Cumbria Partnership NHS Foundation Trust

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Community health services for children, young people and families

Quality Report

Trust Headquarters,
Voreda,
Portland Place,
Penrith,
Cumbria,
CA11 7QQ
Tel: 01228 602000
Website: www.cumbriapartnership.nhs.uk

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RNNDJ	Voreda House	Community Health services for children and young people	CA11 7BF
RNNY1	Workington Community Hospital	Community Health services for children and young people	CA14 2UF
RNNBJ	The Carleton Clinic	Community Health services for children and young people	CA1 3SX

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

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Overall, we rated the service as inadequate.

The trust did not have robust safeguarding systems and processes in place. There was no senior children's safeguarding lead to provide leadership and oversight of safeguarding systems or support for staff. The trust had recently appointed a named nurse for children's safeguarding but this post remained vacant at the time of the inspection. Staff did not have access to a framework for safeguarding supervision in line with national recommendations.

There was no paediatric resuscitation equipment in two locations where children attended for treatment for minor injury and illnesses. There were also no paediatric trained staff at these nurse led treatment centres, and staff did not take part in paediatric life support training. This posed a risk for children whose health may deteriorate whilst at a minor injuries unit. Data provided by the trust showed that children and young people under the age of 16 accounted for 21.4% of attendees across the five minor injury units.

Some policies were out of date for review for example, infection control. It was not clear who had responsibility, in the service, to ensure policies were up dated in a timely way and ensure they reflected evidenced based practice. The children's community nursing service could not show us any specific policies on which they based their care, but said they were in the process of looking at NICE guidelines.

The trust was not achieving the national target of 95% of children being seen within 18 weeks in out-patients departments, across the services provided. The trust had its own target of 92% of children receiving an out-patients appointment from the time of referral: - however, services were still not achieving this. In the speech and language therapy service, only 50% of referrals were seen within 18 weeks. The trust had a recovery plan in place to reduce waiting times for children: however, the trust trajectory report showed waiting times would increase over time, due to lack of appointment times commissioned.

It was not clear from the trust's strategy for children, how young people contributed to the transformation and shaping of services, or how the trust embedded the voice of children in its strategy and vision to ensure their rights and views were promoted.

There were 96 risks reported between 1 July 2015 and 31 October 2015 on the trust wide risk log for children's community services. The risk register had gaps in review dates and control measures to mitigate risks. There was a clinical governance structure in place, but there was limited evidence in the way the trust robustly managed risks through action planning and dissemination of information. Recommendations from audits and service reviews were not acted upon, to improve services and the safeguarding of children.

There was not a culture of sharing best practice across the teams in the county: staff expressed a lack of cohesiveness in the services provided. However, staff talked about a change in culture since a change in management at trust board level. They felt that the culture had moved from one of blame, to a more open and trusting culture, where they could raise their concerns and feel listened to.

Parents and carers were positive about the care they received from the community children's services. People we spoke to told us they were treated with compassion, dignity and respect. They were provided with information about their child's care, in a way they could understand, and were given the opportunity to contribute to their care plan and treatment.

Summary of findings

Background to the service

Cumbria Partnership NHS Foundation Trust provided services to families and children, up to the age of 19 years old, across the county of Cumbria. The services provided were health visiting, school nursing, children's community nursing, physical health teams (comprising of physiotherapists, occupational therapists, audiologists and speech and language therapists), and community paediatrics. The trust also provided specialist services; these were the family nurse partnership team, the children looked after team and the learning disability team. They also provided community sexual health services for people of all ages, and there were five minor injury units of which 21.4% of attendances at these minor injury units were by children under the age of 16 years.

Children and young people under the age of 20 years made up 21.1% of the population of Cumbria, 4.3% of school children were from a minority ethnic group. The health and wellbeing of children in Cumbria was mixed, but infant and child mortality rates were similar to the England average. The level of child poverty was better than the England average with 14.7% of children aged under 16 years living in poverty. The rate of family homelessness was also rated better.

Services provided and coordinated care and treatment for children and young people with long-term conditions, disabilities, multiple or complex needs and children and families in vulnerable circumstances. The services were provided to people in their own homes, in schools, in children's centres and in community clinics across the county.

The county of Cumbria consisted of six districts: Allerdale, Barrow-in-Furness, Carlisle, Copeland, Eden and South Lakeland. During the inspection, we visited 12 localities across the six districts where staff provided services for that geographical area. We spoke with 15 managers, 21 health visitors, 10 school nurses and 26 other clinical and nursing staff members. We spoke with 17 families who were receiving care from the services provided.

We observed practice in clinics and with the consent of patients, in patients' homes. We examined 26 clinical records. We also held two focus groups, one for health visitors and school nurses, and one for therapy services.

Our inspection team

Our inspection team was led by:

Chair: Paddy Cooney,

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leaders: Brian Cranna, Inspection Manager (Mental Health) Care Quality Commission

Sarah Dronsfield, Inspection Manager (Acute) Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant psychiatrists, experts by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting, health visitors, Mental Health Act Reviewers, a social worker, pharmacy inspectors, registered nurses (general, mental health and learning disabilities nurses), a school nurse and senior managers.

Why we carried out this inspection

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

Summary of findings

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 held about the service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 9 to 13 November 2015

We observed how people were being cared for and talked with patients and family members who shared their views and experiences of the care they had received. We reviewed care and treatment records of children and young people who used the services. We visited services based at 12 localities across the six districts of Cumbria.

