were reported, including those of no harm and that feedback was always given and included clear actions to be taken.

- The incidents reported were predominantly related to confidentiality, which resulted in no harm. The services reporting the incidents operated a paper-based records system and therefore experienced a higher number of this type of incident than those using electronic records. Staff told us that an electronic records system would be used in school nursing from January 2015, assisting in the reduction of risks.
- The trust reported one serious incident in relation to a child who developed a grade three pressure sore following an absence from school due to ill health. The service had undertaken a full investigation and had identified lessons learned. Staff were aware of the incident and could describe the lessons identified as part of the investigation.

Cleanliness, infection control and hygiene

- The clinics we visited were clean, tidy and in a good state of repair.
- Staff followed the 'bare below the elbow' policy in clinical areas.
- We observed clinical practice in well baby clinics and immunisation clinics and during the administration of medicines; we saw that hand hygiene standards were met. Staff used appropriate hand-washing techniques and gel hand sanitizers. Staff had access to PPE.
- A hand hygiene observational tool was used each quarter and results were collated by the infection control team. In the last quarter (July to September 2014) we found that one team we visited had achieved 100% for hand-washing and 'bare below the elbow' standards. Action plans were in place where improvements to be made were identified.

Maintenance of environment and equipment

- Clinics were well maintained and were decorated in a suitable manner to meet the needs of families.
- Equipment was of a good standard and well maintained. A maintenance contract was in place which provided an annual service and undertook repairs as required. However, staff told us that a set of infant weighing scales in one clinic was not working and would be out of use until the next year's maintenance cycle. This resulted in staff having to borrow equipment from colleagues.
- We saw patient areas with limited access for disabled people, such as Congleton War Memorial Hospital. Access to the main reception area was via a significant number of steps that wheelchair users or those with walking difficulties would have problems negotiating. There was vehicle access via a sloping road but there was no footpath for safe access for wheelchair users or pedestrians.

Medicines management

- School nurses worked to patient group directives (PGDs) in relation to the school immunisation programme. PGDs are written instructions for the supply and administration of medicines to groups of patients who may not be individually identified before presenting for treatment. We saw that the PGDs were correct and had been signed by a senior clinical manager and by the pharmacy. Staff told us that the PGDs were in place in time for the start of the immunisation programme.
- There was an effective cold chain system for immunisations that was managed by the trust pharmacy. Vaccines were kept in a cool box throughout the immunisation sessions with a thermometer monitoring the temperature.
- A number of health visitors were non-medical prescribers; this was a requirement of the post. The trust commissioned training sessions during 2013/4 and 2014/15 that provided health visitors with updates on the legal and professional framework for Non- Medical Prescribing. However, some staff told us that there was no update training for prescribing available to them. This meant that there was a risk that staff could be unaware of changes to recommendations in the prescribing process.
- We observed the administration of medication to two children by the special school nurses. Medication was administered safely and recorded accurately and in a timely manner. We saw that medications were stored correctly in individual drawers for each child inside a locked room. PPE, such as gloves, were available and used appropriately.

Safeguarding

- Staff were confident about processes for safeguarding children. They were aware of local authority procedures, were well supported and were able to access additional support when it was needed.
- Safeguarding supervision was undertaken every three months by all health visitors and school nurses. In addition, there was also 'looked after children' supervision available. Staff told us that they were well supported by the specialist safeguarding team, which was accessible and provided a high level of professional advice.
- Data provided by the trust showed 88% of school nurses and 86% of health visitors had received level 1 safeguarding training and 90% of both staff groups had received level 2 safeguarding training.
- The trust had clear procedures for the escalation of concerns about a child's welfare. A clear flow chart of the procedures and decision-making tree had been produced by the safeguarding team for staff to follow.

Records systems and management

- Services mainly used paper-based records. Records showed that evidence of planning and assessment, appropriate referrals, feedback and next steps were documented clearly.
- However, records were difficult to follow and it was difficult to find information in them. This observation was supported by two health visitors we spoke with. They did not report any issues of records going missing, or any issues with transportation of records between sites.

