Cornwall Partnership NHS Foundation Trust

RJ8

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJ8	Fairview House	Fairview House	PL31 1LF

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

Overall community health services for children and young people were good. We found that services were safe, effective, caring, responsive and well-led.

Cornwall Partnership NHS Foundation Trust provides community health services for children, young people and families across the whole of Cornwall and the Isles of Sicily. As part of this inspection we talked to professionals delivering these services. We also met and spoke with a range of people who were using services. We visited services for children and young people in a range of environments, including clinics and accompanied staff on home visits.

Services were judged to be safe. Risk was managed and incidents were reported and acted upon. Feedback and learning was provided to staff. There was a robust system in place for safeguarding supervision and all staff reported receiving regular supervision of good quality.

Care was effective, evidence based and followed recognised guidance. There was excellent multidisciplinary team working within the trust and with other agencies.

Care and treatment of children and support for their families was delivered in a compassionate, responsive and caring manner. Parents spoke highly of the approach and commitment of the staff who provided a service to their families.

We saw that staff understood the different needs of the children and young people and designed and delivered services which met the specialist needs of children.

There were clear lines of management in place and structures for managing governance and measuring quality. The trust leadership provided good information to the staff about developments, changes and challenges.

Summary of findings

Background to the service

Information about the service

The trust provides school nursing services, health visiting and speech and language therapy for children in the community. There are also specialist paediatric health services which are provided to special schools, nurses specialising in epilepsy, community nursing teams and a "Diana Team" of nurses which provide a service for families with children who need acute and chronic care in the community and for those with life limiting illnesses. Care was delivered in a range of locations, including families' own homes, education settings from nursery and children's centres to secondary schools, it included special schools, as well as within community located clinics.

Cornwall Partnership NHS Foundation Trust delivers community health services for children, young people and their families. Children and young people under the age of 20 make up 21.6% of the population of Cornwall and the Isles of Scilly. The services include:

During the inspection we visited clinics, accompanied staff on four home visits, attended team meetings and spoke with 25 staff. We spoke with ten children and young people who use the services and their parents or carers. We observed how children and young people were being cared for and looked at six care and treatment records.

Our inspection team

Our inspection team was led by:

Chair: Michael Hutt: Independent Consultant.

Head of Inspection: Pauline Carpenter, Head of MHA and Peninsula Operations, CQC

Team Leader: Serena Allen, Inspection Manager, CQC

The team inspecting this core service included CQC inspectors and a variety of specialists including health visitors and school nurses.

Why we carried out this inspection

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

How we carried out this inspection

During our inspection we reviewed services provided by Cornwall Partnership NHS Foundation Trust across Cornwall and the Isles of Scilly. We visited clinics and accompanied the following practitioners on visits to children and young people in their homes where they were receiving treatment and care: health visitors, school nurses, children's' community nurses, family nurses, Diana nurses and Speech and Language Therapists. We also spoke with a Clinical Psychologist and a pharmacist.

To get to the heart of the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit we held focus groups with a range of staff who worked

Summary of findings

within the service, We talked with children, young people and their parents / carers who use services. We observed how they were being cared for and reviewed care or treatment records.

What people who use the provider say

We spoke with children and parents who used the service and all were complimentary about the care and professionalism of the staff that provided their services.

We were told that staff were respectful, caring and compassionate. We were told how staff could be positive and supportive when dealing with stressful situations, such as children's illnesses.

Good practice

There was a robust system in place for safeguarding supervision and all staff reported receiving regular supervision. We saw sample of training and staff records that supported this.

The Diana and community nursing team provided a caring and compassionate service to children with a limiting illness and their families. The team worked flexibly, liaising with other professionals and demonstrated high levels of commitment to providing the support and advice that was needed.

There were various examples of excellent multi-disciplinary working between the different professional groups. This included between health visitors and school nursing and between community nurses and the psychology service.

Cornwall 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

Services were judged to be safe.

Staff knew how to report incidents using the on-line reporting system. They received feedback following incidents and learning was shared with them.

Infection control procedures were effective and staff had completed the appropriate training. Equipment was correctly serviced and maintained.

The majority of staff were up to date with mandatory training, with data from the trust showing a completion rate of 98%. They were clear about recognising possible signs of abuse or neglect of children and young people and their responsibilities in safeguarding processes. Formal safeguarding supervision arrangements were in place for most staff to ensure that safeguarding concerns were identified and addressed.