What people who use the provider say

Parents and carers were positive about the care they received from the community children's services. They talked about kind and supportive staff, who were approachable and knowledgeable. The feedback from people was very positive.

One negative comment referred to the long time for appointments from referral to treatment.

We were not able to speak with older children who used the services as the inspection took place during school hours.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the trust MUST take to improve

- The trust must ensure there is appropriate paediatric resuscitation equipment in locations where children attend for treatment for minor injury and illnesses.
- The trust must ensure there are improvements in referral to treatment times for children and young people accessing children's community health services.
- The trust must ensure there are robust systems and frameworks for safeguarding procedures and supervision, with oversight and leadership provided by a senior nurse with child protection expertise.
- The trust must ensure staff complete records within the timeframe expected by NMC guidelines.
- The trust must ensure where actions are implemented to reduce risks these are reviewed, monitored and sustained.
- The trust must ensure policies and patient group directives are updated and a system put in place to review these in a timely manner.
- The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal. For example: Paediatric life support, safeguarding children

In addition the trust should:

- The trust should promote the sharing of good practice across teams and work towards a cohesive workforce to promote equity of service across the county.

Cumbria Partnership NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the safe domain as inadequate.

There was not a robust safeguarding system in place across the service. There was no senior children's safeguarding lead to provide leadership and oversight of safeguarding systems or support for staff. Staff did not have access to a framework for safeguarding supervision in line with national recommendations.

There was no paediatric resuscitation equipment in areas where children attended for treatment for minor injury and illnesses. There were no paediatric trained staff at these centres, nor had staff undertaken training in paediatric life support. This posed a risk for children whose health may deteriorate whilst at a nurse-led treatment centre. Data provided by the trust showed that children and young people under 16 accounted for 21.4% of attendees across the nurse-led treatment centres.

Staff in some teams told us record keeping was not always completed in a timely way as required by the Nursing and Midwifery Council (NMC).

Mandatory training levels across the community children's services was low, with staff reporting difficulties accessing both face to face and e-learning training.

Safety performance

- There had been no never events in children's community services reported. Never events are serious, largely preventable patient safety incidents that should not occur if available preventative measures were implemented.
- The trust was involved in ten ongoing serious case reviews. Serious case reviews are multi agency

investigations which occur when a child has suffered serious harm or death. They provide lessons to be learned for services involved in promoting the health and wellbeing of children.

Incident reporting, learning and improvement

- All incidents were reported through a trust wide electronic reporting system called Ulysses. This allowed for management overview of incident reporting and an ability to analyse any emerging themes or trends.
- A total of 285 incidents were reported between 2 January 2015 and 31 October 2015 of which 64 incidents were classified as a 'near miss avoided due to action taken', 111 were classified as resulting in 'no harm'. We found 33 were reported as 'low harm, 45 'moderate harm' and 22 'severe/death'.
- The majority (37%) of incidents reported were categorised as 'safeguarding' followed by 'communication' (16%) and 'information governance (11%) and 'clinical' (11%).
- 16 child deaths had been reported. Of these, five were from natural causes and were expected and 11 were unexpected. In five of those 11 unexpected deaths, there were safeguarding concerns.
- When we spoke to staff about incident reporting we were told they were confident to use the incident reporting system, but staff had recently been informed of a change in what they reported on. Staff had been reporting all referrals and escalations about concerns for safeguarding on the incident reporting system, which accounted for the high number of safeguarding categories.
- At the time of inspection, the reporting of safeguarding referrals as incidents had stopped. However, staff across the services said they felt a lack of clarity about what should be reported on the trust incident reporting system since the change. Clinical governance meeting minutes also recorded there was a lack of clarity for staff around incident reporting.
- Staff we spoke with could provide us with evidence of learning from incident reporting. An example provided was a change to the standard operating procedure for transfer of care from midwife to health visitor, to ensure patients were visited appropriately.
- There had also been an update to the 'transfer in' policy which guided staff on what to do when a patient moved into the area, following learning from an incident. However, when staff were asked about meeting the needs of patients who had moved into the area, they were not using best practice guidelines of the five day target to contact the referrer and the ten day target to visit patients with universal needs. This was the recommendation in the National Health Visitor Service Specification 2014/15 published by NHS England.
- Staff we spoke with were aware of their responsibilities under Duty of Candour, which was introduced as a statutory requirement for NHS trusts in November 2014.

Safeguarding

- The trust had an up to date safeguarding policy published in December 2014. The policy covered the safeguarding needs of adults and children. The policy stated that there should be a Band 8a named safeguarding specialist for children, with responsibility for quality assuring safeguarding practice and ensuring staff had access to expert advice.
- At the time of inspection this post was vacant and had been vacant for a number of months. The trust had recently appointed a named nurse for children's safeguarding and the safeguarding committee meetings from October 2015 showed that this post had recently been filled but had not yet started.
- The trust had recently appointed a lead community paediatrician for safeguarding children.
- There was one Band 7 nurse for safeguarding children, who had recently been appointed. Their key responsibilities included providing expert knowledge and clinical leadership, and to provide or ensure that staff received effective safeguarding supervision, appraisal and support. They were also responsible for disseminating lessons learnt from serious case reviews.
- All of the staff we spoke with told us they did not receive specific safeguarding supervision. They said they discussed safeguarding issues within their one to one management review meetings, with their line manager. We were told not all of these managers had received

additional safeguarding training to support safeguarding supervision. This posed a risk to children if staff were not provided with the appropriate support for safeguarding concerns.