Lone and remote working

- There were lone and remote working arrangements in place. Health visitors told us that, following a risk assessment, families considered as being high risk or living in high-risk areas were not visited alone but were visited by two health visitors where appropriate. High-risk families were made known to the health visitors by the Multi-Agency Risk Assessment Conference (MARAC).
- The lone worker policy was implemented safely in teams, with staff clear about the need to ensure each other's safety, particularly at the end of the working day. However, we did find a lone worker in a clinic setting where there was no formal buddy system in place. The staff member used a variety of informal buddies; this met the requirement of the lone worker policy but colleagues in other bases were never sure what arrangements had been made.

Assessing and responding to patient risk

- Individual teams demonstrated ways in which they assessed and responded to risk in order to provide a safe service for children, young people and their families.
- Termination of pregnancy services were commissioned separately with a clinic based in Macclesfield. However, staff raised concerns to us that in some cases, young vulnerable people had to travel out of area to access this service.

Staffing levels and caseload

- The 'A Call to Action: Health Visiting Implementation Plan' had been successful in recruiting health visitors in accordance with national recommendations, resulting in the health visiting team having the capacity to respond to individual needs. However, while the recruitment process was ongoing, we heard from health visitors that they were unable to make antenatal contact with some families due to a lack of capacity. Records showed that from April 2014 to August 2014 the health visiting (East) team had a staff turnover rate of 4% and the health visiting (Central) team had a turnover rate of 7%. We were told that this situation would be resolved in January 2015 when newly appointed staff would start working in the teams affected.
- In 2009, Lord Laming made a recommendation in his report on the protection of children in England that health visitors should not have a caseload of more than 400 children. The Community Practitioner and Health Visitor Association (CPHVA) recommends that health visitors' caseloads should be around 250 children up to four years of age with a maximum of 400. We found that the average caseload size was in line with recommendations. The 'A Call to Action' plan identified recommended health visiting numbers for East Cheshire and progress towards the recommended numbers had been successful, with only three outstanding appointments to be made.
- We were told by a school nursing team that it did not have sufficient staff to deliver the full Healthy Child Programme (HCP). The team told us that the equivalent of four whole-time staff served a total of 15,000 children

and young people between the ages of four and 19 years in seven high schools and their corresponding primary schools, plus a pupil referral unit and a school for education and behaviour difficulties. The recommendation of one school nurse per high school pyramid (a specified group of a high school and associated primary schools in the local area) was therefore challenged in some areas. However, overall the whole-time school nurse per pupil ratio in the district averaged at one to 3,750, which was better than the recommended level.

Managing anticipated risks

- Services had plans in place to manage and mitigate anticipated risks including seasonal incidents such as bad weather.

Requires Improvement

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

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

Data showed that only 50% of children received a review between the ages of two and two and a half. This demonstrated a reduced level of performance against expected standards as the child progressed from being an infant. Breastfeeding statistics were worse than the England average.

The Healthy Child Programme (HCP) was delivered through the health visitor and school nurse services. We saw good performance in delivery of the HCP at birth and at 12 months. However, the data provided did not include the antenatal contact performance. Some health visiting teams told us that they had been unable to make antenatal contact with some families due to a lack of capacity.

Staff assessed and delivered treatment in line with current legislation, standards and recognised evidence-based guidance. There was evidence that outcomes for children, young people and their families were monitored and that benchmarking took place with neighbouring providers.

Care pathways were used to ensure a consistent approach to needs such as postnatal depression. Staff were qualified and competent to undertake their duties and attendance rates at mandatory training were high. We found that staff received an annual review, but the policy for clinical supervision was not being followed. This meant that operational and clinical supervision was available on request and therefore varied from individual to individual and from team to team.

