Cumbria Partnership NHS Foundation Trust

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Community health services for children, young people and families

Quality Report

Cumbria Partnership NHS Foundation Trust
Voreda
Portland Place
Penrith
Cumbria
CA11 7BF
Tel: 01228 603184
Website: https://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		
RNNY1	Workington Community Hospital		
RNNBJ	The Carlton Clinic, Carlisle		
RNNDJ	Voreda	Springboard Child Development Centre, Carlisle	
RNNDJ	Voreda	Solway Clinic, Carlisle	
RNNDJ	Voreda	Furness General Hospital	
RNNDJ	Voreda	Ulverston Health Centre	
RNNWT	Wigton Community Hospital		
RNNY1	Workington Hospital		
RNNBE	Penrith Health Centre		
RNNDJ	Voreda	Kinta House, Kendal	

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service

Overall, we rated community health services for children, young people and families as good because:

- The leadership, governance, and culture promoted the delivery of high quality person-centred care. Senior managers and staff had made significant improvements since CQC's previous inspection, in November 2015. A strong, cohesive senior leadership team, supported by a proactive team of managers, had good oversight of risks and incidents, which they monitored and reviewed regularly.
- Staff protected children and young people from avoidable harm and abuse, and they followed appropriate processes and procedures to keep them safe. The named nurse for safeguarding children had been instrumental in the establishment of a robust safeguarding supervision model, to ensure staff shared best practice and lessons learnt from serious incidents and serious case reviews involving children and young people.
- Managers and staff managed caseloads well and there were effective handovers between health visitors and school nurses to keep children safe at all times. On a day-to-day basis, staff assessed, monitored, and managed risks to children and young people. This included risks to children who were subject to a child protection plan or who had complex health needs.
- Children, young people, and families felt staff communicated with them effectively, kept them involved and informed about care and treatment, promoted the values of dignity and respect, and were kind and compassionate.
- Services for children and young people were organised to meet the needs of children and young people. Managers and healthcare professionals from the team worked collaboratively with partner organisations and other agencies to ensure services provided choice, flexibility, and continuity of care.
- Since the previous CQC inspection, in 2015, managers and staff had improved waiting times to ensure children and young people received the right care at the right time in community paediatrics, audiology, learning disability nursing, and physiotherapy. Although occupational therapy and speech and language therapy services waiting times were still outside of the required target, managers had taken appropriate action to reduce the time families had to wait.
- Senior managers had developed a strategy that planned to introduce a new service delivery model, which included changes to the structure of the Care Group. Senior managers and staff had worked collaboratively with the local authority and commissioners and had proactively engaged with staff. The planned changes included the introduction of a dedicated team caring for the most vulnerable children and families across the county.

However:

- Staff did not consistently complete care records within the required timescales recommended by the Nursing and Midwifery Council. Although staff had their own laptops, most did not use them to update patient records whilst away from their office base.
- The trust did not provide a qualified specialist community public health nurse (SCPHN) for each secondary school in the county, which was in breach of Royal College of Nursing guidelines. Also, the school nursing service did not provide health promotion initiatives in local schools.
- Morale was low amongst some staff due to the planned service changes. Although staff acknowledged senior leaders had shared information and provided regular updates, staff were unclear if their views had been included.

Summary of findings

Background to the service

Cumbria Partnership NHS Foundation Trust provides healthcare services to children and young people up to the age of 19 across Cumbria. Services include health visiting, school nursing, community children's nursing, looked after children, the family nurse partnership, physiotherapy, occupational therapy, speech and language therapy, and sexual health services. Staff provide services to children and young people in their own home, in schools, and in clinics across the local area.

According to the Child Health Profile 2016, children and young people under the age of 20 years made up 21% of the population in Cumbria. Only 5% of school children were from a minority ethnic group.

The health and wellbeing of children living in Cumbria was mixed compared with the England average. Infant and child mortality rates were similar to the England average. The level of child poverty was better than the England average, with 14.5% of children under 16 years living in poverty. The rate of family homelessness was also better than the England average.

The percentage of children aged between four and five years who were obese was 10%. This was slightly worse than the England average (9%). Obesity in children aged ten and eleven was 19%, which was the same as the England average.

The immunisation rate for the measles mumps and rubella (MMR) vaccine for children aged two was 96%, which was better the England average of 92%. The immunisation rate for diphtheria, tetanus, polio, pertussis, and Hib for children aged two was 97%, which was slightly better than the England average (96%). The immunisation rate for children in care was 95% which was, again, better than the England average of 88%.

The teenage pregnancy rate was lower than the England average, at 20% compared with 24%.

The service was previously inspected in November 2015 and was rated inadequate overall and in the safe and well-led domains. Inspectors rated effective and responsive as requires improvement whilst caring was good.

Inspectors noted the trust did not have robust safeguarding systems and processes in place and had no framework to support safeguarding supervision. Some policies were out-of-date and the trust did not have a system to review them in a timely way. In addition, the community children's nursing service did not have any policies upon which they based their provision of care. Services did not achieve the 18-week referral to treatment time (RTT) target and inspectors found the trust did not promote the sharing of good practice across teams or have appropriate oversight of managing risks.

However, parents and carers were very positive about the care they received and said staff treated them with compassion, dignity, and respect. Staff also felt the culture was changing and moving from one of blame to one of openness and honesty.

During this inspection, we spoke with over 50 healthcare professionals and managers and 12 families. We observed staff practice in clinics and, with the consent of parents, in patients' homes. We looked at 21 care records. During and after our inspection we analysed information provided by the trust.

With the school nursing team, we visited three schools. We also attended two baby clinics and accompanied health visitors, the family nurse partnership, and paediatric therapists on eight home visits.

Our inspection team

Our inspection team was led by:

Sandra Sutton, Inspection Manager, Care Quality Commission

Team Leader: Angie Brown, Inspector, Care Quality Commission

Summary of findings

The team included CQC inspectors and a variety of specialists: Health Visitors, Community Children's Nurses, Speech and Language Therapists, and Safeguarding Children specialists.

Why we carried out this inspection

We inspected this core service as a focussed, follow-up visit to see whether improvements had been made since our previous, comprehensive, acute, and community health services inspection in 2015.

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 core 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 the announced visit from 10 to 12 January 2017.

What people who use the provider say

During the inspection, we heard many positive comments from families and carers of children and young people.

- During a home visit, a mother told us she was very happy with the service. She felt listened to and involved in her child's care and treatment.
- A teenage mother told us the support she received from the family nurse partnership was "excellent", and acknowledged that she would not have known where to access similar support had the service not been available to her.
- Families attending a baby clinic told us the service was very good. One parent described the health visiting service as "fantastic" and told us how easy it was to contact a health visitor for support and advice.
- The parent of a baby who was receiving care from the community children's nursing team told us the nurse cared for her too and encouraged the family to contact the service anytime they had a concern. Other families said community children's nurses "did a great job" and were "really good".

Good practice

- The 'Love Barrow Families' initiative supported families who lived in the most deprived areas of Barrow in Furness and delivered wraparound care, based upon trust and partnership working. The project was designed to improve the way adult and child health and social care services worked together to support families with complex needs. One of the aims

was to improve and transform the quality of life of families who faced severe and multiple disadvantages. Each family had its own goals and was supported by staff to work towards them.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the hospital SHOULD take to improve:

- The trust should ensure all nurses working in sexual health clinics, who provide clinical care and treatment to children and people, are trained to the appropriate level for safeguarding children.
- The trust should ensure premises are secure and clinical areas are appropriately secured to ensure members of the public do not have unrestricted access.
- The trust should ensure staff have access to the equipment they need and there is an effective system for ensuring equipment is tested appropriately, within agreed timescales.
- The trust should ensure records continue to be completed within the required timescales as stated by the Nursing and Midwifery Council, and ensure an appropriate monitoring system is in place.
- The trust should ensure it provides a qualified specialist community public health nurse (SCPHN) for each secondary school in the county, in line with Royal College of Nursing guidelines.
- The trust should ensure the school nursing service participates in health-promotion activities to support children in local schools, as defined by Public Health England in the Health Child Programme (0-19 years).

Cumbria Partnership NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- Managers and staff protected children and young people from avoidable harm and abuse.
- Managers felt more confident that staff reported more incidents than at the time of our previous inspection, and there was an incident reporting culture across the services. Staff formally discussed incidents at team and governance meetings, and managers had good oversight of investigations and lessons learnt through the quality and safety dashboard.
- The trust had a very proactive safeguarding children team which, together with managers and frontline staff, had introduced a new safeguarding supervision model. Safeguarding children and young people was given sufficient priority and staff knew what to do if they had a concern. The named nurse for safeguarding children had a good oversight of the concerns raised by staff and actively shared information and learning across the trust.
- The clinics, health centres, and school premises we visited were clean and staff followed national guidance in relation to hand hygiene and infection prevention and control. Staff managed medicines safely, and the quality of healthcare records was good.
- Managers and staff managed caseloads well, and there were effective handovers between health visitors and school nurses to keep children safe at all times. On a day-to-day basis, staff assessed, monitored, and managed risks to children and young people. This included risks to children who were subject to a child protection plan or who had complex health needs.

However:

Good

Are services safe?

- Staff did not consistently complete care records within the timescales recommended by the Nursing and Midwifery Council. Although staff had their own laptops, most did not use them to update patient records whilst away from their office base.
- Although staff knew how to report equipment faults, staff from one area told us that equipment was not always tested in a timely way and that they did not have access to appropriate equipment to meet the needs of all children who weighed over 50kg.

Detailed findings

Safety performance

- The children and families care group managed safety through the reporting of incidents. The trust had an incident reporting policy, and staff understood their responsibility to report incidents using the electronic reporting system. Managers had oversight of incidents using the new safety and quality dashboard, which displayed current information about the stage each incident was at in terms of investigation and sign-off.
- Every member of staff we spoke with, at all levels and grades, could explain the reporting process. Not all staff we spoke with had reported a recent incident; however, the majority of staff felt confident that managers and senior staff dealt with incidents robustly.
- Managers and staff attended regular meetings to discuss safety performance across the Care Group. We reviewed action logs that showed managers had good oversight of outstanding incidents, investigation progress, and risks, and included the action that staff had taken to address the concerns.

