Pennine Care NHS Foundation Trust

RT2

Community health services for children, young people and families

Quality Report

Trust Headquarters
225 Old Street
Ashton-under-Lyne
Lancashire
OL6 7SR
Tel: 0161 716 3000
Website: www.penninecare.nhs.uk

Date of inspection visit: 13 to 17 June 2016
Date of publication: 09/12/2016

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)
RT2F3	Integrated Care Centre	Children's Speech and Language Therapy Children's Community Physiotherapy	OL1 1NL
RT2D8	Radcliffe Primary Care Centre	Paediatric Audiology	M26 2SP
RT2H6	Milnrow Health Centre	School Nurse Service	OL16 4HZ
RT2HQ	Windsor House	Health Visiting Service	BL9 8RN
RT2HQ	Blenheim House	Family Nurse Partnership	BL9 8RN
RT2HQ	Werneth Primary Care Centre	Integrated Children's Services	OL9 7AY
RT2HQ	The Croft Shifa Health Centre	Community Paediatric Service	OL16 2UP
RT2HQ	Waterside House	Children's Therapies	M33 7ZF
RT2HQ	Ings Lane Clinic	School Nurse Service	OL12 7DW
RT2HQ	Callaghan House	Children's Speech and Language Therapy Children's Occupational Therapy	OL10 2DY
RT2HQ	Glodwick Primary Care Centre	Integrated Children's Services	OL4 1YN

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

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

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

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 5

Background to the service 7

Our inspection team 8

Why we carried out this inspection 8

How we carried out this inspection 8

What people who use the provider say 9

Good practice 9

Areas for improvement 9

Detailed findings from this inspection

The five questions we ask about core services and what we found 10

Action we have told the provider to take 37

Summary of findings

Overall summary

We rated the community children, young people, and families services (the services) at the Pennine Care NHS Foundation Trust (the trust) as good.

This was because: -

Care and treatment across the children, young people and family's services was provided in line with national and professional guidance and evidence based practice. Staff across all four of the boroughs (Bury, Oldham, Heywood Middleton and Rochdale, and Trafford) treated children and young people as individuals and involved them in their care and, when appropriate, in decisions about their care. Although not all services were open seven days a week, individual services worked flexibly to provide additional clinics in the evenings and weekends. To bring services closer to the local population clinics and appointments were provided in local children's centres.

Staff were familiar with the trust's incident reporting policy and understood their responsibilities to report safety and clinical incidents. People were told when things went wrong, and learning from incidents was shared at local levels within teams and boroughs, and across the organisation through emails, written bulletins and newsletters.

Reporting systems were in place to protect people from harm, abuse and neglect, and staff understood where they could obtain further advice on safeguarding issues. We saw evidence of referrals being made to other professionals and multi-agency teams when staff had concerns about children's safety.

Staff were competent and passionate about the care and treatment they provided to children, young people and families, and there was effective multidisciplinary working within teams. However, some services we visited were experiencing capacity challenges, and longer waiting times, because of increased demand for their services. Plans had been put in place to improve waiting times in the affected services. Although we were told about one internal waiting list used in the children's services in Heywood, Middleton and Rochdale, overall the plans put in place by services were showing evidence of improvement in waiting times as a result.

A new electronic computer system was being introduced across the trust, and there was varied progress towards the implementation of this across the services and boroughs. However, technology was used well to engage children, young people, and families with services. This included the introduction of Chat Health by the school nurse service, which enabled children and young people to book appointments with school nurses and ask health related questions. The Sugar3 (Sugar Cube) mobile phone app helped children with type 1 diabetes monitor and self-manage their condition. Plans were in place for all the services to develop a text messaging telehealth service called Florence (FLO). This was to help patients at home benefit from motivation and prompting; questions or education; or to report symptoms and home measurements.

Leaders of the services recognised the ethnically diverse population within each borough, areas of deprivation, and specific health issues affecting their communities. The services worked with the local community to ensure health visiting services met the cultural and religious needs of the local community. Although translation services were available throughout the services and boroughs, we saw little evidence of public health information being displayed in other languages in the treatment centres we visited.

There was good public engagement by the services through local patient forums and support groups. Carers and parents spoke positively about staff and the care provided to their children.

However,

There was a risk to the safety of people who used the school nurse service for vaccinations. This was because the service could not guarantee the 'cold chain' (ensuring an appropriate temperature range) for the storage and transportation of vaccines and medications as maximum and minimum storage temperatures were not recorded. Vaccines and medications stored outside the recommended temperature range may not be effective.

The Oldham children's nutrition and dietetics service did not maintain accurate, complete, and contemporaneous records in respect of each service user. Records were of poor quality and did not always indicate what actions

Summary of findings

staff had taken following previous reviews of children within the service. This increased the risk that children were not kept safe because they may not receive continuity of care.

Care and treatment provided by the Heywood, Middleton and Rochdale speech and language therapy and occupational therapy services were not always provided in a timely way. This was due to high demand for the service and increasing caseloads, leading to long waiting times for treatment.

Staff understood and engaged with the trust's strategy and vision; however, some staff were unsettled by the pace of commissioning and tendering changes, and were concerned about the future

Although some services were working towards agreeing consistent treatment pathways and procedures across borough boundaries, some staff told us they did not feel the boroughs worked together.

Summary of findings

Background to the service

Pennine Care NHS Foundation Trust provided community children, young people and families services across four boroughs in Greater Manchester: Bury; Oldham; Heywood, Middleton and Rochdale; and, Trafford. Services provided included, although were not limited to, children's audiology, community nursing, dietetics, health visiting, school nursing and speech and language therapy. The services varied within each borough due to local commissioning arrangements. This meant other healthcare organisations provided some of the services in some boroughs. We inspected a sample of the services across all the boroughs.

The Oldham speech and language therapy service was available for children and young people from birth to age 16 who had speech, language and communication difficulties and or swallowing problems. It accepted older children with complex needs who were still in education. The service supported 83 primary schools and 13 secondary schools. The service worked with children, their parents or carers and other professionals to help them achieve their communication potential and to promote independence and self-management. The service was delivered in a variety of community settings in the borough including schools, nurseries, health centres, children's centres and in the home. The service also provided pre-referral advice in 'drop-in' sessions for preschool and school aged children, held in schools and children's centres across Oldham.

The Oldham community children's physiotherapy service was available to children and young adults from birth to age 16. The service accepted referrals from GPs, consultants, hospitals and other healthcare professionals. The service worked closed with, and provided treatment to, children and their carers to manage physical difficulties as a result of a disability, accident, illness or other causes. The service aimed to increase children's independence through shared goals to enable them to have as active a life as possible. The Oldham children's occupational therapy service was available to children with a physical disability. The service operated an open referral system for advice about equipment for a variety of problems including self-care dependence, fine motor co-ordination, perceptual and sensory problems, and seating and equipment needs. It accepted referrals from GPs, consultants, paediatricians and school nurses. The Oldham children's community nutrition and dietetics service was available from birth to 18 years old. This included children who were tube fed, those with varying growth, had food allergies or obesity issues.

The Bury health visiting service was available to every family in Bury with a preschool child. It could be adapted to suit individual family needs within the home or a community setting. The health visitors worked with community staff nurses, nursery nurses and support staff to provide help and advice on a range of issues including infant feeding and breast feeding; healthy eating and child growth; immunisation and prevention of disease; child development, teething, sleeping and behaviour; parenting; accident prevention; post-natal mood problems; and domestic violence. The Bury children's audiology service provided assessments of balance and hearing up to age 18. It provided an ear care clinic and assessment for digital hearing aids ensuring they are verified and evaluated

The Bury and Trafford family nurse partnership services worked with first time mothers under the age of 19 to support healthy pregnancy and enable them to care effectively for themselves and their baby from birth to two years old. The services worked to deliver the Healthy Child Programme; a universal preventative service providing families with screening, immunisation, health and development reviews, and which is supplemented by advice on health, wellbeing and parenting. These services were designed to work with the mothers' strengths, and encourage them to fulfil their aspirations for their babies and themselves.

The Heywood, Middleton and Rochdale school nursing service worked across a number of localities with school-age children and young people up to the age of 20 years. It provided a wide range of care in schools, colleges and local health clinics, including screening, immunisations, health assessments, health promotion activities, health advice and signposting and specialist support. The service aimed to ensure children experienced the best health and wellbeing in order to reach their full potential.

Summary of findings

The Heywood, Middleton and Rochdale community children's service provided multi-agency assessments and diagnoses, and planned care for children with neuro-developmental concerns and neuro-disabilities. In clinic and at the borough's special schools, the service provided medical advice for children with special educational needs; statutory health assessments for children about to be adopted and fostered; and assessments for children with suspected autistic spectrum disorder. The trust's designated medical officer for children with special educational needs and disabilities was based in this service.

The Trafford children's physiotherapy and occupational therapy services worked in the community. The service provided holistic therapy assessments, treatments, advice and packages of care to babies, children and young people with disabilities, developmental and acquired movement and or coordination problems. It also provided assessment on behalf of social services for equipment and adaptations. It designed packages of care to improve children's function in daily activities and to encourage them to achieve their maximum potential whilst maintaining health and wellbeing. The Trafford community children's orthoptic service provided care and treatment for children up to the age of seven years old who had vision or eye movement difficulties. The service's aim was to provide treatment that maximised the visual potential of each child personally, functionally, academically and socially.

Our inspection team

Our inspection team was led by:

Chair: Aiden Thomas, Chief Executive, Cambridgeshire and Peterborough NHS Foundation Trust

Head of Inspection Nicholas Smith, Care Quality Commission

Team Leader: Sharron Haworth (mental health) and Julie Hughes (community health), CQC Inspection Managers

The team included two CQC inspectors, a nurse with specialist interest in safeguarding children, and a pharmacist.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

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 organisations to share what they knew. We carried out an announced visit on 14 to 17 June 2016. We carried out an unannounced visit on 30 June 2016. We visited the community teams at the Werneth Primary Care Centre; the Oldham Integrated Care Centre; the Glodwick Primary Care Centre; the Radcliffe Primary Care Centre; Windsor House and Blenheim House in Bury; the Milnrow Health Centre; the Ings Lane Clinic; Callaghan House; the Croft Shifa Health Centre; and, Sale Waterside.

We reviewed the care or treatment records of 38 people who use services. We met with seven children who use services including their parents and carers, and two volunteers from a parents forum and support groups.

Summary of findings

They shared their views and experiences of the community children and young people, and families services. We spoke with 49 staff members including service leaders and managers, administrators, audiologists, dietitians, family nurses, health visitors, a long term ventilation nurse, occupational therapists, an orthoptist, a paediatrician, physiotherapists, school nurses, and speech and language therapists.

What people who use the provider say

We spoke with a number of parents of patients during our inspection. Although there were some concerns about waiting times and continuity of staffing, parents spoke positively about the care provided. They told us staff were very caring, and engaging, with their children. We received one comment card with very positive comments relating to community consultant paediatrician.

Good practice

We did not identify any areas of outstanding practice during the visit.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider must ensure that:

Vaccines and medicines are stored, managed, transported, and disposed of by the school nurse service in accordance with the standards set out in its Storage, handling, distribution, and disposal of vaccines policy.

