

Liverpool Community Health NHS Trust

RY1

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RY1X8	Trust Headquarters, Liverpool Innovation Park	Community children, young people and families, Bootle Health Centre	L7 9NJ
RY1X8	Trust Headquarters, Liverpool Innovation Park	Community children, young people and families, Maghull Health Centre	L7 9NJ
RY1X8	Trust Headquarters, Liverpool Innovation Park	Community children, young people and families, Queen's Drive Family Health Centre	L7 9NJ
RY1X8	Trust Headquarters, Liverpool Innovation Park	Community children, young people and families, Goodlass Road Health Centre	L7 9NJ
RY1X8	Trust Headquarters, Liverpool Innovation Park	Community children, young people and families, Norris Green Health Centre	L7 9NJ
RY1X8	Trust Headquarters, Liverpool Innovation Park	Community children, young people and families, Vauxhall Health Centre	L7 9NJ







This report describes our judgement of the quality of care provided within this core service by Liverpool Community Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Liverpool Community Health NHS Trust and these are brought together to inform our overall judgement of Liverpool Community Health NHS Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall, we have judged that the community service provided to children, young people and their families "Requires Improvement". This is because;

- Safeguarding children policies and procedures did not reflect the most up to date best practice guidance.
- Some staff had inherited caseloads on day one of their employment despite still being in their preceptorship period.
- There were high levels of sickness in some health visiting and school nursing teams.
- Whilst there had been significant improvements in the delivery of services since the last inspection in May 2014, the trust was still not meeting some key aspects of the Healthy Child Programme.
- The numbers of staff who has received an appraisal was lower than the trust's target. Though transition processes were in place, the trust did not have a policy detailing the process of children transitioning either internally across the trust or into Adult Health services.
- Improvements were needed in the way that the service responded to the needs of the children and young people it served. In some parts of the service, there were unacceptable delays in the referral pathways to allied health professionals such as speech and language therapies and dietetics.
- Some risks weren't mitigated in a timely way and some services didn't have clear action plans to improve performance.

However;

- The trust had done a lot of work to improve the culture and the majority of staff stated that the organisation was a very different place to work than it had been, although not all staff felt fully informed and engaged.
- The trust has responded to the risks associated with lone working. The introduction of more training and the use of IT and communication systems has meant that staff working in the community could be more closely monitored and supported.
- Safeguarding concerns were given the highest priority and were taking up more and more of the clinician's time. As a consequence, not as much health promotion work was being undertaken in schools.
- Incident reporting had improved and lessons were being learned. Medicines were being well managed; this included the preservation of the 'cold chain' for vaccines.
- People we spoke with who used the service were positive about the way they were treated by staff. Children, young people and their families said they were treated with compassion and respect. We saw staff ensuring that people's dignity and privacy was upheld.
- In terms of leadership, staff generally spoke positively about the recent changes. Clinician's felt that they now had a voice that was more likely to be heard by senior managers within the trust. The move to localities was welcomed and whilst the organisation was still going through change and transformation very few staff raised this as an issue.

Summary of findings

Background to the service

Liverpool Community Health NHS Trust (the trust) delivers a range of community based services to children and young people across Liverpool and Sefton in a variety of community settings including home visits, at schools and health centres.

Liverpool is currently ranked as the 4th most deprived local authority in the country and in Sefton, nearly one in five residents live in pockets of the borough that are amongst the 10% most deprived communities in the country.

Following a transformation programme undertaken by the trust, services are now delivered within a framework of localities across the trust's geographical footprint. These localities are, North Liverpool, Central Liverpool, South Liverpool and Sefton with each locality led by an associate director and clinical lead.

The trust offers a wide range of community services for children, young people and families. These include health visiting, school nursing, children's speech and language therapy, children's continence service, children's complex needs and a dedicated children's walk-in centre. Other services accessed by children, young people and families are a diabetes service, dietetic service, physiotherapy and a wheelchair service. More than 70% of the trust's 3,000 staff are clinical.

As part of the inspection we spoke with over 100 staff, went on home visits, observed clinics, held focus groups and spoke with children, young people and their families. We also looked at records and talked with other members of the multi-disciplinary team.

Our inspection team

Our inspection team was led by:

Team Leader: Simon Regan, Inspection Manager, Care Quality Commission

The team included two CQC inspectors and a variety of specialists including a health visitor and a school nurse.

Why we carried out this inspection

We carried out a comprehensive inspection of this service in May 2014 and rated it as "Requires Improvement" overall. We judged the service to be "Requires Improvement" for safe, effective, responsive, well-led and "Good" for caring.

This was a follow up inspection to the comprehensive inspection of May 2014. We carried out this inspection to make sure improvements had been made.

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 this service and asked other organisations to share what they knew.

We carried out an announced visit on 2, 3 and 4 February 2016.

Summary of findings

During the visit we held focus groups with a range of staff who worked within the service, such as nurses, health visitors, doctors and therapists. We also spoke directly with over 100 members of staff at all levels including managers, senior managers, directorate leads, health visitors, school nurses and allied health professionals. We talked with people who use services. We observed how people were being cared for in their own homes, in clinics

and in schools. Patients and families also shared information about their experiences of community services via comment cards that we left in various community locations across Liverpool and Sefton.

We carried out an unannounced visit on 11 February 2016.

What people who use the provider say

Parents, children and young people spoke highly of the relationship and support provided by health visitors, school nurses and therapists.

As part of the inspection we asked parents, children and young people, to share their thoughts about the community service provided via the completion and submission of a comment card. The responses were very positive and included the following endorsements;

School Nursing – “the service that I have received from the school nurse has been excellent. She has been very supportive with any referrals that my child has needed”; “We are pleased with the care that our daughter receives

from the nurses in the medical room. The administration of medication at lunch time gives the nurses chance to check on her current condition” and “great communication when there is a problem with your child”.

Children’s Community Dental Service – “the service provided here is outstanding; the staff are attentive and patient with my little girl, which makes it more pleasant for her”.

Friends and family test results trust-wide showed that 99% of respondents in December 2015 would recommend the trust’s services to their friends and families. However, this data could not be disaggregated specifically for the children, young people and families’ service

Good practice

- The school nursing service had responded at short notice to a requirement to carry out a flu vaccination programme, which involved immunising 18,000 children in 200 schools over a 4 week period.

Areas for improvement

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

Action the provider **MUST** take to improve

- The number of health visitors reporting to one team leader was excessive and could lead to a lack of adequate support for the team leaders. The trust must address this to ensure that caseloads are manageable and staff have the appropriate support from their team leaders.

- There is a risk present as long as hybrid paper and electronic recording systems are being used. The provider must ensure that all record keeping risks are mitigated.
- The trust must ensure that policies and procedures relating to safeguarding take account of the latest statutory guidance.

