Nottingham Citycare Partnership CIC

1-186610815

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)
1-298791257	Headquarters	Community health services for children, young people and families	NG1 6GN

This report describes our judgement of the quality of care provided within this core service by Nottingham Citycare Partnership CIC. 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 Nottingham Citycare Partnership CIC and these are brought together to inform our overall judgement of Nottingham Citycare Partnership CIC

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated children and young people service as good overall.

We rated caring as outstanding and safe, effective, responsive and well led as good because:

- Nottingham CityCare Partnership had systems in place for recording, investigating and monitoring incidents. Lessons were learned to prevent similar incidents from happening again.
- Safeguarding procedures were in place with clear lines of reporting. All staff were aware of these procedures and their own responsibilities for the safeguarding of children and young people.
- The feedback we had from children, young people and their parents or carers was consistently positive in all the locations and programmes we visited.
- Staff were kind and caring and we observed excellent interactions between them and children and young people and their parents or carers.
- Parents, carers, children and young people we spoke with and met in clinics were overwhelmingly positive of the staff. They told us staff were kind and listened to their concerns.
- Staff ensured people experienced compassionate care, and care that promoted their dignity. Staff coordinated care for the whole family and were committed to helping meet people's emotional, social and welfare needs as well as their health needs.
- Services were located where people could access them, and offered a range of times to accommodate people's different preferences.
- Overall, children, young people and their families received timely community health services.
- Services mostly met their performance targets. Where there were waiting lists, there were plans in place to minimise the effect on the children and young people.
- Staff worked in partnership with other agencies such as the local authority, education and voluntary organisations. We saw evidence that partnership working was routinely included in every aspect of their work.
- Staff were proud and passionate about their role and they were continually looking for ways to improve services for children and young people.
- Staff thought the service was well led and staff had a clear vision of the future of Nottingham CityCare Partnership.

Summary of findings

Background to the service

Nottingham CityCare Partnership provides a variety of community health services for children, young people and their families. Including health visiting, community public health 5-19 service (formerly known as school nursing service), a youth offending team, family nurse partnership and a behavioural emotional health team. Supporting 65,000 children through universal delivery of the healthy child programme.

The service has relationships with a number of partners including acute and specialist acute hospitals, general practices, local authorities, schools, clinical commissioning groups, the county council, voluntary groups and social services.

Services are provided in health centres, sure start children centres, schools, community buildings and in the home.

Our inspection team

Our inspection team was led by: Carolyn Jenkinson, Head of Hospital Inspection.

Team Leader: Michelle Dunna, Inspector, Care Quality Commission

The team included CQC inspectors, members of the CQC medicines team and a variety of specialists including:

A Resuscitation and Clinical Skills Manager, Physiotherapist, Community Matron, Equality and Diversity Lead, Health Visitor and Director of Nursing.

Why we carried out this inspection

We carried out an announced inspection of Nottingham CityCare Partnership CIC as part of our programme of comprehensive inspections of independent community health services.

How we carried out this inspection

We inspected this service in November and December 2016 as part of the comprehensive inspection programme.

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

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

During our inspection, we talked with eight parents and two children and young people and 34 members of staff including; health visitors, specialist community public health nurses, team coordinators, senior managers, practice teachers, and nurses. We accompanied specialist community public health nurses and health visitors on home visits. We observed clinics and attended an educational programme.

Summary of findings

What people who use the provider say

We spoke with eight parents and two young people. We also reviewed the patient feedback that was available, for example, complaints, compliments, incident reports and service reviews.

Patients gave positive views about the CityCare children and young people's services and said staff were kind and helpful, and services were easy to access and responsive. Patients we spoke with said staff were always helpful and liked home visits. Patients felt involved in the assessment and care planning processes.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider should continue to ensure all staff in the children, young people and families service have received safeguarding adult training.
- The provider should ensure staff in the children, young people and families service receive an annual appraisal.

Nottingham Citycare Partnership CIC

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- There were no never events.
- Staff received feedback from incidents. Learning from incidents was shared with all staff through regular team meetings and the electronic newsletter.
- Record keeping was good and documentation was in line with guidance published by professional bodies.
- Equipment was checked and available for staff to enable them to carry out their role.
- Staff were aware of the major incident policy and knew what to do in an emergency.
- Infection prevention and control policies were followed.
- All staff we spoke with had completed their mandatory training and were supported to do external training relevant to their role.
- An appropriate number of staff had completed level three children's safeguarding training and domestic abuse training in accordance with intercollegic guidance and all health visitor staff had received safeguarding supervision.