Detailed findings

Evidence-based care and treatment

- The HCP is an early intervention and prevention public health programme that offers every family a programme of screening tests, immunisations, development reviews, and information and guidance to support parenting and healthy choices.
- The HCP was delivered by health visitors, school nurses and Family Nurse Partnership (FNP) nurses. School nurses and health visitors told us that some elements of the programme, such as antenatal contacts, were not undertaken in line with requirements and that health promotion and public health activity were not delivered consistently. Staff told us that this was mainly due to staff vacancies but that all activities resumed when vacancies were filled. This meant that the service was inconsistent across the district and individuals experienced different levels of service depending on location and the staffing levels in the area.
- There was no evidence of health needs assessments being undertaken for the school-age population. We were told by school nurses that the demand for safeguarding work had increased and that this had had a detrimental effect on their public health role in schools.
- Health visitors used the Edinburgh Postnatal Depression Scale to assess for postnatal depression. The protocol and decision tree were clear and were demonstrated in the form of a flow chart.
- Several care pathways were developed and used in speech and language therapy, such as the dysfluency care pathway, ensuring standardised evidence-based care.
- East Cheshire NHS Trust provided an FNP programme. We were told that in February 2015 the first children through the programme would transfer to the general health visiting teams. The FNP programme provided intensive support to young mothers and their children up to two years of age.
- Child health records showed that good practice was followed, such as advising mothers to make up formula feeds individually, fresh for each feed, and advising mothers of the risks of letting babies sleep in car seats.

Nutrition and hydration

- Breastfeeding initiation rates were 69%, a rate that was worse than the England average; breastfeeding prevalence at six to eight weeks after birth was 39%, which was also worse than the England average. The service had identified this as an area for improvement and an action plan was in place. Support to breastfeeding mothers was provided by health visitors,

Requires Improvement

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

children's centres and peer supporters, depending on the choice of the mother. Enhanced support by health visitors to mothers who were breastfeeding was delivered as part of the HCP.
- In addition, there was specialist breastfeeding coordination and breastfeeding audits were conducted across the district. The trust had received the United Nations Children's Fund stage 3 accreditation for the Baby Friendly Initiative in supporting parents with breastfeeding.

Patient outcomes performance

- Health visiting teams provided a service to children from birth to four years, at which stage children would move to the school nursing teams, which covered children from four to 19 years. Staff understood the transfer process, which varied according to the child's and family's needs, and they were committed to providing a good service with a smooth transition between teams.
- The delivery of the HCP was monitored on a quarterly basis. Data from quarter 2 of 2014 indicated that 98% of births were visited by a health visitor within 14 days, while 88% of children received a 12-month review. However, only 50% of children received a review between the ages of two and two and a half. This demonstrated a reduced level of performance against expected standards as the child progressed from being an infant.
- Data provided did not include the antenatal contact performance but some health visiting teams told us that they had been unable to make antenatal contact with some families due to a lack of capacity. We were told that this situation would be resolved in January 2015 when newly appointed staff would start working in the teams affected.

Competent staff

- All new and newly qualified staff were offered a period of preceptorship. The trust used the Institute of Health Visiting preceptorship programme, a nationally recognised and validated system.
- Staff reported that they had received an appraisal in the previous 12 months. Although staff received safeguarding supervision every three months, there was no systematic process for clinical or operational supervision in place. The trust had a clinical supervision policy in place. However, this was not being followed. Operational and clinical supervision could be requested and therefore varied from individual to individual and from team to team.
- All staff received mandatory training in a range of areas including infection control and safeguarding. We saw that 96% of mandatory training had been completed by staff.