Action the provider **SHOULD** take to improve

Summary of findings

- There are gaps in mandatory training and appraisals. The provider should improve performance so that all staff complete their respective mandatory training programmes and appraisals to maintain competencies
- The trust should improve performance so that all Healthy Child Programme targets are met and continue to be monitored.
- There are unacceptable waiting times from referral to assessment and treatment for some allied health and therapy specialisms. The trust should improve waiting times so that services are responsive to the needs of children and young people across the four localities.
- Some staff told us that they had inherited caseloads on day one of their employment despite still being in their preceptorship period. The trust should ensure new staff receive the time and support they require to be confident and competent before they are assigned a caseload.
- The trust should review the dietetics service to ensure that service provision is equitable and the nutrition and hydration needs of children, young people and families are met.
- There was no policy or procedures in place detailing the process for transition of young people to adult healthcare. The trust should ensure that policies and procedures are in place to support children and young people who transition to adult services.
- The trust should consider how it continues to engage with staff to ensure that they are kept suitably informed in respect of the on-going transformation of services.
- Numerous models of supervision are being used both formal and informal. The provider should ensure that all staff have access to supervision and that they are assured of the appropriateness of that supervision model.
- There was variability in the understanding and application of Duty of Candour. The provider should ensure that all staff receive appropriate training on the principles of Duty of Candour and understand their responsibilities in its application.
- Access to the x-ray facilities at the Vauxhall Dental Clinic is through the staff changing room. The provider should consider alternative arrangements to allow for the privacy and dignity of both staff and patients.
- Cleanliness audit data was regularly missing for some clinics. The provider should ensure that all clinics submit cleanliness data so that a clearer picture of clinic cleanliness compliance can be reported.

Liverpool Community Health NHS Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement



Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated community health services for children, young people and families as 'Requires Improvement' for Safe because;

- Safeguarding children policies and procedures did not reflect the most up to date best practice guidance.
- Some staff had inherited caseloads on day one of their employment despite still being in their preceptorship period.
- There were high levels of sickness in some health visiting and school nursing teams.
- Mandatory training was below the trust's target in some areas.
- There were problems with accessing records for 5-11 year olds and sometimes children were 'missing' on the electronic system, which led to delays in getting them added.

- The procedures for duty of candour were not embedded and it wasn't clear whether parents always received a written apology following a notifiable patient safety incident.

However;

- There was an embedded incident reporting system with evidence of lessons learned.
- Medicines were well managed, including preservation of the cold chain for vaccines.
- The safeguarding of children and young people was given the highest priority and staff were diligent.
- School nursing staff responded in a safe, professional and calm manner to the deterioration of a young person's condition during a vaccination clinic that we were present at.

Are services safe?

Safety performance

- There were four never events reported in the financial year 2014/2015. These all related to wrong tooth extractions in dental services. One of the four cases occurred in 2012 and two in 2013. However, all three of these cases were retrospectively reported as never events in 2015. The additional case occurred in 2014.
- Following identification of the retrospective never events, the trust conducted an aggregated clinical investigation review of the process, which identified actions such as the introduction of a tooth extraction surgical safety check list (TESSC). The check-list controlled and recorded the essential immediate pre and post-operative checks to be carried out when performing a tooth extraction. We saw this checklist being used when we visited the dental clinic at Vauxhall Health Centre. There had been no further never events at the time of the inspection. We asked about the results of any audits which looked at the compliance rates for TESSC completion but were told that audit results would not be available until March 2016.
- There were a total of 50 child deaths in the period February 2015 to January 2016 which went to Child Death Overview Panel (CDOP). The trust participated and contributed to a review of these deaths. However, none of the CDOP panels identified any lessons learnt for the trust. In addition, there were two critical case reviews in that period, which did not identify any learning for the trust.

Incident reporting, learning and improvement

- At the last inspection, we found that the reporting of incidents was inconsistent and there was limited evidence of learning being shared across teams. This position had improved and at this inspection we found a much more consistent approach to incident reporting.
- Incidents were reported to the trust through an electronic reporting system. Discussions with staff demonstrated an awareness of the incident reporting policy and how to use the reporting system.
- From 1 January 2015 to 31 January 2016 there were 517 reported incidents across the services for children and

young people. The majority (422) of incidents were categorised as “no harm”. There was evidence that incidents had been investigated and remedial actions taken.

- Staff were able to give examples of when incidents had been reported and what had happened as a result. Feedback from reported incidents was given via a number of routes, including face to face, team meetings, a range of cross-organisational newsletters and via email.
- We asked staff about their understanding of ‘duty of candour’.
- There was a duty of candour policy and some staff had received related training and others had yet to be trained. We were given an example of when a mistake had occurred during a vaccination clinic. The clinician duly spoke with the family, documented the issue in the health records and reported the incident via the trust reporting system. However, it was not clear whether the parents always received a response from the trust in writing.

Safeguarding

- An annual safeguarding report was written in June 2015 by the trust’s Head of Safeguarding and presented to the board in July 2015. It considered the trust’s safeguarding work across four distinct areas; safeguarding adults at risk of abuse, child protection, looked after children and youth offender health. The report covered the reporting period April 2014 to March 2015 and aimed to give a broad overview of the service delivered by all aspects of the organisational safeguarding team. The report presented the safeguarding challenges, service achievements and set out the service priorities for 2015-2016.
- The trust had policies and procedures in place which related to safeguarding children. The policy had been in place since 24 March 2015 and was up to date with best practice “working together 2013” guidance. However, new guidance on working together was published on 26 March 2015 and the policy has not been revised since to take account of that.
- In addition, the “Safeguarding Children Procedures for Safeguarding and Promoting the Welfare of Children” that were in place were introduced in March 2013 and

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due to be reviewed in June 2016. However, it referenced the “working together 2010” guidance yet no reference was made to the more recent guidance “working together 2013” which was available at the time the procedures were revised (in 2013).

- Every child health caseload holder across the organisation was allocated a named safeguarding children’s specialist nurse who provided direct advice and support in relation to ongoing safeguarding cases and safeguarding supervision.
- Training data for January 2016 showed that the completion of safeguarding training was generally good in the children, young people and family’s service. The majority of staff had completed safeguarding adults training at level 1 (95.3%) and level 2 (96.3%). Similarly, the majority had completed level 1 child safeguarding training (93%) and level 3 (96.4%). Only 66.7% had completed level 2, which was below the trust’s target of 95%. However, it is important to note that the 66% compliance rate was based on 2 out of 3 staff having completed training.
- There was a safeguarding policy in place and a clear pathway for reporting and dealing with child protection and safeguarding concerns. Staff were aware of them and understood their responsibilities.
- There was an on-call duty safeguarding team in place from Monday to Friday, 9am to 5pm.
- We saw close working between health visiting and school nursing teams in the management of child protection plans. Universally staff told us that safeguarding was given the highest priority in clinician’s workload. It was also expressed that safeguarding involvement had increased and now represented the largest component of caseloads. Staff told us that this often meant the other aspects of work, like health promotion in schools, was not always being delivered to the standard that staff would like.
- Staff received safeguarding supervision every three months from their safeguarding teams. This moved to every 12 months for ‘looked after children’ on their caseloads. We were informed by staff that this supervision was also regarded as one of the highest priorities.

