Cambridgeshire and Peterborough NHS Foundation Trust

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Community health services for children, young people and families

Quality Report

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Date of inspection visit: 18 to 22 May 2015
Date of publication: 13/10/2015

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)
RT13	Trust headquarters	Community Nurses - City Care Centre	PE3 6DB
RT13	Trust headquarters	Paediatric Physiotherapy - City Care Centre	PE3 6DB
RT13	Trust headquarters	Paediatric Speech and Language Therapy - City Care Centre	PE3 9GZ
RT13	Trust headquarters	Children's Safeguarding Team - Cavell Centre	PE3 9GZ
RT13	Trust headquarters	Looked After Children Team - Cavell Centre	PE3 9GZ
RT13	Trust headquarters	School Nurses - City Clinic	PE3 6AP
RT13	Trust headquarters	Family Nurse partnership - Gloucester Centre	PE2 7JU
RT13	Trust headquarters	Community Breastfeeding Team	PE1 5DU

This report describes our judgement of the quality of care provided within this core service by Cambridgeshire and Peterborough NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Cambridgeshire and Peterborough NHS Foundation Trust and these are brought together to inform our overall judgement of Cambridgeshire and Peterborough NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

The service was rated as requires improvement overall because.

- There was evidence that the service was unable to meet the needs of an expanding population with some services experiencing increasing referrals for which they did not have the capacity to meet. Services had been commissioned based on 2010 population figures which were not representative of the population today. The population had increased by 11% and there had been an increase in the transient population who came for seasonal rural employment. As a result the service was struggling to meet the demand for children and young people's services in a safe manner.
- This was particularly evident in speech and language therapy (SALT) where low staffing levels and increased referrals had resulted in an inability for the service to meet demand.
- Community nurses were unable to update electronic care plans in a timely manner due to workload.
- There was a lack of robust data collection to facilitate national comparators for service improvement.

However:

- There had been a change in trust management over the preceding eighteen months which had had a positive effect on the staff working within the directorate who expressed positivity about the future of the service.
- There was a positive incident reporting culture with evidence of sharing and learning from incidents being shared with staff. There were established systems for safeguarding within the children and young people's service which was reflected across the trust.
- Multi-disciplinary teams worked well together to deliver holistic care for children and actively involved parents and carers.
- Staff were passionate about the service they provided to community children and young people. The service planned and provided safe individualised care using a family friendly inclusive approach.
- New young parents were particularly well supported by the family nurse partnership initiative and by health visitors who tailored home visits to meet individual needs when needed.

Summary of findings

Background to the service

Cambridge and Peterborough NHS Foundation Trust is commissioned to provide a range of community health services for children, young people and families, including looked after children. The trust provided universal health services and health promotion, delivered through a coordination of community nursing, school nursing, specialist nursing and therapy services to support children and young people to achieve good health and provide care and treatment for those with long term conditions, multiple or complex needs and those in vulnerable circumstances.

For the purposes of this report we inspected the community services for children and young people in Peterborough. Cambridge and Peterborough NHS Foundation Trust does not provide community child health services in Cambridgeshire.

Peterborough has a rapidly growing population with high level of cultural diversity. Children and young people under the age of 20 years make up 26% of the population with 40% of school children being from minority ethnic groups.

There is a higher than national average number of children living in poverty (23% / national average 20%) and higher than national percentage of young people not in education, employment or training (6% / national average 5%).

Our inspection team

Our inspection team was led by:

Chair: Professor Steve Trenchard, Chief Executive, Derbyshire Healthcare NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Lyn Critchley, mental health hospitals, CQC

The team included CQC managers, inspection managers, inspectors, mental health act reviewers and support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

The team that inspected the community services for children and young people was comprised of an inspector and four specialist advisors including a school nurse, health visitor, children's nurse and a children's community physiotherapist. .

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme of trusts, including provision of community services.

Summary of findings

How we carried out this inspection

To fully understand 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 the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from young peoples at focus groups.

During the inspection we spoke to 24 staff from the service, including managers, consultants, community nurses, health visitors, nursery nurses, school nurses and administrative staff. In addition we spoke to 12 mothers with babies and four fathers.

We also:

• looked at a range of policies, procedures and other documents relating to the running of the service.

