Cambridgeshire Community Services NHS Trust

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Community health services for children, young people and families

Quality Report

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

Summary of findings

Ratings

Overall rating for Community health services for children, young people and families	Good
Are Community health services for children, young people and families safe?	Good
Are Community health services for children, young people and families caring?	Good
Are Community health services for children, young people and families effective?	Good
Are Community health services for children, young people and families responsive?	Good
Are Community health services for children, young people and families well-led?	Good

Summary of findings

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Overall summary

Overall rating for this core service: GOOD

Cambridgeshire Community NHS Trust delivers community based and inpatient services to children and young people, and their families, across Cambridgeshire, Luton, South Bedfordshire, parts of Peterborough and Suffolk.

We inspected the Regulated Activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

There were arrangements in place to minimise risks to children and young people receiving care and staff working alone in the community. Staffing levels were generally safe in the services although there was currently pressure on some teams given the high demands and the current staffing capacity.

Services were effective, evidence based and focussed on the needs of children and young people. We saw some examples of very good collaborative work and innovative practice. The Trust had recognised that staff refresher training was an area to improve and had plans in place to do so. Effective clinical supervision arrangements were in place across the service. Generally, facilities were suitable for children and young people. Parents and carers felt well supported and involved with their children's treatment and told us that staff displayed compassion, kindness and respect at all times.

The children and families service was responsive to people's needs and people from all communities could access services. There was a range of different services to support and treat children and young people with health, educational and social care needs. Effective multidisciplinary team working, including external partners, ensured children and young people were provided with care that met their needs, at the right time and without avoidable delay. There were challenges to achieving referral to treatment times for occupational therapy, and the looked after children (LAC) service did not always achieve their initial assessments within the required timescale. Extra resources had been provided so that the occupational therapy service and LAC teams would be able to meet their targets.

The service was in general well–led with effective decision making and strategic planning. The Board and senior managers had oversight of the reported risks and had measures in place to manage these risks.

Children's inpatient services at Hinchingbrooke hospital were last inspected by CQC at the end of 2013, when we found there were not always enough qualified, skilled and experienced staff to meet patients' needs. At this inspection we found the provider was now meeting this essential standard.

Summary of findings

Background to the service

Cambridgeshire Community NHS Trust was first registered on 1 April 2010 and delivers community based and inpatient services to children and young people, and their families, across Cambridgeshire, Luton, South Bedfordshire, parts of Peterborough and Suffolk.

It provides a range of health services including health visiting, school nursing, family nurse partnership, community paediatrics, community paediatric nursing, audiology, continuing care, infant feeding and breastfeeding support and services for Looked After Children and safeguarding children. Community therapy services are provided by different providers in the Luton area.

The Trust provides inpatient facilties for children including 19 beds and cots on a paediatric ward and 10 special care cots in the neonatal unit at Hinchingbrooke Hospital. Although the children's inpatient services are delivered in Hitchingbrooke Hospital the services and the staff who provide the services are employed by Cambridgeshire Community NHS Trust.

Our inspection team

The inspection team comprised two CQC inspectors, a community nurse, a health visitor, a professor for paediatric nursing and a community occupational therapist.

Why we carried out this inspection

We inspected the Trust as part of our comprehensive Wave 2 pilot community health services inspection programme. The focus of wave 2 is on large, complex organisations which provide a range of NHS community services to a local population.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the Trust and asked other organisations to share what they knew. We also received comments from people who had attended a listening event prior to the inspection. We carried out announced visits on 28, 29 and 30 May 2014.

During the visits we spoke with 22 parents and saw 20 children. We spoke with 90 staff across the service, interviewed the unit lead and clinical lead for the service, held three staff focus groups, and visited eighteen teams. We attended two clinic locations in different community settings, a paediatric and a neonatal unit, as well as accompanying staff on five home visits to children and their parents. We looked at individual plans of care for children, risk assessments and a variety of team specific and service based documents and plans.

What people who use the provider say

As part of our inspection, we received completed comments cards from parents whose children had used services. The vast majority of responses were complimentary about the staff and the care and attention

Summary of findings

their children had received. Examples of comments are "Always found the staff caring and professional, day and night", "All the staff were great and we were kept well informed", "The care was lovely, couldn't ask for any better." One comment was negative about pain relief not given as requested.

The parents we saw all told us how kind and caring the staff were and how well they knew the needs of the children.

Good practice

The Rapid Response Team provided an outstanding level of care and support to babies and young children at home with acute illnesses, and their families.

The Infant Feeding and Breast Feeding Team demonstrated an outstanding commitment to provide feeding advice and support to families from culturally diverse backgrounds in the Luton area. Staff had been pro- active and flexible in the design and delivery of services, in order to engage effectively with the local community.

We saw examples of excellent needs assessment and care planning.

The Trust had received the United Nations Children's Fund (UNICEF) level 2 accreditation for the Baby Friendly Initiative to promote breastfeeding and was working to achieve level 3. We saw particularly good practice in the paediatric and neonatal unit.

Children's community nurses and community neonatal nurses were based in the inpatient services. They attended daily handover within the neonatal unit and paediatric ward to ensure they were aware and up to date with up and coming discharges.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

The provider should ensure that staff are up to date with mandatory training.

The provider should ensure that once referred to the service, children and young people are not waiting longer than expected for treatment.

The provider should ensure quality data, including learning from incidents, complaints, audits and patient feedback is displayed in all areas.

The provider should ensure all environments, particularly in community settings are child friendly and create an atmosphere where children feel at ease.

Action the provider COULD take to improve

The provider could consider the staffing capacity against demand and ongoing caseload management of the Health Visitor and School Nursing services in order to deliver the "Healthy Child Programme" outcomes effectively.