Incident reporting, learning and improvement

- We reviewed incidents reported from June to December 2016. Staff from all services and localities across the county had reported 204 incidents. The majority of incidents (74%) resulted in no injury or harm, or involved minor treatment.
- We also reviewed four serious incidents (SIs) reported from September to December 2016. Staff we spoke with had completed training on how to report SIs, and duty of candour was included within the reporting form. The relevant investigator had completed a comprehensive report, which included evidence of working collaboratively with other services and agencies, a full chronology of events, and immediate lessons learnt and action taken.
- When incidents occurred, staff told us they were open with patients. Staff we spoke with understood the duty of candour requirements. 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 those persons. We saw examples demonstrating that staff had followed the procedure in relation to the serious incident investigations, which included interaction with the family.
- Staff we spoke with told us they discussed incidents (including SIs) and serious case reviews (SCRs) at team meetings. Managers and the safeguarding children leads also produced briefings to share the learning. One manager told us services for children and young people had been involved in seven SCRs over the preceding two years. A recurrent theme highlighted in the SCRs involved children looked after. The designated nurse for safeguarding children was reviewing each case to see if a parent or child had been looked after at any stage in their life, with the purpose of strengthening current services to ensure children and young people are safe.
- We heard examples from staff describing lessons learnt from reported incidents. For example, school nursing had experienced some incidents in which staff had administered the incorrect vaccination to children. Upon review, staff acknowledged the vaccination process was not coordinated, with too much reliance upon bank staff to administer the vaccines. Managers developed a clear plan of action, introduced a new system, and assigned key responsibilities across the team. A dedicated team of nurses now delivered and managed the vaccination programme, which included administrative support.

Safeguarding

- At the previous CQC inspection, in 2015, inspectors found there were no robust systems or frameworks for safeguarding children or supervision, with no oversight and leadership provided by a senior nurse with child protection expertise. We found the trust had made significant improvements in relation to this since then.

Good

Are services safe?

- The director of quality and nursing was the executive lead on the membership of the Local Safeguarding Children Board. The safeguarding children team comprised a named nurse, a named doctor, and a specialist senior nurse. There was also a designated doctor and designated nurse for children looked after.
- The trust had a safeguarding strategy that included information about how to make a referral to the safeguarding hub and flowchart pathways to support staff concerned about female genital mutilation or child sexual exploitation. The trust's policy also included the 'think family agenda', which recognised and promoted the importance of a whole-family approach to safeguarding children. The policy and all related documentation were available on the trust intranet.
- The trust had an electronic safeguarding referral process called STRATA. From January to December 2016, staff had raised 43 safeguarding referrals. However, staff also regularly contacted the safeguarding team for advice. From June to December 2016 892 health contacts had been received from staff by the safeguarding children team. In November and December 2016 the safeguarding team recorded 103 contacts. Of these, six were categorised as significant incidents and reviewed by the quality, safety, and safeguarding team.
- Every member of staff we spoke with told us they felt confident about keeping children safe. Staff knew whom to contact for advice and told us they would speak to their line manager or the children's safeguarding team. Staff could also describe to us in detail actions they would take and which documentation they would complete if they had any safeguarding concerns. For example, a healthcare assistant from one of the sexual health clinics we visited told us that when she was taking a blood sample from a young person she observed a number of marks on the arm, which concerned her. She immediately contacted a senior nurse who took appropriate action.
- Staff told us they had received training to the relevant safeguarding level. Information provided to us by the trust showed the majority of services and staff groups who worked directly with children and young people had achieved the 85% target for Level 3 training. However, when we spoke with sexual health nurses, who provided clinical care and treatment to children and young people, they told us they had only received Level 2 training, although one nurse confirmed they were scheduled to attend Level 3 training the following week. We raised this with the clinical director, who assured us he would take immediate action.
- Managers and safeguarding children leads had recently introduced a new safeguarding supervision model. At the previous CQC inspection, inspectors highlighted a lack of consistency across the Care Group in relation to supervision, and were concerned that there was no formal audit process. The new approach involved mixed groups of staff, from different professional backgrounds, discussing relevant topics, cases, and lessons learnt. The topic at each session would be the same for every group. A dedicated supervisor would lead each group session, and all supervisors had received appropriate training.
- Every member of staff we spoke with, from all services, was very clear about the new arrangements and told us when they were scheduled to attend their first session. To ensure learning from supervision sessions was shared across the Care Group, the supervisors from each session planned to meet with the named nurse to discuss key issues and information. The named nurse had planned a supervision audit later in the year.
- Children's safeguarding group meetings were chaired by the named nurse for safeguarding children, with vice chair responsibility shared between the associate director of nursing and named doctor safeguarding children. The group was attended by representatives from the localities, team managers, safeguarding supervisors, and staff from the sexual health and minor injury units. The named nurse attended the trust-wide safeguarding committee and told us information from the children's group meeting fed into this and the quality and safety committee each month.
- The named nurse attended monthly safeguarding meetings run by the local authority, to discuss cases and issues involving missing, sexually exploited, and trafficked (MSET) children and young people. Safeguarding nurses were also involved in MARAC (multi-agency risk assessment conference) and MASH (multi-agency assessment hub) committees.
- Sexual health nurses completed a full safeguarding assessment with every young person at their first visit, and, for children under the age of 16, the same assessment was completed at each subsequent visit, in line with national guidance. If staff identified any immediate concerns nurses would alert the senior

clinician and the safeguarding children team. The clinical director told us they had oversight of all safeguarding children concerns raised within the sexual health service. Each clinic had a dedicated sexual health nurse who was a safeguarding children champion and who led safeguarding supervision sessions. One senior sexual health nurse also had oversight of safeguarding children across all of the clinics in the county.

- The safeguarding hub alerted the sexual health team about children at risk. Children who were highlighted as missing or at risk from child sexual exploitation were 'admitted' to the service caseload. This meant if a child attended clinic a record already existed for them on the system with relevant notifications attached to alert staff. Nurses also told us they routinely asked women attending clinics if they had any children at home.
- The safeguarding children named nurse and senior nurses had a high profile across all community services for children and young people. All of the staff we spoke with knew the named nurse and told us they could seek advice and support whenever they felt it was necessary. Everyone we spoke with was very positive about the safeguarding team.

Medicines

- All relevant staff had received appropriate vaccination and immunisation training.
- The trust had processes and standard operating procedures to manage the ordering, storage, disposal, and monitoring of vaccines. Evidence provided to us by the trust also included up-to-date, documented procedures for the safe handling and use of vaccinations, packing and transport of vaccines, and monitoring of fridge temperatures.
- We saw staff following the guidelines appropriately and found evidence of good practice, for example, fridge temperature checks and the administration of vaccines. The school nurse immunisations leads were responsible for stock control, and they described the process for managing stock levels and ensuring all vaccinations were stored appropriately.
- Medicines were securely stored and handled safely. Staff were aware of the trust protocols for handling medicines to ensure the risks to people were minimised and expiry dates were checked regularly. Staff also used appropriate chiller packs and freezer boxes to transport and store medication when visiting schools or family homes.
- School nurses adhered to patient group directives (PGD). PGDs are written instructions for the administration of medicines to large groups of patients. We reviewed files that contained current PGDs and all relevant documentation. We noted that the information was up-to-date and included staff signatures to show that staff had received appropriate training. This meant the school nursing service followed national guidance to deliver a safe immunisation programme to school children across the county. PGD expiry dates were displayed on the medicines management pages on the trust intranet.

Environment and equipment

- We found all the equipment in use was clean and had been tested and serviced where required. Weighing equipment was calibrated appropriately, and staff were aware of the process to follow if they needed to report any faults. In the south of the county staff we spoke with told us not all equipment was tested within the required time and there had been occasions when parents had informed health visitors that the relevant equipment needed to be serviced.
- Health visitors and nursery nurses ran baby clinics in accessible venues across the county, such as health centres and GP practices. The environment at those we visited allowed mothers and babies to mix and bond as part of the group.
- In one sexual health clinic we visited we found the door separating the waiting room from the clinical area was unlocked. This meant members of the public had access to a restricted area, which could potentially compromise the privacy and dignity of other patients.
- Children's community nurses had access to their own equipment stores. Staff we spoke with told us this included everything they needed. The store cupboard was clean and tidy, and every box was clearly labelled and had an expiry date.
- The majority of staff told us they had enough equipment to deliver safe care and had no problems ordering equipment. However, we spoke with a community paediatrician who told us they did not have access to scales appropriate for children and young people over 50kg in weight. The clinician had highlighted this to the trust several times.

Quality of records

Good

Are services safe?