- The trust had been involved in three serious case reviews in the 12 months prior to the inspection, where learning for the trust had been identified. There was evidence that action plans had been developed in response to these cases. One set of actions had been completed and the other two cases had a small number of actions still to complete. The actions plans were monitored for progress and updated at regular intervals.
- Staff were involved in multi-agency meetings regarding the protection of vulnerable children. A re-audit was published in November 2015 into information sharing at multi-agency child protection conferences. This showed an increase in the level of compliance with Liverpool Community Health (LCH) procedures in relation to the submission of pre-conference reports for multi-agency child protection conferences. The compliance rate over the whole footprint improved from 18% to 65%. The sample reflected a review of 85 responses for children subject to the Liverpool or Sefton child protection case conference process for the week commencing 22 June 2015. This date was selected randomly and there were no external influences such as school holidays to be considered as part of the process. The original audit results were published in October 2014.

Medicines

- Policies for the safe storage, handling and administration of medicines were in place.
- We saw safe storage of vaccinations in six different locations as part of the inspection. Whilst the Liverpool and Sefton school health teams ordered their vaccines from different suppliers, the safe storage and preservation of the ‘cold chain’ was consistently and uniformly managed. cold chainstoring vaccines
- To maintain the cold chain, vaccines were stored in fridges and records indicated that the temperature was checked and recorded at least twice daily to ensure that the vaccines remained within the required temperature range. Staff were able to tell us what procedures they followed should there be a break in the cold chain. We saw examples of incident reports raised when such a break had occurred. In addition, we saw that temperature monitored cool bags were used to

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transport vaccines to immunisation clinics along with the associated anaphylaxis kit, personal protective equipment, sharps boxes and patient group directive documentation.

- In one health centre we saw that the fridges being used for vaccine storage were situated in the staff room. The fridges were locked but the door to the staff room was wedged open. We were informed that this was a temporary arrangement only until the clinic soon relocated. We were told that there had been a 'cold chain' incident in December 2015, when one of the fridges used to store vaccines reached 30 degrees Celsius. There was no record of this incident in the fridge temperature book though we were told that the incident was reported via the trust electronic reporting system. When examining the incident report log for children's services between January 2015 and then end of January 2016 we could not find specific reference to the aforementioned 'cold chain' incident. However, the report log did show more than 40 incidents for the time period, appropriately reported, relating to either 'cold chain' breaches or extreme temperature recording for non-vaccination drugs such as adrenalin. Appropriate actions were taken in each case.
- We observed a secondary school immunisation clinic and saw that medicines were stored, managed and administered safely. This included the ongoing monitoring of the cold chain alongside safe management and disposal of sharps.

Environment and equipment

- Not all of the bases that we visited were also used for patients. Some were purely office space for the clinical teams, their managers and administrative support. In those environments where patients were also seen, the buildings were visibly clean, if somewhat decoratively tired.
- We visited the dental clinic at the Vauxhall Health Centre, which was a purpose built facility with visibly clean and well equipped clinical treatment rooms. There was an open plan reception area adjoining the co-located general practice and there had been work undertaken to expand the decontamination room to allow for a division between the clean and dirty management of instruments.

- At the clinics we visited, there were adequate arrangements for the management of waste, sharps and clinical specimens.
- We saw evidence that equipment such as baby scales, were appropriately checked and calibrated to ensure their accuracy.
- Where appropriate, for example in the dental clinic, we saw that resuscitation equipment was visibly clean; records indicated that it had been checked regularly and drugs were in date.

Quality of records

- Patient records were being managed across the trust in different ways. Some records were paper based and others were managed using an electronic system. This presented a risk to effective communication. For example, we heard that the trust's electronic system was unable to connect to the GP's electronic system. There were problems reported in accessing records for 5-11 year olds. Sometimes children were 'missing' on the electronic system and there were delays in getting them added.
- Safeguarding reports for all children were recorded on paper and then attached to the electronic system afterwards. Whilst this was not ideal, school nurses and health visitors were diligent about their safeguarding record keeping.
- One of the interfaces raised by staff as a risk was for the child's handover or transition from the health visitors (0-5) to the school nursing teams. Wherever possible we were told that a face to face handover would be undertaken, especially if there were related safeguarding concerns, to minimise any risks relating to differing recording systems.
- Despite the ongoing risks, in the December 2015 strategic risk register, electronic records had been downgraded to an amber risk despite unclear evidence of engagement with clinical staff over these issues.
- We looked at the storage of records at two of the health centres we visited. Records were kept in a separate room in lockable cabinets. The keys were in the locks during the visits but we were told at the end of the day the cabinets were then locked and the keys themselves then locked away securely. All records were stored alphabetically and by year.

Are services safe?

- Safeguarding paper records were colour coded and easily identifiable. They were also kept separately and securely.
- We looked at the records for 10 children, which were a combination of both paper and electronic. Records were legible and entries were signed, timed and dated. A sheet of acceptable abbreviations and acronyms was included. In one of the records we reviewed there were loose paper sheets, which were not secured.

Cleanliness, infection control and hygiene

- The clinic areas that we visited during the inspection were visibly clean and there was evidence of cleaning regimes displayed, visible to the public.
- Infection control training was part of the trust's mandatory training programme. It was delivered as two modules; level one (three yearly) and level two (yearly). Across children and young people's services at the end of January 2016, 92.7% of staff had completed level one, which was slightly below the trust's target of 95%. However, only 82.4% of staff had completed level two, which was lower than the trust's target.
- As part of the inspection, we attended home visits with health visitors and observed immunisation clinics at schools. We observed good hand washing and infection control practices throughout. This included the use of personal protective equipment where appropriate, e.g. disposable gloves and aprons.
- At a baby clinic we saw that the mats, scales and other equipment were cleaned between use and staff also washed their hands before handling each baby.
- Hand cleansing gels were available and used in the areas that we visited, including between home visits.
- We saw an infection control dashboard dated November 2015, which included cleanliness audit results for clinic locations across the trust from December 2014. The results showed a range of compliance between 85% and 100%, although for some locations there was a paucity of data and results submitted. For example, for the York Centre, five months compliance data was missing. We did note that unannounced cleanliness audits had also been carried out and the poorer performing locations in the announced programme also performed poorly by

comparison during the unannounced visits. It was unclear from the information we were given what actions were being taken to tackle those areas of poor compliance.

- Cleaning rotas were displayed in the clinics and health centres that we visited and records indicated that cleaning had taken place.