Staff were managing high caseloads but were being supported by managers to do this. High levels of mandatory training were completed and staff were receiving clinical supervision and annual appraisals.

Safety performance

The Children and Young People's Services Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in people that engage with children and young people's services. This is a point of care survey that is carried out on one day per month. Overall information from a total of 81 patients across three areas were submitted within children's services, of this all had 100% harm free care for all 10 months reported (April 2014 to January 2015).

Incident reporting, learning and improvement

Three serious incidents were reported by health services relevant to children, young people and families between 1

Good

Are services safe?

February 2014 and 31 January 2015 through the Strategic Executive Information System (STEIS). Appropriate investigations were undertaken, or were on-going, in respect of these.

Staff were aware of the systems to report incidents. Staff reported that they received feedback following incidents and that learning was shared across their teams. A health visitor gave an example of an incident that had been reported regarding a late antenatal communication. They had received follow up information about the outcome of the incident that was reported. Following a reported concern from a parent about a delayed appointment a community nurse explained how the team had received feedback and also discussed the issue at the next team meeting. The parent and child were visited and an explanation provided.

Some staff were concerned that as a result of an investigation into a recent incident there were now high levels of intervention in assessing risk. A change in process required staff to refer any child with a bruise to the Multi Agency Risk Assessment Unit for assessment. Staff felt this process undermined their ability to assess and manage risk with little recognition for their professional judgment. Staff were not aware of the rationale for the level of intervention.

Safeguarding

The service was represented on the Cornwall and Isles of Scilly Local Safeguarding Children's Board (LSCB) by an associate director. This was the statutory mechanism for agreeing how organisations work together. Community staff also made up sub-groups of the LSCB and have attended learning workshops and conferences.

There were safeguarding practitioners in place who provided the bespoke safeguarding supervision to staff.

All staff we spoke with were able to describe what constituted a safeguarding concern and were aware of their role and responsibilities to safeguard children and young people from abuse. The staff we spoke with had all received safeguarding training at level 3 with some therapists scheduled to undertake domestic violence safeguarding training.

All staff in every service we visited were very positive about the quality of the safeguarding training and the safeguarding supervision. Nursing staff were receiving this supervision every three months. Staff were clear about reporting protocols and mutli-agency contacts. Nursing staff and speech therapists gave examples of how they had been supported and advised after reporting concerns. Senior staff and managers responded promptly to safeguarding issues. Staff gave examples of the contact they had with the local Multi Agency Risk Assessment Unit which they considered to be responsive to requests for information and support.

The nursery nurses we spoke with were positive about the safeguarding training they had completed but were not receiving the three monthly safeguarding supervision that health visitors and school nurses were receiving. Safeguarding was discussed in their normal supervision and at team meetings.

The electronic records system Kids Information Technology Service RIO required staff to complete a safeguarding assessment form for every child when they were entered for the first time onto the system. If a risk was identified a more detailed assessment was completed which fed into the Common Assessment Framework. We looked at sample of five records and found that the forms had been completed comprehensively.

Medicines

Arrangements for managing medicines kept people safe. A dedicated paediatric pharmacist was in post to focus on safety and processes around medication management with the majority of medicines managed by the special school nurse service. Work had been undertaken to develop consistent policies and procedures across the service. Nursing staff had undertaken bespoke syringe driver training and attended clinical skills days to update their practice.

Following a reported medication error the standard operating procedures for controlled medications for the special schools and residential units had been rewritten. The trust also reported that through the paediatric forum issues around medication alerts were discussed and disseminated to the wider staff group.

Environment and equipment

The maintenance and use of equipment kept people safe. A programme was in place for the calibration of equipment

such as baby scales and hearing equipment and we saw the recording that confirmed these checks had been completed. The trust had a contract with an external provider to service and maintain these scales.

Staff told us it was stressful trying to find available rooms and a desk to work at. Some staff told us this could make them feel undervalued and forgotten.

Staff also told us about the difficulties of parking at clinics and centres. They often spent a long time searching for parking spaces as there were no dedicated spaces available and would consequently be running late for appointments or meetings. Staff had tried to use the trust pool cars but felt they were distributed in a random way with excessive travel to pick up a car.