A re-audit of the service's compliance with its policy is carried out within the first term of the 2016/2017 academic year.

The results of the re-audit, any actions taken, and progress towards overall completion of the existing action plan are notified to CQC monthly until completion.

The Oldham children's nutritional and dietetics service takes action to ensure that it securely maintains accurate, complete, and contemporaneous records, including decisions made, of the care and treatment provided to children who use the service.

Pennine Care NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the community children, young people and families services for 'safe' as requires improvement. This was because, although there were many good things about the children, young people and families services in all the boroughs, there were breaches of regulations 12(1)(2)(g) and 17(1)(2)(c). Specifically:

Children, young people, and families who used the Oldham children's nutritional and dietetics service were not protected from the risks associated with poor quality record keeping. This meant that staff did not always know what had happened previously in contacts with the service, whether or not children had been seen, or that their needs had been addressed on a regular basis. This increased the risk that children were not kept safe because they may not receive continuity of care.

Children, young people and families who used the school nurse service in Heywood, Middleton and Rochdale were not protected against the risks associated with unsafe storage of vaccines and medications. This was due to inadequate recording of maximum and minimum temperatures in the storage refrigerator and transportation cool bags; inadequate checking of expiry dates on needles and syringes; and delayed removal and disposal of out of date medicines

In addition:

Care and treatment for children, young people, and families who used the Heywood, Middleton and Rochdale speech and language therapy and occupational therapy services were not always provided in a timely way. This was due to the high numbers of people using this service, and an increasing caseload for therapists, which meant there was a significantly high waiting time for treatment (up to 53 weeks for occupational therapy).

However,

Requires improvement

Are services safe?

The majority of services in the boroughs had appropriate policies, training, and staff awareness to keep those who used the services safe.

Staff knew how and when to report incidents and learning from these was discussed at both service and local levels and was sent to all teams. The services carried out robust investigations and were open and honest when things went wrong.

A culture of reporting safeguarding concerns was engrained in all the services, and there were good support structures in place for staff to obtain advice, and to raise safeguarding alerts and concerns to the appropriate multi-agency teams.

Staff in each of the services had the appropriate skill mix and training to manage the needs of those who used the services. Although not yet reaching the trust's target in the current year, the mandatory training rates for the services were high.

Although we found an issue with the records in the Oldham children's nutrition and dietetics team, the quality of records, in the rest of the services we visited, was good. Clear and legible histories, assessments, and plans of care were recorded.

Good infection control procedures were in place in the clinics we visited. Although there were areas for improvement in some shared use facilities, the general environment in the clinics was child friendly. Specialist equipment was available where needed, and this was appropriately maintained and tested.

Safety performance

The NHS National Reporting and Learning System Patient Safety Information Report data for 1April2015 to 30 September 2015 showed that the trust had an overall reporting rate of 39 incidents per 1000 bed days. In comparison with other NHS organisations, this reporting rate was within the middle 50% of trusts.

The trust's records showed there were 12 serious incidents requiring investigation reported across all four boroughs by the children, young people, and families service between January2015 and December 2015. Six of these incidents were unexpected or avoidable death or serious harm; three related to suspected suicide, two related to child safeguarding concerns, and the last related to harm to a member of staff.

There were no never events relating to these services.

Incident reporting, learning and improvement

There were processes and procedures in place to identify and report incidents, and if things went wrong to explain and apologise to people who used the children, young people, and families services.

The trust had a current and up to date Incident Reporting, Management & Investigation Policy. There was an electronic reporting system in place, which could be accessed by all staff directly from the trust's intranet web site.

There were 510 incidents reported by children, young people, and families services within the last twelve months. 278 of these related to information governance errors. The remainder related to a range of causes including but not limited to slips, trips and falls; equipment; violence and aggression; and accidents. Oldham reported the largest number of incidents at 211, with Trafford reporting 140. Heywood, Middleton and Rochdale reported 87, while Bury reported 72. This suggested Oldham had a good reporting culture when compared with other boroughs, as the number of incidents was proportionate to the higher number of services the borough offered.

Staff understood their responsibilities to report and record safety incidents. Staff were able to describe a range of incidents, clinical and non-clinical that would be reported. Staff were aware of the need to report near misses (where an accident that could have caused harm was prevented), but could not recall any such incidents occurring. This was due to the nature of the care provided within the children's services, which involved only very limited clinical interventions.

Staff were familiar with the reporting system for incidents and safeguarding concerns, which was accessed through the trust's intranet. The majority of staff logged incidents themselves. Staff members who did not have direct access to the system discussed any concerns with their line manager, who then recorded the incident. Staff assessed, and recorded, an initial severity grade for each incident. Incident reports were subsequently reviewed by staff of appropriate seniority.

The service carried out reviews and investigation of incidents. We looked at two serious incident review

investigation reports for the services. The reports concluded there were no missed opportunities or errors by staff. The investigations were thorough and used the National Patient Safety Agency's root cause analysis toolkit.

There were processes in place to share the learning from incidents when things went wrong. Service leads held regular governance meetings to share learning at trust level from incidents as well as general themes. Learning was then shared directly with staff in team meetings and through briefings, for example a briefing note on non-medical prescribing.

Staff across all the services told us patient safety issues, and learning from safety incidents, were regularly discussed at team meetings. We reviewed a number of minutes from team meetings and divisional business units. These included standing agenda items on risks, health and safety, and incidents.

Duty of candour

People who used the services were told when they were affected by something that went wrong. The trust provided explanations of, and apologies for, what happened.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

The requirements of the duty of candour legislation were embedded within the trust's Incident Reporting, Management & Investigation Policy. Staff we spoke with across all the services were aware of the requirements to be open and honest, and that the duty of candour was initiated through the incident reporting system.

Consideration of the duty of candour was automatically triggered as part of the incident reporting system if an incident was graded as a three, four or five in severity, indicating moderate or serious harm. The system prompted senior staff reviewing the incident to confirm whether or not the duty of candour applied, and if each of the relevant steps (such as providing a written explanation and investigation report) had been taken. The incident report could not be closed without completing all the prompts.

We saw evidence that the duty of candour was followed in the Trafford physiotherapy service, where a child with complex needs suffered an injury following a physiotherapy session. A working party reviewed what happened, identified that the risks of physiotherapy had not been explained clearly, and what needed to change as a result. In line with the requirements of the duty of candour legislation, the service provided the family with a copy of the investigation report detailing an explanation of what had occurred, provided apologies, and also met with the family.

Safeguarding

The trust had systems, processes, and practices in place to keep people who used its services safe. The trust's Child Safeguarding Policy was up to date and available to staff on the trust's intranet, and to the public on the trust's internet site. The policy was supported by up to date Safeguarding Children and Domestic Abuse Guidelines.

There were 22 safeguarding alerts and concerns raised across all four boroughs by the service between 1 June 2015 and 31 May 2016.

Staff in all services were aware of their duties in, and the process for, reporting safeguarding concerns and allegations of abuse within the trust. Staff were able to contact and obtain support and guidance from the trust's safeguarding teams in all boroughs. The safeguarding lead in Oldham had recently transferred to another provider; however, a service level agreement was in place for the safeguarding lead to continue to support and provide supervision to staff for a period of six months until September 2016. There were plans to review these arrangements again in July 2016. Staff told us they continued to have a good working relationship with the lead.

Named nurses within the services attended multi-agency safeguarding meetings, including cared for children, child in need and child protection case conferences, and multi-agency risk assessment conference meetings. The service directors in each borough attended the local safeguarding children's board and local safeguarding adults' board, and fed into the relevant safeguarding strategy groups.

Staff within the central office in Trafford were able to seek informal advice from the on-site safeguarding team. Although this posed a risk that safeguarding concerns may not be appropriately recorded, staff told us they would still seek formal support, and raise concerns and alerts with, the 'front-door' multi agency referral and assessment team.

Requires improvement

Are services safe?

Safeguarding supervision is a process whereby an appropriately qualified, experienced and nominated supervisor meets with a member of staff or volunteer to allow that person to reflect upon and review their safeguarding practice and to raise any concerns they may need advice about.

Safeguarding supervision data provided by the trust for the period July 2015 to June 2016 indicated varying levels of supervision rates. Oldham had consistently high rates each quarter (between 91% and 94%) while Bury's rates were lower (between 71% and 84%). However, both Trafford and Heywood, Middleton and Rochdale rates dropped to 50% and 60% in quarters where there were staff changes and vacancies within the safeguarding team. Staff in the Heywood, Middleton and Rochdale school nurse service told us they had not received safeguarding supervision for approximately 18 months due to changes in the safeguarding team, but they expected formal safeguarding supervision to restart imminently. However, we understand that during this period supervision was offered via an alternative model which included one to one and group meetings and by telephone, and all staff were offered additional management supervision.

Health visiting staff in Bury told us they received direct safeguarding supervision from the Bury multi agency safeguarding hub, and there was effective multi agency working with the police and local authority social work teams. Staff were also supported with group safeguarding supervision every three months. Staff had access to further development through a safeguarding module at Bolton University.

The trust's policy and guidelines set out actions staff should take if they suspected children were at risk from domestic abuse or female genital mutilation. Each health visiting service had a female genital mutilation pathway in place. We saw evidence, within the Bury health visiting records, that staff asked safeguarding questions around female genital mutilation, and had raised safeguarding alerts to the local authority's multi-agency safeguarding hub when appropriate. This meant the relevant multi-agency teams were alerted to any children that were at risk of female genital mutilation abuse.

The health visiting teams attended child in need and child protection case conferences, and multi-agency risk assessment conference meetings. A genogram (a diagram of personal family relationships), which was regularly reviewed, was included in all children's records.

Medicines

The trust had policies in place for the 'Storage, handling, distribution and disposal of vaccines', and for patient group direction medications. patient group directions provide a legal framework to allow some registered health professionals to supply and/or administer a specified medicine to a pre-defined group of patients without the patient having to see a doctor. However, compliance with the requirements of the trust's policy was variable in the schools nursing service. This meant there was a risk to the safety of people who used the service.

Apart from the school nursing service, there were no medicines held by any of the other services we inspected. The school nursing service held medicines included Gardasil (a vaccine for the human papillomavirus), Revaxis (a vaccine for diphtheria, tetanus and poliomyelitis), Nimenrix (a vaccine for meningococcal types A, C, Wand Y), adrenaline, and Levonelle (the morning after pill).

Manufacturer's guidance recommended that Gardasil, Revaxis and Nimenrix were stored in a fridge between two and eight degrees centigrade. Breaches of the recommended storage temperature could cause the medication to become less effective, or ineffective.

In the Heywood, Middleton and Rochdale school nursing service clinic, Gardasil, Revaxis and Nimenrix were appropriately stored in the fridge. The fridge temperature was recorded daily and, at the time of recording, was within the recommended range. However, the clinic did not hold any recorded maximum/minimum fridge temperatures for at least three months. There was no 'backup' thermometer available for the fridge. This was contrary to the trust's policy on vaccines, which stated: '4.1.8 The temperature inside the refrigerator must be checked, using an appropriate maximum / minimum battery thermometer, read, recorded and reset at the same time ….by a named person or deputy. Recorded temperatures should be between 2°C - 8°C, aim for 5°C to give a safety margin of + / - 3°C. The thermometer should be used in refrigerators where vaccines are stored, irrespective of whether the

refrigerator incorporates a temperature indicator dial.' This posed a safety risk in that any breaches of the recommended fridge temperature range could go unnoticed and affect the vaccine stock.