Multidisciplinary working and coordination of care pathways

- There was good multidisciplinary team working and interagency working within the service, although the standard was not consistent across all teams. We found an example of good practice at Hebden Green Community School, where there was shared leadership between the head teacher, lead therapist and lead special school nurse. This ensured that the needs of the child were central, with the aim of keeping children in school to improve individual outcomes. The head teacher told us that the health staff were the "life blood of the school".
- We saw that a number of postnatal support groups were available throughout the district, many of them operated in partnership with children's centres: for example, the Lavender group at Knutsford Children's Centre where the health visitor led the emotional health sessions. The Lavender group was viewed positively by parents: 100% of attendees rated the group five out of five.
- Cheshire without Abuse ran a multi-agency project known as Jigsaw, providing a recovery programme aimed at children who had lived in a situation of domestic abuse but who were now living in a safe environment. The 16-week programme was supported by health visitors working with other agencies to help children and young people affected by domestic violence make sense of their experiences and understand the elements of a healthy relationship. Evaluation of the project in 2013 demonstrated overall improvements in all areas that were measured, such as social behaviour, emotional problems and conduct disorder.

Good

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

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

Summary

Children, young people and families told us that they received compassionate care with good emotional support. Young people told us that they felt informed and involved in their healthcare.

Patient experience surveys showed a high level of satisfaction with services. Children, young people and their families who used the services felt that they had been treated with dignity and respect, and had received support to cope emotionally with their treatment and care. Staff were child- and family-focused and they looked at the family unit when completing their assessments.

Detailed findings

Compassionate care

- Staff were passionate about providing good-quality, person-centred care. Staff were clear about the importance of engaging with families in order to understand their situation and the support they required.
- We observed care given in a number of settings including clinics, schools and patients' own homes. At all times verbal consent was sought prior to interventions and staff demonstrated kindness and a friendly manner in their interactions.
- A recent audit of child therapies showed that 97% of families said that they were always treated with care and compassion. The trust told us that satisfaction surveys for both school nursing and health visiting had been carried out within the previous 12 months and an action plan for improvement was in place. However, staff did not mention this during our discussions with them.

Dignity and respect

- Staff were able to describe how they would maintain dignity and privacy for children in different settings and we observed many examples of verbal and non-verbal communication to aid the assessment of needs and the delivery of care.
- A survey of parents of children receiving speech therapy found that 100% felt that their child had enough privacy when being treated.
- In sexual health services, patients were treated with dignity and respect. Staff were sensitive to the nature of the services provided and the needs of anxious patients.

Patient understanding and involvement

- We spoke to eight young people following human papilloma virus (HPV) immunisation and seven of them told us that they were familiar with the role of the school nurse as she had spoken to them at a school assembly. All eight pupils told us that they would rate the service between nine and 10 out of 10.
- We interviewed the families of children attending for speech and language therapy and were told that the therapist was "very respectful". They also reported that there was no waiting time from referral to the first appointment.
- A recent audit of paediatric therapy determined that 97% of families who had a child receiving therapy said that they received a full explanation and had enough time to discuss any concerns.

Emotional support

- The family of one pre-school child told us that they had not received the level of care from the health visiting service that they had expected after their child had turned one year of age. This was a single-parent family living in a rural, isolated location. We were told that messages were left for the health visitor to contact the family but none were returned. We saw that the patient-held record was incomplete.
- We were told by other families that the support they received from the health visiting and school nursing services met their needs.

Promotion of self-care

- Where possible, children and their families were supported to manage their own treatment and care needs. For example, the speech and language therapist identified work to be undertaken by parents to consolidate the therapy provided.

Good

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

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

Summary

The division provided a range of services, both in the community and in schools, and teams aimed to provide a flexible service where possible. Teams worked well locally and had developed processes and effective ways of working. There was a systematic transfer process for mothers and their infants moving from the care of the midwife to the care of the health visitor. This process worked well, enhanced by personal contact between the midwife and the health visitor. There were clear transfer pathways for children transferring from the health visiting service to school nursing. Pathways were dependent on the needs of the child and their family. Waiting times for therapy services were better than the national 18-week target.

However, health visitors and school nurses did not perform population health needs assessments in order to identify the needs particular to a school or location.