- According to the National Health Visitor Service Specification 2014/5 (NHS England, 2014) health visitors must receive a minimum of three monthly safeguarding supervision which should be recorded in the patient records. The supervision should be provided by colleagues with expert knowledge of child protection to minimise risk. This was also the level of safeguarding supervision expected for school nurses as described in Maximising the School Nursing Team Contribution to the Public Health of School-aged Children, (DH 2014).
- The January 2015 safeguarding committee meeting minutes showed that the trust was aware of the need to act on developing a framework for safeguarding supervision. However we saw there were no timescales for action.
- The Penrith and Kendal Primary Care Assessment Service and Keswick Minor Injury Unit underwent safeguarding assurance assessment, by the CCG, in June and July 2015. At Kendal, it was highlighted that there was no system for alerting staff, when a child known to safeguarding services attended. The report also raised concerns about the lack of robust safeguarding supervision for nursing and medical staff and the need for staff to complete safeguarding children level three training.
- The trust safeguarding policy recommended staff have access to a member of the safeguarding team for group supervision. One health visiting team we visited were trying to implement group supervision for safeguarding but they had not had support to implement this.
- The trust had implemented an electronic safeguarding referral process called STRATA according to trust data provided; this had been in use from August 2014. In September 2015 the data showed 44 safeguarding referrals had been made to the multi-agency safeguarding hub team through the STRATA system. July 2015 reported the most month by month STRATA referrals of 57.
- The trust safeguarding policy did not make reference to this referral pathway, but set out a process linked to the local safeguarding children board website. Staff would make a verbal referral to the multi-agency safeguarding hub team and follow up with written information through an online link to the safeguarding hub. This demonstrated disconnect between policy and practices in the trust, and therefore, could pose a risk to children.
- The multi-agency safeguarding hub was a team which consisted of social services, health care staff and the police. There were three band 7 nurses but to provide cover, for absences, band 6 staff were also utilised; the hub is staffed every day Monday-Friday by health staff.
- The model of practice had changed during our inspection following a service review by Cumbria County council. The review had highlighted that the service was being used as a place to receive safeguarding advice, by staff working in the trust. The council wanted to reduce this type of work in order to focus on the triage and rapid referral of children to the appropriate safeguarding and early help teams.
- We asked the manager of the trust's staff what the objectives of the new service model were and they could not tell us. We were told that the service was still under development, but no timescales were provided for completion of this.
- We spoke to staff about making safeguarding referrals. Staff told us that they had received training for STRATA. However, staff told us they did not always use the system for referrals, as their passwords expired if the system was not used on a regular basis. Staff had to get IT support to renew passwords for the system.
- We asked a group of eight health visiting and school nursing staff to show us how they used STRATA, the staff we asked to log on received an 'access denied' warning and we were unable to look at the electronic safeguarding referral system.
- Staff showed us an example, in a patient record, of how they would make the safeguarding referral. Staff would ring the multi-agency safeguarding hub team to make the referral and then provide written information about the concerns through the Local Safeguarding Children's Boards website. We saw that this written information was printed and placed in the patient record.
- The trust contributed to serious case reviews when a child is seriously harmed or dies. We were provided with data that an outcome of a review in 2014 had identified

risks relating to the safeguarding referral pathway in the trust. We asked staff about feedback from serious case reviews, but they could not recall an example, or any recent feedback. However, the trust provided a report of lessons learned from serious case reviews that was available to staff.

- Staff told us they had received safeguarding level three training, which is mandatory for staff working with children. They had some knowledge of female genital mutilation and child sexual exploitation, but this was yet to be included in their training.
- The Trust target for safeguarding training was 85%. Data provided by the trust showed training rates were between 80-100% across the community children's teams.

Medicines

- The trust had a system and standard operating procedure to manage the cold chain to ensure the safe storage and transportation of vaccines to schools.
- We observed the system for checking fridge temperatures. Maximum and minimum fridge temperatures were recorded to ensure vaccines were stored in a safe environment.
- Patient group directives (PGD) were used by health care staff to enable them to give medication and immunisations without a prescription. We looked at a sample of three PGDs used by school nurses, these had been reviewed recently.
- We looked at a sample of PGDs used by sexual health services. We found 14 out of the 28 PGDs were past their review date. On the intranet system, the hyperlink to each PGD had been updated with an extended review date, but the working document that staff used was not updated. These were amended following the inspection.
- Health visitors and school nurses were independent prescribers and able to prescribe from a predetermined and approved list of medicines. They were autonomous as to when they accessed updates and supervision from the trust pharmacy service. The trust participated in national audit for prescribing.
- The non-medical prescribing policy was out of date.

Environment and equipment

- The trust staffed or operated its community services from buildings across the six districts; these included their own premises and third party premises, such as schools, GP surgeries and children's centres. The trust had a strategy for improving their estates to enable safe working environments for staff.
- The locations we visited had keypad entry systems to office doors for security.
- We visited four locations where children and their families accessed services. These locations had good access for patients with disabilities, children in pushchairs, and were clean and well presented.
- Toys were evident in the waiting areas; we saw that the toys were physically clean and well maintained. However we did not see a cleaning schedule to indicate how often or when the toys were last cleaned.
- All the electrical equipment we observed had been portable appliance tested, for safety. Staff knew how to report faulty equipment.
- Health visitors had their own infant weighing scales, which they took to clinics and on home visits. These were calibrated every six months and we saw in date test stickers on equipment.
- Staff working in the therapy service told us they had access to the equipment they needed, but not as quickly as they would like. Access to equipment in children's services was on the trust risk register.
- The children's community nursing team provided equipment to meet care needs of children in their own homes. The staff maintained a list of equipment being used in the community which recorded when the equipment required servicing or replacing to ensure children had safe equipment. This list was kept on the intranet system as an asset register.
- At the time of inspection, staff could not find access to the asset register. They had not reported this as an incident. We spoke with their manager, who was aware of the missing asset register, but had not reported it. The manager told us that the trust medical engineering department had an up to date list and they would inform staff if equipment in use required servicing.
- During our unannounced inspection, we visited the nurse-led treatment centre at Maryport, which could be