All medicine stock in the fridge was in date. However, the fridge appeared untidy, with stocks of each medication in different parts of the fridge. This posed a risk of the medication not being used in order of oldest stock first, and could potentially lead to medication being wasted.

In order to maintain the 'cold chain' when transporting vaccines to schools, the service used cool bags. Staff told us that, following a school visit, they returned any unused medication back to the fridge. However, at the time of our visit we were not able to locate any working maximum/ minimum thermometers for use in the cool bags, nor could we see any evidence that the transporting temperature had been recorded. This was contrary to the trust's policy which stated: '7.1.3 Insert maximum / minimum probe into the bag…. 7.1.4 When the gauge is reading between 2°C - 8°C vaccines can be placed into the bag…7.1.7 Record the temperature once the vaccines have been placed in the bag on the monitoring chart…continue to monitor and record the temperature regularly during and at the end of the session…..8.12 If the cool bag has not been maintained between 2°C - 8°C inform the Medicines Management Team before placing unused vaccines in the refrigerator'. The lack of working maximum/minimum thermometers for use in the cool bags posed a safety risk as staff could not be assured the storage temperature range had not been breached during transportation. This meant there was a risk that vaccines being transported could become less effective or ineffective.

Levonelle was appropriately stored at room temperature in the locked medicines cupboard but we found no evidence of a date check rota in place to prevent the risk of out of date stock being used.

Adrenaline was stored in the emergency anaphylaxis boxes within the medicine cupboard. The service sporadically recorded date checks for the adrenaline ampoules in these, but not for the needles and syringes. We checked three boxes and these contained out of date needles and syringes. Staff removed and replaced the out of date equipment at our request.

Records also showed that three ampoules of adrenaline had been identified as out of date in November 2015; however, these were only removed from stock and destroyed in June 2016.

The school nurse service held a number of patient group direction authorisation forms for meningococcal ACWY, Gardasil, Revaxis vaccines and Levonelle (morning after pill). The patient group direction forms were full, complete and appropriate. However, the patient group direction form for Revaxis expired on 9 April 2016. We highlighted this to senior staff during our visit.

Although the patient group direction forms we viewed had only one nurse signature, staff told us they each held an individual copy of their patient group direction competency certificates. The full patient group direction authorisation list was held by senior staff in the main office. This was consistent with the trust's draft findings of a patient group direction audit carried out in June 2016, which noted that children's services held a central copy of all patient group direction competency certificates for each staff member.

As there was a risk to patient safety arising from the issues we identified, we intervened with the trust. We asked the trust to take immediate action to rectify the issues we found, and to carry out a borough-wide audit of compliance with its policy. The trust's subsequent audit of the medicine fridges at five of the Heywood, Middleton and Rochdale school nurse service locations against its storage, handling, distribution and disposal of vaccines policy found full compliance with the policy in only ten out of 21 standards, and varying compliance with the remaining standards. The audit included an action plan to address the areas of weakness, with a view to carrying out a comprehensive re-audit early in the 2016/2017 academic year.

During our unannounced inspection on 30 June 2016, we returned to the Heywood, Middleton and Rochdale school nurse service. The clinic had rectified the issues we had found, and we were reassured that appropriate checks were taking place in line with the trust's policy. We also visited another school nurse service clinic in the same borough. We found it to be compliant with the trust's policy.

Requires improvement

Are services safe?

Although we were reassured by the actions the Heywood, Middleton and Rochdale school nurse service clinic took to address our concerns immediately, our findings and the subsequent audit indicated that people using the service were not always protected from harm.

Environment and equipment

The design, maintenance, and use of the services facilities, premises and equipment kept people who used the service safe. Services were delivered in a range of facilities across all the boroughs including modern purpose built shared-use health centres, legacy health centres, children's centres, schools, and within patients' homes.

All public areas we visited, including common areas and treatment rooms, were clean, tidy and well maintained. There were appropriate toilet amenities including baby-changing facilities. Common areas included child friendly furniture, and appropriate easy-clean toys. Art produced by local schoolchildren was displayed in the Oldham integrated child services unit.

Clinic and treatment rooms contained appropriate equipment, and storage cupboards for toys. The shared nature of a number of the buildings meant that treatment rooms were sometimes stark, particularly within the Milnrow Health Centre. However, staff told us they prepare the rooms with age appropriate toys where possible in advance of an assessment.

Facilities to observe children remotely as part of assessment were available in the modern buildings, including one-way viewing windows. One treatment room in the Oldham integrated child services building was equipped with CCTV cameras for observation; however, staff told us these were not working at the time of our visit. A sensory room in the same unit included appropriate sensory equipment, which we observed being appropriately used.

Equipment within the areas we visited was visibly clean, and portable electrical equipment was appropriately tested. Equipment within the modern shared-use rooms was managed and serviced centrally by building management teams. Staff across the services told us equipment was tested regularly and faulty equipment was repaired or replaced quickly. Although two weighing scales in the Heywood, Middleton and Rochdale school nurse service did not have maintenance stickers, these were centrally logged as calibrated and in date.

Staff in all of the services we visited told us they had access to the equipment needed to do their jobs and to undertake testing and treatment of patients. Audiology equipment, including a tympanometer (used for hearing tests) and ear mould filing machine were visibly clean, and calibration checks were carried out and recorded on a daily basis.

Quality of records

In the majority of services we visited the individual care records were written and managed in a way that kept people who use the service safe.

The trust had undertaken a notes audit. However we found there was a poor standard of note keeping within the Oldham children's nutrition and dietetics service, which meant there was a risk to the safety of children and young people who used that service.

The trust was in the process of introducing a new electronic records system across the organisation. As this was an ongoing project, a number of the services continued to use paper records in conjunction with the trust's patient electronic summary record. Paper records were stored securely in all the areas we visited, and the filing system was locked at night. Administration staff within the teams ensured that practitioner and clinic correspondence was filed within the paper records.

We looked at 15 sets of patient paper records in the Oldham integrated child services. The records were clear, legible and up to date. The records included a range of information about the patients, including ethnic origin, and language, although only five recorded the child's religion. Assessments and clear care plans were shared with the patients' parents. Safeguarding issues were identified in four of the records; the notes indicated these concerns had been appropriately reported and followed-up. However, there was a risk to continuity of medical history information for children in the Oldham service born prior to 2011. This was because of the range of different paper records held, which could include records created by the previous primary care trust, the acute hospital trust, the trust's own children's and young people's service, and a neighbouring trust who were providing safeguarding services and advice.

We looked at 10 sets of records from the Trafford speech and language therapy team. The notes were clear and legible, and showed clear evidence of communication and sharing appropriate information with relevant professionals. All except one of the records did not record

the child's religion. One record showed a safeguarding referral had been made, and the staff member involved had taken appropriate action to follow-up when a patient did not attend their appointment and had declined home visits. This meant the safety of the child had been considered.

We looked at three records within the Bury health visiting service. All included a risk assessment, chronology of significant events in the child's history and included the service's family profile tool. This meant that staff were fully aware of the child's background, and were more easily able to identify potential health risks and safeguarding risks.

The Bury audiology service was fully electronic, which meant that paper records were not required and notes were easily and readily available to all audiologists. We looked at four sets of records in the service. The notes were uniformly structured with responses recorded to set questions. This included recorded consent, the results of any assessment, examination or tests carried out, a clear plan for treatment or follow-up, and any outcome that was explained to the child and its parents.

We reviewed three records in the Heywood, Middleton and Rochdale school nurse service. The records were securely stored in the administration office. A robust tracking system was in place for files that were accessed by staff. Files transferred between locations were signed out by staff and placed in a tamper-proof sealed bag. Individual staff members were responsible for the security of the records during transfer. This meant that files being transferred to other buildings were secure.

The quality of all five records we looked at within the Oldham children's nutrition and dietetics service was poor. This included missing cover sheets; lack of continuity/page numbering; pages and letters were not in order, and entries in the records were not always signed or initialled by staff members. In two of the children's records, it was unclear as to what action had been taken; this included one child who, as a result of three missed appointments, had apparently not been seen in over a year. We asked the trust to give us written assurances on the immediate safety of the two children, which it subsequently confirmed following a visit and assessment of both children.

Staff told us they worked in a small team and due to rotas and part-time working staff were not often in the office at the same time to be able to clarify any queries within notes. This meant it was difficult for staff to ensure continuity of care, particularly children with complex needs and those who were tube-fed. Staff were unable to provide evidence to indicate that this had been raised as a risk, or was included on a local or divisional risk register.

We asked the trust to provide us with assurances on the quality of notes for the remaining children using the service. However, in light of the poor quality notes, we could not be assured that the Oldham children's nutrition and dietetics service provided care and treatment in a safe way for its patients or that timely care planning took place to ensure the health, safety, and welfare of patients.

Cleanliness, infection control and hygiene

The trust had systems in place to maintain standards of hygiene and to protect people from healthcare associated infection. The trust had an up to date Infection Prevention and Control Policy in place and a range of related policies, including hand hygiene, personal protective equipment, aseptic technique, and a decontamination policy.

In the services we visited where assessment and treatment was provided, clinic and treatment rooms had appropriate hand washing facilities, including antibacterial gel dispensers for use by staff and patients. Privacy curtains in the Heywood, Middleton and Rochdale community children's service had recently been changed and were in date.

Staff we spoke with were aware of the policy and of aseptic non-touch techniques. We also observed staff following 'bare below the elbow' guidance. Staff visiting patients in the community used portable hand gels and personal protective equipment, such as gloves, if needed.

Audits of staff compliance with infection prevention and control were carried out in the Oldham, Trafford and Heywood, Middleton and Rochdale services. These identified 'moments for hand hygiene' and measured compliance with bare below the elbow, hand washing, and alcohol gel usage. The audits indicated that, on the whole, there was good compliance with the standards. An environmental audit was carried out by the Bury team; however, due to the shared use nature of treatment rooms this did not provide a sufficient level of detail to indicate the level of compliance by staff in the children's service.

Requires improvement

Are services safe?

Sterile wipes were available, visible, and were used to clean toys after use and before storing. A deep clean rota was in place for thorough cleaning of toys, which we saw was up to date. The general cleaning rotas in the clinics we visited were also up to date.

Arrangements were in place for disposing of clinical waste. There was no clinical waste within the Oldham integrated child services unit; however, two dirty utility rooms were available (although not currently in use and being used for storage) with a shared macerator (to reduce waste solids to small pieces). Similar facilities were available in the other shared-use centres we visited during the inspection.

The trust had a current and up to date Waste Management Policy; this included the handling of clinical, non-clinical, sharp and pharmaceutical waste. Due to the nature of the services involved, staff told us they rarely had any clinical waste; however, they were aware of and followed the policy for all the types of waste as appropriate.