Detailed findings

Service planning and delivery to meet the needs of different people

- Access to translation services was available if required.
- The percentage of young people not in education, employment or training in East Cheshire was much better than the England average. We could not determine what level of service these young people received but we were told by the school nurses that no specific school nursing service existed for these young people and it appeared that they were excluded from the Healthy Child Programme. Although this is not an uncommon position, the health needs of vulnerable young people not in education, employment or training should be recognised by services.
- We were told by health visitors and school nurses that, in common with most other districts, they provided health assessments for children looked after by the local authority. These assessments were conducted at prescribed intervals to promote a healthy lifestyle to vulnerable children and young people.
- The trust provided a Family Nurse Partnership (FNP) programme for young first-time parents. This targeted service consisted of five nurses, one supervisor and an administrator. We saw that an action plan for the FNP team was in place to ensure the smooth transition of the service as the formal ownership of the service was due to transfer to the local authority in 2015.
- Staff had limited access to information technology, but electronic systems were due to be rolled out from January 2015. Staff did not have access to mobile electronic devices, with the exception of mobile telephones.
- Health visitors and school nurses did not perform population health needs assessments in order to identify the needs particular to a school or location.
- A range of sexual health services were provided from the sexual health centre based at Macclesfield District General Hospital and a number of clinics in the community. Services offered included: Screening, free treatment, contact tracing and counselling for all sexually transmitted infections including HIV and hepatitis; Hep B vaccination in indicated cases; management of HIV positive clients including blood monitoring and anti HIV treatment; post exposure prophylaxis following sexual and occupational exposure to HIV; management of sexual assault cases; management of genital skin conditions and contraceptive services, including IUD/IUS/implant insertion/removal and smear tests. The services provided took account of the needs and wishes of a diverse group of patients. For example, in relation to age, sexual orientation, pregnancy and religious beliefs.

Access to the right care at the right time

- Therapy caseloads were slightly larger than the recommended levels but the waiting times were all within the recommended 18 weeks from referral to treatment, with some locations having no waiting time at all.
- School nurses had a system in place for a duty nurse to respond to all messages and requests they received each day. The duty nurse role was rotated in the team and it ensured that issues were responded to quickly on behalf of the whole team.

Good

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

Discharge, referral and transition arrangements

- There was a systematic transfer process for mothers and their infants moving from the care of the midwife to the care of the health visitor. This process worked well, enhanced by personal contact between the midwife and the health visitor.
- When a child reached school age, the management of their healthcare transferred from the health visitor to the school nurse. A health assessment was carried out when a child started school. There was a systematic transfer process with different pathways of transfer depending of the needs of the child and family.
- Transition pathways from children's services to adult services were not always as clear. Young people were discharged from the service but for many there were limited adult services for them to transfer to. This was due to reasons beyond the trust's control.
- Children with complex needs were transferred by specialist nurses and therapists to the equivalent adult service: for example, from the children's diabetes nurse specialist to the adult diabetes nurse specialist, or from the child therapist to the adult therapist, where needed.
- Children with complex needs were transferred and discharged using a multi-agency assessment and review.

Complaints handling and learning from feedback

- Meeting minutes showed that learning from incidents and complaints took place at team leader meetings. We saw that issues concerning service delivery were cascaded to staff by the team leaders.

Requires Improvement

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

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

Summary

The divisional management of risk was unclear and therefore it was difficult to understand how risks were managed within the service. Although the trust had a risk register that included risks relating to children's and young people's services, there was no local risk register for community health services for children, young people and their families. Staff operating at team leader level and below did not know what the key risks on the trust register were for their team. The clinical manager identified the three highest risks on the trust register but, although staffing and training were identified as issues, the service did not have significant vacancies and statutory training was 96% complete. It was not clear, therefore, whether the risk register had been reviewed and updated to reflect actions taken to manage these risks.

Staff did not know who the senior managers were and felt that they were not visible. Staff reported that they received good support from their line managers and team leaders. However, there was a disconnect between the trust board and staff providing community services for children, young people and their families.