The trust had completed an audit of all toys used in children's areas and all toys without the required CE mark had been removed. (CE marking is the manufacturers declaration that the product meets legal requirements, including safety, for that particular product)

Quality of records

The nursing practice teachers undertook regular audits of the nursing staff's record-keeping and the outcomes from these audits were reported to the trust quality assurance board. The most recent audits showed that records were being completed satisfactorily.

The electronic system Kits Rio was used to record information. The system had been introduced in December 2013. Designated laptops and touch screen tablets were available for staff to access the system. Staff told us the system was useful and had improved continuity of care for children and young people. Each staff group were able to look at all areas of the record thereby enabling a wider multi-disciplinary understanding of care.

Staff told us that the variable internet access across the region, and the difficulties this caused, could make completing records difficult at times.

Some staff felt the system was very time consuming as they found the format of the system jumbled, difficult to follow and repetitive. We were told that each hour of client interaction equated to approximately two hours for inputting information on to the system. This had impacted on daily caseload capacity. Fewer visits were achieved with a reduction from four to five cases per day to one to two per day. This had been logged as a risk and taken to the care process re-design group. Staff told us they regularly spent two hours after their normal working hours completing the records for the day. However staff and managers told us that plans were in place to refine the system based on staff feedback.

We looked at five records. They contained a full assessment of need. Care plans were clear, detailed, and up-to-date and tailored to meet the child's needs. However, the format was difficult to follow and the same data had to be entered into multiple parts of the templates. Staff also explained about the inconsistencies in dealing with letters from external agencies or consultants. Nursing staff were required to make a judgement as to what to enter or scan and there were no written protocols or guidance for this. This led to inconsistent record keeping and the potential for missing information.

Cleanliness, infection control and hygiene

All staff were required to complete infection control training and also undertake yearly hand washing training. Records showed a completion rate of 95% for this training.

The clinics we visited were well maintained and clean. However, we observed rooms without hand washing facilities with the nearest bathroom available located in the corridor. During home visits with staff we observed cleaning of equipment and sterile procedures undertaken when giving injections. We observed staff using gloves, clinical wipes, blue roll and hand sanitizers before and after patient contact, both in clinics and in patients homes. Staff we spoke with told us they were provided with appropriate protective equipment where required.

Mandatory training

Staff were trained in the safety systems and process and practices. Data from the trust showed that high levels of mandatory training were completed by staff. Staff were only able to undertake training external to the organisation if all their mandatory training was completed and up to date. The trust target for attendance was 95% of all staff. Compliance at 31 December 2014 was 98%. There were gaps in attending training due to time constraints. However, plans were in place to address this shortfall. This meant that the majority of staff remained up to date with their skills and knowledge to enable them to care for

Good

Are services safe?

children and young people appropriately. The training workforce team were able to monitor length of time taken to complete e-learning modules to ensure staff were taking appropriate time to work through the session.

Staff on the Isles of Scilly travelled to Cornwall for the majority of their training however some recent training had been cancelled due to the cancellation of the flight.

Assessing and responding to patient risk

Where required individual risk assessments were placed in patient files. Staff had undertaken training in completing risk assessments.

We saw staff giving advice to parents on how to recognise and respond appropriately to deterioration in their child's condition.

Staffing levels and caseload

The trust had recruited and trained its full complement of health visitors in response to the national "call to action" initiative started in 2011, which was designed to ensure the appropriate levels of trained health visitors were available in the community.

Locality managers explained how they supported staff to manage their caseloads. Action had been taken with some large caseloads through supervision, where through discussion cases were banded 1,2 or 3 depending on priority or need. The new electronic records system had helped facilitate this. This aspect of risk assessing had helped staff to manage their caseloads more effectively but staff still considered caseload numbers to be high.

The local health commissioning group had conducted an evaluation of staff levels and caseloads in 2013 using an independent auditor. This had resulted in the reorganising of some of the health visiting teams. The senior manager for health visiting and school nursing told us that this process was to be repeated at some point during the new financial year, though a definite date had not yet been set. Staff told us that caseloads were high amongst all disciplines with less frequent face-to-face contact and delays in availability of assessments. We concluded however that risks were being satisfactorily and safely managed.

There were challenges in recruiting staff to the area, with a limited number of qualified applicants for posts. Managers told us there was succession planning amongst the workforce with many "home grown" staff progressing in their career thereby ensuring the retention of a skilled and experienced team.