The provider could raise the impact of delayed provision of specifically designed mobility equipment to children and young people with service commissioners to seek to reduce the impact on those children and young people.

The provider could consider providing a specific room for breaking bad news on the neonatal unit.

During the refurbishment programme, the provider could consider providing bathroom facilities for mothers staying on the neonatal unit.

Cambridgeshire Community Services NHS Trust

Community health services for children, young people and families

Detailed findings from this inspection

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

Good

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

By safe, we mean that people are protected from abuse

Summary

Services are safe. There were arrangements in place to minimise risks to children and young people receiving care and staff working alone in the community. Staffing levels were generally safe in the services although there was currently pressure on some teams given the high demands and the current staffing capacity. The service demonstrated initiative in recruitment methods but some teams were experiencing problems in recruiting to a full staff compliment.

There was consistency in incident reporting practice. There was an awareness amongst staff to identify and consider different types of incidents and what to do with that information. There were effective systems in place to learn from incidents and share that learning both within individual teams and across the organisation.

Staff told us about the safeguarding training they had received, and said there were some inconsistencies in recording attendance. Staff said the newly introduced computerised health record system was effective and internet connectivity was generally good.

Detailed findings

Incidents, reporting and learning

Overall we found care had been safe in the past. Systems were in place to protect people from abuse and avoidable harm, support staff out of hours, and provide guidance in case of emergency, including individual staff responsibilities. Staff were clear and positive about reporting incidents and the service demonstrated high rates of incident reporting. Staff told us there was good interagency working to keep children and young people

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

safe. There was a monthly Quality Performance Report for children's services which provided an effective overview of the level of incidents,concerns and the actions taken. No moderate or severe harm incidents had occurred recently.

The Trust had reported 255 serious incidents between April 2013 and March 2014. Of these, 14 related to children and young people's services. There was an effective mechanism to capture incidents, near misses and never events. Staff told us they knew how to report both electronically and to their manager. We saw a robust governance framework which encouraged staff to report incidents. Information on how to complain was made available to the people using the service.

Staff told us they received information on learning and trends from incidents and complaints. Learning from incidents was discussed in staff meetings and specific changes to practice were emailed directly to all relevant staff members.

All the staff we spoke with were able to explain with confidence how they would identify and report incidents using the electronic reporting systems. This meant the provider was able to identify, investigate and learn from incidents. One senior member of staff explained to us they were confident in the systems of reporting and learning.

Cleanliness, infection control and hygiene

The service had effective infection control procedures in place. During our inspection we saw that the environment was clean and free from clutter. Staff also demonstrated a good understanding of infection control precautions. There was a robust infection prevention and control audit programme undertaken. We saw a hand washing audit being conducted in one of the locations we visited. Audits were carried out monthly across the service to ensure staff complied with the Trust's procedures. The recent service audits we looked at showed 100% compliance with hand hygiene procedures.We spoke to a number of people, both in hospital and in the community setting, and asked them how clean they felt the environment was. Everyone told us they found the level of cleanliness acceptable. Information on infection prevention and control was displayed within the paediatric inpatient facilities. This meant staff, patients and visitors were able to view how well the unit was performing. However this was not displayed in the neonatal unit, we were assured that audits were performed and noted the audits were monitored as part of the Trust wide quality performance report.

Personal protective equipment (PPE), such as gloves, aprons, and hand gel were readily available in inpatient facilities and community staff told us they carried PPE in their car. This meant that infection prevention practices were carried out by staff.

Maintenance of environment and equipment

The locations we visited were fit for purpose and well maintained. Fire fighting equipment was tested regularly as required. Buildings had appropriate security measures in place. Equipment was well maintained so it was safe for use. The majority of locations we saw were child friendly and welcoming.

We saw the environment in the paediatric unit was very suitable for the children and young people using the service. It was bright, clean and decorated in a manner conducive to the age of the children using the service. The equipment was clean and well maintained. Both the paediatric and neonatal ward were part of the productive ward programme. This meant that all equipment was checked and cleaned and clearly marked as ready for use. All the equipment was stored in an orderly manner and staff had easy access to it.

We also visited two locations within the community. Although the environment was clean and well maintained it did not always reflect the age of the patients who visited the location. The corridors and consulting rooms did not always cater for children and younger adults; they were neutral with no pictures or decoration suitable for children, although children did have access to toys and activities such as paper and crayons.

We carried out spot checks on equipment in the inpatient services and found all the equipment to be clean and well maintained. All the equipment we saw in the inpatient facilities were clearly marked when cleaned and all had been serviced in the last year.

Parents and staff in the community setting told us there had been some problems receiving equipment in a timely manner. Equipment was supplied by a third party provider. Staff explained to us this had been identified as

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

an issue and the process of receiving equipment, in particular wheelchairs, was improving but the service continued to monitor equipment provision and reported delays to the head of service and the Trust board.

Medicines

Medicines, including first aid boxes, were kept secure and handled safely. Staff were aware of the Trust's protocols for handling medicines so that the risks to people were minimised. During our inspection we randomly checked medicines held in the inpatient areas. We found they were stored correctly and in date. We also checked the controlled drug cupboard and found the contents were accurately recorded.

We saw the necessary daily and weekly checks were carried out on fridges where drugs were stored. We also selected prescription charts in the inpatient facilities and found them to be completed correctly. An audit of prescription charts was undertaken on a weekly basis as part of the documentation audit.

Medication errors reported using the electronic incident system were recorded as part of the quality performance report and were discussed at the service's Clinical Operational Board. This meant the provider had suitable medicine management processes in place.