Mandatory training

- The trust kept detailed records of mandatory training. Staff told us that the trust gave a high priority to staff receiving mandatory training, which they were always able to complete in work time.
- Included in mandatory training were; complaints management (once only), health record keeping (3 yearly), infection control, immediate life support (ILS), investigation of complaints and root cause analysis (once only), prevent training for clinicians, conflict resolution (every 3 years), consent, equality and diversity (every 3 years), fire safety, bullying and harassment awareness, health and safety (every 3 years), infection control, information governance, medicines management, moving and handling, resuscitation and safeguarding (child and adult).
- There was a high level of compliance across most of the mandatory training programme, with the majority of subjects similar to, or above, the trust's target of 95%. However, there were some key areas that fell short of this target for staff in the children and young people's service. For example, at the end of January 2016, the compliance rate for ILS training was 73.7%. This was compounded by the fact only 80% of staff had received resuscitation training. Further areas where the trust fell short of the target included 'Prevent' training for clinicians (35.2%), information governance (81.5%) and moving and handling (73%).
- Staff told us that they appreciated the importance of attending mandatory training and were keen to do so.

Assessing and responding to patient risk

- We saw an example of how staff recognised and responded appropriately to the rapid deterioration of a young person. This occurred during an immunisation clinic when a young person experienced an adverse reaction to a vaccine. The situation was managed safely and appropriately by the immunisers present. An

Are services safe?

ambulance was called and the young person was put into the recovery position on a floor mattress and provided with privacy screens. The school nurse notified the young person's parents and accompanied the patient safely to hospital. The whole scenario was managed professionally and calmly.

- We saw from the incident log for January 2015 to the end of January 2016 a number of examples where patient risk had been identified and actions and responses appropriately initiated. For example, following a local crime, were children and young people may have been implicated or at risk.

Staffing levels and caseload

- Staffing numbers for health visitors and school nursing were determined in conjunction with commissioners. The health visitor staffing establishment had been increased in line with national call to action.
- We spoke with staff from both health visiting and school nursing teams across the trust, including team leaders and managers. Caseloads for health visitors and school nursing were predominantly determined by the numbers of children or young people on child protection plans or the numbers of children looked after. Deprivation indices were also factored in. However, there was no review of whether caseloads were equitable.
- At the end of November 2015, there were some teams with a high sickness rate, such as School Nurse South Liverpool - Team 1 and the Health Visitors Sefton - Team 2 which both had a 5.6% staff sickness rate.
- Some staff told us that they had inherited caseloads on day one of their employment despite still being in their preceptorship period.
- A health visiting team leader raised some concerns about the number of staff that they were responsible for and highlighted that some team leaders had over 30 staff that directly reported to them which could be challenging. The risks associated with this, including stress of team leaders had been identified as a risk by the trust but actions hadn't been taken to address them at the time of the inspection. The plan was to develop a core offer and put it to commissioners for consideration but there were no practical measures in place.

Managing anticipated risks

- At the last inspection, staff told us they did not always feel safe when performing home visits. At this inspection we found that the trust had taken action in response to the increased risks to lone workers in the community. The trust had introduced a revised lone worker policy (March 2015) and invested in devices and training to improve the safety of their staff. For example, staff working alone in the community were issued with an identification badge that also enabled two way communication and GPS tracking. We saw this device being used in practice by a health visitor who reported in before attending a home visit. Community staff were also issued with a mobile phone. Reports were produced on how often lone worker alarms were activated or used. However, this was dependent upon there being a signal. If the lone worker device experienced signal problems, staff used their mobile phone to establish contact.
- Risk assessments were carried out for staff before they visited potentially risky areas. For example where there was known drug misuse or previous evidence of firearms use. This was particularly important if staff were taking on additional hours with unfamiliar caseloads.
- Whiteboards were used in the offices to indicate when staff were in or out and where they intended to visit.
- Services had plans in place to manage and mitigate anticipated risks including changes in demand and disruptions owing to bad weather for example.

Major incident awareness and training

- At our last inspection we told the trust it should develop major incident plans for all services. At this inspection we found that local plans were in place and staff were aware of the emergency plans within their teams.
- The trust provided health and safety training, and fire safety training as part of its' mandatory training programme. Data supplied by the trust showed that 94.8% of staff in the community children, young people and families service had completed health and safety training and 96.9% of staff had completed the 3-yearly fire safety training against a trust target of 95%.

Are services effective?

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

Summary

We rated community health services for children, young people and families as 'Requires Improvement' for Effective because;

- Whilst there had been significant improvements in the delivery of services since the last inspection in May 2014, the trust was still not meeting some key aspects of the Healthy Child Programme.
- The numbers of staff who has received an appraisal was lower than the trust's target.
- Although transition processes were in place, the trust did not have a policy detailing the process of children transitioning either internally across the trust or into adult health services.

However;

- We saw positive examples of multi-disciplinary working.
- Staff were confident in the consent process and used recognised techniques in gaining consent.

Evidence based care and treatment

- Health visiting and school nursing teams aimed to work in accordance with the Healthy Child Programme. However, the trust was not yet able to deliver all aspects of it at the time of the inspection. The Healthy Child Programme is an early intervention and prevention public health programme that offers every family a programme of screening tests, immunisations, developmental reviews, information and guidance to support parenting and healthy choices. The Healthy Child Programme identifies key opportunities for undertaking developmental reviews that services should aim to perform.
- Each health care professional cited best practice guidance and research in their specialism on which care, treatment and support was based. For example, there was an infant feeding policy in place that was based on national guidance. We also saw evidence

based information produced for staff in line with UNICEF guidance by the infant feeding co-ordinator, which included detailed information about breastfeeding and set out the benefits to both baby and mother.

- Other examples of evidence based guidance were produced by the children's speech and language therapy service, the dietetic service and the paediatric continence service.

Pain

- The vaccination and immunisation team offered advice to young people following injections on safe use of paracetamol in case of pain or fever during the day of vaccination.

Nutrition and hydration

- The trust provided a children's dietetic service though this was run as two distinct services, one for the three Liverpool localities and one for Sefton. The respective paediatric dietitians were both passionate about the service they provided despite their clear frustrations at the limitations of what they were single-handedly able to offer. For example, the commissioned service for Sefton only covered the 0.8 whole time equivalent (WTE) dietitian and didn't include any administrative support or consumables costs.
- The paediatric speech and language therapy teams were involved closely in the care and management of children who had additional feeding and drinking needs.
- There was also an infant feeding co-ordinator for both Liverpool and Sefton localities. As a joint initiative Sefton Health Visitor teams, Children's Centres and Healthy Living Centres (including Breast-Start, the Sefton peer support organisation) achieved full Unicef Baby Friendly Initiative Accreditation (stage three) in April 2014. Liverpool Health Visitors, Children's Centres and their peer support organisation achieved stage two accreditation in November 2013.