- Services for children and young people had recently transferred from using a paper-based records system to an electronic database. If a child also had a paper record there was a flag attached to the electronic record to indicate this and make staff aware. Staff we spoke with acknowledged there were challenges in adapting to the new system; however, they felt they received appropriate support if they needed to ask questions or seek help.
- All staff we spoke with were very positive about the benefits of being able to share information more effectively using the new electronic records database. Each child or young person had only one record that all services, where appropriate, could update. This also included the child and adolescent mental health service (CAMHS). Staff told us the new system helped them to be more organised and gave them a clearer oversight of children in their care.
- However, staff from all services acknowledged the new electronic system required additional improvements to enable staff to record all relevant information relating to a child or young person. For example, we accompanied a health visitor on a home visit to a new-born baby who was categorised as 'universal plus' (where families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning, or sleepless children). There was no facility on the new system to record this information. Other risks, such as children on a protection plan, did have an alert within the system and managers assured us work was ongoing to address the outstanding issues.
- We looked at 21 care records across school nursing, health visiting, and community children's nursing. Most of the records we saw were clearly set out, legible, and comprehensive. Records also included individualised care plans, risk assessments, action plans, and relevant pathways where required. Additions were made in a timely manner. We also reviewed five medication charts at a children's community nursing clinic. Nurses had completed all of the personal details, including the weight of the baby, on each record. Prescribing doctors had added their signatures and all entries were clear and legible.
- At the previous CQC inspection, in 2015, inspectors found that health visitors did not complete records within the timeframe expected by the Nursing and Midwifery Council (NMC) guidelines, which state nursing records should be completed within 24 hours of patient contact. Most health visitors we spoke with told us they struggled to complete their records on the same day but usually managed to do so within 48 hours. Staff told us they always prioritised the key information and added this to the record first, or they scanned a document, adding it to the electronic database as a contingency, and then completed the record at a later stage. However, on the majority of records we reviewed, we noted staff had completed records within the required period.
- Some health visitors faced travel times of over 30 minutes between home visits and their office, and the trust had provided staff with laptops. However, we found that not all health visitors were using their laptops to update records in a timely way in between visits.
- The trust was planning to audit record-keeping practice within the next three months to assess whether staff were completing records in line with the NMC guidelines. The trust had updated the record-keeping audit tool to reflect the changes from paper records to the new, electronic, patient record. We reviewed the tool and saw it incorporated all appropriate indicators; however, we noted it did not include an indicator to assess the timeliness of record updates. It was not clear how the trust planned to monitor how services met the requirements outlines by the NMC.
- Staff and managers reviewed the quality of care records during individual supervision sessions. Staff told us managers gave feedback and agreed actions as appropriate. We observed one session and noted the manager acknowledged the practitioner had completed the record within 24 hours and had provided an in-depth analysis of the child.
- We observed health visitors and children's community nurses updating the parent and child record (red) books when families attended baby and vaccination clinics. We also observed this in practice during home visits.

Cleanliness, infection control and hygiene

- Staff were aware of safe infection prevention and control (IPC) measures and knew how to access the IPC policy on the intranet.
- The majority of staff had undergone infection control training in the preceding 12 months. The current level of compliance across all services was 85%, and managers were confident all remaining staff would receive the required training before the end of the year.

Good

Are services safe?

- The clinics we visited were visibly clean and tidy. We observed staff using hand gel to clean their hands and adhering to the bare below the elbows guidance, in line with national good hygiene practice. We also observed staff practice good hand hygiene within family homes.
- We saw personal protective equipment was readily available for staff to use and we observed staff using it appropriately.
- In baby clinics staff cleaned the equipment after every use using antibacterial cleaning wipes. Staff also used a blue paper roll to line the baby scales and replaced it for each new patient.
- Staff from all services used toys and games to engage and interact with children. Staff cleaned toys using antibacterial sanitary wipes after every use. In one clinic, we reviewed the toy-cleaning schedule and noted it was up-to-date, with a deep clean every two to three months.
- The IPC team had recently introduced a hand hygiene audit tool and was rolling this out across all services. Some audits had already been completed; however, we did not have any results to review. The team had also recently completed a walk round with the staff at a children's hospice and developed an action list following this informal review which included some additional training for staff.

Mandatory training

- The trust set a target of 80% for completion of mandatory training. Mandatory training courses for staff included safeguarding children, information governance, fire safety, infection control, health and safety, and basic life support.
- Staff told us they were fully compliant with all of their mandatory training requirements. Evidence provided to us from the trust demonstrated compliance levels were good across all services. For example, 90% had achieved the training target for basic life support and 87% for information governance. However, equality and diversity and informed consent compliance were quite low, at 67% and 65% respectively. Managers we spoke with were confident all remaining staff would receive the required training before the end of the year.
- Training resources were accessible and available face-to-face or online via an e-learning package.
- Individual members of staff were responsible for making sure they were up-to-date with all of their own training; however, they also received notifications from line managers.

Assessing and responding to patient risk

- In the 21 records we reviewed, we observed patient risk assessments were completed appropriately, including those for child sexual exploitation, and updated as required. Services used a risk and vulnerability assessment tool. This looked at areas such as mental health, domestic violence, and recreational drugs.
- Staff from all services told us assessing risk was a standard part of their role. For example, risks within the family nurse partnership were identified through various means including DANCE (Dyadic Assessment of the Naturalistic Caregiver Experience) assessments. DANCE helps to enhance the relationship between the parent and child and educates the parent on the benefits of reciprocal interaction. It is also a means to identify risk in the relationship between the new mother and her baby.
- School nurses completed risk assessment forms each time they visited a secondary school as part of the vaccination and immunisation programme. Although nurses tended to use the same room at each visit, they told us they always ensured children were safe.
- Health visitors told us they completed maternal mood assessments if this felt there was a cause for concern, but did not do this as a matter of course.
- The children looked after team completed review health assessments with children aged between five and 18 years. The assessment, where age appropriate, included risk-taking behaviour that focused on areas such as substance misuse and sexual health. Nurses told us this gave them the opportunity to identify any concerns and helped identify young people who were at risk of child sexual exploitation or who were in an abusive relationship.
- Staff told us there was no standard operating procedure to support staff when dealing with domestic violence notifications from hospital A&E departments or from the police. Health visitors told us they followed up all such notifications with the relevant families; however, there was no standard procedure to ensure consistent practice across the service. Information from acute hospitals about children who had attended A&E or minor injury units was not always shared in a timely

way, which meant healthcare professionals within the care group were delayed in making a relevant risk assessment about children in their care. Managers had identified this as a risk on the care group risk register.

- Standards were in place to support timely information sharing between health visitors and school nurses. Health visitors we spoke with told us handover arrangements with midwives were good. When we spoke with school nurses, they told us a face-to-face meeting took place with the respective health visitor when a child leaving the service had complex needs or was subject to a child protection plan.
- We saw evidence of the systems to monitor and track children looked after. Once the local authority notified the team of a new child, nurses arranged an appointment for the initial health assessment. This took place within 28 days. The team discussed new notifications at weekly team meetings. The business support team produced weekly business reports to ensure all children were accounted for and appropriate action had been taken.

Staffing levels and caseload

- Information provided to us by the trust showed no significant gaps in staffing in all services across all localities. For example, the contracted whole time equivalent (WTE) for health visitors was 93.18 and the actual staff in post equated to 93.95 WTE. However, health visitors we spoke with told us when staff left the trust managers did not recruit to fill the position, although we did not see any evidence of this. Staff felt this had a negative effect on caseloads. For example, we spoke with one health visitor whose caseload increased to over 500 following the recent departure of a colleague. Due to capacity issues, health visitors from the same location told us they were no longer able to visit families in their home to fulfil the 12-week contact. Instead, staff asked parents and carers to meet with them at their local baby clinic.
- The average caseload for health visitors, based on the number of WTE staff and the total caseload figure across the whole county, was 335. However, the actual number of cases varied depending upon location. Caseloads were higher in the west of the county and staff told us complex cases involving child protection and safeguarding were shared across teams to ensure caseload capacity was managed safely. Managers also held regular meetings to discuss workload and allocation. According to guidance produced by the Community Practitioners and Health Visitors Association, caseloads should be, on average, 250 children per one WTE health visitor. This should vary according to deprivation indicators, with a maximum of 400 in the most affluent areas and fewer than 200 in the most deprived areas.
- The school nursing team based in the Carlisle area shared the caseload across all schools in the locality and managers allocated work each week. In the west of the county, nurses managed their own caseload. School nurses who delivered the immunisation and vaccination programme described their caseloads as manageable. The service also managed the Chat Health SMS messaging helpline service. There was a rota and teams across the whole county held responsibility for a full week before the duty rotated to the next team.
- The children looked after team operated across the whole county. The team adopted a RAG (red, amber, and green) rating system to identify the level of need for each child looked after. This enabled the team to distribute the work in an equitable way to ensure nurses had the capacity to meet the needs of each child appropriately. A senior manager told us the current caseload was 650 children and the team monitored this weekly, utilising information from the trust's electronic record system and information received from children's social services. Although the team members felt the caseload was manageable, they were concerned about the ability to complete health assessments within the required period. Performance data showed the team was consistently meeting the threshold target.
- Family Nurse Partnership caseloads were below the national recommendation of 25. The current staffing establishment was 6.0 WTE, although managers had granted one member of staff a career break. Staff told us caseloads were usually between 15 and 20 clients per nurse.
- A team of community paediatricians worked across the county, specialising in assessing and managing children and young people who had a developmental delay or a disability, including autism. Clinicians also assessed the health needs of children looked after. There were 7.27 WTE paediatricians in total, which included the associate medical director and clinical director. There were no locum doctors.
- The community children's nursing service actual WTE was 21.21 and this was on par with the budget

requirements. From April to November 2016, the average caseload for the whole service was just over 400. Many of those children had complex or long-term health needs. Staff we spoke with told us individual caseloads ranged from 15 to 30 cases per nurse and could change depending upon the needs of the children. The children's continence service had higher levels of activity, and the average caseload for all teams was 646. Staff we spoke with told us they felt caseloads were manageable.

- There was a good skill mix across and within most of the teams and services. For example, specialist nurses from the children looked after team had professional backgrounds in school nursing, health visiting, district nursing, and community children's nursing. However, the skill mix in therapy services was very static. Staff told us a number of therapists were close to retirement age and they were not aware of any succession plans to replace them. Physiotherapy staff in the south of the county told us the service planned to establish a rotational band 5 physiotherapist post to improve the skill mix across the teams.
- We reviewed sickness absence statistics across all services from data provided to us by the trust. In 2016, the majority of services were below 5%.
- We also reviewed turnover statistics across all services. In 2016, the overall turnover rate was 12.96%. There was no apparent theme or trend from any service.