Safeguarding

There were proper procedures for child protection planning, investigations and outcomes of safeguarding concerns. We also saw that learning from concerns, including serious case reviews, was embedded across teams and staff were supported by the Trust's Safeguarding Children Team. This included the provision of advice for urgent concerns and by providing safeguarding supervision sessions for staff. There was a designated doctor and lead nurse for safeguarding available to staff should they require support and guidance.

Shared learning from concerns was incorporated into ongoing training and development events across all service areas. The Safeguarding Children's Team had an effective audit system and produced quarterly reports that summarised the level of risk and target dates for completion of any required actions. It included a summary of incidents and themes of referrals.

Staff told us they had received appropriate safeguarding children training and were confident in reporting concerns.

For Level 3 safeguarding children training, the service reported 96% of staff had had this training by April 2014, against the Trust target of 95%. Staff told us there was some inconsistency in recording some external training events that impacted on the overall training figure for staff but arrangements were being put in place to rectify this. Domestic abuse training was also provided to staff by the Trust, as well as culturally specific training regarding child protection issues.

The parents and children we spoke with told us they felt safe. One parent told us: "We always feel safe, either when an inpatient, receiving care in the community and even during telephone consultations".

Records

Staff told us there was a computerised record system which was secure and easy to navigate. Effective sharing of information was in place when required as local doctors also used the same computerised recording system. Children's audiology teams used a separate system and good records were also kept. This demonstrated to us there was a robust record keeping system in place. Care was recorded promptly and was available to all professionals providing care. The staff we spoke with were enthusiastic about this electronic system and felt it encouraged a comprehensive record of patient care.

The Trust carried out a clinical audit on record keeping for parent held personal child health records (Red Books) and Audiology in the last quarter of 2013-2014 and implemented an action plan for improvements identified including staff awareness and training. There was also a documentation audit carried out on a weekly basis in the inpatient facilities.

Lone and remote working

Lone working policies were in place and staff followed them. The computerised record system had an alert system so staff were aware of any potential risks when carrying out visits. Staff told us of the Trust's protocols for arranging, and carrying out home visits. Staff told us sharing information on risks with partner organisations was generally effective.

The Trust had provided conflict resolution training to staff and was in the process of arranging for staff to have mobile alarm devices, linked to a call centre, for emergencies. However, not all staff were aware of these devices.

Good

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

Adaptation of safety systems for care in different settings

Teams operated local risk assessment protocols to reflect the type of service delivered. The parents we spoke with were aware of support systems in place should they wish to report concerns.

Assessing and responding to patient risk

Overall we found systems were in place to monitor and respond to risk. We found staffing levels and skills mix supported safe practice in the areas we inspected. Risk assessments had been conducted to ensure staff and patient safety. The Trust had implemented The Quality Early Warning Trigger Tool (QEWTT) in 2012, and the service area's results were reported to the Trust's Quality Committee which meets every two months.

Staffing levels and caseload

Some teams told us they were stretched at times, but this did not compromise children and young people's safety. We saw management plans were in place to address these concerns and that staff had appropriate support mechanisms in place. The children and families services staff were clear of the systems in place to monitor and escalate risks. We found that areas of risk were reported to the Board using the QEWTT for each team in the service. Overall, for April 2014, the service had agency and bank staff usage of 8.10%, compared to the overall Trust position of 6.70%, reflecting the higher level of staff vacancies within the service.

There had been a lack of nurses in the Looked After Children's ("LAC") service in Luton. This service assessed and reviewed the health of children placed in foster care. Not all reviews of care needs were carried out within the Trust's target timescales. This concern had been escalated to the Board and Commissioners and extra funding resources had been agreed for a second nursing post.

The Continuing Care team, which provided care and treatment for children with complex needs at home, was recruiting more nurses so that the capacity of service to meet local need was increased. Caseloads were rising in the community paediatric team and staff told us that a new part time consultant was due to start shortly so that locum cover would be reduced.

Mental Capacity Act

Staff said relevant training was offered by the Trust. We asked all the staff we spoke with if they had attended training in the mental capacity act .All told us they had. We looked at some local departmental training records and saw that the majority of staff had attended the appropriate training. However the service had recorded that overall only 45% of staff had attended this training. The Trust target for this training was 95%. We found discrepancies with the recording of attendance at local level and the Trust overall numbers.

Managing anticipated risks

Each area or department had an electronic system for recording potential or actual risk identification, risk analysis and the controls in place to reduce the risks. All risks were reported to the Children and Young People's clinical operational board. The board discussed controls and ensured they were put into place to mitigate or prevent risks from occurring. However if risks were not sufficiently controlled at the service level they were reported to the Trust Board for further consideration. Staff demonstrated the electronic system and we were able to see controls were put into place to mitigate the risks. The top three risks were procurement of equipment in the community, the environment in the neonatal unit and numbers of staff. All risks had controls in place and we saw improvements were being made to monitor the procurement process, the neonatal unit was being upgraded during our inspection and the staff vacancies were being reduced.

In relation to safety in the future we found the Trust had systems in place to deliver safe care both now and in the future. The impact on staff of different services being in a tendering process staff were being monitored by the Trust. Information and learning from serious incidents and safeguarding concerns was being used to provide the Board with assurance that good, safe care was provided within all its services, both currently and plans had been made for potential future risks.

Major incident awareness and training

The Trust had protocols in place to respond to major incidents and staff were of aware of escalation procedures for areas of risk.

Good

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

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

Summary

Services were effective, evidence based and focussed on the needs of children and young people. We saw some examples of very good collaborative work and innovative practice. The Trust was actively working to ensure the different parts of the service worked together to provide an effective service across the region. The service was providing good outcomes for patients and their families.

The Trust had recognised that staff refresher training was an area to improve and had plans in place to do so. Effective clinical supervision arrangements were in place across the service, together with regular team meetings being held, with the exception of the neonatal unit at Hinchingbrooke Hospital. Generally, facilities were suitable for children and young people. Some delays in the provision of individually adapted mobility equipment from another provider were identified, and this issue had been escalated to the Trust Board and Commissioners.