Good practice

- Multi-disciplinary teams worked well together to deliver holistic care for children and actively involving parents and carers.
- New parents were particularly well supported by the family nurse partnership initiative and by health visitors who tailored home visits to meet individual needs when needed.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure staffing levels are appropriate in community nursing and speech and language therapy teams to meet the needs of the local population.
- The trust should ensure care planning documentation is updated onto electronic patient records systems in a timely way.
- The trust should ensure performance monitoring is established to monitor service performance, levels of achievement and to identify areas in need of improvement.
- The trust should ensure waiting times for referrals to speech and language therapy services is addressed to meet the needs of patients.
- The trust should ensure service provision meets the needs of the local population, including the needs of specific ethnic groups and increases in the local population.

Cambridgeshire and Peterborough NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the service for children and young people as requires improvement for safety because:

- Staffing levels within the children and young people's service was identified as in need of review to reflect local population increases. Staffing levels within community nursing and speech and language therapy (SALT) being of key concern. SALT was not able to meet demands for their service with long waiting times from referral.
- Community nurses were unable to update care plans in a timely way due to workload commitments.

However:

- There was a positive incident reporting culture with evidence of sharing and learning from incidents being shared with staff. Two serious incidents had been reported in the last 12 months. Both had been or were under investigation using a robust and recognised methodology.
- There were established systems for safeguarding within the children and young people's service which was reflected across the trust. Staff demonstrated a good knowledge of the safeguarding processes which was supported by a locally developed IT program for staff called 'satchel'. This was accessed via all trust computers and laptops and provided safeguarding information, access to policies and guidelines and an educational platform for sharing and learning.
- Infection control, hygiene and environmental appearance were all found to be of a high standard.

Detailed Findings

Incident reporting, learning and improvement

Requires improvement

Are services safe?

- The trust had an electronic incident reporting system. Staff told us that they knew how to input onto the system and team leaders were supportive and encouraged incident reporting. There was a genuinely open culture in which staff could raise concerns. We saw that there were 37 patient safety incidents reported between March 2014 and February 2015. A patient safety incident is any unintended or unexpected incident which could or did lead to harm for one or more patients receiving NHS care. Of the 37 incidents, 35 were recorded as no or low harm. Two were recorded as serious incidents requiring investigation (SIRI).One relating to vaccines remained under investigation and one relating to multiple failures to attend clinic appointments was signed off in April 2015 and an action plan was in place.
- We found the investigatory process was robust and followed the National Patient Safety Agency (NPSA) guidelines for incident investigation. Sign-off was by the paediatric clinical director and action plans were clear with identified individual responsibilities.
- A monthly multidisciplinary staff meeting, which included incidents on the agenda, took place. Open discussion was encouraged and minutes were available for all staff to access via the hospital intranet.

Safeguarding

- All nursing staff who had face to face contact with children were trained to level three safeguarding and received regular supervision. Safeguarding had three levels of training; level one for non-clinical staff, level two for all clinical staff and level three for staff working directly with children and young people.
- Safeguarding systems were robust and embedded within the children's and young people's service and staff demonstrated a good understanding of trust policies.
- Staff were aware of the triggers for raising a safeguarding concern and understood the procedures required.
- The trust had a computer programme accessible via all computer desktops called 'satchel'. This enabled staff to access safeguarding information and guidance including up to date policies, local information and referral forms.
- Satchel was an in-house developed programme and staff told us it was user friendly and had raised the profile of safeguarding within the children's directorate and across the trust. The programme was also a forum for sharing and learning with outcomes of serious case reviews available for those with access to the programme.
- There was a consultant led safeguarding team and a director champion at board level.

Cleanliness, infection control and hygiene

- Hygiene was observed to be in accordance with infection control policies including correct adherence to the five steps to hand hygiene as set by the World Health Organisation (WHO).Hand gel dispensers were available and visible in all buildings, with instructions for use. Visitors and staff were observed using the gel on entering and leaving clinical areas. Personal protective equipment (PPE), including gloves and aprons were available in all clinical areas.
- Toys and equipment used within hospital or community settings were observed to be wiped with anti-bacterial wipes after use and speciality equipment, such as mats for Yoga sessions (run by the Family Nurse Partnership), were wiped and visually checked for integrity after each use.

Environment and equipment

- All premises visited appeared clean and in good order.
- Check lists for emergency equipment within the hospital buildings were signed and dated.
- Weighing machines for both hospital and community use were serviced and calibrated every six months, a sticker on the scales indicated the last inspection date.
- The environment within clinic areas was child friendly with age appropriate toys and books but there was no visible provision for older or adolescent children.