Technology and telemedicine

- The speech and language therapy (SALT) team had been involved in the 'KIT' (Keeping in Touch) project, which

Are services effective?

evaluated the use of video consultations remotely via the internet in speech and language therapy sessions. This involved both qualitative and quantitative methods and involved seven therapists and nine patients and their parents who were recruited and consented to undertaking speech and language sessions remotely rather than face to face. The children ranged from 3 to 14 years old and at the end of the study all participants were invited to take part in an interview. The findings of this review were consistent with others undertaken. Both clients and therapists indicated that video consultations should not wholly replace face to face therapy, but could offer an alternative means of contact in between such sessions and/or a way of having more, but briefer contacts, e.g. to monitor progress and advise on practical exercises. It should be noted that not all children or young people would have the skills or desire to engage with SALT in this way. There was a consensus that video consultations should only be used for pre-arranged appointments with a specific purpose.

- The SALT team received the trust's award for Innovation in 2013 for the KIT project and were nominated for a Health Service Journal (HSJ) award.

Patient outcomes

- At the last inspection we reported poor performance against the key performance metrics in the Healthy Child Programme told the trust it should take steps to address the issue. For example, only 24% of infants in Liverpool and 48% in Sefton received a face-to-face new birth visit within 14 days from birth. We also noted that 72% (Liverpool) and 43% (Sefton) of new parents received a face-to-face new birth visit after 14 days from birth but it was unclear how long after the 14 days.
- At this inspection we found that whilst significant improvements had been made, progress had been slow. Performance was still below key national targets. Taking into account the health profile and demographics of the areas the trust serve, further improvements are still required.
- The trust were working towards a target count for antenatal contacts, which should include a first face to face antenatal contact with a Health Visitor at 28 weeks gestation or above as outlined in the Healthy Child Programme. However, as at the end of January 2016, the trust had only seen 15.6% of the mothers in Liverpool

and 23.8% in Sefton against their agreed target count. The trust reported that some of the problems experienced in Sefton were attributed to the lack of accurate and timely data from a local acute trust.

- The Healthy Child Programme stipulates that a new born visit should take place within 14 days of birth, with the parents in order to assess maternal mental health and discuss issues such as infant feeding and how to reduce the risks of sudden infant death syndrome.
- Performance against national new birth visit targets within 14 days were below the 90% national target for every month from the last inspection to this one. In some months, performance was really poor and dipped as low as 23.8% (for Liverpool health visiting service) and 42.4% (for Sefton health visiting service) in May 2014. In 2015, the year started poorly with 42.8% (Liverpool) and 63.7% (Sefton) compliance in January 2015 but both services continued to improve throughout 2015. At the end of December 2015, the combined year to date figure was 84.8%, though this was still below the national target of 90% and monthly performance was still below the 90% target.
- The Healthy Child Programme also stipulates that children should have a further 12 month development review by age one and another at age 2 – 2.5 years.
- Performance against the 12 month development review by age 1 criteria was 83.5% at the end of December 2015 against a national target of 85%, although progress had been slow in achieving these levels. The 2014/2015 financial year end figure was 62% and performance was consistently below 80% in both Sefton and Liverpool until the end of June 2015.
- Performance against the age 2 – 2.5 year reviews had also improved from 81% in 2014/2015 at financial year end to a position of 86.7% at the end of December 2015, which was above the national target of 85%. However, there performance of the two areas (Liverpool and Sefton) was mixed. The Liverpool team were generally above 80% from May 2014 but the Sefton team only achieved above 80% from February 2015, with a small dip in March 2015 (71.2%) before performance improved to above the national target from April 2015 onwards.
- The shortfalls in Healthy Child Programme delivery and targets were known by the trust and figured on the trust risk register along with existing controls, actions and updates. The trust told us that it expected performance against the health visiting targets to improve by March

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2016 as it would then have met its target for recruitment in line with the national 'Call to Action' initiative along with the gradual release of capacity in line with the transfer of pre-school vaccinations to primary care.

- The trust measured performance against vaccination targets of 95%. The latest data from December 2015 showed that 95.5% of children aged 1 had received DTaP/IPV/Hib (this is a 5 in 1 vaccine given as a single injection for protection against diphtheria, tetanus, whooping cough, polio and haemophilus influenza type b); 93.6% of children aged 2 had received the PCV vaccine (this is a vaccine given to infants to protect against diseases associated with Streptococcus pneumoniae); 93% of children aged 2 had received HibMenC (this is a single booster against haemophilus influenza and meningitis C) and 93.2% of children aged 2 had received the MMR vaccine (this is a single injection given to protect against measles, mumps and rubella). In addition, pre-school vaccinations for children aged 5 for DTaP/IPV/Hib were at 90.8% and MMR was 90.6%.
- All girls aged 12 to 13 should be offered HPV (human papilloma virus) vaccination as part of the NHS childhood vaccination programme. The vaccine protects against cervical cancer. Figures for December 2015 in Liverpool showed that the uptake of the vaccine was 94.6% and for Sefton was 90.4% but the uptake had improved dramatically.
- The school nursing teams expressed the view that it was difficult to benchmark or measure their performance other than by immunisation rates.
- At the end of December 2015, the trust reported a breast-feeding prevalence rate of 32.2% in Liverpool and 28.9% in Sefton, against a national target of 30%.

Competent staff

- There were systems in place to ensure that staff, equipment and facilities enabled the effective delivery of care and treatment.
- Staff received an annual appraisal from their line manager. Dentist's appraisals were undertaken by the clinical director.
- Information provided by the trust showed that only 77% of staff across services for children and young people had received their annual appraisal against the trust's target of 95%.
- All newly qualified staff were offered a preceptorship although some staff told us that they had been given a

caseload, including safeguarding cases, from day one. This meant that on occasions it was unclear how the trust assessed the clinician's readiness and competence to receive a working caseload.

- At the last inspection we identified that clinical supervision processes were informal and varied from team to team.
- At this inspection we found that there were still a range of clinical supervision models, which varied across the trust and across teams but the trust were now monitoring the position in relation to supervision. We were provided with a breakdown of the clinical supervision rates for all staff (not just those in children and young people's services) across localities, which showed that 82.3% of staff in Central Liverpool were recorded as receiving supervision (58.2% informally), 91.2% of staff in South Liverpool were recorded as receiving supervision (62.7% informally), 91.6% of staff in North Liverpool were recorded as receiving supervision (35.7% informally) and 85.3% in Sefton (59.4% informally).
- Safeguarding supervision was entirely a separate process and was received by all staff involved with child protection and safeguarding cases.