Most governance arrangements ensured a robust, cyclical process of information sharing between operational services and the Trust Board. Most teams had a clear overview of their own performance and outcome measures which were based on the needs of the population.

Detailed findings

Evidence based care and treatment

Overall we found the care provided was evidence based and followed recognised and approved national guidance. Staff were clear of their roles in care pathways. The Trust had robust systems in place for the ratification of new policies and guidance. For example, the Rapid Response Team, which provided short term nursing support for children at home to prevent hospital admission, had developed clinical pathways for seven medical conditions using the National Institute for Health and Care Excellence (NICE) guidance.

All new policies were identified and communicated to staff through staff meetings, emails and the weekly updates. All the staff we spoke with were able to demonstrate to us that they received regular communication from the Board, head of service and team leaders. This meant that staff were able to keep up to date with current practice and national guidance

Staff worked well with multi-disciplinary colleagues to ensure optimum health and well-being of children and young people. They involved parents in planning children's care, including consent and they followed national guidance on consent for children assessed as competent. Staff had spoken with local GP surgeries so the referral process for children and their families was clear, effective and timely.

Pain relief

Care plans were in place as required for children requiring pain relief and the service had systems for ensuring the regular review of medicines by the appropriate doctor. There were clear guidelines for staff to follow regarding palliative care and staff had received appropriate training.

Children's pain levels were appropriately assessed according to the age of the child. We saw different methods were used such as pictures and assessment of facial and body language, where verbal communication was not possible.

Nutrition and hydration

Staff demonstrated a good understanding of individual children's needs and care plans were in place to minimise risks from poor dietary intake as required. The Infant Feeding and Breastfeeding team demonstrated robust monitoring of outcomes for children and reported that for Luton, 56% of children were being breastfed at 6 weeks, compared to the national average of 49%. For mothers who accessed the service following discharge from acute hospital, between 74 and 78% were breastfeeding six weeks later at home.

The Trust had received the United Nations Children's Fund (UNICEF) stage 2 accreditation for the Baby Friendly Initiative in Luton, supporting parents with breastfeeding. Staff were working to achieve the stage 3 accreditation. We saw particularly good practice in the paediatric and

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neonatal unit. One parent told us how they had been supported in expressing and giving expressed breast milk to their baby. Another parent told us how they had been positively supported to breastfeed. We saw evidence that mothers were given privacy to feed or express breast milk. Breast feeding mothers were also offered meals during their child's admission to hospital.

Children were nutritionally assessed on admission to hospital and care pathways were developed for children at risk of malnutrition. The pathways included care in the hospital and community settings.

Patient outcomes

Patients' needs were assessed before care and treatment started and we saw comprehensive needs assessment and care planning. This meant that children and young adults received care and treatment appropriate to their needs. The service monitored the outcomes of interventions. The Continuing Care team provided effective complex nursing care packages for children at home and at school. They told us that requests for changes to the existing package of care were processed quickly and effectively so that the changing needs of the children were met appropriately.

For April 2014, in Luton the Health Visiting team had offered 100% of new birth visits to children at home within the target timescale of 14 days. The impact of staff vacancies in the Health Visiting team meant that the Trust was not yet in a position to meet all the outcomes of the Healthy Child Programme, as Health Visitors were not attending antenatal visits with midwives. The Trust was planning to adjust the team's caseloads based on the complexity of the cases in an area.

In Cambridgeshire, the service was making progress in reaching its workforce requirements. In Luton, the Health Visiting team were in the process of recruiting another 27 Health Visitors to meet the requirements of the Health Visitor Implementation Plan 2011-2015 A Call to Action. However, difficulties in recruitment had impacted on the team's ability to deliver against their performance targets. The Trust had plans in place to address the skill mix imbalance in the Health Visiting team as there was a high proportion of newly qualified staff in this area. However staff told us this had impacted on other services. For example school nurses told us their numbers had reduced. This meant that School Nurses across the Trust had high caseloads and were not able to provide all the services to meet the Public Health agenda. Plans were being developed to review the team's service specification with commissioners.

Parents and children were asked for their views about the care they received. The majority of parents we spoke with had been asked to comment and most told us their comments had been taken seriously and were able to give examples of changes to practice. For example we saw that distraction toys and games had been purchased to improve children's experiences. Staff demonstrated a good understanding of the social and economic factors and cultural diversity of the local community so sensitive and respectful care and support could be provided.

Performance information

Performance was monitored and areas for improvement were identified. The Trust Board had clear oversight as there was effective information sharing from the teams delivering care through to Board level.

Information provided to the Board included: quality and safety reports with performance and delivery against key performance indicators and outcomes of clinical audit activity. There were also reports on patient experience, including an analysis of any trends.

Action plans were developed to ensure targets were met where required improvements had been identified. For example in March 2014, the occupational therapy service failed to meet the 18 week referral to treatment target for 12 children. The Trust had a plan in place to stop this happening again. The service was taking part in National Clinical Audits Patients Outcome Programme (NCAPOP) audits for paediatric diabetes, paediatric asthma and childhood epilepsy.

Competent staff

New staff received a comprehensive induction, and effective appraisal processes and clinical supervision arrangements were in place. There was good access to and attendance at mandatory training for the majority of teams in the service.

The Trust reported in April 2014 that just over 90% of staff had had an appraisal in the last year, against the Trust wide target of 95%. Just over 70% of staff had attended

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mandatory training in April 2014, against the Trust target of 95%. Staff told us that providing services to children and their families took priority over training and supervision and that staff shortages had impacted on this.