accessed by children over the age of five years for treatment for minor injuries. We saw that the resuscitation trolley used for the treatment centre did not contain any equipment needed for paediatric resuscitation. This posed a risk for children whose health may deteriorate whilst at a treatment centre and was brought to the attention of the service manager.

Quality of records

- The trust record keeping system was paper based. Records were secured in locked filing cabinets in staff offices.
- We saw patient notes being safely transported to community visits and back to staff bases in sealed bags.
- We looked at 26 patient records across health visiting, school nursing, learning disabilities, family nurse partnership and children's community nursing.
- All the records we saw included appropriate risk assessments and evidence of individualised care planning. The records were legible; they had been dated and signed.
- During the inspection 38% of health visiting staff we spoke to expressed concerns that they could not always complete records in a timely way. Nursing and Midwifery Council guidelines state that nursing records should be completed within 24 hours of patient contact. Some staff we spoke with told us they took clinical records home to complete them during their days off. At the time of the inspection we raised this with the director of nursing.

Cleanliness, infection control and hygiene

- Staff we spoke to were aware of infection control procedures. They had access to personal protective equipment such as gloves and aprons, and alcohol-based hand gel.
- There were infection control policies on the intranet for staff to access. We looked at three of these policies which were relevant to community based staff. All three policies were out of date for review (2012 and 2013).
- We observed staff using alcohol based hand gel when they visited patient's homes, however we observed not all the staff adhered to bare below the elbow guidance.
- We observed staff to clean weighing equipment before and after use.
- Infection control training was variable across the teams, with the majority of teams not achieving the 80% trust target. Only five out of 28 teams achieved above 80% staff having completed the training.
- Hand hygiene training was better attended with 13 teams achieving 80% or above.

Mandatory training

- There was a programme of mandatory and statutory training available for all staff, which covered areas such as moving and handling, safeguarding, information governance and infection control.
- Mandatory training rates were variable across the children's services teams, with an overall representation of 32.6% of staff undertaking all elements of mandatory training. The trust target for mandatory training was 80%.
- We were told by staff that it could be difficult accessing training due to long travelling distances, whilst ensuring patient's needs are met.
- Staff were encouraged to uptake e-learning elements of the mandatory training; however staff told us it was difficult to register and find available dates for training on the e-learning system.
- School nursing teams had achieved above the trust target of 80% for training in immunisation and vaccination, where most teams had achieved 100%.

Assessing and responding to patient risk

- Staff used a range of risk assessment tools to assess and manage individual risks. For example, maternal mood assessment, pressure areas and moving and handling.
- Health visitors undertook a holistic assessment of children, known as a pre-CAF (common assessment framework), which enabled them to identify risks and protective factors.
- In the Children Looked After team they had a process of following up children who did not attend for health assessments, to ensure they could assess any new risks or issues. They also used the strengths and difficulties questionnaire to assess mental health risks.

Inadequate

Are services safe?

Staffing levels and caseload

- Health visitor caseloads varied between 220 families to 317 families across the county. Lord Laming (2009) recommended that caseloads should not exceed 300 families. The caseloads were corporate, meaning teams worked together to ensure there was equity in workloads. We saw evidence of a caseload analysis file, so teams knew of the vulnerable families within the corporate caseload.
- Health visiting staff reported a positive impact of the 'Health Visitor – Call to Action' in that they had seen staff increases in their teams across the county.
- Vacancies rates across the all services were low, however school nursing had a vacancy rate which was impacting capacity in delivering the healthy child programme, and was on the trust risk register. The school nurse vacancy rate was 5.5 whole time equivalent.
- Family nurse partnership nurses had lower than average caseloads, we were told this was due to the wide geographical area covered. The expected caseload for the team was 125. The actual caseload for the team was 65. This had resulted in the team not accepting all the referrals for people who met the criteria.
- The community paediatric service reported a shortfall of 1.8 whole time equivalent consultant paediatrician and this was being covered by locum staff.
- Community children's nursing had covered vacancies and sickness with agency staff, but this equated to only 0.4 whole time equivalent.
- The overall sickness rate for children's community services was 4.9%.

Managing anticipated risks

- A business continuity/resilience plan was in place for each of the children's services. It demonstrated the children's services plan to respond to incidents and disruptions in order to continue their operations at an acceptable level.
- The trust also had a policy to respond to severe weather which would affect access to patients. A team leader we spoke with explained the actions required in cases of severe weather to ensure risks to patients were minimised and the recovery actions to ensure patients clinical needs were met.
- The trust had a policy to protect staff who may be lone workers. Staff were aware of the policy and of their own local team arrangements for lone working. Teams used a buddy system and a system to sign in and out of the office. Staff also used electronic diaries which allowed colleagues to see where staff were working.

Requires improvement

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 effective domain for the service as requires improvement.