Mandatory training

Staff received mandatory training in health and safety, infection control, moving and handling, equality and diversity, conflict resolution, information governance, fire safety, and the Prevent Strategy. Prevent Strategy training was aimed at identifying individuals at risk of extremism or radicalisation.

The average completion rate for mandatory training in children and young people's services across all the boroughs was 91% against the trust's target of 95%. Information governance, Prevent Strategy and fire safety modules had lower individual completion rates at 74%, 81% and 78% respectively, against the trust's internal target of 95%.

Staff also received mandatory training in the safeguarding of vulnerable adults and children. By May2016, the majority of staff across the trust had completed safeguarding children level one training; 95% against the trust target of 95%. 88% of eligible staff had completed level two training against the trust target of 75% and 88% of staff had completed level three (advanced) training against a target of 95% of eligible staff.

There were local variations in the training completion rates throughout the individual children's services teams in all four boroughs; however, many of the teams achieved 100% completion in all three levels. Where individual teams did not achieve 100% completion in the relevant safeguarding training, this reflected the very small size of the teams where only one or two members had not completed the relevant module.

Locum staff told us they had completed basic life support and safeguarding training, were aware of how to identify safeguarding and other incidents, and knew how to report these on the trust's system. A reception staff member confirmed they had completed mandatory and safeguarding training.

Assessing and responding to patient risk

Initial risk assessments were carried out for all children, young people and families who were referred to the services. Health and safety risk assessments were in place for the services we visited.

Assessments took into account information provided in referrals, and included consideration of any indications of safeguarding issues such as female genital mutilation and child sexual exploitation.

In Heywood, Middleton and Rochdale, the school nurses made immediate safeguarding referrals if child sexual exploitation was suspected, and also contacted the Rochdale specific child sexual exploitation team, which included social and health professionals. Safeguarding alerts were escalated where appropriate and 360° feedback was maintained between school nurses and the child sexual exploitation team. The service also had a pathway to use following notification of any incident of domestic abuse in a family with school-aged children. The school nurses service were notified of any cared for children at least eight weeks prior to starting school, and tracked attendance and outcome of assessments.

In the majority of services we visited, staff managed their own caseloads, and told us they would escalate any concerns or risks to their managers. Staff were aware of the need to monitor for, and identify, any changes in patients' circumstances or health and wellbeing that may indicate a risk to safety. Risks to services and patients were discussed at team meetings and clinical business unit meetings.

We saw evidence within integrated child services health visiting records of referrals being made to other professionals when risks were identified, such as to GPs and safeguarding multi-agency services. The community children's service consultants attended cared for child (looked after child) meetings. Children referred to the

Requires improvement

Are services safe?

Oldham speech and language therapy team had an initial assessment in clinic, with all further care, treatment and assessments provided in school. Occupational therapy staff told us they carried out risk assessments of equipment to be used, and could seek specialist advice on moving and handling patients. Parents and families were encouraged to contact the service if there were any changes to circumstances that would need a further assessment.

Defibrillators were available in a number of the buildings we visited. Although not all staff were trained in the use of defibrillators, they told us they would contact the emergency services in the event of a child or carer collapsing.

Staffing levels and caseload

The majority of services we visited had sufficient numbers of trained health professionals and support staff with an appropriate clinical and non-clinical skill mix to ensure that patients were safe and received the right level of care. However, staff in a number of services we visited across the boroughs were concerned about high caseloads. Staff also told us there had been a number of significant changes in the past year as a result of the commissioning tendering process, with restrictions on recruitment, and with some services moved to other providers.

Information provided by the trust showed that, against a planned number of nursing staff of 927 whole time equivalent (WTE), the service had 44 WTE vacancies. Against a planned number of nursing assistants of 271 WTE, the service had 31 WTE vacancies. 205 shifts were filled by bank or agency nurses to cover sickness, absence or vacancies; 16 shifts were not filled. This indicated the services had good staffing levels overall with minimal numbers of unfilled shifts.

Although the Oldham integrated children's service had no current vacancies, following a Royal College of Paediatrics review of medical cover, the service had recently recruited to one new consultant post and a staff grade doctor returned to post following an extended leave of absence. This had been an identified risk on the service's risk register.

There were caseload challenges in the Heywood, Middleton and Rochdale speech and language therapy and occupational therapy services. The speech and language therapy service had worked hard to reduce assessment caseloads and waiting times by using a locum therapist. For example, the autism waiting list had reduced from approximately 25 weeks to 12 weeks and from 20 children waiting to three. However, staff told us that some children with complex needs who meet the criteria for the autism team had remained on an internal waiting list due to a lack of capacity in the receiving team. At the time of the inspection there were three children on this internal waiting list. In the meantime bespoke care plans were put in place to be carried out by schools and parents in order to support the child while waiting for further treatment. This had been flagged up as a risk at team meetings and a review of the waiting lists has been carried out to understand whether or not the children on the list still required therapy.

Speech and language therapy staff told us they received requests for Education and Health Care Plans but were unable to accept the child onto the caseload due to capacity issues. This could prevent the child accessing correct support.

The service lead for Heywood, Middleton and Rochdale occupational therapy service acknowledged there had been a historic long-term waiting list for the service. Demand continued to increase beyond capacity, and maternity leave impacted on the team's capacity to manage its caseload. This had been raised as a risk for the service and additional funding had been requested. At the time of the inspection, the maximum caseload held was 63 with an average caseload of 59. However, the service had plans in place to reduce the caseloads and waiting times. This included increasing the existing band 5 team member's hours to full time, and advertising a new band 5 post. Additional targeted training was provided to upskill staff particularly in sensory therapy, and the service was reviewing its pathways and referral criteria.

There were also challenges within the Oldham children's nutrition and dietetic service. The service had three permanent part time staff members (1.8 WTE) who did not always work at the same time. The service's caseload included 100 tube-fed children and children who had complex and neurological needs. The service's caseload also included children from an ethnic background who were at increased risk of consanguine disorders, metabolic disorders, and high levels of obesity in the community. The high caseload meant there was a risk that the safety of children could be impacted as a result of length waits for reviews.

Requires improvement

Are services safe?

The children, young people, and families services had an overall staff sickness rate of 4% between February and January 2016. The sickness rate for individual teams generally varied within the range of 0.2% (for the Oldham Child Protection Team) and 8% (for the Oldham School Nurses). However, sickness rates for two of the teams were significantly higher at 13% for the Oldham Specialist School Nursing, and 27% for Trafford Immunisation. There was an overall staff vacancy rate in the service of 13%, with 132 staff leaving the service in the past twelve months, the majority of which related to changes within the services.

Managing anticipated risks

The trust had current and up to date Staff Working Alone policy. The policy set out the responsibilities for staff, managers, the security management director, the local security management specialist, and the chief executive. It set out the actions staff should take to request assistance, to report incidents, and described the lone working technology used to raise an emergency alert. The policy included a risk assessment checklist and a managerial checklist to ensure staff were appropriately trained and had the relevant competencies for working alone.

Staff told us they were aware of the lone working policy. Staff told us they carried mobile telephones and were aware how to use these to request emergency assistance. Each service also had a board or daily register to indicate staff whereabouts and expected return times.

Major incident awareness and training

The trust had arrangements in place to respond to major emergencies, and to keep people who used its services safe.

The trust, and each of the services, had an up to date Major Incident policy and Business Continuity Plans in place. These set out the contact details for key members of the service, and actions to be taken by staff on implementation of the plan. An on-call service manager was available 24 hours a day to report major incidents, and escalate appropriately with the local commissioners and hospitals.

While the majority of operational staff were aware of the policy and plans and knew where to find more information, they told us they had not received specific major incident training. Senior staff in the Oldham integrated care centre had received silver commander training with emergency drills carried out approximately twice a year. Staff within the Bury audiology team had also attended training and joint exercises with the police and fire services. School nurse service staff followed individual school plans, and were guided by school staff, when running clinics in schools.

Good

Are services effective?

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

Summary

We rated the community children, young people and families services for 'effective' as good. This was because:

Children, young people, and families received care and treatment from skilled and competent staff who had received training and supervision appropriate to their roles.

Staff involved the children in the consent process as well as obtaining consent from parents and carers. Child engagement with the services was also enhanced using technology applications including Chat Health (for school children to make appointments and obtain advice from the school nurse service) and Sugar3 (sugar cube, to provide help and support in managing diabetes).

Care and treatment was provided using pathways that took into account and followed recognised national clinical and professional guidelines, which also included input from multi-disciplinary and multi-agency teams when appropriate.

Although the project to introduce a new electronic record system was ongoing, with varying levels of participation in the roll-out by individual services, staff had access to all relevant information to carry out effective assessment, and to provide relevant care and treatment.

Evidence based care and treatment

Care pathways in all the services were based on recognised and approved guidelines, including from the National Institute for Health and Care Excellence, the Scottish Intercollegiate Guidelines Network, the Royal College of Paediatrics, and other professional standards and guidelines.

Services reviewed and incorporated updates to guidelines within care pathways. A National Institute for Health and Care Excellence guidance appraisal system was in place for the community children's service. As an example of this, the service implemented a new treatment pathway as a result of new guidance on autism.

Similarly a monthly governance meeting within the audiology service reviewed any updated guidelines and, where appropriate, reflected these within updated service policies and processes.

The Bury health visiting and family nurse partnership services followed the healthy child programme. the National Institute for Health and Care Excellence guideline CG45 Antenatal and postnatal mental health: Clinical management and service guidance (2007). The services also carried out assessments in relation to female genital mutilation in line with the National Institute for Health and Care Excellence guideline CG62 Antenatal care for uncomplicated pregnancies (March2008 updated March 2016). The health visiting service also incorporated the autistic spectrum quotient behaviour assessment to ensure consistency with child and adolescent mental health service assessments.

The Oldham speech and language therapy service carried out an audit of compliance against the National Institute for Health and Care Excellence guidance on autism which identified additional actions for the team. This resulted in the development of an action plan to identify key workers for each child, a co-ordinator for autistic spectrum disorder assessment for families, awareness training for child and adolescent mental health services, the need for pathways for transition into adult services, and for culturally appropriate information.

The audiology service incorporated guidelines into its processes and pathways from the National Institute for Health and Care Excellence modernising children's hearing aid services, British Association of Audiologists, and British Association of Audio vestibular Physicians. It also carried out peer reviews of traces from children's Auditory Brainstem Response test.

Technology and telemedicine

The trust was developing the use of technology to support the children, young people, and families who used the services. This provided additional flexibility and effectiveness in the ways that patients could interact with their services.

Good

Are services effective?

Tablet devices were being given to staff to enable them to access and update the new electronic records system at the point of care. These were used by the Heywood, Middleton and Rochdale school nurse service and meant staff could record notes and make relevant referrals while in the school clinics.

The Heywood, Middleton and Rochdale school nursing team developed and launched of the Chat Health service. This was a text based confidential service for children and young people that enabled them to book appointments with the school nurse, or to ask any health, wellbeing or general questions. The service was available Monday to Friday, excluding bank holidays.

A number of the services were engaged in the development of the Florence text messaging telehealth service. This linked patients' mobile phones to the trust's computer systems and was used for any condition where a patient at home might benefit from motivation and prompting; questions or education; or reporting symptoms and home measurements. The Oldham children's occupational therapy team were exploring the feasibility of using online video conferencing systems to provide home consultations.