Team leaders were working on meeting the Trust's requirements for mandatory training. Staff also told us a range of developmental training was available and staff had been supported by the Trust with their Continuing Professional Development. Most staff said they had regular supervision with their managers and there were clear systems in place for the sharing of information across the service.

Staff also told us they generally felt very well supported and cared for by their managers and we saw effective systems for staff one to one supervision and peer group support were in place. Staff also were provided with regular safeguarding supervision in a small group setting and the service showed 98% compliance (above the trust target of 95%) in April 2014 in providing this support to staff.

Use of equipment and facilities

Equipment and facilities were generally fit for purpose. Some delays in the provision of individually adapted mobility equipment from another provider were identified, and this issue had been escalated to the Board and the Commissioners for the service. Some staff also told us about IT issues regarding remote working but most staff told us the new IT system was effective and fit for purpose. On the whole the facilities were suitable for children and young people. In particular the paediatric ward was bright, colourful and a very pleasant environment for children. However the environment in the neonatal unit was less suitable for children and babies. The environment was not child friendly. This was because the décor was dull and there were no family friendly pictures or bright colours evident. We saw this had been identified and refurbishment of the unit was underway; it was highlighted on the service risk register and discussed at service and Trust level. We also noted in some community locations the facilities were neutral and not inviting for children to visit. This was particularly evident when we visited the Ida Darwin location.

Multi-disciplinary working and working with others

Overall we found good collaborative working within the multi-disciplinary team (MDT). Staff worked well together; there was effective communication between staff and healthcare professionals valued and respected each other's contribution to the planning and delivery of care. This work was underpinned by the implementation of approved care pathways, for example, within the Children's Community Nursing and Rapid Response teams. There were clear plans on what to do if support was needed out of hours when the Rapid Response Team was not operating.

The Children's Community Nursing team had developed strong links with a local hospital and hospice to provide timely, flexible and responsive child and family centred palliative care services. The Safeguarding Children's team said there were strong relationships with external organisations and effective information sharing so that child protection concerns were responded to quickly to minimise risks to children.

Some community therapies, including speech and language therapy (SALT), physiotherapy and occupational therapy, were not provided by the service but had been commissioned from other providers. The Trust did not receive performance information from the other providers regarding referral and assessment timescales. However where community therapies were provided by the service we saw excellent interprofessional working practices. Staff also explained that the electronic records system, which enabled all staff to document their care on one system, had greatly enhanced the multidisciplinary working partnerships.

Co-ordinated integrated care pathways

The Trust was committed to ensuring the care of children and young people was delivered as close to home as possible, minimising disruption to their daily life. Services were provided from clinics across the area and there was good multi-professional staff engagement. This ensured the delivery of care met the needs of children, young people and their families, both from a clinical perspective and also close to home.

Generally transition arrangements were effective across services with appropriate referrals and with the provision of key information. In Luton, the local Child and Adolescent Mental Health Service (CAMHS) was provided by a different provider and staff reported this service had declined a number of the Trust's referrals. This meant some families

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

had sought counselling support from a local voluntary organisation where CAMHS had not accepted the referral. Some delays were reported in referrals to social services due to the capacity and demand on the local authority.

We did, however, see excellent integrated pathways. Children community nurses and community neonatal nurses were based in the inpatient services. They attended daily handover within the neonatal unit and paediatric ward to ensure they were aware of patients who were about to be discharged back home. Children and families were visited before leaving hospital and care pathways were developed. We saw evidence of families visited at home following discharge. This meant discharges were planned and families prepared for care and support within the community environment.

Good

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

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

Summary

The vast majority of people told us they had positive experiences of care. Parents and carers felt well supported and involved with their children's treatment and told us staff displayed compassion, kindness and respect at all times.

We observed some staff undertaking home visits and we found staff to be dedicated, flexible, hardworking, caring and committed. They showed a good understanding of the policies and procedures relating to their practice and were respectful of the cultural diversity of the communities they worked in.

Most staff spoke with passion about their work and were proud of what they did. Staff knew about the organisation's commitment to people and their representatives and the values of the organisation they worked for.

Detailed findings

Compassionate care

We found the care and treatment of children and support for their families, within all services was flexible, empathetic, and compassionate. Staff across the service promoted and maintained the dignity of children, their parents and guardians. People's beliefs and values were taken into account in the planning and delivery of care. Staff ensured confidentiality was maintained when attending to care needs. We found staff had developed trusting relationships with parents and representatives that focussed on maximising children's and young people's independence.

The majority of families we spoke with could not praise the quality of care highly enough. One parent told us: "The care my son has received is over and above what we would have expected". Another parent told us "We all feel very involved in the care provided". However one person who used the children service told us that : "The doctor who came on the ward told us they could only see us for ten minutes. We were not happy with how she spoke. Although the overall treatment was good".

We saw an excellent example in the Children's Community Nursing team where a nurse had carried out a risk assessment of a sporting venue to enable the child to attend a sporting event to support their favourite team. The Health Visitors we accompanied on home visits were passionate and committed and demonstrated an excellent understanding of the children's needs. Although we received one negative comment about health visiting services, feedback was overwhelmingly positive.

Dignity and respect

The staff interactions with children and their parents we observed on all the home visits were positive, respectful and centred on the child. Staff showed great sensitivity and care. Staff gathered regular feedback from children and their families. In all the responses we looked at, feedback was very positive and evidenced the compassionate and respectful approach by staff to ensure the service they delivered was focused on the children. We saw that generally parents' expectations of the service and staff had been met.

We spoke with some external agencies that supported children using services provided by the Trust and they gave positive feedback about the effective working relationships with staff and how individual outcomes for children were set and met. They told us staff were flexible, responsive and respectful in meeting the needs of the children and young people.