Multi-disciplinary working and coordinated care pathways

- We saw numerous examples of multi-disciplinary working with clinicians co-operating and collaborating around the needs of children, young people and their families. For example, we observed a child developmental clinic run jointly by a health visitor and GP. Both spoke of the benefits of their close working for the children in their care. Health visitors were linked to GP practices for the purpose of continuity.
- It was apparent that different referral pathways were in place dependent upon the locality. For example, the paediatric dietician for the Liverpool localities did not treat patients with certain conditions that included diabetes, coeliac disease, cystic fibrosis or those with enteral feeds. Support for these children and young people was provided by the neighbouring children's trust.
- The health visiting and school nursing teams worked closely together to support children as they developed through their early years and into primary and secondary education.

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- The trust was working with multiple key partners as it negotiated its transformational journey to “pursue a different future for our services to sustain and take forward the improvements our staff are making”. For example, local clinical commissioning groups, local NHS trusts and local authority bodies.

Referral, transfer, discharge and transition

- Though transition processes were in place, Liverpool Community Health did not have a policy detailing the process of children transitioning either internally across LCH services or into Adult Health Services.
- The children’s Community Matrons were members of a transition group with the neighbouring children’s hospital which was looking at the development of an overarching transition policy for children with complex needs. They were also working closely with a paediatric consultant from a neighbouring adult hospital who was planning to set up a joint transition clinic at their hospital, where the child would attend to agree a plan for transition care to the acute hospital if required.
- When a child reached school age, the management of their health care needs moved from the health visitor to the school nurse. A health assessment for all children was carried out when they started school.

Access to information

- An electronic record system was being introduced across the trust. But the level of its integration varied within localities and teams. As a result, both paper and electronic record systems were being used. Safeguarding records were paper based and then attached to the electronic record. The inherent risks associated with the hybrid record systems in use was on the trust strategic risk register. This included existing controls, actions and updates.

- We saw examples of the personal child health record or ‘red book’ being used and given to parents. The red book held medical information about a child from birth to 4 years of age and recorded child, family and birth details, immunisation records, screening, routine reviews and growth charts.
- Some of the school nursing teams were using a tablet and a customised application or ‘app’ to calculate and record growth percentiles.

Consent

- We saw, where required, parents’ written consent was obtained prior to immunisation.
- In cases where the child or young person presented for immunisation without appropriate consent then the clinician involved contacted the parent without delay to explain the situation.
- Staff understood and were able to explain Gillick competency guidelines in relation to consent. Gillick competency guidelines refer to a legal case which looked specifically at whether doctors should be able to give advice or treatment to under 16 year olds without parental consent. They are now used more widely to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. We saw the principles of assessing Gillick competency used in the case of secondary school immunisation consent. Where a young person was judged competent to give voluntary consent after receiving appropriate information beforehand. This had on occasions resulted in a call from a parent stating that they had not known that their child was going to receive an immunisation. On such occasions the principles of assessing Gillick competency were explained to the parent.

Are services caring?

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

Summary

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

- People we spoke with who used the service were positive about the way they were treated by staff. Children and young people said they were treated with compassion and respect.
- We saw staff taking steps to ensure that patients' dignity and privacy were maintained.
- Children and young people were mostly involved in making decisions about their care and treatment.
- Patients were encouraged and supported to manage their own care and develop and maintain their independence.
- Children, young people and families had appropriate emotional support.

Compassionate care

- Staff treated children and young people with kindness, dignity, respect and compassion. We spoke with 13 young people (year 11) during the course of an immunisation clinic at a local college. We saw care that was led by the needs of the young people and families.
- Within the school setting, there was a room set aside for the school nurse to use, which helped to provide the child or young person with some privacy and confidentiality for their discussions.
- Friends and family test results trust wide demonstrated that 99% of respondents in December 2015 would recommend the trust's services to their friends and families. However, this data could not be disaggregated specifically for the children, young people and families' service.
- We observed staff that were compassionate and supportive care in a children's speech and language session. The therapist was skilled in gaining the confidence and cooperation of the child to facilitate the assessment. The child's parent spoke highly of both the therapist and the service provided by the trust.
- We also observed a visit to a parent by the health visitor. The parent spoke highly of the relationship and support provided by the health visitor and it was clear from their interaction that a trusting, helpful and inclusive relationship had been formed.

Understanding and involvement of patients and those close to them

- We spoke with several parents during the inspection who told us that they were kept informed. We also saw incidents reported on the incident log relating to communication issues with parents. For example, where a child had been judged competent to consent to their own vaccination.
- Staff took the time to interact with children and young people who used services and those close to them in a respectful and considerate manner.
- As part of the inspection we asked parents, children and young people, to share their thoughts about the community service provided via the completion and submission of a comment card. The responses were very positive and included the following endorsements;
- School Nursing – "the service that I have received from the school nurse has been excellent. She has been very supportive with any referrals that my child has needed"; "We are pleased with the care that our daughter receives from the nurses in the medical room. The administration of medication at lunch time gives the nurses chance to check on her current condition" and "great communication when there is a problem with your child".
- Children's Community Dental Service – "the service provided here is outstanding; the staff are attentive and patient with my little girl, which makes it more pleasant for her".

Emotional support

- We attended home visits with health visitors and saw that appropriate emotional support was given to new Mothers.
- We observed an immunisation clinic and saw that young people were given time. Their anxieties were managed well by experienced staff who were caring, compassionate and friendly. Of the 13 young people we spoke with, only three actually knew the name of the school nurse. Though the feedback given by the young people was universally positive about their dealings with them.
- We saw another example of a school nurse providing emotional support over the telephone to a parent

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whose child was having health problems at school. The support was given in a sympathetic and non-alarming manner whilst not losing the importance of the message being delivered.

- The school nursing team worked very closely with the school learning mentors. We saw school nurses were often involved in supporting the child or young person in conjunction with their learning mentor. For example,

this support often related to areas of health education such as supporting children and young people to develop healthy relationships and support positive sexual health. The school nurses were also involved with helping young people manage and cope with the anxieties of managing the relationships and pressures associated with social media.

Are services responsive to people's needs?

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

Summary

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

- In some services, children, young people and their families were having to wait far too long to receive help. For example, average wait times for speech and language therapy were highest in North Liverpool at 35 weeks but some children had been waiting 51 weeks at the time of the inspection.
- We also found that increasing pressures on the dietetic service at Sefton led to an increased risk to patients, who as a result had to be triaged in order of priority. This had an impact on the ability to train parents and carers, and little or no public health and prevention work was being carried out by the service.

However;

- We saw some really positive examples of services responding to the needs of children and young people. For example, the delivery of flu vaccines to 18,000 children in 200 schools in a 4 week period in 2015.

Planning and delivering services which meet people's needs

- Across the trust footprint there were many challenges in meeting the needs of the diverse population. At the time of the inspection, Liverpool was ranked as the 4th most deprived Local Authority in the country using the overall index of multiple deprivations. Liverpool was also ranked 8th on the income deprivation affecting children index in 2015.
- We heard from staff that safeguarding cases were taking up more and more of their time and a greater proportion of their workload. This meant that they were not always able to deliver on all aspects of their role. For example, the opportunities for school nurses to deliver planned and targeted health promotion sessions were limited. Often they would make themselves available during 'drop-in' sessions where children and young people could discuss whatever might be concerning them.