However:

- The service had not met the attendance target for staff attending safeguarding adult training.
- Forty percent of support staff had not received the three-monthly safeguarding supervision.

Incident reporting, learning and improvement

- There were no never events related to children, young people and families services in the community in the 12 months preceding our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how

to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff were able to refer to the incident policy on the provider intranet if they needed to. Or staff we spoke with told us they could ask a senior member of staff for guidance.
- The service reported no serious incidents between July 2016 and October 2016.
- Incidents were reported electronically. Between November 2015 and October 2016 a total of 1470 incidents had been reported, with 80 relating to children young people and their families services. Staff knew their responsibility for reporting incidents and were encouraged to do so.
- Staff said they received feedback from incidents through supervision, meetings, and newsletter emails. Staff gave us examples of where they had received learning from incidents. Staff were able to give an example from an information governance incident that led to the improvement of the information governance policy.
- The majority of staff had an understanding of their responsibilities under duty of candour (DOC). The 'duty of candour' is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.

Safeguarding

- The service had children's safeguarding policies and procedures available on the intranet for all staff to access. All staff we spoke with were aware of the safeguarding lead and how to make a referral.
- There was an electronic system in place to highlight vulnerable and at risk children and families. We observed accurate records detailing plans of how the child and family were being supported.
- Staff routinely talked to mothers about domestic violence, and we observed posters which highlighted how to get help. During a first home visit consultation the member of staff was unable to discuss this with the mother due to her partner being present. The member of staff invited the mother to attend clinic where they could approach the subject whilst the mother was alone.
- A local protocol had been developed for health visitors and specialist community public health nurses on female genital mutilation (FGM) this is when part or all of the female genitalia has been removed. Training about FGM had also been provided for practitioners.
- The safeguarding team worked closely with the local hospital if a referral to a paediatrician was required for an urgent medical examination.
- A child death overview panel reviewed all unexplained deaths for children and young people under 18 years old. The findings from the multi-agency review were fed back to the family and lessons learnt shared through operational and team meetings.
- Staff told us that when a child was seen in an accident and emergency department the child's health visiting team and the General Practitioner were notified. We saw evidence that this took place.
- Safeguarding children level 3 training was 89% and mandatory domestic abuse training attendance was 86%. Both were slightly less than the service target of 90%.
- The service could access a safeguarding children team. The team provided specialist advice, training, supervision and support for health care professionals so they could carry out their responsibilities in all aspects of safeguarding children and act as an expert resource to other agencies carrying out their safeguarding responsibilities.
- All staff received safeguarding supervision which was undertaken with a member of the safeguarding team. Staff told us that this was really helpful and supportive and it enabled staff to have the stamina to deal with the inner city safeguarding issues such as physical and/or emotional abuse, neglect.
- Between April 2016 and September 2016 100% of health visitors received appropriate safeguarding supervision. However the number of support staff who received safeguarding supervision was not compliant at 60%.
- The safeguarding team provided safeguarding supervision. In addition to this the organisation provided restorative supervision. A staff member told us this was easy to access via the intranet and very helpful to have in addition to the regular safeguarding supervision staff received.

Good

Are services safe?