Throughout the inpatient facilities we saw private rooms or screens were used when mothers were feeding their babies. The neonatal unit did not have a specific room for breaking bad news, but we saw rooms were available should a private conversation be needed. Parents told us there were no rooms available for fathers to stay on the neonatal unit and mothers who stayed had to use the toilet facilities in the main corridor and the shower facilities were on other ward areas. This meant there were no bathroom facilities on the neonatal unit for mothers to use when staying with their babies.

Patient understanding and involvement

We found staff delivered child centred care within all its services and that children, their parents and carers were involved in and central to decisions about the care and support needed. Overall we found parents had an understanding of their children's care and treatment that

Good

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

the service provided. Through observation of practice and review of records, we found robust evidence of actions taken by staff to ensure parents understood what was going to happen and why, at each stage of their child's treatment and care. This included adapting the style and approach to meet the needs of individual children and involving their relatives. One parent told us: "The care has been perfect. It has all gone very smoothly. My only criticism is that we are sometimes given conflicting advice from staff". Another parent told us: "The staff are very caring and patient. They always give us a good explanation of what is happening".

We saw excellent evidence that parents and children were asked to comment on their care and treatment. We also saw changes were made because of comments made about care. For example one parent told us: "The staff have acted on my comments. My child has a needle phobia and has been referred to a psychologist". A member of staff also gave an example when parents had difficulty making their wishes known an advocacy service was provided to ensure the parents' and their child's best interests were maintained.

Emotional support

We found the Trust delivered good emotional support. The parents we spoke with told us that there was effective communication from staff and any concerns were addressed quickly and appropriately. Guidance was available for parents about a range of support services if required. Staff told us of a range of voluntary services that were available for parents if required.

We also saw mothers were able to stay with their babies in the neonatal unit, prior to going home. Parents and children were also visited by community teams to enable the transition from inpatient services to community to be seamless and supportive. One parent told us: "The staff have really supported me emotionally. I was also able to stay with my child so that I was able to support them". Another parent explained that had received enormous strength from access to the chaplain.

Promotion of self-care

Care plans gave guidance for staff in supporting families and were focused on the children and maximising their independence. Parents were kept fully informed on all aspects of the care provided. We saw that health visitors supported new parents and were able to offer advice and guidance to parents on different types of services available.

We saw and heard examples of staff promoting independence and self-care. Parents could stay with their child when preparing to go home. We also saw there were kitchen and dining facilities where families could sit in a homely environment. Staff visited families before their child was discharged from hospital so that the care and independence of their child could be maintained in the community setting. One parent described to us how their child was taught to administer their own medication. They told us: "The staff were very patient and reassuring. They never pushed my child to do anything but patiently explained and coached them".

Good

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

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

Summary

We found the children and families service was responsive to people's needs and people from all communities could access services. There was a range of different services to support and treat children and young people with health, educational and social care needs. Effective multidisciplinary team working, including external partners, ensured children and young people were provided with care that met their needs, at the right time and without avoidable delay.

Overall we found effective systems were in place to ensure children, their relatives and those close to them received the support they needed in the community, despite some differences in local commissioning arrangements. There were challenges to achieving referral to treatment times for occupational therapy, and the looked after children (LAC) service did not always achieve their initial assessments within the required timescale. Extra resources had been provided so that the occupational therapy service and LAC teams would be able to meet their targets.

Detailed findings

Service planning and delivery to meet the needs of different people

The service delivered individualised and child centred care. We found multi-disciplinary professionals worked flexibly to ensure joint approaches to care delivery to combine the meeting of identified needs of children with minimal disruption to family routine. There were arrangements in place so that the service informed commissioners of the local needs of the population. The type of service delivered varied across the region depending on the commissioning arrangements in place but the needs of the local population were being met. The School Nursing team was in the process of establishing links to Faith schools in the community.

The staff we spoke with had a good understanding of the population who used the service and were all able to explain with confidence the requirements of the people they cared for. Staff told us about various community groups. For example local groups had been set up for the Polish community. We also heard from staff that monthly visits had been set up to visit the local travelling communities. This meant care was planned in a way which reduced isolation and non-attendance at appointments.

Staff had access to interpreters and could access the language line service. The majority of staff told us they used this service when required and found it useful. The staff were able to explain the most common languages used in the area. We also saw a variety of information leaflets in departments. Staff told us they were easily accessible in different languages and we saw examples of these.

Community paediatrics teams were led by community consultant paediatricians, working with children's nurses, therapists and other agencies across Cambridgeshire and Luton. They provided a wide range of medical advice, assessment, diagnosis, treatment and support services for children with a wide range of developmental difficulties, special educational needs and complex health care needs. Children were referred to the service by GPs, consultants, health visitors, school nurses and others including schools, therapists and social workers. The Consultant Paediatricians also provided specialist medical opinion in child abuse and neglect cases

In Luton, the special needs nursing team provided clinical care to children and young people with complex health needs or disabilities attending special or mainstream schools and social care settings. The paediatric epilepsy nursing service, also in Luton, supported effective diagnosis and care of children and young people with epilepsy, avoiding unnecessary hospital attendances. Children were referred to these services by community and acute paediatricians, GPs, health visitors, school nurses, and other health and social care professionals.

The Trust employed three early support coordinators in Cambridgeshire for families with young children with disabilities or complex additional needs. The coordinators were a central point of contact, providing information and resources and coordinating services across education, health and social care.

Access to care as close to home as possible

Good

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

We found that access to the majority of services was good. We found services were accessible and tailored by front line professionals to meet children's individual needs, at the times and in the places to best suit their needs. For example the Infant Feeding and Breastfeeding service had set up Breastfeeding cafes six times a week. They were also piloting a Saturday morning clinic for children and families from minority ethnic groups which led to increased attendance and engagement from the population.