Managing anticipated risk

- Staff told us they undertook risk assessments when working in the community. For example, when visiting a new family in their home for the first time, health visitors told us they would visit in pairs or gather information from different sources to inform their risk assessment. Staff could document any risks on the electronic record. However, there were different options to choose where to record the information, which meant some risks might not be picked up by staff visiting the family. Managers told us work was in progress to address this to ensure staff recorded all risks in the same way.
- Staff we spoke with told us the trust was very good at warning them about adverse weather conditions. In 2015, the region had experienced severe flooding. Staff explained managers contacted them on an individual basis to provide support and help them prioritise children and families. Managers and staff followed the trust major incident plan and worked collaboratively with the local council.
- The trust had an incident response plan which set out the trust's generic response to internal and external critical incidents. This included roles and responsibilities, communications, and co-ordination and plan activation. Services for children and young people also had up-to-date business continuity plans. We reviewed the plans that outlined the procedures that services should take in the event of a serious business disruption.

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 effective as good because:

- Policies and guidelines were evidence-based, and there were good examples of multidisciplinary and multi-agency working and collaboration.
- Staff completed comprehensive assessments of children's needs, which took into consideration of clinical needs, physical health, and mental health.
- The care and treatment of children and young people achieved good outcomes and promoted a good quality of life. Health visitors and the family nurse partnership delivered the Healthy Child Programme and managers routinely collected and monitored the data using a performance dashboard.
- The trust was working towards stage one accreditation with the UNICEF Baby Friendly Initiative and had taken steps to improve breastfeeding initiation rates and to support mothers to breastfeed their babies over a sustained period.
- There were effective arrangements for young people transitioning to adult services. Needs were assessed early, with the involvement of all necessary staff, teams, and services, and staff applied Gillick competency and Fraser guidelines appropriately in relation to obtaining consent. Arrangements fully reflected individual circumstances and preferences.
- Staff were qualified and had the skills they needed to carry out their roles effectively. There was also a new preceptorship programme for staff joining the service.

However:

- The trust did not provide a qualified specialist community public health nurse (SCPHN) for each secondary school in the county, which was in breach of Royal College of Nursing guidelines.
- Information provided by the trust showed only 74% of staff had received an appraisal. However, managers assured us all staff would have received an appraisal by the end of the current year.

Evidence based care and treatment

- Children and young people's needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence based guidance. Policies and procedures were based on guidance produced by the National Institute for Health and Clinical Excellence (NICE) or other nationally or internationally recognised guidelines.
- We saw evidence of standard operating procedures and pathways across all services to ensure service delivery was effective. For example, we reviewed procedures for the health of children placed for adoption and the evidence-based constipation pathway. Managers and healthcare professionals introduced new policies and pathways as appropriate and were currently developing a new pathway for children with asthma.
- Managers and staff reviewed and ratified new evidence-based policies and guidelines at clinical policy task and finish group meetings. In March 2016 there were 72 expired policies, and there were currently 24 remaining, all of which were in the process of ratification.
- At the previous CQC inspection, inspectors found that community children's nursing did not have any policies upon which the service based its care. We spoke with nurses who told us managers had established a new reference group in which every nurse developed one policy each. Seven evidence-based policies had been created and were scheduled for ratification at the task and finish group by March 2017.
- The children looked after team followed guidance and recommendations from the CQC 'Not Seen, Not Heard' report published in July 2016. The team also used Strengths and Difficulties Questionnaires (SDQs) as a monitoring tool to identify any concerns around the emotional health of a child or young person. Specialist nurses informed the child's social worker if the SDQ reported medium or high scores to ensure the child received timely support.
- The sexual health service had patient group directives, as did the school nursing team for all vaccinations. These included the management of anaphylaxis, nasal flu, and adrenaline.
- The sexual health services followed guidance when assessing young people under the age of 16 at their first

appointment. 'Spotting the Signs' was a national tool and evidence-based framework to support healthcare professionals in the detection of child sexual exploitation (CSE).

- All health visitors, school nurses, and family nurse partnership nurses we spoke with knew all of the guidelines relevant to their practice and said they were embedded within their service. They followed the national initiative called the Healthy Child Programme. This is a Department of Health programme of early intervention and prevention for health visitor contacts with babies and children. It offers regular contact with every family and includes a programme of screening tests, immunisations and vaccinations, development reviews and information, guidance, and support for parents. The programme was delivered across the 0-19 age range.
- Health visitors and the family nurse partnership used Ages and Stages Questionnaires (ASQs) as part of their assessment of children. This is an evidence-based tool to identify a child's developmental progress and readiness for school, and to provide support to parents in areas of need.
- The family nurse partnership worked with young people across Cumbria. The service provided evidence to demonstrate they followed the national programme, including meeting targets and achieving key milestones with participants of the project.

Nutrition and hydration

- The trust had an infant feeding policy. This included support and care for breastfeeding mothers and Department of Health recommendations. Staff displayed breastfeeding posters and weaning group information in most of the baby clinics we visited.
- Health visitors provided information and support for children with complex feeding needs. For example, we reviewed notes made by a community children's nurse who asked the asked the child about their feeding regime and empowered them to make decisions regarding their ongoing care.
- We observed baby clinics led by health visitors and nursery nurses. The information and advice provided followed national guidance, for example, not introducing solid foods until six months of age, and we observed this in practice.

Technology and telemedicine

- All staff had access to laptops, smart phones, and software that could be used if there were connectivity problems within the geographical areas. This technology could upload records when staff were completing notes in areas where there was no connectivity. The trust had also trialled the use of virtual private networks (VPN) to enable staff to access to the 'live' record.
- However, most staff we spoke with felt using laptops within a home environment presented a barrier between themselves and the families they visited. We accompanied one health visitor on a home visit and observed they completed their notes upon their return to the office due to the complex nature of the visit. Other health visitors we spoke with were concerned about connectivity issues; however, most acknowledged they had not tried to access their laptops during a visit.
- The school nursing team engaged with school children through an SMS messaging service called Chat Health. This enabled children and young people to use familiar technology to contact a nurse to seek help, advice, or information.
- Staff from the sexual health service used texts as a means of delivering test results to young people who had attended a clinic. The service also sent texts to remind young people of their appointments 24 hours prior to their visits.
- Services were looking at different ways to use technology effectively. For example, health visitors in Furness maintained a Facebook page, which shared details about clinic times and information relating to postnatal depression plus medical advice.

Patient outcomes

- We saw evidence that staff thoroughly assessed patient needs before care and treatment started and there was evidence of care planning. This meant children and young people received the care and treatment they needed. There was also a clear approach to monitoring, auditing, and benchmarking the quality of services for children and young people and outcomes to improve care and treatment.
- The children looked after team was responsible for ensuring all children in its care received an initial health assessment (IHA). The IHA is a statutory requirement which staff must complete within 28 days of a child becoming looked after. The service aimed to complete each IHA by day 20 to ensure a health plan was in place

for the child's first review. Managers set a target threshold of 85% and data reported in quarter one (April to June 2016) showed the team achieved this. In quarter two (July to September 2016) compliance was just below target at 81%; however, in the latter two months staff exceeded the target, achieving 92% and 88% respectively.

- The children looked after team also achieved good patient outcomes (exceeding the same 85% threshold target) in the immunisation and vaccination schedule, dental attendance performance, and review health assessments (RHA). RHA is another statutory requirement. Assessments should be completed annually for children aged between one and five years and for children and young people between five and 18 years. Although RHAs achieved for children under five-years-old was slightly below the local threshold, the service performed better when compared to regional and national performance. The team completed regular quality assurance audits to review all RHAs and shared outcomes and recommendations with other services across the Children and Families Care Group. Managers monitored performance weekly and the team planned to benchmark the service against outcomes for children looked after highlighted in the CQC 'Not Seen Not Heard' report (July 2016).
- The school nursing service was on schedule to meet the immunisation targets for 2016/17. The uptake for the childhood influenza vaccine was currently at 55% compared with 50% in the previous year. The current uptake for the HPV vaccine was 89% and 84% for dosages 1 and 2 respectively.
- The school nursing team delivered the National Child Measurement Programme (NCMP) and visited school age children in Reception and Year 6 to record their height and weight. Information provided to us by the trust showed in quarter one 70% of Reception children participated in the NCMP, and this increased to 93% in quarter two. For Year 6 children performance was more consistent. Over 90% of children participated in NCMP in quarters one and two.
- The health visiting service used a performance dashboard to record and monitor patient outcomes. We reviewed data from quarter one (April to June) and quarter two (July to September) of this year. Performance outcomes were mixed in relation to criteria outlined in the Healthy Child Programme. Some of the key findings are summarised below:
- In quarter one, 70% of mothers received an initial face-to-face antenatal visit from a health visitor at 28 weeks or later, before they gave birth. This increased to 90% in quarter two.
- In quarter one, 81% of families received a new birth visit, which took place within 14 days of the baby's birth. The percentage was very similar in quarter two.
- Over 90% of families were offered a 12-month assessment, which health visitors completed before the child was 15 months old. Performance was not as good for the delivery of two-year reviews. The service achieved 70% in quarter one, and in quarter two this increased to 84%.

- Feeding status data was recorded in the same performance dashboard and we reviewed information collected in quarter one and quarter two. At birth, only 26% of all new babies were breastfed and this decreased to 21% in quarter two. Initiation rates were higher in teenage mums who were supported by the Family Nurse Partnership. The percentage was 50%; however, only 16% continued to breastfeed when their baby was six weeks old. Staff told us they worked with clients during the antenatal period and provided support and information to help them make an informed choice. To improve the initiation rates, managers had developed a strategy and appointed two project leads to work with staff across the whole county.
- The trust was also working towards stage one accreditation with the Baby Friendly Initiative. This is a global programme of the World Health Organisation and UNICEF, which encourages health services to improve the care provided to mothers and babies so that they are able to start and continue breastfeeding for as long as they wish. We spoke with staff who had already received training. Health visitors who had a specialist interested in breastfeeding had also completed national training courses and had shared the learning with colleagues. Health visiting teams included breastfeeding champions, and we spoke with staff who ran a weekly breastfeeding support group.
- The family nurse partnership recorded and monitored outcomes using the 'Open Exeter' information system. The service specification included a set of fidelity 'stretch' goals. Information published in the latest annual report showed the percentage of teenage mothers who enrolled in the programme by 16 weeks was 51%, below the 60% target; however, the attrition

rate (the number of teenage mothers who did not complete the programme) was very low. Another fidelity stretch goal stated young people should receive at least 80% of the planned programme visits in pregnancy, 65% in infancy, and 83% in toddlerhood. The team achieved 82%, 72%, and 83% respectively.