- Staff referred families with potential safeguarding issues to appropriate support to try to prevent safeguarding incidents occurring. Staff were knowledgeable about who could offer support, including volunteer services for example asylum housing and food parcel organisations.
- Children and young people's services worked collaboratively with multi-disciplinary (different members of staff) including their own services the youth offending team and the behavioural and emotional health team and multi-agency teams (different agencies working together). For example childrens and adolescence mental health services (CAMHS), police education and voluntary groups.
- Serious case reviews (SCR) are undertaken when a child or young person dies or is seriously injured, and abuse or neglect are known or suspected to be characteristics in the death. Not all members of the team could recall all of the three recent incidents. Staff we spoke with said learning from SCRs was reported back through the provider newsletter and professional meetings following the completion of the serious incident or case review. Staff gave examples of learning from an incident which changed practice to ensure both parents received information on safer sleep and abusive head trauma.
- Staff we spoke with told us they would receive learning points from incidents after the investigation was completed. We were not assured that immediate actions after a serious incident were shared effectively and raised this with the executive team during our inspection. Assurances were given that this would be dealt with as a matter of urgency.
- We reviewed three sets of minutes from safeguarding forum meetings. It was minuted that the safeguarding lead shared information on female genital mutilation and child sexual exploitation with team managers to share with their staff.
- Staff attended level two adult safeguarding training. As of November 2016, 60% of staff were in date with this training which did not meet the service target of 90%. However, 99% of staff had attended a safeguarding adult's awareness course.
- The organisation had recognised compliance with safeguarding training across the workforce was not being achieved in some areas and had identified it as a risk on their corporate risk register with a series of controls to mitigate risk in place. Controls included for example, regular meetings with workforce departments to review compliance and attendance, reporting to the executive board all essential safeguarding training, establishing a task and finish group to review training and an increase in training sessions.
- In addition to this safeguarding compliance had been raised through the organisation's quality and safety group and was an agenda item at executive board meetings. A safeguarding training compliance action plan was in place and demonstrated a month on month improvement in compliance figures. For example, between September and November 2016 there had been a 14% increase in the number of staff up to date with level two safeguarding adults training.

Medicines

- A medicines management policy was in place across the whole service and available for staff on the provider intranet.
- There were no medicines kept within the locations providing clinics.
- Health visitors were non-medical prescribers and had received training to enable them to prescribe medications to children under the age of five.
- Children and young people over the age of five would be prescribed medication by their general practitioner or a non-medical prescriber.

Environment and equipment

- Equipment had visible safety tested stickers to inform staff when it was last maintained according to manufacturers' instructions which ensured it was safe to use.
- Portable weighing scales were calibrated every six months we reviewed five sets, all had been serviced within the last 12 months.
- Staff told us they could access the equipment they needed to provide care to children and young people.

Quality of records

- The service used an electronic record keeping system. Patient information was encrypted and required a password to access the information and staff had also attended information governance training.
- Staff we spoke with told us the electronic record keeping system had improved care as it enabled different professionals to share information effectively and quickly.

Good

Are services safe?

- We reviewed eight records which were up to date and reflected the needs of each individual child and young person. We saw examples where clinical staff had updated individual records after each consultation. The records demonstrated effective interagency working for example handovers from the midwifery teams.
- Entries were legible, signed, dated and followed good practice guidelines for record keeping in line with the Nursing and Midwifery Council (NMC).
- Information governance training was mandatory and we reviewed training information, which demonstrated 78% of the team had completed information governance training against the provider's target of 90%.
- Not all pages in the child health record (red book) had the child's name and date of birth documented. This meant that if a page became detached it would be difficult to detect which child it belonged to.

Cleanliness, infection control and hygiene

- All the places we visited were visibly clean and well maintained.
- Staff adhered to the infection prevention policy and were bare below the elbows in clinical areas.
- Signs were displayed in public areas such as clinic waiting rooms and treatment rooms emphasising the importance of good hand hygiene.
- We observed staff demonstrating a good understanding of infection prevention and control. This included staff cleaning equipment between patient use.

Mandatory training

- The provider had a target rate of 90% for mandatory training. Mandatory training included fire, infection prevention, conflict resolution, medicines management, information governance, health and safety, equality and diversity manual handling, The service overall compliance rate was 89% for mandatory training.
- Basic life support (BLS) training compliance, as of September 2016, was 91% and better than the organisation target of 90%. In September 2016 the organisation introduced a new annual BLS course that included awareness of automated external defibrillators (AEDs) and anaphylaxis. Between October and December 2016, 46% of staff had completed this training.
- All staff we spoke with said they were up to date with their mandatory training. Staff were responsible for managing their own training and booking on courses. Staff used an electronic system which kept a record of courses they had completed. Managers monitored staff completion rates of training and emailed reminders when training was due.
- Staff told us that course availability was not an issue and that it was not difficult to get a place on training days, staff valued face to face training and being able to complete some training on line.
- The service employed practice teachers to support staff in training and newly qualified staff during their preceptorship programme. The practice teachers met monthly to organise training for students and review their progress.

Assessing and responding to patient risk

- Staff told us they had access to urgent medical advice throughout the day. Staff were able contact the GP or the urgent care centre for advice.
- We observed risk assessment of health conditions using the electronic assessment framework (this is a set of questions to assess the child's physical and emotional welfare) at a home visit and in clinics. Families were involved in the treatment plans of their children and young people.
- Basic life support (PBLS) training which included babies, children and adults compliance was 91% and met the service target of 90%.