The vision and strategy for the trust and for community health services for children, young people and their families were not clear. Although staff knew that the trust had a vision, they were unclear what this was and how children's community services fitted into the vision. Practice innovation and improvement were limited due to organisational change and appeared to be 'on hold' while the health visiting and school nurses were going through a retendering process.

We found a culture of openness and flexibility among the teams we met. Staff spoke positively about the service they provided for children, young people and their families. Staff felt that placing the child and family at the centre of their care delivery was seen as a priority and everyone's responsibility.

Detailed findings

Vision and strategy for this service

- The vision and strategy for the trust and for community health services for children, young people and their families were not clear. Although staff knew that the trust had a vision, they were unclear what this was and how children's community services fitted into the vision.
- Health visiting staff were aware of the 'A Call to Action' plan and could see that the increased staffing levels were enabling them to deliver elements of the Healthy Child Programme (HCP), such as antenatal contacts, that had been suspended due to staffing issues.
- However, school nurses did not know what the trust plan was to enable full delivery of the HCP for children aged four to 19 years. We were told by the staff and operational managers that the service expected to be retendered in February 2015, so no additional resources would be made available until after the tendering process, when a new service specification would be implemented from September 2015.

Governance, risk management and quality measurement

- While most staff could describe the management structure within the division, they could not describe the governance structure within the trust or how quality groups fitted into that structure. However, we did find that some learning was cascaded via team leaders to front-line staff.
- The trust held an annual awards event to celebrate good practice. Staff told us that in the first year of community services being part of the trust they had felt quite separate, but the following years had resulted in greater recognition of community services' contribution.
- Although the trust had a risk register that included risks relating to children's and young people's services, there was no local risk register for community health services for children, young people and their families. Staff operating at team leader level and below did not know what the key risks on the trust register were for their team. The clinical manager identified the three highest risks on the trust register but, although she identified

Requires Improvement

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

staffing and training as issues, the service did not have significant vacancies and statutory training was 96% complete. It was not clear, therefore, whether the risk register had been reviewed and updated to reflect actions taken to manage these risks.

- Learning from incidents and complaints was cascaded through a number of team meetings including team leader meetings, therapies meetings, health visitor meetings and school nurse meetings.

Leadership of this service

- Staff reported that they received good support from their line managers and team leaders. However, there was a disconnect between the trust board and staff providing community services for children, young people and their families. Staff did not know who the senior managers were and felt that they were not visible.
- There had been a condensing of leadership roles, with some team leader posts being reduced from 11 to four. We were told by staff that, as a result of these changes, leaders were less visible and support had decreased since the changes had been made. The service was managed in four locations, and there was no-one in the line structure above a band 7 who was Specialist Community Public Health Nurse (SCPHN) qualified and experienced. This lack of experience in SCPHN impacted on the public health role around the healthy child programme.

Culture within this service

- We found a culture of openness and flexibility among the teams we met. Staff spoke positively about the service they provided for children, young people and their families.
- We observed staff working well together in their teams and across teams and agencies in the delivery of community health services.
- Staff felt that placing the child and family at the centre of their care delivery was seen as a priority and everyone's responsibility.

Public and staff engagement

- We found mixed evidence of staff engagement with the trust board. We were told by community staff that the trust was focused on Macclesfield District General Hospital and they felt separate from the acute trust.
- Staff were involved in some aspects of improving service delivery, such as the development of the universal antenatal contact tool created by the health visitors and midwives working party.
- The trust had recently restructured services in order to meet the needs of the population. However, there was little evidence that children, young people and families had been involved in decisions about the service redesign.

Innovation, improvement and sustainability

- Practice innovation and improvement were limited due to organisational change and appeared to be 'on hold' while the health visiting and school nurses were going through a retendering process.
- One health visitor was a fellow of the Institute of Health Visiting and was being seconded one day per week to work for the Department of Health as part of a national audit programme.