- There was a diverse student population in Liverpool; staff worked with the colleges and universities to configure teams to have an appropriate skill mix and a base within different campuses to form a multi-agency approach.
- We spoke with representatives of the senior teaching staff in all the schools that we visited. They all spoke highly of their relationship with 'their' school nurses and how valuable and responsive the service was. There was a real sense that the school nurses worked in a collaborative way with the school staff to produce better individualised care of children and young people.
- In one primary school we saw that a school nurse regularly attended the parents' coffee morning to advise and support parents and carers.
- We visited the dental clinic at the Vauxhall Health Centre, which was generally appropriate for the provision of care and treatment. However, the x-ray room for patients could only be accessed by walking through the small staff locker and changing area which was not ideal for patient experience.

Equality and diversity

- Liverpool Community Health had a contract with an external company that provided face to face interpreter services along with access to a telephone interpreter, '365 days a year in over 120 languages'. We were told of one primary school class where there were 28 out of 30 children whose first language was not English.
- We saw staff using the translation services within schools at the time of the inspection. For example, when needing to clarify information relating to vaccination consent and assessment it was often necessary to utilise the language and interpretation service to check out information with parents beforehand. Staff reported there was sometimes a delay in being able to access the service. In such cases teachers and support workers were often able to assist.
- Staff also told us that they had access to computer software that could change English to other languages as required when writing letters to parents.

Are services responsive to people's needs?

Meeting the needs of people in vulnerable circumstances

- When discussing risks, we were told that an area of particular concern were schools for children with complex needs. More specifically, staff training and competence around medicines management. Analysis of incident reports had shown that medicines management was an issue in special schools and additional dedicated training by pharmacists had been introduced. An increase in staff had also been put in place so that drug administration was safer and practiced in accordance with Nursing and Midwifery Council (NMC) guidance 2010.
- There was an out of school nursing team who dealt with school non-attenders of which there were around 400 children in Liverpool. There was also another specialist team that looked after the children of Romany families and asylum seekers.

Access to the right care at the right time

- At the last inspection, we identified that there were concerns in some areas relating to waiting times. For example, the wait time for access to paediatric speech and language therapy (SALT) was 26 weeks.
- At this inspection, we looked at performance against a range of targets up until the end of December 2015, which showed that there were some waiting times that were worse (longer) than at the last inspection. For example, the paediatric SALT team aimed to see 92% of children within 18 weeks from referral. However, the service did not meet this target across all four localities. The worst performing locality was North Liverpool where 92% of children and young people were waiting 35 weeks and the best performing locality was South Sefton where 92% of children were waiting 22 weeks.
- We also looked at the longest wait time for children in the paediatric SALT service and the best performing locality was Central Liverpool where the longest wait was 47 weeks. The worst was South Liverpool where some children and young people had been waiting 51 weeks. The trust told us they had experienced a 76% increase in demand for paediatric speech and language therapy, and had suspended the waiting list in October 2015 in the interests of patient safety, and were working with commissioners on a recovery plan.
- We spoke with speech and language therapy (SALT) teams to better understand the complexities and

demands of their service. There were completely separate speech and language teams for the Liverpool and Sefton localities. Some of the services provided by the SALT therapists were mainstream school 1:1 support, complex needs team, pre-school specialists/ ASD/SPOT, social communication assessments (in Sefton there was a 36 week waiting list for this service), training and prevention work with individuals and families.

- Paediatric occupational therapy was delivered in North and South Sefton. The target was for both of these services to be delivered in an average mean time of 126 days. At the end of November 2015, performance was at 151 days in South Sefton. However, North Sefton were performing much better at 47 days.
- There were two separate dietetic services. The Sefton service comprised one 0.8 whole time equivalent (WTE) dietician who carried out the nutritional management of children with significant and complex disabilities and acute medical conditions including the management of enteral feeding regimes. The service accepted referrals from the multi-disciplinary team with the consent of parents for children with a Sefton GP. The service covered children from 0-19 (19 years in special schools). There was no service specification in place. The referrals had been growing in recent years with 76 enterally fed children 0-18 being referred in 2014. National guidance suggests a caseload for 1.0 WTE should equate to about 50 enterally fed children per annum. The pressures on the service have resulted in a number of risks; there is no longer any holiday cover provided for the one dietician running the service, increase in safeguarding component of workload, impact on the opportunities for training with parents and carers, little or no public health and prevention work being undertaken, limited professional support and supervision. As a consequence of the aforementioned pressures the post holder had prioritised and triaged the caseload. From the latest figures we had from November 2015, the time for referral to initial assessment and the commencement of treatment was a maximum of 55 days.
- The Liverpool service was also run by one dietician but funded as a whole time post. Unlike the Sefton service, the Liverpool dietician did not manage the enteral feeding component of the workload; this was managed by the local children's hospital. The service provide by the trust rarely exceeded the 8 week referral to

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treatment time. Referrals were similarly from a range of disciplines and working alone the post holder experienced similar isolation in terms of networking, supervision and support.

- There was a single point of access for referral to the children and adolescent mental health services (CAMHS) but an initial assessment could take up to 15 weeks depending upon the degree of concern.
- The school nursing service had responded at short notice to a requirement to carry out a flu vaccination programme, which involved immunising 18,000 children in 200 schools over a 4 week period. The school health team had been nominated for a trust award for completing this work.

Learning from complaints and concerns

- A trust-wide policy included information on how people could raise concerns, complaints, comments and compliments with contact details for the Patient Advice and Liaison Service (PALS).

- Information was displayed in the clinics about how patients and their representatives could complain.
- All complaints were logged on a trust wide database and investigations undertaken before final responses were made to the complainant. There were very few complaints received in respect of services to children, young people and their families. Eight complaints in total were recorded on the database for the past 12 months for children's services. Of these four were upheld and apologies were made. One related to the length of the speech and language waiting list.
- We were told that very often parents rang up the service to request information. For example, a young person judged as being Gillick competent may have consented to a vaccination that the parent only found out about when the young person came home from school. In these circumstances the situation was dealt with verbally and such instances didn't generally develop into a formal complaint. This type of information was then factored into staff meetings for wider learning.

Are services well-led?

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

Summary

We rated community health services for children, young people and families as 'Requires Improvement' for well-led because;

- The trust was undergoing major service redesign and was working with partner organisations as part of this process although the pace of change had been very slow.
- Staff were clear that efforts had been made to change and support services. However, other staff felt that their service was still under pressure and performance had regressed.
- The local population had not been involved in the reshaping of services.
- Some risks weren't mitigated in a timely way and some services didn't have clear action plans to improve performance.