The Bury, Oldham, and Heywood, Middleton and Rochdale services developed a website and smartphone app called Sugar3 to help children with type 1 diabetes to monitor and self-manage their condition. Plans were in place to develop a similar app to help children with asthma; it was hoped this would be launched later in 2016.

The trust was also in the process of introducing a performance data dashboard system, Tableau, to the services in Oldham. This provided managers and staff with a view of their performance data and enabled managers to look at the impact of staffing on capacity, safety, and finance.

Patient outcomes

Staff across a number of the services told us that outcomes were difficult to measure or quantify given the nature of their patients' complex and long term conditions.

The Oldham integrated care services lead told us progress is monitored through child centred review; for example, long term functional language improvement through speech and language therapies; or re-access/re-referral rates. However, the Oldham children's therapy service measured outcomes in terms of the child's level of improvement in their impairment, level of activity, participation in sessions, and overall well-being. Between June 2015 and May 2016 this showed that an average of 88% of children had an overall improvement, 10% of children had sustained their existing levels, and 1% had not improved. This indicated that the physiotherapy service had made a positive impact on the lives of the children staff had seen. The Trafford therapy services measured outcomes in a similar way. Sample data provided by Trafford indicated functional improvements had been made by all children in the sample measured bar one who did not complete the course.

The Trafford health visiting and school nurse services met the national Call to Action requirements by 1 April 2015, and were maintaining service levels throughout 2015/2016 despite the need for regular recruitment to the programme. The Call to Action was a programme of improvement and support for children and families, which called for strong partnership working. The borough delivered all five healthy child programme mandated contacts, although it faced some challenges in the lower numbers of antenatal contacts due to late notifications from the midwifery services, which the service highlighted to the local clinical commissioning group. Health visitors received additional leadership training and in the Solihull method, which is an evidence based psycho-therapeutic approach to working with children and families.

Due to the long term nature of the family nurse partnership service, it had not been in place long enough to measure its patient outcomes. Staff were aware the programme was expensive due to its intensive nature, and were unsure of how the service would develop in the future. The family nurse partnership service were in line to achieve their targets of 80% of visits during pregnancy.

Family nurse partnership staff understood Dyadic and Naturalistic Caregiver Experiences observations with the mothers and children in the service. These observations helped to identify and build on the mother's strengths and to improve on her weaknesses, and enabled staff to assess and score the interactions between the mother and child. The licencing requirements of the tool meant that staff were assessed on the use of the tool and had to achieve within 15% of the gold standard to be identified as competent to use it in the community. The service also used the Partnership in Parenting Education model, which was designed to increase parents' emotional availability and relationship building skills.

Good

Are services effective?

Competent staff

Trust staff had the skills, knowledge, and experience to deliver effective care and treatment to their children, young people, and families who used the services.

The trust had a formal Induction Policy in place. New staff including agency, bank or locum staff were given an induction, which included mandatory training

There were arrangements in place for supporting staff through clinical supervision. Trust records showed that in the 12 months to May 2016 an average of 90% of staff within the services across all boroughs had received clinical supervision with all but the health visiting teams (in Bury, Oldham and Trafford) achieving 100% supervision. Although the level of clinical supervision in the health visiting teams was lower, all clinical staff we spoke with told us they had received, and were supported, in clinical supervision.

Eighty-six per cent of non-medical staff within the service had an annual appraisal within the last 12 months. This was better than the average appraisal rate across the trust of 80%. This was reflected by the staff we spoke with who confirmed they had a completed appraisal.

As of 31 January 2016, the trust's data showed that 77% of eligible staff in the community service had completed basic life support training, and 83% of eligible staff had completed children's life support training. These were both against a target of 95%. This was just slightly below the trust's average figures (for all services) for completion in May 2016 of 79% and 83% respectively. This meant the majority of staff within the children, young people and families community services were competent to carry out emergency life support training for both adults and children. There remained a small risk that lone staff, who had not received this training and were visiting children at home, could potentially face a situation where these skills were required. However, staff we spoke to said they would always contact the emergency services for immediate back-up in any situation when life support was needed.

A competency framework and client specific assessment framework were in place for new staff members on the Oldham long term ventilation team. This included mandatory training, role specific training, and supervised practice across a range of skills. This ensured that staff were competent, and felt confident, to carry providing care for children with ventilation needs, including tracheostomies.

Staff told us they had regular one to one meetings and appraisals with their managers, and support was always available. 94% of staff in the children, young people, and families services had received clinical supervision between June 2015 and May 2016. Although the trust did not have a target for this, the rate was higher than the trust's average.

Family nurse partnership staff received weekly supervision, which was in line with the licence requirements of the family nurse partnership programme.

Multi-disciplinary working and coordinated care pathways

Staff and teams within the children, young people, and families service worked well together and with other professionals and agencies to deliver effective care and treatment. Communication within and between multidisciplinary teams was clear and effective. This included involvement, and sharing appropriate information, with patients, parents and carers, GPs, consultants, the local authority and social services, and where appropriate the police.

The Trafford and Bury family nurse partnership services had close links with midwifery services in the region's hospitals, the health visiting teams, and patients' local GPs. This ensured eligible mothers were identified and referred to the service, that appropriate assessments and interventions were carried out quickly, that there was continuity of care between all the services, and that any safeguarding concerns could be identified and flagged at an earlier stage. Referrals had increased to one to two per week as a result of the work carried out with midwives in the local hospitals and maternity units.

The Trafford orthoptics service had an agreement with Manchester Eye Hospital for children's ophthalmologists to attend clinics once a month to assess children with complex needs.

A child development service co-ordinator within the Oldham integrated care linked with the wider services to ensure assessment pathways were up to date, and assessments and medical reviews were timely.

The Oldham speech and language therapy service worked closely with the other therapy services to provide a co-ordinated approach to care and treatment. It was developing joint speech and language therapy, occupational therapy and physiotherapy clinics where appropriate for the child's needs, and shared reports with

each of the teams involved including other relevant professionals. Staff told us the service had excellent links with local schools and the educational psychology teams, and there was good multidisciplinary team working across all areas. The service was involved in a Commissioning for Quality and Innovation steering group to improve child to adult transition services, particularly for vulnerable children. The three year project worked with local GPs to understand their needs for a child who is transitioning between services. The project introduced transition templates, created a transition practitioner post, and service leads met with a local GP cluster every quarter to keep them informed of any developments within children's services.

The Heywood, Middleton and Rochdale and Trafford community children's teams developed a multidisciplinary integrated Team Assessment Pathway, which was designed to be completed within 12 weeks. The core assessment team included speech and language therapy, occupational and physiotherapists, orthoptists, nurse practitioners, community paediatricians, and representatives from the local education authority's Early Years Team, the area Special Educational Needs co-ordinator, and the special educational needs team. Following assessment, feedback was provided to parents, and copied to local health visitors and the child's GP.

The Trafford orthoptist service worked with teams in Bury and Heywood, Middleton and Rochdale to harmonise the care pathways. This meant teams were able to provide some services across borough boundaries. The service also worked with the Allied Health Professionals network.

Referral, transfer, discharge and transition

The children, young people, and families services each had protocols and criteria in place for referrals into the individual services. Referrals to the services were made in a variety of ways: by local GPs and other health professionals, local hospitals, school nurses, health visitors, social services, through the NHS e-Referral Service, and by self-referral.

The services used a range of manual referral forms for referring children into each of the services in each borough. These requested information such as the patient's details, reason for referral, allergies, medical history and details of any medications taken by the patient. Signed parental consent was also requested on a number of referral forms. All referrals were screened on receipt, and staff contacted referrers if additional information was required.

The Trafford orthoptist service operated an open referral system, which included parental self-referral. It accepted children from birth though to age seven, with 99% of children seen at school reception stage. Approximately 10% of these were referred onwards into clinics.

The Bury and Trafford family nurse partnership services accepted referrals for first time mothers between 16 and 28 weeks pregnant if the mother was under 19 years old at last menstrual cycle. The service worked with midwives in the local hospitals to improve identification of suitable mothers for referral to the programme. This resulted in an increase of up to two new referrals each week. Although the service had a policy in place to transfer a child to the health visiting service at the age of two, this had not yet been used as the programme had not been operating long enough.

The audiology service accepted referrals for children up to the age of 16 (or 19 if the child had learning disabilities), including the assessment of babies. The service had a policy in place for children transitioning into adult services; however, at the time of the inspection, the policy had not yet been used as none of the children in the service had reached the transition age.

Each service had a transition plan in place for young adults who were transitioning from children's services into adult services. The Heywood, Middleton and Rochdale children, young people and families service was developing its transition service further through a Commissioning for Quality and Innovation programme. This put in place 'The Futures Club'; a multi-agency drop in service led by a cared for children nurse, established nurse led transition clinics, and provided web-based health links for cared for children and children leaving care through the local authority websites.

A similar Commissioning for Quality and Innovation project was implemented in Oldham. This established two transition nurse practitioner posts; a new neurological transition pathway was developed with the Royal Manchester Children's Hospital and Salford Hospital; and developed closer transitional links with GPs.

The Heywood, Middleton and Rochdale services Commissioning for Quality and Innovation project focused

on the development of a transition programme for children and young people with diabetes. The Sugar3 app was developed as part of this project to engage children and young people in managing their condition.

Appropriate information was provided to patients' GPs and other relevant health professionals when a child was discharged from services. However, staff within the Oldham children's nutrition and dietetics service told us that discharge could be difficult given the complex needs of the children, which included tube-fed children. This had a potential impact on the services work-load and capacity. Staff told us this was because there was usually no other relevant service to place the child into and, as such, most discharges from the service were to the health visitors or to the school nurse adviser.

Access to information

Staff in the majority of services we visited had all the information needed to deliver effective care and treatment to children, young people, and families who used the services.

The trust was introducing a new electronic patient records system, which was envisaged to hold all clinical records for people who used its services. The trust's aim was to introduce the system initially on a like for like basis, replicating any information currently stored on other electronic systems used by services such as the audiology service or the school nurse service. This was an ongoing project, and during our inspection the new system had not yet been fully introduced in all teams within or across all the boroughs. For example, the Oldham children's community nursing service was using it as a full clinical system, whereas the Bury health visiting service mainly used it to record patient demographics and the type of visit carried out.

Staff in the school nursing service were provided with electronic tablet laptops to record information when in school clinics.

The family nurse partnership service had fully electronic records. However, records had to be printed off for handover to the health visiting service when the child was two years old.

A number of the services still relied on paper records. There were appropriate processes in place for storage and retrieval of paper records to ensure that staff could access them in a timely way, and securely transfer them when necessary. Service level agreements were in place in Oldham to access records for cared for children that were held by a neighbouring trust.

The majority of electronic and paper records in the services we looked included all the information needed by staff to carry out full and effective assessment and provide appropriate care.

Although there was a risk related to the varying levels of usage of the electronic and paper systems, we saw no evidence to indicate that staff could not access the information needed to carry out their roles and assessments.