Of the twelve policies that we saw, nine were out of date for review, for example, gastrostomy care, hand hygiene and record keeping. It was not clear who had responsibility to ensure policies were up dated in a timely way and ensure they reflected evidenced based practice. Community children's nursing service could not show us any specific policies on which they based their care, but said they were in the process of looking at NICE guidelines.

School nurses were undertaking the health assessments and reviews as defined by the Health Child Programme (5-19), but due to staffing levels they were not delivering health promotion as a routine part of the service, as recommended by national guidance.

Paediatric immediate life support (PILS) was not part of children's community services mandatory training, despite some staff caring for ill and vulnerable children. For example, staff visiting children at home with complex health needs and staff seeing children at the nurse led treatment centres.

There were delays in information sharing when a concern for a child's safety was raised if the right staff were not available to access the paper records. However, the trust was in the process of implementing an electronic record system.

Evidence based care and treatment

- Of the twelve policies that we saw, nine were out of date for review, for example, gastrostomy care, hand hygiene and record keeping. It was not clear who had responsibility to ensure policies were up dated in a timely way and ensure they reflected evidence based practice.
- Community children's nursing service could not show us any specific policies on which they based their care, but said they were in the process of looking at NICE guidelines.
- Health visitors were delivering the Healthy Child Programme (0-5) to families on their caseload. This was an evidence based programme focussed on a universal preventative service. It provided families with screening, health and development reviews, supplemented with advice about health, wellbeing and parenting.
- The development reviews for 2-2.5 year olds were undertaken using Ages and Stages Questionnaire (ASQ-3). This was a research based developmental screening tool which assessed children's physical and emotional development to identify any delays in a child's development.
- Family nurse partnership was an intensive, evidence based and preventative programme for vulnerable, first time young mothers. It was delivered from pregnancy until the child was two years of age. The service was delivered within a licenced programme, which was regularly audited, to ensure staff were delivering care within the well-defined and structured service model. This ensured compliance with national Family Nurse Partnership guidelines.
- School nurses were undertaking the health assessments and reviews as defined by the Health Child Programme (5-19), but due to staffing levels they were not delivering health promotion as a routine part of the service. However, we were told that in some areas the school nurses were about to re-establish drop-in health clinics based in schools.

Nutrition and hydration

- The trust did not hold UNICEF Baby Friendly accreditation. The UNICEF Baby Friendly Initiative is a global accreditation programme developed by UNICEF and the World Health Organisation. It was designed to support breast feeding and promote parent/infant relationships. The trust told us they were planning to implement this initiative in partnership with Cumbria county council.
- We saw staff providing information to parents about feeding that was in line with national guidelines.

Requires improvement

Are services effective?

- School nurses carried out the national child measurement programme across the county. Children in Cumbria had average levels of obesity: 10.0% of children aged 4-5 years and 19.3% of children aged 10-11 years were classified as obese.

Technology and telemedicine

- A health visiting team in the South of the county had developed a social media resource for parents about breast feeding. It provided information about breast feeding for patients and where to access support. Its purpose was to increase breast feeding rates. However we saw this initiative was not shared across the county with other health visiting teams.
- The school nursing teams had successfully made an application to develop a project called 'Chat Health', a text service to promote young people's access to health information and support.

Patient outcomes

- We saw evidence that patient needs were assessed before care and treatment started and there was evidence of care planning. This meant that children and young people received the care and treatment they needed.
- Childhood immunisation rates across all ages were above 96% for the year 2014-2015, according to NHS England data.
- The 6-8 week breastfeeding prevalence rate was 39% in June 2015, which was worse than the England average of 47.2%
- Health visitor key performance indicators were based on commissioners' requirements and were quantitative, relating to waiting times and patient contacts. Health visitors were responsible for inputting data onto the child health information system to indicate when contacts had been undertaken. We were told by senior staff that this was not robust, in that staff did not always make the entries onto the system about patient contact.
- According to the most recent data we were provided with, 83% of families received new birth visits from health visitors, of which 74.5% occurred within 14 days of birth. 84% of children received a 12 month review in the month of their 1st birthday and 98.5% of children had a review by the time they were 15 months old. 96.5% of children received a 2-2.5 year review. Only 67.2% of those children had an 'ages and stages' questionnaire completed as part of the review, however this was an increase of almost 25% from the previous quarter, suggesting a positive drive towards improving outcomes. There was no data available to compare these statistics against the England average.
- Family Nurse Partnership outcomes were robustly monitored and measured and the service undertook quarterly reporting. The target for expected visits during pregnancy was 80% and the service achieved 67%. The targets for expected visits during infancy and toddlerhood that were completed, were met, reaching 74% (target 65%) and 67% (target 60%) respectively.
- Audits had been completed within the service; there were three relevant to children's community services. Staff we spoke with were not involved in auditing their service and outcomes. Lack of audit information made it difficult to establish the systematic effectiveness of the service as a whole.

Competent staff

- The percentage of non-medical staff who had an appraisal in the last 12 months was 54%, according to data provided by the trust.
- None of the staff in community children's service had received training in paediatric life support. This included staff who worked in the nurse-led treatment centres across the county, where children over five years old, who were unwell, may attend.
- We also found none of the staff at the nurse led treatment centres held a paediatric nurse qualification. The Royal College of Nursing recommends that where children are treated there is a minimum of one qualified nurse with appropriate training to care for sick children, ideally a qualified children's nurse.
- The community services had a preceptorship programme for newly qualified members of staff; this provided the staff with support and a framework to develop competencies.
- We found 100% of medical practitioners had undergone professional revalidation.