Staffing levels and caseload

- The service had a number of different clinical teams, such as health visitors, specialist community public health nurses, youth offender team and behavioural and emotional.
- Managers had oversight of health visitor's caseloads and all staff we spoke with told us their caseloads were manageable. Team coordinators held weekly meetings to ensure staff were supported and work was shared.
- Staff vacancy rates for the service were 5.8 Whole Time Equivalent (WTE) band 5 posts, 12 WTE band six posts, one WTE clinical specialist, and 4.6 WTE support worker posts. The service was finding it difficult to recruit and advertisements were ongoing.
- Bank staff were only used in children's services for the behavioural emotional team to ensure psychology cover. If there was insufficient staff on duty within a team the escalation policy was put into place and the team manager notified. The team manager will work with the team to mitigate shortages and/or staff from

Good

Are services safe?

other teams will be called to help, if work cannot be reassigned the Assistant Director is notified to commence the business continuity plan and an incident report is completed.
- Staff told us they often worked longer hours to cover staffing to ensure it was safe.
- Staff told us staff vacancies and sickness were impacting on capacity to provide as many clinics and contacts with children and young people as they would have liked. However, with the exception of antenatal contact, staff told us they were meeting their key performance indicators.

Managing anticipated risks

- A lone worker policy was in place across the service. Health visiting and specialist community public health nurse (SCPHN) teams told us that they followed the policy and were not concerned about remote working.
- Staff felt confident that effective systems were in place to reduce the risk to staff who worked alone. These included check-in arrangements and, when concerns had been identified, joint visits were arranged.
- The staff we spoke with during our inspection were aware of the lone working policy and the measures they needed to take to maintain their own safety during home visits.
- Staff we spoke with told us they were aware of plans to anticipate risk such as adverse weather or staff disruptions.

Major incident awareness and training

- The service had a major incident and emergency policy in place, a heatwave plan, winter resilience plan and a flu outbreak plan.
- Staff attended prevent training once (this is awareness training and early identification of potential terrorist attacks). Ninety three percent of staff had attended the training which was better than the organisation target of 90%.
- Eighty six percent of staff had completed fire safety training which was just under the service target of 90%. Each location we visited had a fire procedure and evacuation route displayed.

Good

Are services effective?

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

Summary

We rated effective as good because:

- Assessments, care and treatment were delivered in accordance with best practice and evidence based policies and guidelines.
- We observed examples of multidisciplinary, multi-agency collaborative working with children, young people and their families.
- Consent was sought appropriately dependant on the circumstances from parents, children and young people.
- Staff at all levels demonstrated their commitment to working in partnership with others to achieve the best possible care for children and young people.

However:

- Not all staff had completed an appraisal; the service target had not been met.

Evidence based care and treatment

- Policies and guidelines were based on the latest evidence and best practice. Policies and guidance were easily accessible for staff on the provider's intranet. We reviewed three policies which were version controlled, in date and referenced.
- Staff we spoke with in health visiting and the community public health 5-19 service were aware of the national guidance relevant to their practice. Staff were encouraged to attend the clinical effectiveness group to discuss new or updated policies prior to being published.
- Children, young people and their families received care, treatment and support that achieved positive outcomes. Staff promoted healthier lifestyles choices to improve good quality of life based on the national institute for health and care excellence (NICE) or other nationally or internationally recognised guidelines. For example NICE Health Visiting guideline (September 2014) and NICE Knowledge of 5 Key NICE clinical guidelines relevant to Health Visiting and School Nursing Practice (April 2015)
- The family nurse partnership (FNP) programme provided families with an intensive, evidence based preventative programme for vulnerable first time mothers, from pregnancy until the child was two years of age. Family nurses delivered the licensed programme with a well-defined and structured service model.
- We reviewed the use of the health visiting perinatal mental health tools audit 2015, which demonstrated a positive impact on mothers for example. On-going listening visits to support the mother in prioritising issues she needs to address and listening visits to help the mother to recognise and overcome a traumatic birth
- Specialist community public health nurses (SCPHN's) delivered the national child measurement program (NCMP). This measured the height and weight of children in reception classes (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to identify overweight and obesity levels in children within primary schools.
- We observed staff treating people holistically, taking into account their ability, race and religious beliefs. For example staff would signpost families to groups specifically supporting their race and culture.