Consent

Consent for care and treatment was always sought from the people who used the children, young people, and families services. The trust had a current and up to date Consent to Examination or Treatment Policy. The policy included sections on the consideration of assessment of capacity to consent in line with the Mental Capacity Act 2005, and a specific section on the treatment of children and young people. This included consideration of Gillick competency (a child's capability to give consent) and the Fraser guidelines (to make a best interest's decision to provide contraceptive advice, treatment or both without parental consent).

Staff we spoke with who were involved in the care and treatment of children were aware of the need and process to obtain consent, before providing care and treatment. This included awareness of Gillick competency and the Fraser guidelines. Staff across the services told us they aimed for child centred care, and with a view to obtaining 'the child's voice'. Audiology staff also told us it was their practice to also seek consent from the child. We saw evidence in records across the services of consent being obtained. This included four records within the audiology service, which recorded consent within the electronic notes.

Consent was obtained in a number of ways across all the services. This included parental consent on referral forms, verbally, or as implied informal consent. Staff told us that, where possible, they obtained consent directly from the child or young person, ensuring the child understood what they were consenting to. If staff were concerned about an individual child or young person's capacity to consent they

Good

Are services effective?

could refer them for a separate capacity assessment. For example, a mother within the family nurse partnership service who was also autistic was referred to the autism team for assessment.

By end of May 2016, 90 staff in Trafford, 58 staff in Heywood, Middleton and Rochdale, 128 staff in Oldham, and 121 staff in Bury had received training in awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). This meant staff had the relevant skills to assess children's capacity to consent to care and treatment, and to recognise situations that may be indicative of inappropriate restraint. For example, staff in the Oldham children's occupational therapy service told us they were aware of the need to carefully consider equipment requests that may have an implication on the restraint of a child. Staff took advice on this from the safeguarding team if needed.

Good

Are services caring?

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

Summary

We rated the community children, young people and families services for 'caring' as good. This was because:

Children and young people were treated by staff as individuals and as partners in their care and treatment. They were treated with kindness and dignity and where appropriate were supported to make their own decisions.

Staff recognised the emotional impact to children and young people of the care and treatment being provided and took this into account when making decisions about priority.

Parents and carers were positive about the care provided to their children, and felt supported.

Compassionate care

People who used the children, young people, and families services were treated with compassion, kindness, dignity, and respect. All staff we spoke with were passionate about their roles and about the care they provided to children, young people, and families.

We met seven children and their parents in the services that we visited. Although some of the parents were concerned about initial delays between referral and assessment, they all spoke positively about the staff members, therapists, nurses and doctors involved in the care of their children. Two parents we spoke to in the audiology service were happy with the care provided to their children. One told us the service was 'excellent, very responsive, very helpful'.

We observed a sensory therapy session with a child and his mother. The therapist provided compassionate and considerate care and there was an excellent rapport between the therapist and the child. This was reflected in the child's level of animation and engagement in the session. The child's mother told us they both 'love the sessions' and that she could see clear progress over the two years her child had been receiving sensory therapy.

A member of staff in the Heywood, Middleton and Rochdale nutrition and dietetics team had received a thank you card from the mother of a child who had sadly died, which said 'thank you for loving my daughter'.

We looked at the NHS Friends and Family Test results for the services across all the boroughs. The Friends and Family Test asks patients to rate how likely they would be to recommend the service to their friends and family. The monthly results varied for each borough over the six month period we looked at. In Trafford between 93% and 100% (average 99%) were extremely likely or very likely to recommend the services. In Oldham this was between 99% and 100% (average 100%); Heywood, Middleton and Rochdale between 78% and 99% (average 95%); and Bury between 84% and 100% (average 96%). This indicated a high satisfaction with the services received.

Staff in the Heywood, Middleton and Rochdale community children's service told us they introduced a child friendly feedback system known as 'Kiddie Tiddlywinks' in order to get feedback on services from children. Children were given a counter to place in a box of their choosing based on how they felt after a session, Although we do not have the figures for this, staff told us that children liked using the system, although often they placed the counter in the same box each time.

We received a comment card from a parent relating to a community consultant paediatrician, which said 'The consultant…was amazing, compassionate, diligent, thorough and professional. She interacted amazingly with my three year old son and excelled in her communication'.

The service received 71 compliments for the twelve months prior to February 2016 with the largest number, eighteen, received by Trafford's health visiting west team.

Understanding and involvement of patients and those close to them

Staff across all the services were aware of the need to understand and involve children, young people and families in the care they provided. Staff were focused on the needs of each child, treating each child as an individual, and listening to the 'child's voice'.

We saw evidence of staff seeking consent from children, as well as from their parents in the audiology service, which indicated that staff were including children in discussions about their care. Staff in other services told us they carefully explain what will happen with each child. This meant that staff recognised patients' rights to make

Good

Are services caring?

decisions about their own care and treatment. For example, the school nurse service recognised young people's ability to understand, weigh-up and consent to care and treatment without parental consent. Staff were aware of their responsibilities and duties in carrying out assessments of ability to consent.

The Oldham long term ventilation service developed a service level agreement with families on the level of support that could be expected and would be provided. It set out details of what staff would and would not be responsible for. Alongside regular email contact with the families to provide a duty rota, the service lead met all parents every year to discuss each family's needs and to capture any changes. This was reviewed every twelve months as a minimum. This was particularly highlighted in the case of a child who was within a foster family, where there were differing responsibilities with the family, the service and the local authority. The service introduced a bespoke process in order to be able to support this family.

Emotional support

Staff understood the need for children, young people and families to be supported emotionally with their care. The services worked closely with a number of patient and family support groups, including Parents of Oldham in Touch and children's' centres across the boroughs.

Parents told us staff in the Heywood, Middleton and Rochdale community children's service provided good emotional support. Parents said that doctors and therapy staff always involve their children in care, explained what was happening during the sessions, kept them up to date and sent additional information. One parent told us about the 'Sam's Siblings' group, which supported siblings of children on the autistic spectrum to help them understand how they see the world.

Staff in the Oldham physiotherapy service told us they were aware of emotional triggers for children during assessment in clinic, including anxiety. Staff used toys, and remote viewing to allow the child time to get used to the environment, and could assess children in more familiar surroundings at school or home if needed.

The Heywood, Middleton and Rochdale community children's service recognised the particular emotional needs of children who were transitioning between primary and secondary schools, and those who were about to sit examinations. The service prioritised these assessments to ensure a diagnosis was given before the start of the academic year.

Good

Are services responsive to people's needs?

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

Summary

We rated the community children, young people and families services for 'responsive' as good. This was because:

Services were planned and delivered in ways that met, and supported, the needs of local people in the different localities within each borough. Staff were working towards harmonising services and procedures across borough boundaries, and Trafford community services were integrating effectively with the local authority services.

Equality and diversity needs, including the needs of different groups of people, were taken into account in the planning of services. Translation services were available when needed, and services worked effectively with representatives of ethnic communities.

In most services, care was available and provided at the right time, and in accessible locations.

Complaints were handled effectively, and learning was shared across the trust and at local level as appropriate.

However,

There were long waiting times in children's nutrition and dietetics, speech and language therapy and physiotherapy services in Heywood, Middleton and Rochdale.

There was limited availability of printed information, including public health information, in other languages. There was a risk that people may not always get the information they needed.

Planning and delivering services which meet people's needs

The community children, young people and families services provided a range of specialist services across a number of localities within each borough. Service provided included, but were not limited to, community children's services which incorporated neurodisibility care and treatment and assessment and diagnosis of autistic spectrum disorder, audiology, orthoptics, speech and language therapy, physiotherapy and occupational therapy, and children's nursing. Universal child health services were also provided by health visiting and school nurse services.

Due to local commissioning arrangements some services were provided by other healthcare providers within the region. There were service level agreements in place between the trust and other providers.

Trafford services were in the process of developing core functions and services within each of its four localities. This was supported by centralisation of specialist services for children with additional and complex needs. Joint outcomes had been agreed between the services and the local authority, which meant greater integration of the health and social care services in the borough. The service was also identifying opportunities to dual skill staff in both health and social working competencies.

The audiology services across Oldham, Bury and Heywood, Middleton and Rochdale were in the process of standardising their standard operating procedures and treatment pathways with the aim of working as one service.

The community children's service was working to harmonise its processes, procedures and service across the boroughs. The service had also introduced an epilepsy clinic (which had not been commissioned), which saw 80% of all children with epilepsy in the area, including those with neurodisabilities. This clinic was supported by an epilepsy nurse from the local acute hospital trust. A palliative care pathway for children with complex conditions and ventilation was developed by the service.

The Bury family nurse partnership service was part of a national licenced programme to work with first time mothers under the age of 20 who were less than 28 weeks pregnant at the time of referral. Working alongside the family nurse partnership team in Trafford, the service had been funded for two years to work with midwives, and worked intensively with the mother until the child was two years old, after which care was transferred to the health visitor team.

The Bury community nursing team worked with hospital staff to identify children who could be appropriately cared for at home. This meant hospital staff could develop a safe discharge plan which was supported by a package of home care developed by the community nursing team. This meant that children could be discharged back home more quickly.

Good

Are services responsive to people's needs?

The Oldham speech and language therapy service worked closely with the services in other boroughs through the speech and language therapy forum which met each quarter. This aimed to undertake joint recruitment and joint working, particularly with Heywood, Middleton and Rochdale which had similar population demographics.

The Oldham occupational therapy service worked flexibly with families and other professionals to provide focused, and planned, care that meet individual children's needs. Care pathways were adjusted for individual children, and were aimed at improving patient outcomes through self-management rather than direct therapy. Staff told us 'we listen to what people say. We make our interventions optimal for parents and patients'.

The sensory therapy service had an 'opt-in' system. However, children with urgent needs were seen within seven days of referral. The service worked with other health professionals involved in a child's care to explore joint sessions for children with complex needs whose parents had not opted-in.

School nurses in Heywood, Middleton and Rochdale wore uniforms when delivering clinics in school. Staff reported this had a positive impact on both pupils and teachers. This had raised awareness of their role within each school and resulted in increased engagement with young people.

Equality and diversity

Services were planned to take account of the equality and diversity needs of different groups of people and those in vulnerable circumstances were taken into account by the children, young people, and families services. Staff and leaders of the services recognised the ethnically diverse population within each borough, including levels of deprivation.

Patients who were not able to speak English were identified when they were referred to the services. Each service had access to interpreters, and did not rely on parents or carers to interpret. The Oldham speech and language therapy team had three members of staff who were bi-lingual (in Bangla, Punjabi, and Urdu). The services also had access to British Sign Language interpreters when required, and information could be produced in large print and braille.

Information leaflets were available in all the areas we visited; the majority of these were in English. Staff across the services in Oldham were in the process of developing service specific information leaflets. Although staff told us leaflets in other languages could be provided if requested, there was a risk that non-English speaking patients, parents, and carers could be excluded in obtaining important public health information. For example, in Oldham where 29% of the population speak a language other than English, information about a 'drop-in' clinic was displayed in the reception area, but in English only.

A staff member developed a guide for staff on 'Working with families of Asian Heritage in Oldham'.

The Bury audiology service provided a range of leaflets, including those by 'Action on hearing loss' and for 'Lip reading classes'.