Multi-disciplinary working and coordinated care pathways

Requires improvement

Are services effective?

- Staff we spoke with told us of good working relationships with other professionals. Multi-disciplinary staff often shared office bases and communicated frequently.
- Children who were suspected of having autistic spectrum disorder were referred to the community paediatrician. Following paediatric assessment, the children followed a care pathway towards a multi-agency assessment team diagnosis. If a positive diagnosis was given, the family were provided with information about support from voluntary organisations and would be advised of medical follow–up and therapy interventions.
- There were other multi-disciplinary care pathways for children with specific illnesses, for example, cystic fibrosis, Downs's syndrome and epilepsy.
- The children looked after team, had developed good working relationships with social services, community paediatricians, therapy services, health visitors and school nurses to ensure looked after children were prioritised.
- We observed staff working collaboratively with other agencies to meet the needs of children and families, for example, children's centres and schools.

Referral, transfer, discharge and transition

- Children and young people were referred by their health visitors and school nurses for assessment and treatment to the specialist services. Speech and language therapy services accepted referrals from others, such as referrals from teachers or parents and other health care professionals.
- Health visitors and school nurses completed a transfer form when children or young people using the service moved to another service or school. The transfer arrangements included a detailed risk assessment of the child's needs.
- There was a referral pathway between midwives and health visitors.
- We attended a multi-disciplinary meeting, with the community children's nurses, at a school to discuss the transition of a child with complex needs into high school.
- School nurses used a pathway for school children transferring to high school, to assess children's needs for emotional support during the transition.
- The therapy teams aimed to get young people self-sufficient and ready for transition to adult services. They had a programme called 'ready, steady, go'. The programme of transition started at age 11 (ready) next stage at age 15 (steady) and final stage at 18 (go).

Access to information

- Health visiting teams provided a named link to GP surgeries. Staff would attend monthly GP meetings to share information about vulnerable families.
- The trust used paper based records, which could present a risk of delays in the transfer of information, for example, outside of working hours. The trust was in the process of introducing an electronic records system in the Spring 2016.
- Staff working in the multi-agency safeguarding hub told us they frequently had difficulty in accessing health information about children who had been referred for safeguarding. They told us this was because they had to rely on staff being available to access the child's paper records, for information to be shared. This issue had been highlighted by the Local Children's Safeguarding Board and they had made a request for the trust to review the timely provision of information, according to their service review paper in September 2015.
- The intranet was accessible to all staff; however, many of the policies we observed on the intranet were out of review date.
- We saw information leaflets for patients in the clinic areas and waiting rooms we visited.

Consent

- We were told children and young people were involved and supported by staff in making decisions about their health care and treatment.
- Where necessary, written consent was obtained from parents or carers.
- School nursing and sexual health staff demonstrated a good working knowledge of relevant legislation about consent, for example applying Gillick competencies and Fraser guidelines.

Requires improvement

Are services effective?

- The average across all children's community teams of staff who had training in the 'Informed Consent to Treatment' was 63%. This was below the trust training target of 80%.

Good

Are services caring?

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

Summary

We rated the caring domain for the service as good.

Parents and carers were positive about the care they received from the community children's services. People we spoke to told us they were treated with compassion, dignity and respect. They were provided with information about their child's care, in a way they could understand, and were given the opportunity to contribute to their care plan and treatment.

Compassionate care

- All the staff we spoke to were passionate about their roles and were dedicated to making sure children had the best care possible.
- We observed staff delivering care to children and their families in clinic settings and in their own homes. We saw staff treat children and families with dignity and respect at all times. They were sensitive to the children's needs, demonstrating kindness and compassion. We observed good relationships between the staff and patients and their carers.
- Feedback from the parents we spoke with was consistently positive. They told us staff were caring, accessible and knowledgeable.
- Friends and Family Test data for October 2015 showed that 94%, of the 50 patients who responded, would recommend children's services.
- Of the 20 CQC comment cards completed by families, 17 had positive comments about the service they used. Three comments were mixed, positive and negative experiences of the service, for example: staff kind, caring and helpful, but waiting times were too long.
- We were not able to speak with older children who used the services as the inspection took place during school hours.

Understanding and involvement of patients and those close to them

- We saw staff interact with children in a way that was appropriate to the child's age and level of understanding.
- We saw staff being respectful of family's lifestyle choices, whilst providing information and advice on the opportunities to improve family health. Staff undertook holistic assessments and care planning which considered patient's social and emotional wellbeing.
- Parents told us that they felt involved in the discussions about care and treatment plans, they felt confident to ask questions about care and treatment and make decisions based on the information they received.

Emotional support

- Children and families were provided with emotional support from the services. The staff had the ability to refer children to children and adolescent mental health services if more specialised support was required.
- Parents told us staff communicated effectively with them, addressing their concerns in a timely way.
- We saw how staff provided information to families about other services which could offer support, for example, services at children's centres and voluntary organisations.

Requires improvement

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 responsive domain for the service as requires improvement.

The trust was not achieving the national target of 95% of children being seen within 18 weeks in out-patients departments across the services provided. The trust had its own target of 92% of children receiving an out-patients appointment from the time of referral; however services were still not achieving this. In the speech and language therapy service, only 50% of referrals were seen by 18 weeks. The trust had a recovery plan in place to reduce waiting times for children; however the trust trajectory report showed the waiting times would increase over time, due to lack of appointment times.