Nutrition and hydration

- The provider had achieved full accreditation under the Unicef Baby Friendly Initiative (BFI) December 2014. This enabled staff to consistently support mothers with their choice with feeding their babies. Health visitors completed a breastfeeding tool and completed a template to identify any problems that required additional support.
- Staff referred families with unhealthy diets and/or weight problems to a six week healthy eating programme. Between April and September 2016 298 families attended a programme all rated it as good or better than good.

Patient outcomes

- The service provided all of the core requirements for the Department of Health's 'Healthy child programme'. This included early intervention, developmental reviews, screening, prevention of obesity and promotion of breastfeeding.

Good

Are services effective?

- The number of mothers who received a first face to face antenatal contact with a Health Visitor at 28 weeks was 70%
- Families that received a face to face new birth visits by a Health Visitor within 14 days met the service's key performance indicator (KPI) target at 96% between April 2016 and September 2016.
- Children who turned 12 months and received a 12 month review between April 2016 and September 2016 was 91% and children who received a two and a half year review in the same reporting time was 98% which met the service's KPI.
- The recording of breastfeeding rates at six weeks post-natal were 99% from April 2016 to September 2016 this was better than the provider's target of 85%.
- The provider exceeded their target of 85% for infant reviews. The health visitor review contacts were 96% from April 2016 to September 2016.
- The health visiting team had audited the post-natal group. The feedback was positive a comment from a mother stated 'Been attending the postnatal group for 13 weeks with baby. We both enjoy the group have made friends, had regular weigh ins and advice. The staff are always helpful and try to support all parents and their babies!'
- An infection prevention audit in childrens services had just commenced the clinical audit specialist had held an initial meeting with the member of staff due to carry out the audit.

Competent staff

- All of the staff we spoke with told us they had received an annual appraisal. Staff told us they found appraisals very useful to discuss concerns and to plan their objectives for the following year. The appraisal rate for staff within the service was 76%; this was below the service target of 90%.
- All staff we spoke with told us they received monthly clinical supervision. Clinical supervision is an activity that brings skilled supervisors and practitioners together in order to reflect upon their practice.
- Additional training needs were identified through supervision and annual reviews. Staff we spoke with felt supported by the provider to access external training. Development opportunities were discussed and identified in supervisions and personal development reviews.
- Staff said they were encouraged and supported to access additional training to develop their knowledge and skills.
- Staff gave examples of when they had accessed additional training. A member of staff attended a conference on child sexual exploitation and was able to feedback to the team. A support worker was supported to be trained in baby massage and provided groups for mothers and their baby's to attend.
- New staff were mentored by more experienced staff. For example, more experienced health visitors mentored the newly qualified health visitors whilst they gained experience and additional training. Staff we spoke with told us they felt supported through preceptorship and the group preceptorship meetings enabled them to feel part of the team.

Multi-disciplinary working and coordinated care pathways

- The health visiting and school nursing teams worked in partnership with other staff and agencies on a daily basis, including voluntary agencies, surestart staff, general practitioners (GPs), social services, midwives and staff in schools.
- All staff we spoke with were confident to escalate to other professionals to ensure the care was integrated and coordinated effectively to meet the child's individual needs.
- The youth offending team liaised regularly with other health services for example child and adolescent mental health services (CAMHS), dentists, general practitioners, specialist community public health nurses and sexual health teams.
- We reviewed two electronic records in the emotional and behavioural service which showed evidence of joint working with children and specialist community public health nurses. The team also offered consultation and advice to professionals regarding open and non-open cases.

Referral, transfer, discharge and transition

- There were processes for transferring children from health visitors to specialist community public health nurses. Transfer summaries were documented for children who were diagnosed with a medical condition, had safeguarding concerns or child in need concerns (multiagency working with the family).

Good

Are services effective?

Access to information

- The provider used an electronic recording system. Staff we spoke with reported an improvement in communicating with other health professionals and being able to review other services documentation where the child had attended.
- Staff could access the provider's intranet which contained links to guidelines, policies and standard operating procedures and contact details for colleagues within the organisation. This meant staff could access advice and guidance easily.
- We observed the personal child health record or 'red book' being used; this was given to parents following birth. The red book held medical information about a child from birth to four years of age and recorded child, family and birth details, immunisation records, screening, routine reviews and growth charts.
- Staff were issued with mobile phones, which meant staff could have contact with their office base during working hours to ask colleagues for further information if required.