- Information provided to us by the trust stated community services for children and young people did not have any specific CQUIN (Commissioning for Quality and Innovation) national goals in addition to delivery of the Healthy Child Programme.

Competent staff

- All staff new to the trust underwent a corporate induction followed by a comprehensive local induction within the relevant service.
- Staff from all services also received additional training to ensure they met the requirements of their role and ensure children and young people received the best care possible. For example, nurses from the looked after children service had received training in oral health from the trust's oral health improvement team. There was a system to provide tracheostomy training for community children's nurses, comprising on-line training and competency workbooks. Staff from the sexual health service had also completed enhanced training, in areas such as sexually transmitted diseases in young people, to support children and young people accessing the service and had attended relevant conferences.
- Although most staff we spoke with told us they had had an appraisal within the last year, information provided to us by the trust showed the actual figure was 74%. Discussions included personal development, and staff told us they had opportunities to participate in additional training as agreed with their line manager. Managers we spoke with were confident all remaining staff would receive their appraisal before the end of the year.
- The trust had a new multi-professional preceptorship policy, which included competency frameworks based on job grade. In a paper presented at a recent trust-wide governance meeting, it was acknowledged that preceptorship had not been a priority for the organisation. A project team from the Education and Learning department had recently developed a new framework to strengthen preceptorship across the trust. The team had held workshops to engage with staff from services for children and young people, and meetings had been arranged to discuss the roll out of the new policy. We spoke with health visitors who told us they felt new staff received good support and did not usually receive complex or safeguarding cases within their first year of service.
- Within the health visiting service, community practice teachers supported students. Staff also had opportunities to develop specialist interests and shared their knowledge and learning with the wider team. For example, we spoke with health visitors who maintained portfolios of special interest in mental health, domestic violence, and breastfeeding.
- Staff did not report any problems in relation to revalidation, and health visitors we spoke with at a focus group described the process as a positive experience.
- Nurses, therapists, administrative staff, and clinical leads told us they received regular formal and informal supervision from line managers and peers. Informal supervision occurred daily while formal supervision varied from service to service. For example, nurses from the family nurse partnership had weekly supervision meetings with their supervisor and three-monthly face-to-face tripartite supervision. Health visitors and school nurses received formal supervision at least every three months.
- Royal College of Nursing guidelines state there must be a minimum of one qualified specialist community public health nurse (SCPHN) for each secondary school. In one team, based in Workington, there were two qualified SCPHNs; however, another team, based in Wigton, did not have any qualified staff. Although we were aware school nursing teams worked corporately across schools in each local area, it was not clear whether qualified SCPHNs worked outside of their own team remit.

Multi-disciplinary working and coordinated care pathways

- Services for children and young people worked together with each other and with external agencies to assess, plan, and co-ordinate the delivery of care. Staff described a patient-centred approach and included parents where appropriate as well as all healthcare professionals involved in a child's care. Staff demonstrated a good awareness of the services available to children and contacted other teams for

advice and made referrals when necessary. This meant staff from all services shared information appropriately and cross-agency working ensured concerns about vulnerable children were shared and managed.

- Staff described positive links with local multi-agency risk assessment conference (MARAC) and multi-agency assessment hub (MASH) committees. Staff also attended a monthly child sexual exploitation (CSE) oversight group where multi-agency services discussed and reviewed current cases. Managers told us they encouraged their staff to attend the meetings, and some staff we spoke with confirmed they had been. The group shared information and updates from the meeting with relevant healthcare professionals across the region. In west Cumbria, staff worked collaboratively with the local police force to collate information in relation to CSE and gang culture to ensure children were safe.
- Specialist nurses from the children looked after team told us about recent improvements in the administration of information and data. Staff explained this was largely due to close working links with the local authority. An administration officer worked alongside the service's business support team one day a week, and staff described positive results in terms of communication and information sharing across the two teams.
- Staff reported good links with maternity services provided by the local acute hospitals. One manager told us that, if a pregnant mother disclosed she had been looked after as a child, the midwife contacted the children looked after team directly to notify them at the antenatal stage and again once the new mother had given birth. The manager told us this had worked effectively in practice. Health visitors also reported good relationships with community midwives and, on occasions, visited families together where appropriate. However, acute midwives did not always notify the health visiting services when they discharged babies from hospital. Health visitors told us managers were taking appropriate steps to improve this practice.
- The children looked after team worked with colleagues from outside of the immediate area when a child moved into the county. Although this could be challenging, as the team did not always receive timely information, we heard examples of good practice.
- Communication between services for children and young and GPs was good. Every health visiting team was affiliated with a GP practice and staff reported there were no issues when they needed to discuss a child in their care.
- Community children's nurses worked closely with the local acute hospitals and hospices. During evenings and weekends, children and families could access the children's ward at their local hospital. Nurses told us they liaised with hospital ward staff if they had concerns about a child to ensure the ward was prepared in case the family contacted them that same night.
- The children's community nursing service also had good links with local specialist schools attended by children with special educational needs and/or disabilities. Nurses told us they created a care plan in conjunction with the school and family and supported staff from the school with appropriate training where necessary.

Referral, transfer, discharge and transition

- The trust had a transition policy that outlined the process when children and young people with long-term conditions were ready to move on and receive ongoing care, treatment, and support from adult services.
- The trust followed NHS England's 'Ready Steady Go' programme to support young people in this transition. A key principle of the programme was empowerment. Staff we spoke with understood the value of empowering children and young people to take control of their lives and equip them with the necessary skills and knowledge to manage their own healthcare needs effectively.
- Health visitors and school nurses told us they worked closely with each other to discuss vulnerable school-age children and ensure they shared important information. Children with special needs or those subject to a child protection plan were 'handed over' in a face-to-face discussion. Parents were involved in the handover if appropriate.
- The children looked after team supported young people ready to leave the service by building their confidence and promoting empowerment. Specialist nurses told us transition arrangements started as early as possible. Each young person was provided with his or her own, unique 'passport'. This included details about their full health history and relevant information about their GP and other healthcare services. If a young person had

medical problems, the team liaised with acute services or, if the young person was receiving care and treatment from the Child and Adolescent Mental Health Service (CAMHS), staff would support the young person through their transition to the Adult Mental Health team.
- The children looked after team also explained how they maintained contact with children who moved away from the local area. When a child relocated outside of the region, administrative and nursing staff kept track weekly. The team maintained links with the child and the new regional team. One member of staff told us 'we always know where our children are'.
- Staff from other services also followed a pathway for any child or young person, not just those who were looked after, who presented with a mental health problem. The CAMHS was an integral part of the Care Group, and staff described close working relationships.

Access to information

- Staff we spoke with told us they were able to access the information they needed to ensure they provided safe and effective care to children and young people. This included policies, templates, standard operating procedures, and best practice guidance.
- The intranet was available to all staff and contained links to current guidelines, policies, procedures, and contact details for colleagues within the trust. This meant staff could access advice and guidance easily. All staff we spoke with knew how to access the intranet and the information contained within.
- Information about children receiving care from CAMHS was readily available through the electronic patent record system. However, information about children from GPs was not easily accessible as the electronic systems were not compatible. Staff told us work was ongoing to identify an intermediate system that would connect with various other systems operating outside of the trust.
- School nurses told us they received timely information from schools, which helped them to plan their immunisation clinics. This included information about children who were nervous about the procedure or who had severe needle phobia.
- Midwives sent referrals of births via internal post, and administrative staff added the notifications to the electronic care record. Staff told us they usually received the referrals promptly.

Consent

- The trust had a new consent policy, due to be ratified at the next clinical policy management group meeting. It included specific references to children and young people and parental responsibility.
- Staff we spoke with told us they understood the Fraser guidelines and Gillick competency and explained how they applied them in practice.
- Consent was obtained from parents and children at the initial assessment stage. Health assessments for children looked after included evidence of consent from young people to sharing their health information following discharge from the service.
- Staff from all services told us they took into consideration the voice of children and young people when obtaining consent. Staff also explained the reasons and rationale when and why they may need to breach the consent given and share information with other health or social care professionals
- We saw evidence of correctly completed consent forms. We observed staff obtaining verbal consent correctly prior to a home visit and saw staff ask parents' permission before handling babies at a baby clinic.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Staff treated children, young people, and families with dignity and respect and involved them in their care.
- All staff we spoke with were passionate about their roles and were clearly dedicated to making sure children and young people received the best patient-centred care possible. Throughout our inspection, we observed staff delivering compassionate and sensitive care that met the needs of children, young people, and parents.
- We observed members of staff who had a positive and friendly approach towards children and parents. Staff explained what they were doing and took the time to speak with them at an appropriate level of understanding.
- Feedback from children, young people, and families was positive about all aspects of the care they received. Staff were very caring, compassionate, understanding, and supportive. Staff worked in partnership with children and young people and promoted empowerment, enabling them to have a voice.