There were 50 speech therapists working for the trust and each carried a caseload of between 250 and 300 children. Staff told us they worked primarily as consultants, providing advice and guidance to staff and parents, as the large caseload made one- to-one therapy difficult to accommodate. They completed assessments and then provided plans of treatment and care for parents and staff in nurseries and schools.

Managing anticipated risks

The trust had a lone working policy in place and staff were aware of this. Processes to ensure the safety of staff working alone were organised at a local level. The Diana team had a nominated person who expected telephone calls each day from staff to say they were safe and the duty health visitor checked everyone was accounted for at the end of the day. Staff also explained that action could be taken when poor weather was anticipated, as this could pose risks due to the distances travelled by some staff.

The trust had recently completed an audit of its lone working practices. Staff confirmed that the required arrangements had been distributed. More recently employed staff explained how safe working had been covered in their induction. There were measures in place which included online diaries detailing staff locations and management on call arrangements

Major incident awareness and training

The trust had business continuity plan in place to respond to major incidents such as severe weather or other occurrences that could interrupt the delivery of continuous services. The trust used the nationally required Integrated Emergency Planning cycle to ensure readiness.

Within the community teams a data base of staffing skills that could be utilised in an emergency was kept and managers were required as part of their appraisals to ensure this was updated and reviewed on an annual basis.

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

Services were following evidence based practice and all were involved in regional and local forums.

Children and young people who used the services received care, treatment and support that achieved good outcomes.

There was a multidisciplinary and collaborative approach to care and treatment. Staff were appropriately trained and competent to carry out their role.

Detailed findings

Evidence based care and treatment

Policies and pathways were developed in line with national guidelines. Care pathways were used to guide care and treatment for children and young people. Health visiting and school nursing delivered the evidenced based Healthy Child Programme and community and Diana nursing teams adhered to National Institute for Health and Care Excellence (NICE) guidelines including those around continence. There had also been specific work relating to NICE guidance for other areas including self-harm, depression and epilepsy.

Health visiting staff had been trained to use the Ages and Stages Questionnaire (ASQ) which considers the development skills of the child. The purpose of the questionnaires is to provide a strategy to monitor the development of young children where there may be concerns over their progress. Staff supported parents to complete these on-going assessments. The trust reported that within the health visiting and school nursing services band 5 and 6 staff were also trained in the "Solihull Approach". This is a behavioural approach to child health and well-being which increases the parents understanding of their child's development.

Nursing staff and speech therapists were required to complete their Continued Professional Development training. Clinical supervision was provided to support these programmes.

Parents and young people using the service told us their needs were regularly assessed, they were aware of their goals and their care plans were changed to reflect their changing needs. Outcomes of care and treatment were routinely collected.

Pain relief

There was guidance in care plans about pain management for children where it was appropriate.

Nutrition and hydration

Where required we saw that guidance around a child's nutritional needs were recorded in the plan of care.

Technology and telemedicine

Whilst some staff we spoke with had experienced difficulties in using the new system, many staff explained how it had helped them to be better and more easily informed about patients. Staff explained how they could access the information entered by other professionals where before they may have had to travel to access files.

Staff were developing the use of social media such as Facebook and twitter as a way of communicating with young people. Discussions with the wider trust were planned to address governance and communication restrictions.

Funding received in March 2014 had accelerated the trust IT strategy across the service with touch screen tablets or laptops available to staff.

The trust reported they had acquired funding from the Healthy Child programme for a band 7 "technology dependent nurse". When appointed the nurse will provide support and training to families who have children living at home who require the use of specialised equipment.

Patient outcomes

Outcomes were measured to ensure that the needs of children and young people were being met in the service. The school nursing team mapped its contribution to Public

Good

Are services effective?

Health Outcomes Framework within the following areas: excess weight of four and five years old; population vaccine coverage; infant mortality and school readiness. The trust were within national averages for these outcome measures.

The health visiting team also mapped and monitored its contribution to the framework in the following additional areas: breastfeeding initiation and prevalence; child development; hospital admissions caused by intestinal and deliberate injuries in under five year olds; access to non-cancer screening programmes and tooth decay. The trust were also within the national averages for these outcome measures.

For some children with complex needs, outcomes of care and treatment were recorded in liaison with other areas, for example Great Ormond Street Hospital and the Bristol Children's Hospital. Staff from these hospitals travelled to Cornwall to train staff or attend meetings, or staff travelled to London or Bristol as required.