Consent

- Staff understood and were able to explain both Gillick competency and Fraser guidelines. Gillick competency and Fraser guidelines refer to a legal case, which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16 year olds without parental consent.
- School nursing staff worked within Fraser and Gillick guidelines to make decisions about whether young people had the maturity, capacity and competence to give consent themselves.
- We observed staff asking the child or parent for verbal consent before any examinations.

Outstanding ☆

Are services caring?

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

Summary

We rated caring as outstanding because:

- Feedback from families was consistently positive about the way staff treated them.
- We observed strong person-centred care.
- Staff built meaningful relationships and ensured children, young people and parents understood the care and treatments they received.
- Without exception we were told staff were valued by children, young people and families and that they felt staff really cared.
- Staff were highly motivated and inspired to offer care that was kind and promoted children, young people and families dignity.

Compassionate care

- Without exception feedback from children, young people and their families about the service was consistently positive.
- We observed good interactions and communication between staff and children, young people, and their parents or carers. Staff were confident and their approach was relaxed and caring.
- All staff we spoke with or observed in practice demonstrated the children and young people were at the heart of what they did. They were sensitive to the needs of the child and provided extra support visits when necessary.
- Staff were able to develop trusting relationships with children, young people and their families and were also attentive to the needs of the parents as well as the needs of children and young people.
- We attended several clinics where staff demonstrated an excellent rapport with children and young people and were sensitive to their needs. We observed a member of staff talking to a child using appropriate language to help the child understand. This person was also sitting at the correct level to give reassurance to the child.
- We attended home and school visits with the health visitors and specialist community public health nurses (SCPHNs). Staff were aware of their child past and present history and of any impact that this might have on their current care.
- We observed a SCPHN delivering compassionate care to a child when performing a height and weight check. The nurse was asking questions to make the child feel at ease and was showing an interest in the child's hobbies and activities in school.
- Children, young people and their families were treated with dignity and respect. During home visits staff respected the wishes of the home owner asking permission to enter and where they should sit.

Understanding and involvement of patients and those close to them

- There was a strong emphasis on person centred care; staff worked in partnership with children and young people to find ways to provide care that they would engage in. We observed a member of staff sensitively encouraging a young mother who had moved to England from another country to engage in a clinic or group to enable her to makes some friends.
- We observed staff helping children and their families understand the treatment and support available to them. Staff ensured parents understood what was going to happen and why at each stage of their child's treatment.
- We saw excellent interactions where staff empowered parents and children to speak out and directed them to other services to get the support they needed for their child. A parent told us how a therapist had accompanied her and her child who was living with a disability to obtain a specific piece of equipment.

Emotional support

- We observed staff encouraging skin to skin contact with their baby, teaching parents about the early attachment theory, which is known to improve emotional development of the child and bonding between parents and their children.
- Young people in schools received timely emotional support, the SCPHNs ran drop in sessions. Young people could have support on any issues that were causing them to worry.
- We observed staff delivering holistic care often having an awareness of all family members and any additional support that the family may require.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- Children, young people and families had a choice of services at various locations and times to access health care and support.
- The service understood the different needs of the population it served and designed services to meet those needs.
- The service promoted person centred care, good health and wellbeing.
- In clinics children, young people and families were encouraged and supported to feedback or make a complaint about their care.