However;

- The trust had done a lot of work to improve the culture and the majority of staff stated that the organisation was a very different place to work than it had been, although not all staff felt fully informed and engaged.
- Staff engagement events and roadshows had taken place in each locality, led by the executive team. The culture had improved and clinicians felt they were being now being listened to.

Service vision and strategy

- The service was going through a period of transformation. During this time there were inevitable changes to the way in which services were delivered. For example, the re-organisation into localities and empowering those localities with clinical leadership. Throughout this on-going change the trust's vision remained clear "to provide high quality services that deliver care for people and communities we serve as close to their home as possible". This vision was underpinned by a set of values and objectives. The vision and values were known by staff and were on display in the health centres that we visited.

- There remained uncertainty for some services about what the organisational transformation would ultimately mean in terms of their future employer but very few of the staff that we spoke to during the inspection actually shared any concerns about their future.
- Progress against delivering the strategic plan were being monitored and reviewed as the organisation moved through further integration and transformation.

Governance, risk management and quality measurement

- We had previously told the trust they should continue to evolve and embed the improvement to the trust's clinical and corporate governance structures and improve the quality of governance, risk management and quality measurement. At this inspection we found that improvements had been made although the localities were still maturing in their knowledge and understanding of risk management and quality measurement.
- There was a strategic risk register, which included details of the risks, its rating, controls and actions with review dates. Risk registers had also been devolved to the localities to encourage local ownership.
- Senior managers could articulate the process for completing the risk register and the escalation process to ensure locality and executive level management oversight. Service managers were aware of their service risks and we saw examples of local risk registers which identified local issues such as speech and language therapy capacity. However, some risks weren't mitigated in a timely way. For example the number of staff reporting to one health visiting team leader had been identified as a risk by the trust but actions hadn't been taken to address them at the time of the inspection. The plan was to develop a core offer and put it to commissioners for consideration but there were no practical measures in place.
- There were several examples of action plans that had been put in place to make improvements to performance, such as improvements in performance with regard to the healthy child programme. However, it

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was noted that whilst improvements had been made in some areas, the pace had been slow and the performance in some areas had regressed since the last inspection. There were also examples of areas the trust knew they were underperforming, such as the provision of antenatal contacts, but there was no clear action plan in place or timescales for improvement.

- The trust prepared a monthly integrated quality and performance report, which provided performance information for the board via a red, amber, green, (RAG) rated dashboard. This monitored both adult and children's services including access rates, incidents and components of the healthy child programme. It also included progress against the CQC action plan developed after the last inspection.
- Services for children and young people were regularly discussed at locality and board meetings.
- There were clear lines of accountability within children and young people's services. Staff knew who was responsible for managing communications both up to senior managers and downwards to the front line staff. Staff referred to the information flow now being much improved.

Leadership of this service

- Generally staff spoke positively about the move to localities and felt better connected to the other teams within their service. Each locality had an associate director and clinical lead assigned to the area.
- We found that there was strong local leadership from team leaders and managers who had the skills, experience and capability to lead effectively. However, the responses from staff about leadership did differ. A minority felt that there were still too many managers and that senior managers were disconnected from what was going on in the localities. Whilst others described the benefits of a 'flatter' managerial hierarchy and that senior managers were now much more visible.

Culture within this service

- There was generally a positive attitude and culture within children's services. The overall ethos centred on all the services working together with best practice coming from the whole group rather than any individual. Staff felt patients received high quality, evidence based, safe care.

- Staff from all teams praised the local support from peers and managers. Examples were given of the one to one, often informal peer support that was available by working closely with colleagues in the same office base.
- Staff generally told us that they felt clinical staff were now being listened to by the senior managers in the organisation. For example, health visitors in North Liverpool told us about the introduction of a 'duty' health visitor rota. This rota was put in place to manage the safeguarding enquires that came in regularly from the multi-agency safeguarding hub (MASH) team and freed up the other health visitors who were not on 'duty'. This was seen as a positive change in practice and had been developed and presented as a business case to the trust managers. It was said that in the past this type of service innovation driven by the clinicians themselves would not have happened.
- Some staff told us that 'things had changed markedly' since the last CQC inspection. Local support from managers was better. There was 'great emphasis' on meeting key performance indicators.

Public engagement

- Public engagement amounted really to the friends and family test information, which was analysed and produced every month for board approval before being shared. The results were disaggregated to locality but not service type. So it was not possible to see from the results which responses specifically related to children and young people's services.
- We asked the executive team about what consultation had there been with the public in respect of the transformational changes taking place within the organisation. The response was that according to the trust development authority framework for transformation "there was no legal obligation to consult with the public in respect of the organisational transformation".

Staff engagement

- We were told that staff engagement events and roadshows had taken place in each locality, led by the executive team. Staff knew who the chief executive was and described her involvement in the staff engagement plan.
- We saw an engagement plan, which set out a range of initiatives introduced to keep staff informed about the ongoing changes in the trust. There had been four

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phases of roadshows in the localities with a fifth phase planned for March 2016. Over 1,000 staff had attended the previous events. There was also an email inbox where any staff could directly contact the chief executive; there had been some 200 email contacts via this route. There was also a monthly team brief, newsletters, locality and team meetings at which staff were able to raise any concerns they had about the future transformation of services.

- The most recent staff survey in 2015 showed a 42% response rate which was worse than national average but 4% more than 2014. The results showed 72% of staff would recommend the trust as a place of care and 48% would recommend the trust as a place of work. This was a marked improvement on previous staff surveys but the data could not be disaggregated specifically for staff working in the community children, young people and families' service.
- The trust monitored staff satisfaction as part of their integrated performance. NHS Friends and Family Test

results for December 2015 showed that 64% of staff would recommend the trust as a place to work and 84% would recommend it as a place to receive treatment. These results were based on a 12% completion rate across the trust and could not be disaggregated just for the community children, young people and families' service.

Innovation, improvement and sustainability

- Funding had just been secured with the local authority for a 2 year fixed term secondment into the post of Emotional Health and Wellbeing Nurse. It was planned that these nurses would work across Liverpool to improve the work with children that have particular emotional and social needs. We were told they would work with the acute sector, child and adolescent mental health services (CAMHS), education and mainstream school nurses to provide their service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Nursing care Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <p>Systems and processes were not always operated effectively to ensure that the risks relating to the health, safety and welfare of service users and others were assessed, monitored and mitigated in a timely way.</p> <p>This is because:</p> <p>All components of the healthy child programme were not being met in a timely way;</p> <p>There were unacceptable waiting times in some allied health and therapy specialisms;</p> <p>The number of health visitors reporting to one team leader was excessive and although this was recorded as a risk, steps had not been taken to mitigate this risk in a timely way;</p> <p>The risks in the management of records had not been mitigated in a timely way.</p> <p>HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 17(2)(a)(b)</p>