Competent staff

All staff had specialist knowledge and skills to treat children with their presenting conditions.

All nursing staff we spoke with were positive about the quality and the frequency of supervision they received. Clinical supervision was undertaken every three months, performance management every six months and safeguarding supervision every three months. Appraisals were also completed annually with a six month review being undertaken. All of the staff we spoke with told us they had received an appraisal during the last year. We saw a sample of records that showed that staff supervision was being completed within the timescales and being recorded. Staff also said that if they felt they needed additional support this would be requested and provided. Staff were also having additional supervision around the use of the new electronic records system. Staff also had the option of receiving "restorative" supervision, which was provided as a way of supporting to staff to reflect on particular past practice issues or concerns.

The psychologist working with the community nursing team was positive about the support they received and also the clinical supervision which was provided regularly by the lead psychologist for the trust. They told us they were also supported to access professional supervision from an external source which helped maintain their professional development.

During our visit we observed a supervision session where a clinical psychologist reviewed a case with a clinician and the rest of the team and incorporated "compassionate mind" exercises to support the emotional well-being of the team. This was provided monthly. We also observed a team meeting where experiences of practice were shared particularly around engaging young people in the programme.

Staff told us that policies were authorised by the trust and were not always specific to children and young people's services. Appendices often had to be written to relate to the specifics of the services, for example health visitors performed restorative supervision and an appendix was written to the policy for clinical supervision.

Staff were encouraged to think about their own development with external funding available. Three CPD days per year were available for staff to access appropriate training and skills to carry out their specialist roles. Several staff commented that completing additional or developmental training was difficult due to the time restraints of a heavy caseload.

We were told about a training tool being initiated by a nurse in the homecare team for children requiring chest physiotherapy. Community physiotherapists were not able to provide specialist chest management and physiotherapists from the acute trust were unable to provide training for community clinicians.

Induction training was reported as well organised and effectively delivered.

The nurse consultant confirmed she had contributed to the quality monitoring of the training programmes with the training workforce team.

Multi-disciplinary working and coordinated care pathways

We saw evidence that staff worked professionally and cooperatively across different disciplines and organisations. Each locality had a multi-disciplinary forum for all staff that met every two months.

The Diana nurse team and the community nurse team had a psychologist attached to their team, to which they had access to for professional guidance and support.

Good

Are services effective?

Staff reported good multidisciplinary team working with meetings to discuss children and young people's care and treatment.

Plans were being developed and implemented for increased integrated working with the local authority. There was proactive engagement with other health and social care providers and other bodies to co-ordinate care and meet children and young people's needs. The school nursing team ran a number of partnership working activities and had generated effective working relationships with the schools they were attached to through a range of initiatives.

Health visitors had link roles in children's centres and GP surgeries. Health visiting workshops had been held to improve integrated working between local authority children's centres and health visiting.

The epilepsy nursing staff explained how a child's care pathway was developed. Following diagnosis from a paediatrician and if the epilepsy was uncontrolled after two years a referral was made to a paediatric neurologist. The neurologist met with parents and discussed the various treatment and care options that were appropriate. If for example vagal nerve stimulation was recommended the epilepsy nursing service would support the child and family through this process, providing support and information about the surgery and treatment.

Referral, transfer, discharge and transition

Referrals were made via the care management centre with direct verbal handover in most cases.

We observed a transition to school meeting with an in-depth assessment of the child's needs, including training for teaching staff and carers and clear and detailed care plans covering physical, emotional, sensory and social well-being for the child. We saw that staff worked across teams to plan consistent care for children and families.

A discharge liaison nurse in the acute trust co-ordinated discharges for those requiring prompt attention. This helped to promote a consistent care pathway for children and their families.

Access to information

Staff were able to access records and information from the electronic records system on touch screen tablets and laptops to deliver effective care and treatment.

When the new electronic records system had been introduced and staff we spoke with told us they had received training and support to learn how to use this. It was recognised by staff and managers that some aspects of the system needed to be adjusted to make it more user friendly. Staff we spoke with explained how they had feedback the issues that concerned them, particularly about the complexity of some of the recording documentation. Parts of the system were being redesigned to address the issues identified. It was intended that information would be easy to enter and therefore save staff time.