Planning and delivering services which meet people's needs

- Clinics were provided at a variety of locations across the geographical area within doctor's surgeries, medical centres, and schools.
- The service met the needs of the population. Clinics, drop in sessions, support groups and teaching sessions were available at various venues across their geographical area to enable good access for families. Staff also offered home visits.
- Specialist community public health nurses (SCPHN) ran drop-in clinics in secondary schools. SCPHN's were previously named school nurses. Young people attended, and discussed issues such as; depression, self-harming, stress, contraception, positive pregnancy tests, sexually transmitted infections, alcohol, drugs, puberty, and bullying.
- A member of staff explained an example of changing service provision to meet the needs of their children. The team targeted a school where attendance at the drop in clinic was low. They attended a school challenge day and listened to the needs of the children, who told them they wanted a designated room for the clinic with sofas and soft lighting. The engagement of the children added strength for the school to listen and make changes.
- The SCPHN completed a health framework for children and if continence problems were identified, they would complete a specific template. The SCPHN would then start a package of care for the child. If the plan had no positive outcome or the case was complex the child would be referred and seen by the continence team.
- The children's continence service was not able to meet their waiting times target. To ensure that the child and family were cared for the SCPHN continued to support the child until their appointment came through.
- The health visiting teams offered a number of services to children and families. For example an antenatal contact, a post birth visit between 10 to 14 days, parent and baby groups, breastfeeding groups, post-natal group, introducing solids workshop, walking groups, one and two year reviews and drop in clinics. This provision was the universal offer which all families are offered. Which is that every new mother and child have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation.
- If the health visiting teams identified a child who needed further support they would be offered services within the universal plus, families accessed timely, expert advice from a health visitor when they needed it on specific issues such as postnatal depression, weaning or sleepless children. This support targeted a specific programme of care for example; breastfeeding support, maternal mental health visits, extra home visits for attachment and bonding, behavioural, growth and development and speech and language issues.
- Another package of care offered by the health visiting teams was partnership plus where health visitors provided ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition.
- The family received an early help assessment for children with complex needs that required multi-agency interventions. All staff we spoke with had knowledge of a vast number of external agencies to signpost families to.
- The service referred families through the healthy change programme to improve food choices. Mothers or fathers attended six cookery sessions. The families we spoke with enjoyed the cookery sessions; this also gave them

Good

Are services responsive to people's needs?

an opportunity to meet other parents. We observed a cookery session, which engaged the group from the beginning and provided an interactive session. The cookery sessions evaluated very well. From July to September 2016, 90% of parents that attended rated the service as excellent, very good or good. Families were also given the option to join a gym.

- Young people were seen by the youth offending team at the office, in medical centres or at home. There were two members of staff who had a caseload of 90 young people.
- The provider offered an emotional behavioural service which was a pilot provision due for review in July 2017 to establish if it would continue.
- The service provided early and ongoing care planning and support for children and young people with behavioural, emotional, or health wellbeing needs.
- Identified young people were supported by inter-agency packages of care to support them, their families and carers.

Equality and diversity

- All staff we spoke with had a good understanding of the population who used the service and were able to explain the specific needs of the people they cared for.
- There were a number of areas that had high levels of deprivation and ethnic minority groups. We observed staff treating children, young people and parents equally and respectfully.
- Staff told us they had good access to face to face interpreting services for people whose first language was not English. We accompanied staff on home visits that required interpreters; they arrived on time and worked well with the member of staff and the mother.
- Staff had excellent knowledge of groups and volunteer services for diverse groups and would signpost families to them for counselling, peer support, cooking lessons and outings with families of a similar background.

Meeting the needs of people in vulnerable circumstances

- Staff sign-posted families to groups and other agencies to support their needs and to improve outcomes for those families. For example the service was able to signpost people who were refugees to voluntary organisations so they could seek help with housing and food parcels.
- Staff share information if people have language difficulties. If the family received an antenatal visit health visiting teams were able to arrange the appropriate services to accommodate the family's needs. For example if communication was an issue they would arrange an interpreter or signer to each or their appointments.
- Staff offered home immunisations for hard to reach vulnerable children to ensure they completed their immunisation programme. For example families living in remote areas with low income and no transport.
- People with learning disabilities would be assessed on individual needs and referred to other agencies if required to ensure support was allocated to the person and family. This could be social care, or schools or a person's carer.
- All teams we spoke with were passionate about the involvement between different agencies and promoting partnership working with parents/carers and the children and young people to prevent families becoming vulnerable.

Access to the right care at the right time

- There was no waiting list for young people to access the youth offending team therefore young people were seen in a timely manner.
- Mother's we spoke with were overwhelmingly positive about the health clinics. They were accessible and could attend anywhere in the community which allowed them to access care and advice when they need it.
- The waiting list for the behavioural emotional service was six to eight weeks for the initial visit. The service has recruited agency staff to reduce this time. Health Visitors and SCPHNs continued to support the children and young people until the appointment. This was a pilot scheme which was due for review in July 2017.

Learning from complaints and concerns

- The service had systems in place for children, young people and their parents or carers to raise their concerns or complaints. Information on how to provide feedback was displayed in most of the locations we visited during our inspection.
- Staff could explain what actions to take when concerns were raised and how they tried to resolve any problems as soon as they were raised.

Good

Are services responsive to people's needs?