Health visiting services within the Bury townships also worked closely with the local Jewish community including the Jewish Federation, and local doulas, to meet the needs of new mothers. (A doula provides continuous support for the mother and family through pregnancy, birth and the early days of parenthood.) This raised awareness of the health visiting service. Staff recognised the impact on meeting the two-week check performance target where orthodox mothers convalesced away from home. However, staff worked with local Rabbis and GPs who were able to carry out the first check. This enabled staff to be flexible with the post birth two week check visits.

Meeting the needs of people in vulnerable circumstances

Services were planned, and delivered, to meet the health needs of different groups of people including those in vulnerable circumstances. To enable this trust staff worked closely with other healthcare organisations, local authorities and police. Cared for children and other vulnerable children were identified on referral into the children young people and families services.

Staff had a good understanding of the potential health impact on children and families from specific ethnic backgrounds. For example, although the Oldham integrated services team told us there had been no unexpected child deaths in its area, staff told us the Child Death Overview Panel and the Local Safeguarding Children's Board had raised concerns about child deaths and abnormalities in children born within consanguine (first cousin) relationships. Genetic issues in these situations could lead to a higher child death rate. As a result, a new band five nursing post was created for staff to work with the local communities in the children's centres.

Good

Are services responsive to people's needs?

The community children's service had a lead consultant for cared for children who also sat on the adoption panel. Staff carried out special educational needs medical assessments and adapted their clinics to meet the 28-day criteria. The service had a dedicated medical officer in place who worked on special educational needs reviews. The service had a specialist support worker for hearing impaired children and young people. It was also developing, in conjunction with the local authority's additional needs service, a language acquisition through motor planning approach with the use of assistive technology for children with language developmental issues.

The Oldham physiotherapy team had recently produced a picture leaflet to help children understand the service and the exercises they had been given to do. Staff involved patients in their care, and incorporated exercises into 'play'. Staff also had the option to ask patients to draw the exercises in a way that would help them to remember easily.

Staff in the family nurse partnership service had received 'escape the trap training' to support mothers and children who were at risk of domestic abuse. The service also met mother's at children's centres to encourage engagement with the service.

Child friendly toys were available in the majority of areas and clinics we visited. Although there was no specific play area within the Bury audiology department, staff told us that colouring packs were available to children on request.

Access to the right care at the right time

The children, young people and families services did not routinely offer seven day working, although some services had introduced late weekday clinics and Saturday clinics. Although the majority of services provided the right care at the right time, we saw evidence of delays in referral to assessment in some of the services.

Generally, services were provided across all boroughs Monday to Friday. Opening hours varied by each service, but were mainly between 8am and 5pm. Some services provided additional early evening and Saturday appointments. Services were provided in the local communities at health centres, children's centres, patients' homes and schools. This meant that people were able to access care and treatment at convenient times and close to home.

Referral to treatment times measured the time between a patient being referred to the service and treatment being commenced for consultant led services. Often referred to as the '18 week pathway', the aim was for 95% of patients to start treatment within 18 weeks of referral. However, the trust also recorded waiting time targets for services which were not consultant led. These targets varied with the type of service provided, and each individual service's agreements with the local commissioners.

The trust's data for 2015-2016 indicated the majority of children's services across all the boroughs met the relevant waiting time target for the service. This meant that patients received care in a timely manner. For example, at the time of the inspection the Trafford children's medical team had no children waiting for longer than 18 weeks. The Trafford children's orthoptic service had an average waiting time for assessment of approximately six weeks.

However, there were delays in the Heywood, Middleton and Rochdale children's occupational therapy and speech and language therapy services. In 2015-2016 the average waiting time for review by the Heywood, Middleton and Rochdale speech and language therapy service was 25 weeks against a target of 18 weeks. This meant that children referred to this service had an approximate six month wait to be seen. This risk had been added to the trust's risk register. The speech and language therapy service lead acknowledged there had been significant historical challenges related to a period of change between 2013 and 2016 when the service was not allowed to recruit to vacant posts. The lead told us the poor waiting time figures were compounded as a result of some system information errors in the changeover to the new electronic system. This was because a number of children had been discharged from the service, but were still showing in the waiting time figures as the record had not been closed on the new system. The service was working to correct these figures.

A number of initiatives were put in place from the middle of 2015 to reduce waiting times. These included recruiting four new band five therapy staff and using locum cover. The service was also working to introduce new referral criteria, reorganise and restructure the clinical pathways. This meant that following referral, parents were sent an opt-in letter which included additional information about the service. The service introduced a new speech pronunciation pathway and a mild, moderate and severe

language pathway. The service introduced additional self-help advice and information to assist parents in helping their children at home, and it had also increased the services liaison with children's centres and specialist schools. As a result, we were told that by March2016 the average referral to treatment waiting time had been reduced to less than 18 weeks, with only one case that did not meet the target. This was supported by the latest 2016 data, which indicated the current average and maximum referral to treatment waiting time was 17 weeks.

In 2015-2016 the average waiting time from referral to treatment for Heywood, Middleton and Rochdale occupational therapy service was 29 weeks against a target of 18 weeks. The occupational therapy service lead told us the service had similarly been affected by historical challenges, including difficulties in backfilling posts for maternity leave. Demand for the service was, and continues to be, greater than the service's capacity, including for children with complex needs who are on long-term care pathways. This meant that children referred to this service had an approximate seven month wait to be seen.

The occupational therapy service had introduced a number of initiatives to reduce waiting times. These included introduction of packages for use at universal service level prior to referral. This included clarification of the service's criteria, and new pre-referral criteria. It also developed a joint initiative with Healthy Young Minds. This funded locums to see approximately 130 children on autistic spectrum pathways from the service's current waiting list. Training for school staff on meeting children's needs particularly when they related to sensory impairments was included. The service was also in the process of recruiting to a new band five therapist post.

To help reduce waiting times, the Oldham physiotherapy service developed a physiotherapy assistant programme, where a child was assessed within four to six weeks by an assistant, then referred onward to the physiotherapist within six to eight weeks. This meant that physiotherapists were able to review more children in a shorter period. The service also introduced clinics on Saturdays and clinics to 7pm on two weekdays. This allowed the service to be more flexible for parents.

At the time of the inspection, the average waiting time for the Heywood, Middleton and Rochdale occupational therapy service was 29 weeks, with the maximum wait time of 53 weeks. This meant that the actions the service was taking to try to reduce this time had not yet significantly improved waiting times.

Patient did not attend rates and clinic appointment cancellation rates varied across all the services and boroughs. For example, Trafford patient did not attend rates varied between 0% for the school nursing service and 7% for children's medical service, with clinic cancellations varying between 0% and 3% for the same services. The orthoptic service had a patient did not attend rate of 7%; however, it worked to reduce this by sending a patient did not attend letter asking parents to get in contact. If no further contact was received after a second patient did not attend letter was sent the patient was discharged.

The Oldham integrated child services lead told us that, against a current waiting time background of approximately 21 weeks for initial assessment, patient did not attend rates were running at approximate 4% but had seasonal fluctuations. This was on the service's risk register. The service increased the number of assessment clinics within school holiday periods, and used a text reminder system to reduce the number of missed appointments. We were told clinic cancellations by the service were low as staff commitments and holidays were planned in advance.

The Oldham children's nutrition and dietetics teams was in the process of producing a new patient did not attend protocol.

In Bury, between June 2015 and May 2016, the highest patient did not attend rates were 12% (average) for the children's dietetics and 8% for the children's speech and language therapy service. This was above the services' targets of 5%. Over the same period, these services also had the highest clinic cancellation rates, at 10% (average) for dietetics and 1% for speech and language therapy.

In Heywood, Middleton and Rochdale for the same period, the highest patient did not attend rates were in the children's orthoptic service at 18% (average) and children's physiotherapy at 6%. The children's speech and language therapy service was above target at 6%. The community children's service had the highest clinic cancellation rate at average of 5%, which was followed by the children's speech and language therapy team at 2%; however, this was based on only a small two-month sample for April and May2016.

Good

Are services responsive to people's needs?

Learning from complaints and concerns

The trust had an up to date Complaints and Compliments policy. This stated that complaints should be acknowledged either orally or in writing within three working days. The policy did not specify a timescale for investigating and responding to complaints; however, it said this should be discussed and agreed with the complainant, or set by the complaints manager if no agreement could be made. A risk based assessment, dependant on complexity and severity, was used to categorise the complaint and to determine the level of investigation to be used and the type of response to be sent.

For the twelve months prior to February 2016 the trust received 23 formal written complaints about the children, young people and families services. Of these eight complaints were fully upheld and one was partially upheld. The largest numbers were received by Oldham community health service; five for community paediatricians of which three were fully upheld, and three for the health visiting service of which one was fully upheld and one was partly upheld.

We reviewed seven complaint investigation reports carried out by the service across all four boroughs. These covered a range of fully upheld, partially upheld and not upheld complaints. The investigation reports were robust, and took into account relevant service policies, care pathways and guidelines. The written complaint responses gave appropriate explanations and apologies, and where appropriate explained what would happen next. Action plans were also developed to make improvements where shortcomings had been identified.

Staff across the service told us the nature of their work meant that the number of complaints were low. However, staff were aware of the complaints process, and were able to direct parents and carers towards the trust's Patient Advice and Liaison Service, or complaints team. Staff told us they dealt with oral complaints within the team, where possible, as soon as they were received.

Learning from formal complaints affecting each service were discussed in monthly team meetings, Staff received individual feedback from managers for complaints related to care they were involved in. They also received learning from complaints and incidents via trust newsletters and the trust-wide seven-minute briefing. The Heywood, Middleton and Rochdale community children's service shared learning with colleagues across boroughs because of the close working of its specialist neuro-disability teams. However, there was less evidence of learning being shared across boroughs within other individual services.

Good

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 the community children, young people and families services for 'well-led' as good. This is because:

Staff had a good understanding of and engagement with the trust's vision, strategy, and values, although we saw no documented service specific strategy.

Staff were supported by their local teams, managers, and senior managers in providing care and treatment against key performance targets.

There was a clear governance structure in place at senior and local level, which enabled regular review of performance, developments, and risks.

The services engaged well with the public through parents groups and forums, and feedback was sought from all those who used the service.

However,

Some staff were concerned about the pace of commissioning and tendering changes, and the impact this was having on their services.

Some services were working towards harmonising pathways and procedures across borough boundaries; however, some staff told us they did not feel the boroughs worked together.

Service vision and strategy

The trust had a clear vision and strategy to deliver good quality care. Its vision was 'to deliver the best care to patients, people, and families in our local communities by working effectively with partners to help people to live well'. The trust's values, known as the '10 Principles of Care', underpinned the vision. The principles were embedded in the trust's individual performance and development review, which ensured that developmental objectives were aligned to the values.

The trust's strategy for 2016/17 included five goals, supported by 10 core objectives. These ranged across a number of areas including promotion of self-care and management; working with partners and commissioners to develop contracts and care models, and to align with the Greater Manchester Strategic Plan; improvement in the quality and safety of its services; and, to develop a comprehensive workforce plan and development programme to improve its employees' experiences.