Detailed findings

Compassionate care

- All staff we spoke with were very passionate about their roles and were clearly dedicated to making sure children and young people received the best patient-centred care possible. Every member of staff we spoke with told us about the importance of capturing the voice of the child in their work.
- Staff showed respect for the personal, cultural, social, and religious needs of children and young people. For example, school nurses ensured female children had privacy if they needed to expose their skin for the administration of a vaccination. Nurses made sure they preserved a child's dignity by covering exposed areas with their jacket or found an alternative room with more privacy.
- We observed the way staff treated children and their parents both in their homes and in clinic settings. Staff were kind, sensitive, supportive, and compassionate, and they treated children and young people as individuals. Parents told us they had confidence in the staff they saw and the advice they received.
- We spoke with two families who accessed 'Love Barrow Families', a service for complex families living in the two most deprived wards of Barrow-in-Furness. Parents felt staff at the project were fantastic and believed they had helped changed their lives. We saw the rapport between families and staff, and parents told us this had helped build their confidence. Parents commented they felt staff had not judged them, were honest, and treated them as equals.
- The patient experience team gathered feedback from children, young people, and families each month. We reviewed the results from patient experience surveys from July to December 2016, and the feedback was very positive about all services. For example, 97% of parents said staff were kind and caring and their child was treated with dignity and respect. One parent was very pleased with the care provided by the physiotherapy team and commented, "they have listened to what my son wants and not just told him what to do".
- Children also had the opportunity to participate and share their feedback about services. Overall, 97% of children and young people said staff who looked after them were kind, 94% felt staff listened to them, and 94% said they felt safe. In relation to the school nursing service, one child commented how much they appreciated the fact staff 'were nice and respected me'. Another child said the community paediatrician "was very understanding and patient" and "explained everything in detail".
- School nurses sought feedback from children after each vaccination session to ensure they could address any concerns immediately. Some children said they felt intimidated by the equipment displayed on the table, such as vomit bowls. A school nurse told us they now arranged the room so children faced away from the equipment table and it was out of their immediate sight. Following further feedback, school nurses also played

music as children told them it helped them to feel calm and helped to distract them from the immunisation treatment. We reviewed feedback from children who described nurses as "kind and caring".
- The trust participated in the national Friends and Family Test, and we reviewed data gathered from July to December 2016. There were 212 responses and, of those, 95% said they would recommend services for children and young people to their friends and families. Parents included positive comments about all services.

Understanding and involvement of patients and those close to them

- The children looked after team members told us they put the child or young person at the heart of their care and encouraged them to participate in discussions. We reviewed five case studies, and in all cases it was evident the voice of the child had been heard. One young person completed their strengths and difficulty questionnaire (SDQ) with support from the specialist nurse. Another 17 year old attended a multi-agency meeting to share their own thoughts about what continued support they needed.
- Services involved children, young people, and families in the planning of their own care. For example, teenage mothers were encouraged to talk about any anxieties they had about their pregnancy and developed plans to incorporate addressing those into their next visit. During a home visit, a young mother told us she had really benefited from the support she had received from the family nurse partnership, which began before her baby was born and continued afterwards.
- Parents told us staff focused on the needs of the child and their family. They felt involved in discussions about care and treatment options and told us they were confident asking questions. One parent told us her nurse did a "great job" and was always available when she needed her. However, we also spoke with two parents who told us they had not seen their child's care plan and were not aware of any documentation about their child.
- Staff told us they supported children and their parents or carers to manage their own treatment needs whenever possible. Staff also encouraged children to describe how they were feeling, and we heard examples from nurses who encouraged children to use drawings to articulate their thoughts.
- We observed health visitors and nursery nurses interacting with children and parents at a baby clinic and in family homes. Staff created a warm and caring environment, and we observed them positioning themselves in a way that was unthreatening and promoted open communication with the family (by sitting on the floor with them and using clear, non-jargon language). We also noted staff gave parents the opportunity to ask questions and were very patient, giving parents enough time to talk about concerns or queries.
- We observed a meeting with a school nurse and a parent with two young siblings from a local primary school. The school nurse gave both children, and their parent, the opportunity to express their thoughts and feelings about their current situation. The nurse was very sensitive towards the children and acknowledged their reluctance to talk about certain issues. We watched her gently coax the children to disclose their worries and witnessed them increase their communication with the nurse as she slowly gained their trust. The school nurse also encouraged the parent to engage, sharing information and advice.
- Information was provided in a format suitable for children and young people. The trust had produced a series of factsheets to provide health advice and information to support children and families to live a healthy life.

Emotional support

- Staff from the trust supported children, young people, and their families and carers in the first instance. Referrals to other services such as psychologists, GPs, and counselling services could be made if further, specialised support was needed.
- Staff understood the impact conditions and their treatment had on children and young people, and this was embedded in their care. For example, school nurses understood some children felt very nervous and worried about receiving a vaccination. Nurses told us they had arranged separate sessions for some children, away from the school environment, to make them feel more comfortable.
- Staff in health visiting teams managed their own caseloads. This meant mothers met the same health visitor at each appointment in their home. Consistency

Good

Are services caring?

meant health visitors built up relationships with mothers and children; we saw evidence of this during home visits. One health visitor also gave us an example of supporting a family during bereavement.

- Families told us staff provided good emotional support, especially when parents were anxious and children required additional care. For example, one parent told us they spoke with their health visitor regularly prior to their child's hospital admittance. The same health visitor also visited the family at home, in recognition of the family's difficulty in attending clinic due to geographical constraints and travelling with a child who had a long-term condition.
- During a very busy baby clinic, we observed staff spending time with individual parents, discussing their concerns in a manner that was not rushed or hurried. A health visitor also provided one mother, whose baby was unwell, with their mobile number and encouraged her to contact them for support at any time.

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 responsive as good because:

- Managers and staff planned and delivered services to meet the needs of children and young people and worked collaboratively with families, partner organisations, and other agencies.
- Since the previous CQC inspection, in 2015, the trust had made improvements in referral to treatment times, which meant children received the right care at the right time.
- Care and treatment was coordinated with other services and providers. For example, the looked after children team had developed a fast-track process to ensure children with mental health problems received immediate care from the child and adolescent mental health service (CAMHS). Community children's nurses also delivered care and treatment to children with long-term and complex health conditions, working alongside staff in a local hospice.
- There was a proactive approach to understanding the needs of different groups of children, and staff delivered care in a way that promoted equality. This included children and young people who were in vulnerable circumstances and those who had complex needs.
- There was an open and transparent approach to handling complaints. Information about how to make a formal complaint was widely available; however, families tended to contact the service directly.

However:

- The school nursing service did not participate in health promotion activities in local schools, such as drop-in clinics or public health-related presentations. This meant children and young people had limited access to the service, although the Chat Health SMS messaging helpline service meant children could contact a nurse at any time during the day.
- There did not appear to be any defined standards or targets to determine when a community children's nurse should see children and young people. Nurses also told us there was also no set criterion for referral into the service, although managers were currently reviewing the process.

Detailed findings

Planning and delivering services which meet people's needs

- Senior managers told us they had visited other care providers to review and gather feedback from staff about different models of care to help inform their own planning.
- The trust engaged with children, their families, and other stakeholders in the design and running of services. For example, the Care Group recently redesigned the multi-agency assessment team (MAAT) process for children requiring a diagnosis of autism. Clinicians and managers organised a stakeholder event to share outcomes from the project report and invited families to work with them to implement the recommendations. The Care Group was also working collaboratively with a local branch of the National Autistic Society and a parent's group.
- The trust had worked with the county council and the Lankelly Chase Foundation to develop Love Barrow Families, a wraparound service for complex families living in a deprived area.
- The trust had a policy that outlined duties, responsibilities, and implementation of non-medical prescribing. Within services for children and young people, there were 116 staff who could prescribe medication. This meant children and young people had timely access to medicines and treatment. Staff attended non-medical prescriber workshops and received regular supervision and training. However, nurses from the children's community nursing service told us there were no prescribers within their teams, although one nurse was scheduled to attend a course later in the year.
- The sexual health service had proactively participated in the You're Welcome toolkit, a quality criterion highlighted in the National Service Framework for Children. The toolkit sets out a number of principles to ensure young people aged 11 to 19 (including vulnerable groups) are able to access services better suited to their needs. The toolkit covers 10 key areas

assessed, including accessibility, publicity, confidentiality/consent, the environment, staff training, skills, attitudes, and values. The team expected full accreditation by the end of March 2017.

- Health visitors provided a paediatric liaison service to the local acute hospitals. The trust was in the process of developing the function using technology. This meant acute services for children and young people would share information about children electronically, which would negate the need for a physical presence on site. Although the paediatric liaison role was originally assigned to a lead person, staff told us the service currently relied upon health visitors to volunteer for the additional task and responsibility.
- The Care Group had developed new pathways for children suffering from attention deficit hyperactivity disorder (ADHD), including a nurse-led service and increased involvement from community paediatricians.
- Managers had recently restructured the community children's nursing service to ensure children received coordinated care and treatment. Dedicated teams delivered different services, for example, in one area, an 'acute' team, based in a child development centre, delivered care for children to prevent hospital admittance. Another team, based at a local hospice, cared for children with complex, long-term, health needs and other nurses specialised in continence care.
- We found services contributed to addressing the public health needs of children and young people. For example, family nurse partnership nurses recognised smoking was a major challenge amongst their teenage client population and had purchased special carbon monoxide monitors to support young mothers to manage their health more effectively.
- The school nursing service did not support schools to achieve the Healthy Schools Standard. This is a national programme focused on the personal, social, and health education (PHSE), healthy eating, physical activity, and emotional health and well-being of primary and secondary school children. School nurses told us they did not hold any drop-in sessions or clinics, or lead classroom discussions with children covering topics such as contraception or puberty and growth. Staff expressed their disappointment that they were no longer involved in health promotion initiatives. We spoke with one nurse who felt vulnerable children not already identified through protection plans or safeguarding only had limited access to the school nursing service because of this. Although they could contact a nurse via the Chat Health service, the only other access they had was through an immunisation clinic.

Equality and diversity

- Staff were able to access interpreting services. In most cases, they used the telephone service and had not experienced any problems when they needed to book an interpreter to attend an appointment. In one area, staff had worked closely with the local school and a volunteer organisation to provide amenities and services specifically for Polish families. However, staff we spoke with from all services told us information leaflets were only available in English.
- The Chat Health service was available to all schools within the geographical area; of these, only two schools had decided not to engage with the service. School nurses were currently working with specialist schools for children with special educational needs to include them in the programme.
- The school nursing team had also made amendments to the Chat Health literature at the request of a religious school to remove the information relating to sexual health. Staff created a bespoke leaflet specifically for the school to ensure the children could still access the service.
- Staff could describe the ethnic and religious diversity of the people who used their services and explained how they could make modifications to ensure they were culturally sensitive.