The nurse led treatment centres did not have the support of paediatric trained staff to meet the needs of young children who may attend. The sexual health service drop-in clinics were not held at times and places appropriate for young people's needs due to lack of transport links and conflicting with school times.

Planning and delivering services which meet people's needs

- The health visiting service delivered the healthy child programme as commissioned by Cumbria CCG.
- The trust worked in partnership with Cumbria County Council and Cumbria CCG to staff the multi-agency safeguarding hub.
- The UNICEF baby friendly initiative was a recognised programme which promoted breast feeding and parent – child relationships. The trust was planning with Cumbria county council to implement the programme but we were not told when this would happen.
- The county of Cumbria covered a large geographical area. Within the county, there were 3 sites that were minor injury units/ primary care assessment services and 2 nurse-led treatment centres which provided minor injury services for the community. These were nurse-led units which could assess and treat children aged 5-18 years. However, we had concerns that staff working in these units did not have training in safeguarding, or paediatric immediate life support. We also had concerns that the units were not staffed, at any time, by a paediatric nurse. RCN guidelines stipulate that services provide at least two paediatric nurses in out-patient and in-patient services. We requested information, from the trust, regarding the number of children who attended these units, but this was not provided.
- Sexual health services provided drop-in clinics across the county. However, we were told that due to the times and locations of the clinics they did not meet the needs of young people effectively.
- The services provided care in patients' homes, as well as in local clinics that were accessible to patients.

Equality and diversity

- All services we spoke to were aware of the diverse needs of the population and planned for interpreter services where needed. Access to interpreter services was offered as a telephone service. The need for an interpreter was identified before the first appointment so that suitable arrangements could be made.
- Staff were aware of the cultural diversity of the community they worked in. However we found less than half of the children's community teams had taken part in the trust's equality and diversity training. The trust training target is 80%.
- Staff reported they had access to equipment to meet patient's needs.

Meeting the needs of people in vulnerable circumstances

- The trust's children looked after team worked closely with local authority social care teams to ensure children and young people in care had initial and annual health reviews. There had been a recent drive to improve this service following a review of the service which had shown that targets for undertaking health reviews for looked after children had not been met. The quarterly report demonstrated that the service was working

towards meeting the target of 85% of looked after children receiving a health review by 28 days. The latest report provided demonstrated that two out of three months the team were meeting the target.

- Staff we spoke with could tell us about child sexual exploitation, only the children looked after team had experience of working with victims.
- Staff told us about some of the vulnerable groups in their areas, for example, travellers, young mothers, people from a particular cultural background. Staff told us they were encouraged to by management to engage in their areas of interest. One staff member had set up a group to meet the needs of young mothers.
- We were not made aware of any specialist nursing posts to support vulnerable groups within the service.

Access to the right care at the right time

- Access to community paediatricians following referral was below the 18 week national referral to treatment target. Only 77% of referrals are being seen by 18 weeks. The trust's target was to see 92% of patients by 18 weeks against a national target of 95%.
- The trust reported the decline in meeting the target to be linked to capacity and increased demand for assessments, particularly for autistic spectrum disorder.
- Following initial assessment by a paediatrician, those children who need assessment for autistic spectrum disorder can expect to wait over twelve months for a diagnosis by the multi-agency assessment team.
- The trust provided a recovery plan. They were undergoing a recruitment drive for 1.8 whole time equivalent consultant paediatricians to be able to provide more clinic hours for initial assessments and review appointments. However, the trust trajectory report demonstrated that waiting times will continue to increase due to increased demand and lack of appointment times to meet that demand.
- Speech and language therapy services were achieving 50.5% of referrals being seen by 18 weeks. Some children had waited five months for an appointment. The recovery plan to increase the number of paediatric patients seen by 18 weeks was to realign staff and caseloads, and to have a standard operating procedure for booking appointments. There was no timeline with the recovery plan.
- Other therapy teams were meeting the trust target for seeing patients by 18 weeks, except for physiotherapy in East Cumbria (64%).

Learning from complaints and concerns

- We asked families if they knew how to make a complaint. They told us they were not sure of the process of making a complaint, but they would be happy raising their concerns to the staff visiting them.
- The trust had received 43 complaints between September 2014 and September 2015. 18 of those complaints were upheld.
- The complaints were across five themes: Lack of service provision, delays in receiving appointments, communication from staff, lack of support and complaints from parents who received letters about the national child measurement programme.
- We were told that the school nursing services were reviewing the way parents were communicated to, about their child's weight, following their assessment in the national child measurement programme.

Inadequate

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.

We rated the well-led domain for the service as inadequate.

It was not clear from the trust's strategy for children, how young people contributed to the transformation and shaping of services, or how the trust embedded the voice of children in its strategy and vision to ensure their rights and views were promoted.

There were 96 risks reported between 1 July 2015 and 31 October 2015 on the trust wide risk log for children's community services. Data provided on the risk register had gaps in review dates and control measures to mitigate the risks. There was a clinical governance structure, but there was limited evidence in the way the trust robustly managed risks through action planning and dissemination of information.

The trust did not have senior clinical leadership for safeguarding to ensure systems and processes for safeguarding children were embedded in staff practices. There were no frameworks to ensure staff undertook safeguarding supervision to maintain their competencies in safeguarding children.

Recommendations from audits and service reviews were not acted upon, to improve services and the safeguarding of children.

There was not a culture of sharing best practice across the teams in the county; staff expressed a lack of cohesiveness in the services provided. However, staff talked about a change in culture since a change in management at trust board level. They felt that the culture had moved from one of blame, to a more open and trusting culture, where they could raise their concerns and feel listened to.