The children's community nursing teams provided direct nursing care to children and young people in their own homes. Services included wound care/dressings, oxygen therapy, care for complex health needs; palliative and terminal nursing care; chronic disease management including; specialist occupational therapy support for children with life threatening/limiting illness and specialist play input to enable children to manage their fears about their illness and provide pre- and post-bereavement support to siblings.

The Rapid Response Team provided care and support to babies and young children at home with acute illnesses, and their families. The service was both innovative and responsive to meet the needs of the local population, as well as supporting children through a short period of illness in their own home without the need for hospital admission. In addition members of the team were working with the local acute trust to support the discharge process and enabling babies and young children to return home as soon as practicably possible.

Community staff visited people in their own homes or in local centres to ensure people were able to access the care they required. The parents we spoke with told us care had been received in a variety of settings. One parent told us: "We have access to specialist advice and care. The specialist nurse also visited us at home". Staff told us effective consultation across all sectors of the population was variable depending on the cultural background of the community group. We saw that the LAC service had creative ways of working to meet the needs of adolescent users of services, so there was a better rapport with professionals. We also saw teams had information available to parents regarding access to other services, for example from the local authority.

Access to the right care at the right time

We found that the community children's services delivered good safe care co-ordination within all its services. This was generally supported in all areas we inspected where we found that care arrangements met the needs of children and their parents. We found effective communication between community multidisciplinary teams and partner organisations to focus care and treatment on the needs of children using the service. We saw effective liaison between physicians and community nurses so that effective care and treatment for children was designed to meet their needs. The Community Paediatric team held a variety of clinics for children to assess medical needs. It had met its targets for assessing new referrals within 18 weeks and it had analysed referral rates to determine the type of assessment required and whether inappropriate referrals had been made.

Staff told us there were challenges to achieving some performance indicators; in particular referral to treatment for occupational therapy and the LAC service did not always achieve their initial assessments within the 20 day time scale or their annual review. Performance reports to the Board in April and May 2014 showed that the paediatric occupational thereapy service was not always able to see children within the 18 week timescale from referral. In February only six children waited longer than 18 weeks and none waited longer than 22 weeks. There were also small numbers of children who did not see speech and language therapists and physiotherapists within 18 weeks. An increase in referrals compared with the previous year and staffing absences were impacting on the waiting times.

Concerns with access to treatment and care were discussed at service and Trust level as well as with local commissioning groups, and extra resources had been provided so that the occupational therapy service and LAC teams would be able to meet their targets. This meant that the Trust was monitoring the controls in place and taking action where required so that care and treatment was delivered in a timely manner. All teams we spoke with understood the performance measures and targets set; for example, assessment timescales following referrals to see a therapist. Monthly reviews of the teams' performance by the Trust took place so fluctuations in staff capacity and potential risks were indentified.

Flexible community services

In Luton, the Children's Community Nursing team had introduced an evening service designed specifically to

Good

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

provide intravenous antibiotic administration. Nurses were also working a flexible rota at weekends so children could receive care at home as opposed to hospital admissions. The service had a specialist nurse to support children and families with specific medical conditions prevalent in some ethnic groups in the community. There were flexible drop-in clinics which provided better access for the community.

The Infant Feeding and Breastfeeding teams were flexible and committed in the planning and delivery of their services. They were trying different models of provision so there was better access from all members of the culturally diverse community.

Staff and parents shared examples with us of how individual needs were met in the various care settings. For example families were able to visit the inpatient facilities before admission. This meant that children and their families were able to discuss their care plan, hopes and fears.

Children and young people had access to social media sites. One parent told us: "The social media site is very useful. It has given my child friendly, helpful advice. More importantly the service has given my child control over their care".

Meeting the needs of individuals

We found all staff were focused on the needs of the children and young people and actively sought to minimise risks to them. Staff told us how hearing the voice of children and young people was fully reflected in the way care was planned and delivered. Feedback and comments from parents was positive and confirmed their views were sought at all times.

Moving between services

Handover arrangements were in place for those children and young people moving between services and the introduction of the new computerised record keeping systems had led to enhanced information sharing between professionals. Staff told us relationships with partner organisations, such as social services, was generally good.

Staff explained to us plans were developed for children who would require further care from adult services. Staff explained these plans commenced at around 15 years of age. This meant plans were initiated and developed to make the transition from children to adult services smooth and seamless. One parent explained to us that their child was in the process of their transition to adult services. They told us: "My child's next appointment is with both the children and adult service. This means we will meet the team who will be taking over my childs care in the future".

We also saw examples of transition pathways from inpatient services to community care. These pathways included care pathways for children and babies discharged from hospital.

Learning from experiences, concerns and complaints

We found the service had systems in place within all its teams for learning from experiences, concerns and complaints, and these systems were generally effective in all areas we inspected.

The responses and feedback from parents and children using the service were collated into a monthly quality and risk report for the service. Concerns and themes emerging from feedback were shared with staff and used to further develop and enhance the service. Feedback was then evaluated and passed to commissioners. We saw that access hours to some clinics had been changed to reflect feedback from parents. Most staff we spoke with considered the Trust did listen to and respond to their feedback. Team leaders told us how they used local resolution methods to meet with people who had concerns and to facilitate effective outcomes to the issues.

Staff told us there was a good link with the Patient Advice and Liaison service (PALS) and explained to us the majority of complaints were dealt with at a local level where possible. Staff, however, were able to explain how they would escalate a concern if they were unable to resolve the issue.

We saw examples of complaints and the learning that had taken place following the concern being raised. One parent told us: "The trust are reactive to our concerns. I have never felt the need to complain but have made suggestions and the trust have listened and acted". A senior member of staff also told us: "I take comments and concerns very seriously and meet with all the complainants personally".