Meeting the needs of people in vulnerable circumstances

- Many young families supported by health visitors and the family nurse partnership (FNP) had high levels of need. Some teenage mothers were children looked after and some suffered from mental health problems. Feedback from the FNP national service development lead was very positive about the work of the service in relation to supporting and meeting the needs of its vulnerable client group. Services worked closely with other agencies to ensure children and young people received the right level of care.
- The children looked after team had developed a 'fast-track' process for children and young people who needed support from the child and adolescent mental health service (CAMHS). The NSPCC produced a report in

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Are services responsive to people's needs?

2015 which highlighted that children looked after were four times more likely to have a mental health disorder than children who lived with their birth families. According to the Cumbria Joint Health and Wellbeing Strategy 2012-2015, almost half of all children looked after in Cumbria had a clinically diagnosable mental health disorder. However, only a small proportion received the appropriate level of care. The fast-track process meant CAMHS would meet with the child or young person within 15 working days. In 2015/16, 90% of all children looked after received a referral within the required period.

- The children looked after team had also incorporated the principles of the 'Ready Steady Go' pathway into the review health assessments for young people who had additional health needs such as asthma or eczema. This helped young people to understand and manage their conditions.
- Nurses from the community children's nursing service supported children with long-term and complex health needs. Some staff were based at a local hospice to deliver direct care and treatment.
- The trust had recently updated its policy in relation to female genital mutilation (FGM). Staff we spoke with showed a good awareness of FGM and told us they had attended training to improve their overall knowledge. Many staff had not encountered any children or mothers who had experienced FGM. However, one health visitor gave us an example when she had provided information and advice to a mother who was returning to Africa with her female baby and was concerned about potential risk.
- Love Barrow Families supported families who lived in deprived areas in Barrow-in-Furness. However, only a limited number of families could access the service. Staff were currently evaluating the project and were looking at the next cohort of families who might benefit from the service.

Access to the right care at the right time

- Since the previous CQC inspection, in 2015, the Care Group had made improvements in referral to treatment times (RTT) for children and young people accessing community paediatric services. Current performance was 97% (a 20% increase since the last inspection). The Associate Medical Director had been in post since July 2016 and had, according to senior management colleagues, "revolutionised" the Care Group's approach to ensuring children and young people received the right care at the right time.
- RTTs for audiology, learning disability nursing, and physiotherapy were also good at 99%, 98%, and 92% respectively. However, referrals for occupational therapy and speech and language therapy were lower, at 69% and 64%. The Care Group had an action plan to improve the RTT for speech and language therapy and the occupational therapy service was developing parent 'workshops' and targeting children who did not have complex needs to minimise waiting times
- At the previous inspection, inspectors found there was a long waiting list for the community paediatric multi-agency assessment team (MAAT) for children requiring an autism assessment. It had been identified that children and families could wait up to three years from referral to receiving feedback about a diagnosis. In response, the trust commissioned an external review to evaluate the current service provision. The report included several recommendations for improvement and the author recognised the "genuine commitment" from the trust to improve outcomes for children. We reviewed the trust's MAAT service improvement plan, which included the recommendations from the external review and an action to address the MAAT backlog. Clinicians provided additional sessions for children who were already awaiting diagnosis through MAAT, and new processes had been introduced so a diagnosis could be given early. A community paediatrician also told us they now assessed children with a query diagnosis of autism and only referred to MAAT if there was a definite diagnosis. Changes to the process meant fewer children overall required a MAAT assessment and the trust was about to launch a new MAAT pathway.
- Not all new mothers received a new birth visit from a health visitor. From April to September 2016, 81% received a visit from a health visitor within 14 days of their child's birth while 82% received a visit at six to eight weeks. However, when babies reached 12 months, the health visiting service offered over 90% of families a relevant assessment.
- The children looked after team received electronic notifications from children's social services. Staff told us the move from paper to electronic records had improved the speed of notifications. The business

support team received all referrals and uploaded all of the data onto the systems, notifying nursing staff in the process. This meant the team could organise health assessments within the required timeframe.

- Nursery nurses supported health visitors to run baby clinics in accessible venues across the county, such as GP's surgeries and health centres. We visited two clinics, which were very busy (although health visitors pointed out the level of activity varied each time). Busy clinics meant it could be difficult to speak with a health visitor. In one clinic, we observed one mother waiting with her baby, who was unclothed in the scales, while the health visitor held a discussion with another mother. Although it was a drop-in clinic, there was no queueing system. The health visitor relied upon the group of parents to tell them who was next. Parents we spoke with did not report any problems accessing a health visitor during or outside of baby clinics.
- School nurses also ran specific clinics for children who received their education at home. The team liaised with the local authority, which provided a list of all relevant children. School nurses then contacted families directly, sending all appropriate information, and organised clinics to ensure those children received their vaccinations as part of the programme.
- The sexual health service arranged dedicated clinic times specifically for children and young people (although they could also attend clinic at any time). A consultant saw very young children immediately. Young people who attended these dedicated clinics had shared positive feedback with staff. To seek views from the wider population, the team was working with the local Youth Council.
- Children were predominantly referred to the community children's nursing service by staff from their local hospital. Nurses provided care during core working hours, Monday to Friday. However, staff gave examples of working flexibly to ensure children received the right care at the right time, and this included evening work when appropriate. Nurses told us there were no defined criteria for referral into the service; however, managers were currently reviewing the process. Nurses from the south of the region told us there was a substantial waiting time for children waiting to attend a continence clinic. Staff told us some children had been waiting for an appointment since April 2016. According to nursing staff, there was no target or standard to define when nurses should see children in clinic or at home.
- Health visitors identified there was a high 'did not attend' (DNA) rates for contact assessments and told us they followed the trust policy to ensure they took appropriate action. This involved contacting the family, completing relevant documentation, and liaising with other agencies to ensure children received the right care at the right time. Nurses from the children looked after team also told us they had developed a system to improve the DNA rates for children attending the acute hospital.
- School nurses aimed to respond to text messages through the Chat Health SMS messaging service within two hours. Texts received out of hours generated an automated reply confirming the hours within which they would receive a reply from a nurse. The out-of-hours message also included information advising how the child or young person could access urgent help. School nurses told us the service was very popular. From June to November 2016, 169 conversations had been initiated and 573 messages received throughout those conversations. School nurses also told us parents and teachers had sought advice through the service.

Learning from complaints and concerns

- The trust had a complaints policy and staff we spoke with knew how to access it. Staff felt the process was open and honest
- Staff knew what actions to take when concerns were raised and this included trying to resolve problems as they occurred. Staff we spoke with were aware of concerns and complaints about their own service, for example, occupational therapists told us they received complaints about disability funded grants. School nurses also knew a small number of parents were unhappy with the national child measurement programme, specifically in relation to the standard letter template, which parents received after their child had been weighed.
- Staff proactively worked in partnership with children, young people, and their families, which minimised the need for people to raise complaints. If there were complaints, staff knew what to do and how to signpost people to the complaints procedure if they could not resolve concerns locally.
- We reviewed complaints made from July to December 2016. Parents and carers had raised 12 complaints about community services for children and young

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people. There were no discernible themes or trends, although two complaints related to the long waiting time for an appointment with the speech and language therapy service.

- Managers shared information and feedback from complaints at team meetings. Staff told us they discussed complaints and identified areas of learning at these meetings, and received updates through trust newsletters and emails.

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 well-led as good because:

- The leadership, governance, and culture promoted the delivery of high-quality, person-centred care. There was a clear strategy, and senior leaders were in the process of developing a new model of care. This meant significant changes to the way the Care Group delivered services. Senior managers had proactively engaged with staff, the local authority, and other stakeholders.
- A triumvirate senior leadership team led the Care Group, and there was a good governance structure. Monthly operational and governance meetings provided opportunities to discuss regular agenda items such as risk, incidents, and safeguarding.
- Senior managers were dynamic, had an inspired shared purpose, and strived to deliver. Leadership was good across every service. There was a clear management structure, and line managers were visible and involved in the day-to-day running of services. Staff spoke positively about local and senior managers.
- Since the previous CQC inspection, in 2015, managers had reviewed the risk register and established a new monitoring system. Current risks were linked to the overall Care Group priorities and managers maintained good oversight at monthly governance meetings.
- Staff were positive about working for the trust. They felt respected and valued by managers at all levels and described them as approachable and supportive.

However:

- Morale was low amongst some staff due to the planned service changes. Although staff acknowledged senior leaders had shared information and provided regular updates, staff were unclear about whether their views had been included.

Detailed findings

Service vision and strategy

- The Children and Families Care Group strategy was based on a set of key drivers, which included the transformation of 0-19 services, a single point of access to all services, and integrated and joined-up pathways with acute services for planned and unplanned care. The strategy defined three key priorities that demonstrated how the trust planned to deliver high-quality services and care to all children and young people in Cumbria.
- Managers had been working with the local authority to create a partnership agreement for the new contract to deliver services for children and young people (0-19 years) across Cumbria. This included the development of a new service delivery model, in line with the Care Group strategy. This meant significant changes to the structure of the Care Group and affected specific services such as school nursing and the family nurse partnership, which the trust planned to decommission from April 2017. New public health nursing roles for school-aged health and a new 'Strengthening Families' team, plus a redefined early years' service and integration with children's centres, were the key changes in the new structure. The Strengthening Families team included specialist nurses from the children looked after team and the family nurse partnership. It presented a multidisciplinary approach to working with the most vulnerable families across the county, including children in need, those on child protection plans, and children looked after.
- Health visitors would continue to deliver early years care for babies and young children up to the age of five. Caseloads would increase, however, as children with complex needs would be supported through the Strengthening Families workforce and would no longer form part of the generic health-visiting team caseloads. Some staff were concerned that new health visitors joining the service (with a generic caseload) would not have the opportunity to develop new skills in relation to complex cases and safeguarding. Staff we spoke with were also concerned about maintaining their own skills and experience in this area.
- Senior managers from the care group and local commissioners had held three engagement meetings with staff to share information and gather feedback about the future strategy. Most staff spoke positively about the events; however, a small number told us they

did not know whether their views had been taken into consideration. School nurses and health visitors, in particular, told us they did not feel they had received sufficient information from senior managers in relation to the future of the service. Plans were due to take effect within three months and staff told us they still did not know if they would have a job.
- Staff told us they had contributed to the trust values and attended action groups in respect of this. The trust values were embedded into the daily work of the staff.