Staff reported that the trust intranet was a good forum for communication and links between groups.

Consent.

Staff told us they obtained consent from children, young people and families prior to commencing care or treatment. We observed staff obtaining consent in the clinics and in peoples homes. Staff were aware of the assessment of competency / Fraser guidelines for children and young people.

Staff told us they always gave children and young people choices when they accessed their service and we observed during clinic sessions and a home visit staff discussing the treatment and care options available. For example we observed discussions with a teenage mother about her pregnancy, labour and parenting where she was supported to make her own choices and decisions.

Good

Are services caring?

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

Summary

Parents, carers, children and young people were treated with compassion and respect. All of the people using the service told us they were happy with the care provided by the staff.

Staff explained treatment plans to children, young people and their families, and witnessed positive interactions between staff and patients.

All parents felt they had enough information about their child's condition and treatment, and that emotional support was offered.

Compassionate care

We observed children, young people and their parents / carers being treated with respect at all times.

Parents felt they were treated with dignity and respect by staff. One parent told us "it's a brilliant service, always there for you." A young person told us "it's good to have someone to listen to me and help me when I was frightened about what would happen to me." Another young person told us that "everything was discussed with me and I feel I'm in control … nothing will be done to me if I'm not happy about it."

We observed staff taking time to talk to children in an age appropriate manner and involved and encouraged both children and parents as partners in their own care, for example self-care in keeping intravenous sites clean and dressed.

There were good responses to the Meridian surveys that recorded the levels of satisfaction for dignity and respect. From the forms we saw there was a satisfaction rating between 96 - 100%.

Understanding and involvement of patients and those close to them

Nursing staff we spoke with explained how they worked with children and parents. They said they tried to ensure parents and children were fully involved and as informed as possible about their care and treatment. Parents we spoke with were positive about this aspect of the service. Parents of children being treated for epilepsy explained how they had been involved in the care pathway planning and were also aware of how the transition process worked. Two parents we spoke with explained how they had always been kept informed of options about treatments and new ideas. Another parent described how the nurses tried to explain as much as possible to the child about the treatment they were receiving.

Parents and carers told us that staff always involved them in decisions about care and treatment for their children. We observed parents being listened to, supported and asking questions about treatment.

Emotional support

A parent who was receiving support from the epilepsy nursing service said staff were always available for support and advice and that the nurses and the paediatrician were "amazing". They told us "they are always positive and never give up on treatment". Another parent also told us, "the support is great, I know I can talk to them if I need to".

Staff supported parents, young people and their families emotionally. During clinics and home visits we saw positive engagement and support. Parents told us they felt supported emotionally by staff. Staff were always available on the phone for advice and support between visits.

Counselling support was also available for staff as required.

Good

Are services responsive to people's needs?

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

Summary

The trust provided a range of services that were developed and adapted to the needs of the local population. Staff attempted to ensure that services were as accessible as possible to the widespread community.

Services were meeting targets for their referral to treatment times.

Staff understood the different needs of the children and young people and designed and delivered services which met the specialist needs of children.

Detailed findings

Planning and delivering services which meet people's needs

We saw evidence that the services responded and changed in response to identified needs. For example the Diana and community nursing team had changed their structure to work as a county wide team. Due to the geographical area and the size of caseloads, the team felt this had enabled them to provide an improved service to children and families. The new electronic records systems had also helped them facilitate this change.

A multi-disciplinary team had been providing a course for prospective parents entitled Great Expectations. The course ran for six weeks of two hour sessions and was open to both parents. The course included various sessions on different subjects including, a healthy pregnancy, changes to relationships and parental support. Staff had received training to run these groups, which had their own steering group.

A team of staff provided services on the Isles of Scilly. This was a health visitor, a support worker, a part time school nurse and a mid-wife. The population was around 2000 and had a birth rate of around 20 per year. A paediatric clinic was run four times a year and other specialist services including speech therapy and occupational therapy visited the island every three months. Any children with acute illnesses were flown to the mainland.