Good

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

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

Summary

The service was in general well–led with effective decision making and strategic planning. The Board and senior managers had oversight of the reported risks and had measures in place to manage these risks. There were risk management systems in place across the service and generally staff had a clear oversight of risks and quality in the organisation.

The service engaged well with children and young people, and their parents, and feedback was incorporated into service design and delivery. Staff generally felt well supported and valued by the service despite staff recruitment issues in some teams. Innovation was encouraged by the leadership of the service and this led to improvements in the delivery of services.

Detailed Findings

Vision and strategy for this service

The service had focused management at team level that gave staff clear plans to develop the services further so that the needs of children using the service were met. Most teams felt that there was a forward plan for their service to ensure a consistent and flexible service was delivered. Some teams felt more work was required to redesign their service to meet the needs of the population and that effective liaison with commissioners was required.

Staff generally felt able to contribute to this process so their voice was heard to represent the needs of the children using the service. The service had an Annual Plan, which set out the plans for services for children, and their parents, in the context of the Trust's strategic objectives and ongoing commissioning negotiations.

Some of the staff we spoke with were not clearly able to identify the Trust's vision and values. However they were aware there was a transforming community service review being undertaken and that this would lead to the ultimate vision and strategy for the service. The majority of staff we spoke with understood the difficulties the Trust was experiencing, in particular the challenges to the commissioning of services. They went on to explain that communication from the board was good. We saw an edition of the weekly cascade communication which clearly set out the children and young people's programme and an update on growing and sustaining the service.

Governance, risk management and quality measurement

There was a robust governance framework and reporting structure. We saw from the monthly quality performance report and risk register there were clear lines of responsibility and communication. Key performance indicators, workforce issues and learning from incidents, complaints and patient experience were discussed at the children operational board and reported through to the Board. Risks to the delivery of high quality care were identified, analysed and controls put into place. Key risks and actions were discussed at the children operational board and reported to the Board

We found the service had effective process in place for carrying out clinical audits and that any actions required to resolve concerns were taken. The service contributed to the governance group and practice development groups. We found that the service supported effective practice development, linking activities to effective outcomes for children and their families using the service.

Leadership of this service

We saw effective and committed leadership at team and service manager level and staff told us they generally were well supported by their managers. Effective processes were in place to support front line staff via effective supervision, appraisals and ongoing training and development. Information from the Board and seniors managers was cascaded to staff via regular email messages and team meetings.

Some teams had performance boards on display to show how they were performing against their targets. The board also included compliments and complaints, with lessons learned from these comments. However, some teams did not have these on display.

Good

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

New staff told us that senior managers attended corporate induction sessions to promote the vision of the Trust. Staff explained that members of the Board visited different locations on a regular basis. For example a member of staff told us the chief executive had recently worked with them and access to IT was identified as a concern. The member of staff told us: "Because of what the Chief Executive saw, changes are being made to the way we use IT in the community. I have a lot of time for the Board members". Another member of staff told us: "The executive team are approachable and I feel able to raise issues".

However some staff said they did not think the Board fully understood the needs of the culturally diverse population in Luton and felt the Board could be more visible in Luton. Not all staff were clear about the purpose and function of the Trust Board.

Culture within this service

Staff told us of their commitment to provide safe and caring services for the children and young people in their communities. Staff morale was generally positive as represented by the Staff Survey. Staff told us the Trust's ongoing negotiations with commissioners about the type of services to be delivered in the future was not affecting their day to day work and that they had a high degree of job satisfaction. The service's staff sickness rates were reducing and the service's staff sickness rates of 4.5% in April 2014 compared favourably with the Trust's overall sickness rate of 5.34%.

Most staff we spoke with were positive and passionate about the care and service they provided. One member of staff told us: "The Trust has been on a massive journey of change over the last 18 months. We all deserve a pat on the back. There is no doubt this is a caring organisation".

Public and staff engagement

Patient experience reports were reviewed by the Board monthly. This report included an update on actions to date relating to issues raised from internal audits, patient surveys and complaints. The report outlined individual complaints and how they were dealt with and the key learnings to be shared with staff.

We saw strong partnerships within services provided to children and their parents and the service demonstrated effective multi-agency working to focus the service on the needs of the children using the service. The service carried out regular patient surveys and achieved 98.8% satisfaction rate in April 2014 compared to the overall Trust target of 95%. The combined results from the Net Promoter and Family and Friends Test Scores surveys for the service was 94% compared to the Trust wide average of 76%, indicating a high satisfaction rate with the service. Comments cards were not available in languages other than English so full engagement with all people in the local community may not have been achieved.

Children and families' comments were displayed in the paediatric ward areas. We did not see comments displayed in the neonatal area but saw there were monthly meetings with parents. Most people we spoke with had been invited to comment on their care.

Innovation, improvement and sustainability

The majority of staff had completed mandatory training and considered the organisation to be supportive of new initiatives. We found several examples of service led innovation, for example the Rapid Response Team and Infant feeding and Breast Feeding Team.

The Trust had developed a new Child Health Action Plan template. This was generated by parents and young people who were tired of having to re-tell their story to different health professional. It was developed with a range of health professionals, young people, parents and the Trust's Caldicott Guardian. It is now being routinely implemented at transition reviews for young people aged 14 and over.

There were systems for identifying and investigating safety incidents and an emphasis in the organisation to reduce harm. We saw consistent systems in regards to safeguarding practices, including prioritisation of training and awareness of appropriate escalation process for those working alone in the community who may observe safeguarding concerns.

There was appropriate monitoring, reporting and learning from incidents. We saw clear and effective management across the teams in the service. The main area of concern for some teams was the recruitment and retention of new staff in some geographical locations, which the Board had plans in place for.