None of the services we visited were able to show a documented service specific strategy. However, the majority of services had recently gone through a tendering process with the local commissioners in each borough. This had resulted in a number of the services transferring to other providers, changes to service specifications, or limited 12 month extensions to service contracts. With a view to many of the services re-tendering in 2016, this turbulent commissioning landscape (against the background of devolution of health and social care in Greater Manchester) had affected the individual services' abilities to plan specific strategies.

Staff across all the services and boroughs were aware of the trust's vision and values, and how these related to their annual appraisals.

Governance, risk management and quality measurement

The children, young people, and families service had governance arrangements in place, which ensured that staff were clear about their responsibilities, risks, quality, and performance.

Each service had a clear reporting structure, through heads of service to their relevant borough service director. The executive team met monthly in a Quality Governance and Assurance Committee, which discussed updates from each of the divisional business units. Divisional business units met monthly in each borough to discuss quality and performance. Each unit published a quarterly Quality and Performance Assurance Report, which covered performance against core standards; contractual performance; progress against business planning objectives; and review of service risks, issues, developments, and achievements. Children, young people, and families services were also represented at monthly Health Integrated Governance Group meetings in Trafford

and Oldham. Trafford also held monthly operational managers meetings. All meetings reviewed existing risks on the register, and put in place action plans for newly identified risks.

The current trust risk register included six risks relating to community services for children, young people, and families. Of these, four were assessed as moderate risk, with one each assessed as low and high risk. The highest risk, identified in December 2015, related to significantly higher than expected demand on the Heywood, Middleton and Rochdale community children's services. The register identified a number of key actions and control measures to mitigate the risk, including any gaps within these, and a review date was in place. The risk register also recorded the Oldham children's physiotherapy and occupational services' concerns about caseloads, capacity, and impact on the waiting list. The register recorded the control measures put in place, including the use of a locum and recruitment to the vacancy. The risk was due to be reviewed again in August 2016.

Each individual service team held regular meetings. For example, the Heywood, Middleton and Rochdale health visiting and school nurse service held joint locality meetings. These included standing items to discuss: policy and guideline updates; health and safety issues; risks and incidents. Team performance against key performance objectives was monitored and shared with teams in meetings, team noticeboards and online. Staff understood how they contributed to the performance against the measures.

Leadership of this service

Children's community services were provided across the trust's boroughs within divisional business units, which also incorporated adult services, each led by a service director. There were some local structural differences within the Bury, Oldham, and Heywood, Middleton and Rochdale units, which reflected historical structures and local commissioning of services. For example, the Bury services were provided within a township structure, which enabled services to be transformed from April 2016 to an integrated all-ages community structure.

Trafford's structure reflected its unique position of a partnership agreement with Trafford Council. The agreement, implemented on 1 April 2016, integrated children's health and social care services within four neighbourhood localities across the borough, and set out detailed guidance on roles and responsibilities within the partnership. Each locality offered core services of health visiting; family nurse partnership; school nursing; immunisations, social services, and youth services. Additional services were offered centrally, including but not limited to community children's, speech and language therapy, neurodevelopment, early development, and orthoptics.

Each service had a clear local management and leadership structure. In all but one service we visited, staff spoke positively about their managers and leaders and described them as supportive, visible, and approachable. However, some staff expressed concern that senior managers were not aware of the impact on staff of the commissioning tendering process: 'everything was put aside for the tender process'; there was 'too much change, too fast'; and 'systems, processes, staff and role changes all came at once'. There was also concern that the orthoptic service could become fragmented if it moved to become an all-ages service.

Staff gave varying responses about whether or not individual services worked with colleagues across borough boundaries. Staff recognised the challenges in this given services were commissioned by different clinical commissioning groups in the region. However, the audiology service and the community children's service were in the process of harmonising their processes and procedures across the whole of the service.

Culture within this service

The culture of the children, young people, and families service reflected the trust's 10 Principles of Care values. The majority of staff we spoke with were positive about the culture within the service. Staff described it 'as a good place to work and supportive team' and 'it is like a family'.

Staff were passionate about the care they provided to their patients, but were open an honest about the challenges faced by increased referral numbers into the services during a period of significant change.

Although staff were not always familiar with the executive team, the majority of staff spoke positively about their teams and immediate line management, and felt supported; 'everyone helps each other' and managers 'make time to listen'. However, in one team we visited staff were concerned that their service lead was not addressing team performance and quality issues.

Good

Are services well-led?

Public engagement

All services we visited had a strong focus on patient and public engagement.

The Oldham community teams worked closely with the POINT Forum Parents of Oldham in Touch. POINT was an 846 member strong parent and carer group for families with children and young people who have additional or complex needs. POINT volunteers provided a stall at each site when clinics were being held, offering leaflets, help, and advice. POINT also worked with local mosques in the area and the Mahdlo 'Youth Zone' centre to engage the community, and to provide additional awareness and training. Staff told us the services worked with POINT to develop engagement values for the area, and experiential design input of new policies.

The Oldham services also worked with the Barrier Breakers forum, which gives young people the opportunity to have fun with friends while working on issues that affect children and young people with additional needs or disabilities.

The Heywood, Middleton and Rochdale community children's service collected data on the NHS Friends and Family Test as one measure of engagement with the public. The Friends and Family Test asked patients how likely they were to recommend a hospital after treatment. This indicated a score of 100%. The service also developed a child-friendly friends and family test, referred to as 'Kiddies Tiddlywinks', in order to ensure the 'child's voice' was heard. This allowed children to rate their experience by placing a coloured counter into the relevant slot of the rating box.

The Oldham speech and language therapy service used a child friendly friends and family test form, as well as taking feedback at the end of every programme. The Heywood, Middleton and Rochdale school nurse service gave family feedback questionnaires to young people to obtain direct feedback. Although this highlighted concerns with the waiting times for enuresis (involuntary urination) clinics, the feedback for the service overall was positive.

The Heywood, Middleton and Rochdale community children's service attended and provided a stall at Rochdale Rugby Club to raise awareness of its service at an event for children with special educational needs. The service also included parental involvement in the autism steering group, and took 360° appraisal feedback on doctors from parents of children who used the service.

Staff engagement

Team meetings took place in all services, and arrangements were in place for sharing the minutes of meetings with any staff member who was unable to attend. Regular trust wide and local newsletters and briefings were distributed to staff. Noticeboards and displays were used in all services we visited to provide staff with a range of information, including key achievements and progress towards targets.

The NHS Staff Survey for 2015 asked staff how likely they were to recommend the organisation as a good place to work or receive treatment. Although not broken down by service or speciality, this indicated that staff were more likely than not to recommend the trust and was marginally below the national average for all NHS services. The survey also indicated a three per cent decrease in staff reporting they felt work related stress in the past 12 months, and 88% of staff believed the trust provided equal opportunities for career progression or promotion, which was in line with the national average.

Staff engaged with the trust's vision of the 10 Principles of care. Within the Trafford children's physiotherapy team, staff entered the trust's Principles of Care Award. The team, who got through to the final round, produced a video, delivered a presentation to the Chief Executive.

The services carried out a number of staff engagement sessions to introduce and discuss the tender processes and new structure models, for example the township model in Bury. A local staff survey in Oldham led to development of a borough wide action plan on engagement, particularly in relation to the tendering process. The trust also developed an action plan based on staff experiences collected through the SPARK Ignite Your Ideas survey.

Two of the services we visited had entered, or been nominated for, the 10 Principles of Care Awards, which provided staff with an opportunity to demonstrate how their team's work contributed to the values and strategy.

The children, young people and families services were going through a period of change in commissioning requirements, with a number of the services having been given only a twelve-month extension in their tender contracts. Despite this, staff were positive about the achievements they had made.

Good

Are services well-led?

Innovation, improvement and sustainability

The Trafford children's physiotherapy service developed a 24-hour postural management service for children with complex needs. Staff were trained and accredited to assessor level to be able to assess children and provide night-time postural managements. The team also developed links with the local schools, and had agreed a goodwill arrangement for the use of a school gym to carry out physiotherapy exercises and to give disabled children confidence in using equipment.

The Bury and Heywood, Middleton and Rochdale health visiting services achieved UNICEF Baby Friendly Initiative stage three accreditation. The Baby Friendly programme included standards for maternity, health visiting, neonatal units, children's centres and universities that were designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways that support health and development.

The audiology service achieved a grant of accreditation against the IQIPS (improving quality in physiological services) standards, from the UK Accreditation Service.

The Oldham nutrition and dietetics team worked with the Royal Manchester Children's Hospital to develop allergy guidelines. It also linked with the North West Allergy Network, the Alder Hey feeding clinic and the Oldham child development service.

A diabetes nurse specialist in Bury and a paediatric diabetes nurse in Oldham were awarded 'Queen's Nurse' status by The Queen's Nursing Institute. This status is awarded to individual community nurses who have demonstrated a high level of commitment to patient care and nursing practice.

The Bury community nursing service introduced a nursing navigator role within a local acute hospital trust. This role, which received additional funding from the clinical commissioning group, enabled support services to be identified and put in place early, enabled earlier discharge of children from hospital. The impact of this on cost and number of 'bed days' for each inpatient admission is currently being evaluated.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Children, young people and families who used the school nurse service were not protected against risks associated with unsafe storage of vaccines and medications. This was because, during our inspection of the service at Milnrow Health Centre: We found evidence the service could not guarantee the cold chain storage of vaccines. Maximum/minimum fridge temperatures were not recorded in line with the provider's policy on the storage of vaccines, and the manufacturer's guidelines. Maximum/minimum thermometers were not available for use in cool bags for transferring vaccines to and from school clinics. We found no evidence the maximum/ minimum temperatures of cool bags were recorded. Vaccine stocks held in the fridge were untidy. This increased the risk that new stock could be used before older stock, leading to the possibility of vaccines going out of date. We found date-expired needles and syringes in the emergency anaphylaxis kit. Medicines disposal records showed that three ampoules of adrenalin were identified as out of date in November 2015, but were not removed from stock and disposed of until June 2016. We found no evidence of an expiry date check rota for Levonelle. The provider’s subsequent audit of the medicine fridges at five of the Heywood, Middleton and Rochdale school

This section is primarily information for the provider

Requirement notices

nurse service location against its storage, handling, distribution and disposal of vaccines policy found full compliance with the policy in only 10 out of 21 standards.

This was a breach of Regulation 12 (1)(2)(g).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The Oldham children's nutritional and dietetics service did not maintain accurate, complete and contemporaneous record of the care and treatment provided and decisions taken. This meant that children, young people and families were not protected from the risks associated with poor quality record keeping. This was because, during our inspection: We reviewed five sets of records for children using the service, all of which indicated elements of poor quality record keeping. This meant staff did not always know what had happened previously in contacts with the service, if children had been seen, or if their needs had been addressed on a regular basis. This impacted on continuity of care and raised the risk to the safety of those using the service These record keeping issues included missing cover sheets; lack of continuity/page numbering; pages and letters were not stored in order, and entries in the records were not always signed or initialled by the person recording the entry. In two of the records we reviewed, it was unclear what action had been taken by staff following previous reviews. This included a child who was on the child protection register for neglect. The other child, because of three missed appointments, had not been seen by staff in the service in over a year. This was a breach of Regulation 17 (1)(2)(c)