We attended a consultation meeting that was organised for parents of children with epilepsy. This was attended by range of staff from all over the county and was organised in conjunction with a provider that produced equipment for vagus nerve therapy (VNS). VNS therapy is used together with medication to reduce the number and intensity of seizures in difficult-to-treat epilepsy. The meeting provided information for parents regarding the surgical options, which had to be performed out of county in Bristol. The epilepsy nurse specialists worked in partnership with the consultant paediatrician, a charitable organisation, the private business and other nurses who may be involved with the families. Parents we spoke with told us the service was very supportive and that an excellent range of information was provided. For example information was also given to parents about the ketogenic diet, which is a high protein low-carbohydrate diet that can be used, in conjunction with medication, to manage some types of epilepsy.

The epilepsy nursing team had also increased the number of clinics that are run by two in the previous twelve months. This had meant a reduction in the number of home visits that had to be made and the nurse felt this provided better access for parents and children for their services.

Health promotion was an integral part of the school nurse core service with action plans being drawn up for schools and revised as necessary. Staff felt this allowed the team to meet the needs of the children and the school. There were school drop-in meetings in all secondary schools and a few primary schools along with pupil referral visits.

Services were committed to delivering care as close to home as possible, minimising disruption for families. Staff visited people in their own homes or in local centres, schools and nurseries, though the wide area that the services covered presented challenges to staff around travelling times. The access to the majority of services was good, though transport could be difficult for some of the more remote parts of the county.

During our focus groups staff raised concerns about the lack of and suitability of accommodation available for clinical sessions and meetings. This resulted in less flexibility of appointments and cancellation of clinics. Some of the rooms we inspected were not child friendly with too many chairs and tables.

Equality and diversity

Good

Are services responsive to people's needs?

Staff received equality and diversity training as part of their mandatory training. During treatment sessions and in care records children, young people and their families were asked about their cultural needs. Telephone translation services were available to staff if required.

Areas we observed were accessible to disabled people

Meeting the needs of people in vulnerable circumstances

The family nurse partnership nurses provided a service for vulnerable young mothers through a programme offering support during pregnancy, labour and parenthood. We observed a case review where we saw staff discussing emotional and behavioural aspects of a case and a home visit where a teenage mother was provided with practical and emotional support about her pregnancy and imminent labour, and her aspirations for the future.

In some circumstances medications for children attending school were dropped off at the school with a member of staff to ensure they were safely stored and administered.

Access to the right care at the right time

All the services were meeting the national target for referral to treatment time of 18 weeks. For example the epilepsy nursing service was meeting a 28 day target for new referrals and referrals for the Diana nursing and community nursing team were being seen within three weeks. Referrals for the speech and language service were commissioned to be seen within 13 weeks and this target was being met.

The health visiting service were completing between 89% and 96% of the new birth, three month 15 month and two year review visits.

The wide geography of the trust meant that all staff were travelling considerable distances to deliver the service and this had an impact on what was able to be achieved. Staff told us that clinics ran on time and while they did their best to arrive on time for home visits, delays occurred as a result of traffic problems in rural areas, particularly during the summer months in the holiday season and weather conditions that could affect travel between the Isles of Scilly.

Learning from complaints and concerns

Parents knew how to make a complaint if they needed to and also felt they could raise concerns with the nursing staff they met. Information about making complaints was displayed in the clinics we visited.

Staff encouraged children, young people and their parents or carers to provide feedback about their care. For example parents or young people could use the laptop of the nurse to complete the online survey about the service they received.

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

Good local leadership was provided through the various team managers. There was regular contact with senior managers who were available for support and guidance. Staff were kept informed of issues, concerns and developments in the trust

Managers were visible and approachable and encouraged openness and honesty. Frontline staff, managers and the senior management team were passionate about providing a high quality service for children and young people.

Most staff were positive about working for the trust.

Detailed findings

Service vision and strategy

The trust had held vision and values events which staff had the opportunity to attend. Individual staff and teams told us they believed the trust promoted a positive image of the services provided. Several staff mentioned the trust values of commitment to the provision of "high quality, safe and accessible services".

The core children's services, with the exception of the home care team and the short breaks respite service, were being recommissioned and were subject to a tendering process at the time of our inspection. Staff felt informed about the tendering but unsettled about the consequences of the process and the future of their role.

Staff felt supported by their managers and well informed about corporate strategies particularly since the introduction of the Clinical Cabinet meeting when senior managers looked at children and young people's services across the region.