- There were three complaints for children and young people's services between July 2015 and July 2016; none of which were upheld.
- We read a complaint response dated August 2016, which included an apology; it addressed all the concerns raised.
- We reviewed learning from a complaint and there was a plan to update information given to parents as a result of the complaint investigation.

Good

Are services well-led?

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

Summary

We rated well-led as good because:

- Staff were able to explain or give examples of the service's strategy, statement of vision or values.
- The executive team and senior management were visible locally.
- The service had a strategy, vision and values which was reviewed regularly.
- Staff were supported to be innovative and take action to improve services in response to local need.

Service vision and strategy

- CityCare had clear strategic objectives which concentrated on delivering quality services and putting patients at the centre of them. The service developed four strategic outcomes that were about the nature of care that people who used services should experience.
- The children's and young peoples service adopted the CityCare strategy within their practices and this was also embedded throughout the appraisal process.
- CityCare's vision was underpinned by values developed in partnership with patients, parents/carers, staff and stakeholders. The values included putting patients at the centre of everything the service did, focussing on staff and involving them to make decisions and deliver excellence.

Governance, risk management and quality measurement

- CityCare had a quality framework and strategy which set out how the service would measure and discuss governance, its structure (including committees and groups), and quality.
- A risk register was held at provider level, 13 risks were specific to CYP. All of the risks had actions to mitigate the potential risk. All of the risks had been reviewed and were in date.
- Patient safety incidents were reviewed at board level. For example we reviewed the board minutes for October 2016 and saw that two child deaths were cited and that they were being fully reviewed by all agencies involved.
- Services for children and young people were discussed at monthly operational group and quality and safety group meetings.
- There were team meetings across the individual teams. Previous meeting minutes we reviewed indicated where staff shared good practice and highlighted areas of concern.
- Audit results were reviewed and good practices shared areas of improvement for example further training needed to implement the perinatal mental health tool was agreed.

Leadership of this service

- The senior management team had a clearly defined vision to lead the service forward and involved the teams when planning the development of the service. There were discussions taking place when we inspected to utilise staff teams more effectively for more effective use of staff time and support for children young people and their families.
- Staff knew their manager and the senior management of the service, the majority of staff were aware of members of the service executive leadership team.
- Staff were positive about the skills, knowledge and experience of their immediate managers and told us they felt well supported.
- Managers involved the specialist childrens public health nurse (SCPHN) with the redesign of their teams. Due to the difficulties recruiting, staff decided to reduce the teams to three to provide continuity of care and a corporate approach during busy times.
- The SCPHN produced a quarterly newsletter to share information within the service and wider organisation.

Culture within this service

- Staff we spoke with described a supportive culture and said they supported each other. Staff enjoyed working with each other and valued their teams. Staff told us they pulled together and supported each other and other teams when they were experiencing capacity issues.

Good

Are services well-led?

- All staff we spoke with told us they were proud to work for the service and enjoyed their role. Staff were enthusiastic to continually improve the services they delivered.
- Groups of staff we spoke with said they felt they were doing a good job and felt privileged to work with children and their families.
- Staff told us they felt confident to contact their line mangers or senior managers if they had concerns and managers were approachable.

Public engagement

- Staff recognised the importance of receiving the views of people who used the service and encouraged them to complete feedback forms
- The provider encouraged an active patient experience group which met six weekly.
- The school health team gave parents a tell us what you think form to complete to help improve their service.

Staff engagement

- CityCare Voice encouraged staff engagement through the alignment of the culture and values. It facilitated communication between staff and the senior management team through nominated CityCare Voice Ambassadors.
- Staff told us they were encouraged to be involved in how the service was delivered and were able to feedback any comments or concerns they had. An example was that the SCPHN's were having difficulties recruiting and decided to reduce the teams from seven to three to have more support from colleagues and work corporately during busy periods.
- Some specialist staff told us they would like to be given more development and encouragement to take on some management responsibilities.
- The SCPHN teams attended a twice yearly partnership event with schools, commissioners and the local authority. The event was themed for example the last one was 'emotional health' which included speakers, presentations and group work.
- Health visitor forums were held every four to six weeks where they discussed caseloads, new initiatives, best practice and staffing. Staff we spoke with told us that these were useful and supportive forums to attend.

Innovation, improvement and sustainability

- The senior team led an application and had been awarded a £45million Big Lottery Grant as part of a National Programme to test what works in the early years.