Governance, risk management and quality measurement

- Services for children and young people sat within the Children and Families Care Group, and there was a governance structure with clear lines of responsibility and accountability. A triumvirate senior leadership team composed of an associate medical director and associate directors of nursing and operations maintained overall management responsibility. They reported directly to the executive board. Two clinical service managers led the individual services, and team managers line-managed the staff working within each service.
- The Children and Families Care Group had its own risk register, which included all of the risks for each service. At the previous CQC inspection, in 2015, inspectors found gaps in review dates and control measures to mitigate the risk, compounded by a lack of management oversight. We found senior managers had introduced significant changes to improve the management of risks within the Care Group. The whole assurance framework had changed over the preceding 12 to 18 months, particularly with the introduction of two quality and safety lead roles. Senior managers identified the top three risks as safeguarding (in terms of the new supervision model), IT and infrastructure, and culture (in relation to merging teams within the new model of service provision and the impact this would have on staff).
- Senior managers told us they had reviewed the old risk register, removing all historical risks and agreeing current risks with clinical governance and operational management staff. We reviewed the current risk register and there were 47 risks, all of which were linked to the Care Group priorities outlined in the annual business plan. Care Group managers and staff monitored, reviewed, and updated the register at clinical governance meetings and told us work was ongoing give greater visibility to frontline staff from all services.
- There was a quality assurance system, and the Care Group captured performance in a quality and safety dashboard. Staff we spoke with understood the outcomes they were measured against but told us these were not reported and measured regularly in team meetings. Health visitors told us they only discussed the Healthy Child Programme contacts during management supervision sessions when line managers asked them if they were up-to-date. Managers told us they were increasingly utilising performance data captured within the quality and safety dashboard and acknowledged this was still work in progress. The dashboard was accessible to all staff via an icon on the trust intranet.
- Quality and safety had a high priority within the Care Group. Team managers from each service met with the quality and safety leads every month to discuss incidents, safeguarding issues, and risks. One manager told us they were planning to introduce a weekly telephone call to maintain effective oversight of issues and progress. We saw evidence that staff reviewed and discussed risks regularly at team and governance meetings.
- Monthly governance meetings ensured senior managers maintained robust oversight of the issues affecting services, root cause analysis investigations, and lessons learnt from incidents. Although not quite embedded with staff across all services, the Care Group quality and safety dashboard presented current and active data in relation to incidents, risks, and safeguarding concerns across all services.
- Team meetings took place across all services and localities. Managers utilised video-conferencing facilities to include staff from across the whole county. We reviewed meeting minutes from all services and attended a combined team meeting with school nurses and health visitors. Agendas included feedback from Care Group clinical governance and operational management meetings, incidents, risks, safeguarding, staffing, complaints, service developments, operational issues, plus training and development. Feedback from staff was very positive about the meetings. Staff told us they welcomed the opportunity to meet with their service leads and colleagues, particularly those who worked remotely from each other and in rural locations.

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- There were systems in place to review National Institute for Health and Clinical Excellence (NICE) guidelines and other nationally recognised guidance. Managers and clinical leads reviewed new guidelines at care group clinical governance meetings before sharing the information with staff through the team meeting structure.
- The trust policy task and finish group met monthly and reviewed all expired policies across the organisation. The group proactively reviewed policies that were due to expire and prepared updates and amendments as required.
- The Care Group participated in a continuous quality improvement initiative called the 'quality building blocks framework'. Based upon the principles of person-centred care, culture and infrastructure, and systems for learning, managers completed a baseline assessment against 12 criteria linked to the overarching principles. They completed documentation that identified the planned improvement and included barriers, benefits, support required, and timescales.
- We saw evidence of an internal quality audit programme. Audits included 'when to suspect child maltreatment' and 'hip surveillance in children and young people with cerebral palsy'. Services were also involved in re-audits, for example, the speech and language therapy team had reviewed its referral process.

Leadership of this service

- Clinical service and team managers told us the senior leadership team of the care group promoted a very collaborative style of leadership. Staff described them as supportive, visible, inclusive, and open to challenge. The associate director of operations for the care group chaired team manager meetings, which meant they were able to keep abreast of current issues and developments within each service and maintain links with frontline staff.
- We heard and saw examples of proactive, supportive leadership across the children and families Care Group. The managers and clinical leads we spoke with were very passionate about delivering an excellent service and ensuring the child was at the very heart of each service. We observed a team meeting, which was managed well and encouraged participation from everyone involved.
- The trust had recently appointed a new medical director for the community paediatric service. Staff we spoke with told us this had made a significant improvement to the way services worked with the community paediatricians.
- Most frontline staff we spoke with were very positive about the local leadership across each service and at senior management level. Staff felt well supported by their line managers. There were clear management structures within each service, and managers were very approachable. Managers were also visible, and most staff felt connected to their wider team. However, some staff from the community children's nursing team told us they rarely met with colleagues from other areas in the county.
- School nurses told us they felt very unsettled by the impending changes to the structure of the Care Group. Although they felt valued by their immediate managers, they did not feel well-informed about the plans for their service. Senior leaders from the care group, however, had met with the teams and had arranged another meeting to provide further updates.
- Leaders promoted involvement and empowerment across the workforce to encourage participation in leading change. For example, occupational therapists told us managers had given them freedom to look at how they could influence and develop the service.

Culture within this service

- Staff told us they felt valued and respected by managers within their own service and by senior managers leading the Care Group. They described them as approachable and supportive.
- Managers and staff told us health and wellbeing was discussed during one-to-one meetings and supervision, and following any period of sickness absence. One manager told us the trust had recently introduced a resilience tool which the Care Group planned to roll out to staff across all services. Staff who had been involved in safeguarding children cases received additional support from managers individually or as a group.
- Staff worked well together. We heard positive examples from each service and staff were very supportive of each other. One nurse commented, "as a team, we work towards giving the best possible care".
- Morale was low in some staff we spoke with, due to planned restructuring within the Care Group. For example, school nurses were concerned about the

future, and team managers were supporting them through this period of uncertainty. Discussions took place during one-to-one meetings, and staff told us they could complete stress assessments if they felt they needed to.

- Other staff we spoke with, such as those in administrative roles, told us they felt the team ethos was strong and were very positive about what they did and how they influenced the service. They felt empowered and shared ideas with the team.
- The trust had a lone-working policy, of which most of the staff we spoke with were aware. Most teams and services had agreed local procedures in place, although this varied across different teams, and all staff carried a mobile phone. Staff we spoke with told us they always told a colleague where they were going. Most staff relied upon shared diaries and calendars; however, this practice was not consistent across every team and service. In addition, if a member of staff undertook a home visit at the end of the working day, we found there was no system to check whether they had returned safely. Staff we spoke with acknowledged this was a potential risk.

Public engagement

- Health visitors with a specialist interest in breastfeeding worked collaboratively with voluntary organisations and peer supporters to organise picnics to celebrate national and international breastfeeding weeks last year. The team also planned to work with the trust communications team to generate more interest and produce the event on a bigger scale in the upcoming year, to engage with more families.
- Staff from the sexual health service worked with the local Youth Council to seek the views of young people in relation to dedicated clinic times. The team also engaged with children and young people via feedback forms and made changes based upon the comments received. For example, one request was for refreshments in the waiting room and, in response, the service installed vending machines.
- School nurses used immunisation clinics as a way of engaging with children and gathering feedback about the service. Nurses presented children with 'post-it' notes and encouraged them to write down their thoughts and suggestions regarding their experience of the clinics held in school. Staff told us this was a successful initiative as over 80% of children participated.
- 'Weston' the elephant was the Children and Families Care Group mascot. The trust ran a competition for children to design a logo that described what made them feel welcome. The trust also visited schools to engage with children and young people to gather feedback about the Weston's Welcome webpage and find out what information they would like to see included. Overall, feedback was positive.

Staff engagement

- Staff we spoke with told us they felt involved in developments and initiatives within their own service. For example, senior managers and safeguarding leads proactively engaged with staff regarding the new safeguarding supervision model. Staff were also involved in the ongoing development of the electronic patient record system to ensure the system was more efficient and that it recorded all relevant information.
- Senior managers from the Care Group had held a series of engagement meetings with staff to discuss the impending changes to the Care Group. Staff were invited to share their thoughts and ideas about the proposed changes, although not all staff felt their views were actually considered.
- Staff participated in the national staff survey. Although we did not review any statistical evidence, senior managers told us the Children and Families Care Group had received the highest scores across the trust.

Innovation, improvement and sustainability

- The children looked after team had created a new standard operating procedure for when a child moved from being a child looked after to pre-adoptive status. The procedure outlined what staff should do at each stage of the process and who they should notify. It also included guidelines for health visitors about completion of records. Health visitors we spoke with gave positive feedback about the new process.
- Two health visitors we spoke with had received nominations for an award from the Community Practitioners and Health Visitors Association for the category of 'health visitor of the year' 2016, and one of them had won the award.
- The community children's nursing team had developed strong links with a local hospice. The children's hospice was a small unit attached to the main hospice site. Managers and staff developed the role of the

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community children's nurses to ensure they met the needs of children who required complex care. Nurses were based within the hospice itself, and community paediatricians visited children when appropriate.

- The 'Love Barrow Families' initiative supported families who lived in the most deprived areas of Barrow-in-Furness and delivered wraparound care, based upon trust and partnership working. The project was designed to improve the way adult and child health and social care services worked together to support families with complex needs. One of the aims was to improve and transform the quality of life of families who faced severe and multiple disadvantages. Each family had its own goals and was supported by staff to work towards them.