Governance, risk management and quality measurement

There was an organisational structure of various meetings for the different professional groups with a clear pathway for information, issues or concerns to be reported in either direction. For example each locality held a school nurse forum meeting within a six week window and issues were passed up from these meetings to a county wide forum. This was chaired by the senior school nurse practitioner. The county forum was responsible for deciding practice and policy and updating service protocols. There were similar structures in place for the speech and language service and the health visiting service. Staff we met were clear about the structure and purpose of the forum meetings.

The trust had a county wide children's service assurance group and operational assurance group. Senior staff from the various locality forums were present on these groups.

There were systems in place for reporting risks up through the trust. For example team meetings fed information into the locality forums which in turn reported to the operational assurance group. The trust reported that risks and incidents could be reviewed and discussed here and then communicated to the wider organisation.

For the health visiting staff practice guidance was provided by the practice teachers. Safeguarding practice supervision was delivered to staff by the safeguarding practitioners. This ensured that staff were appraised, and also guided and advised, in relation to the appropriate policies of the trust.

Leadership of this service

Regular meetings were held with all staff teams with managers present. For example the practice teachers, the Diana nurse and community nurse team met every month with their respective manager. There are six localities in the Cornwall area consisting of a number of health visiting and school nurse teams and these meet every two weeks. These six localities were managed by three managers and all met with their manager every two weeks and within these teams a nominated Band 6 School Nurse or Health Visitor respectively, acted as a team co-ordinator at the team base overseeing team allocation of work and appraisals of more junior staff. This was seen as a development role for those wishing to pursue a management role in the future. There was a rolling programme of performance management at these meetings, which considered the school nursing service at

Good

Are services well-led?

one meeting and the health visiting service at the next. We observed part of one of these meetings. We saw that a wide range of issues were discussed and that action points with timescales given to staff attending.

Staff and managers across all areas, told us they were kept informed of trust developments and issues. The majority of staff considered the trust to be transparent about the challenges it faced and that sufficient action was taken to ensure that staff were kept informed. The managers of the locality teams and the community nursing and Diana teams felt they had good access to the senior managers and we were also given examples of senior managers attending team meetings and some of the monthly locality forums.

Most staff felt there was a good team spirit. One member of staff told us "I love my job" and another who was leaving was "Very sad to leave."

Culture within this service

Staff were passionate about the care they provided. Staff were positive about peer support within the service and told us that they were proud of their teams.

Managers we spoke with told us they were proud of the staff they supervised and that there was a high level of commitment to providing quality services to the community. Staff were positive about working for the trust, although at times they told us they felt under pressure because of the volume of their caseload.

Staff told us there was an "open culture" and they felt confident about raising concerns. Staff were aware of the trust whistleblowing policy and felt confident about using this process if required.

Public engagement

We saw there were systems in place to ensure regular feedback on service provision for analysis, action and learning.

The community service conducted patient experience surveys on a regular and ongoing basis. These were completed every two months. We saw the results from the questionnaires completed during the first two weeks of March 2015. We saw that 307 had been completed. A breakdown of the results which included questions about the attitude of staff, the condition of facilities and the information provided by staff was completed and circulated to the staff teams. These had produced positive feedback across all areas.

Patients and families were able to complete these surveys directly online or by using the health visitor or school nurse's laptop computer.

Staff engagement

The trust organised a "staff experience group" which met every two months and included staff from across the wider organisation. We observed information and feedback from this meeting being disseminated at two team meetings we attended.

At the time of our inspection a number of services were going through a tendering process and staff told us they felt they had been kept informed about this process and the various timescales associated with it.

The trust provided newsletters and there had been a number of trust wide consultation meetings which staff could attend. Staff were positive about these meetings though some staff felt that they were often given information about them at short notice making attendance difficult.

A trust-wide monthly newsletter called Cascade was sent to all practitioners electronically. Staff we spoke with said they felt the trust communicated most information to them in a timely and effective manner.

Innovation, improvement and sustainability

An "early help hub" was being established in conjunction with the local authority. A manager was being recruited to run this service at the time of our inspection visit. This service will provide a single point of access for children's early help services. There will be an integrated team that will identify and respond to requests for help. The purpose was to ensure that help from the appropriate services was provided at the earliest possible stage. A team of health, social care and education professionals will provide advice information and guidance.

Staff told us there was succession planning amongst the workforce with many "home grown" staff progressing in their career thereby ensuring the retention of a skilled and experienced team.

Good

Are services well-led?

Staff were clear that their focus was on improving the quality of care for children, young people and their families.