Service vision and strategy

- The vision of the service was to provide improved services in partnership with other organisations as part of the 'better care together' strategy.
- There was no robust children's strategy as Cumbria Children's Trust Board is in the process of creating an overarching strategy within which health priorities will be set.
- The care group clinical governance group strategy was based around three transformations: Transforming through technology, 0-19's health child programme, improving the emotional health and wellbeing of our young people. Some of the staff we spoke to knew about the transformation strategies, but other were not aware of it.
- It was not clear from the strategy how young people contributed to the transformation and shaping of services, or how the trust embedded the voice of children in its strategy and vision to ensure their rights and views were promoted. A safeguarding audit undertaken in 2014 identified the trust needed to develop 'a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services'. There was an action plan to develop this but there was no evidence that the plan was completed, or the timescale for completion.
- Senior management across children's services had been reorganised in April 2015. We found that service managers, recently into post, found it difficult to articulate the objectives of the service they were managing. Some were not clear about their roles and responsibilities.

Governance, risk management and quality measurement

- There were 96 risks reported between 1 July 2015 and 31 October 2015 on the trust wide risk log for children's community services. Data provided on the risk register had gaps in review dates and control measures to mitigate risks.
- Safeguarding, service delivery, staffing levels and resources were the most reported risks across the departments. Data migration and safeguarding children accounted for the highest rated risks.
- Clinical leads for children and family services took part in monthly clinical governance meetings and operational management meetings. Discussion of the

universal, specialist and CAMHS services were standing items on both meeting agendas. The clinical governance meetings also looked at developments in the three transformation areas and at the risk register.

- There were safeguarding committee meetings. Minutes showed that the issues relevant to children's safeguarding standards, such as ensuring there was a children's safeguarding lead and a robust framework for staff to access supervision, had been known to the clinical leads since January 2015. Neither of these had been addressed by the time of our inspection.
- The meeting minutes were not clear as to how, and to what timescales, issues were to be actioned and how information was to be cascaded to staff. Staff we spoke with told us information was generally shared informally when the team leader was at the base, or they would receive an email.
- The trust had implemented a 'quality and safety dashboard' system on the intranet. Its purpose was to have accessible information to staff about caseloads, incidents and risks. When we asked to look at the dashboards, in the areas we visited, staff were not able to access them.
- Health visitors and school nurses had their own reference groups. These were used to look at improving practice and the needs of the service, for example, developing pathways of care.
- We were provided with data that four audits had been completed for children and families service for 2015. All of them were in the children looked after service and contributed to the improvements in looked after children receiving health assessments and immunisations.

Leadership of this service

- The executive director of quality and nursing acted as children's lead on the trust board. There was no non-executive lead for children at board level, as recommended by the National Service Framework for Children (2003) to ensure that children's voices were an influence on decisions made.
- There was no senior clinician to provide oversight and leadership in the safeguarding of children.
- Staff had concerns that services were not cohesive across the county. There were examples where good practice was not being shared across teams.
- There was a lack of monitoring outcomes. Targets for services were not being robustly measured due to information not been logged onto the systems in use.
- Staff told us they felt that communication was improving between staff and the executive team, but staff generally did not feel directly involved in the development of the strategy or vision for community services.
- Staff told us there was good local management and leadership. Team working was good and this was encouraged by their managers. Staff said they felt valued and respected.

Culture within this service

- Staff told us they enjoyed working in the community service. Morale appeared good and staff were positive and enthusiastic about their jobs.
- Staff talked about a change in culture since a change in management at trust board level. They felt the culture had moved from one of blame, to a more open and trusting culture, where they could raise their concerns and feel listened to.

Public engagement

- A system was in use to collect feedback of children and young people's experience of using the school nursing service. An iPad was used to collect the information as a user friendly system for children. We did not receive any information about school age children's experience of the service.
- Staff provided comments, compliments and complaints cards to patients and families. These were returned to the patient experience team. We saw three of these completed by families. The comments were very positive about the support received from staff.

Staff engagement

- Staff were aware of the roadshows, 'you and the big picture', being held by the trust to engage staff in developing their service. Not all staff had attended a roadshow due to the constraints of workloads and the travelling involved.

Inadequate

Are services well-led?

- Staff told us about the 'Small change, big difference' initiative, which allowed staff to contribute to improving care for patients and staff.

Innovation, improvement and sustainability

- There were plans within school nursing to introduce a text service to enable children and young people to get access to health information.
- The trust was promoting a 'small change, big difference' initiative to encourage staff to contribute to service improvements.

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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (1), (2 a, b, e, h) Safe care and treatment. The trust must ensure there is appropriate paediatric resuscitation equipment in locations where children attend for treatment for minor injury and illnesses. The trust must ensure there are improvements in referral to treatment times for children and young people accessing children's community health services.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 13 Safeguarding (1,2) The trust must ensure there are robust systems and frameworks for safeguarding procedures and supervision, with oversight and leadership provided by a senior nurse with child protection expertise.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance (2 a, b, f) The trust must ensure where actions are implemented to reduce risks these are monitored and sustained.

This section is primarily information for the provider

Requirement notices

The trust must ensure staff complete records within the timeframe expected by NMC guidelines.

The trust must ensure policies and patient group directives are updated and a system put in place to review these in a timely manner.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 Staffing (1) (2 a) The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal. For example: Paediatric life support, safeguarding children.