Medicines

- Medicines were safely managed by community nurses and school nurses in line with trust policies.
- An established 'cold chain' system, directly managed by the pharmacy department, was in place. The cold chain system was described within a trust policy and was a process that ensured that temperature sensitive vaccines were purchased, stored, transported and administered safely. It also covered the disposal of expired or damaged vaccines.

- Staff involved in administering vaccines in the community were able to describe how the cold chain system worked and how the vaccines were maintained at an appropriate temperature with the use of fridges and cold boxes.
- There had been a SIRI (April 2015) which resulted in the loss of a substantial amount of vaccines due to a breakdown in the cold chain process, this was under investigation by Public Health England. This incident had not directly affected patients requiring vaccines but staff were aware of the incident and the need for strict adherence to the cold chain process.

Records

- The children's directorate operated a paper light approach to patient records using an electronic patient record system. This was accessible by password across the health community by all health professionals including General Practitioners (GPs)
- Health professionals working in the community were provided with lap-top computers which were password protected.
- We observed two electronic records being completed following community visits. These were found to be concise, comprehensive and included clear objectives for each visit. Appropriate alerts were seen and noted to be acted upon appropriately, such as allergies or safeguarding.
- Some staff wrote paper notes or relied on memory uploading the information at the end of a clinic or shift. They told us they later shredded their notes as this was considered to be an information governance risk however there was no evidence or recorded incident to support this.
- There was a lack of updated care plans within community nursing. When asked how many of the 200 caseload within community nursing had updated care plans in place we were told 'not many'. Community nursing staff were unable to quote specific numbers. The explanation provided was that due to clinical commitments there was not enough time to continually update records on the electronic system. Information was generally recorded on paper and later transferred to the electronic system on return to the community nurses' office, paper copies were then shredded.
- Complaints were recorded electronically. However not all concerns raised were recorded on the system, meaning that the recorded level of concerns was thought to be falsely low in comparison to national data. Only one complaint is recorded for community nursing within the pre-inspection data pack.

Mandatory training

- Mandatory training was delivered by the trust in the classroom or through e-learning. Attendance or completion was monitored by the service administration team and reminders sent by email when further updates were required. The trust target for staff completing mandatory training was 100%. Completion rate at time of the inspection was 97%
- All of the staff spoken to said they had attended all required mandatory training which included manual handling, fire safety, infection control, information governance plus role specific updates.

Assessing and responding to risk

- Referrals into the children's and young people's service were discussed at a multidisciplinary group meeting and prioritised according to risk and complexity. We observed this meeting which was attended by representatives of all children's services and included a presentation from a child's mum who was very positive about the service and was willing to work with them to improve services where possible.

Staffing levels and caseload

- Community nursing staff levels were within the funded establishments although there was some long term sickness and two nurses told us that they were leaving. The community nursing staff consisted of one team leader and six community nurses who were supported by two administrative staff. This team provided cover over seven days 08:00 – 18:00hrs. The team operated an on-call system for families and those on end of life care in conjunction with the local hospice team 'True Colours'. As a team the staff were mutually supportive providing cover for each other for annual leave or sickness. However it was considered that this service operated on the 'good will' of its employees and without additional resource may not be sustainable in the long term. This could therefore be a risk to those patients dependant on the community nursing service.
- School nurse numbers had not increased in line with population increases in recent years. The school nurse team consisted of eight band six, six band five, two band

Requires improvement

Are services safe?

two nurses and two band four nursery nurses. This team cared for a population of 45,000 with each staff nurse having an average caseload of 4,000. Staff described their caseload as 'incredibly large'. This meant that there was not a named schools nurse for a set school family as recommended by the Royal College of Nursing (RCN). The RCN recommends that there is one qualified school nurse for each family of schools consisting of a secondary school and associated primary schools, supported by a team of registered nurses, nursery nurses and health care support workers. This was recorded on the risk register and had been escalated to the board and we saw meeting minutes that reflected this. We considered caseloads were not being managed by the current trust level of community nurse staffing. This had a direct impact as there was no planned health promotion due to the pressure of individual caseloads.

- The Family Nurse Partnership consisted of one lead nurse and five family nurses. Staff told us they were able to support all young mums referred to them and their caseload averaged 19 which was within the partnership recommendation 25.
- Health visitors were managing a caseload of 450 plus families. The recommended caseload is 300 with an ideal caseload of 250 families, depending on the complexity of the individual family needs. Recommended caseloads for health visitors can be variable and should be based on area deprivation and population. The team was mutually supportive, providing cover for each other when needed.
- Therapy staffing was found to be at a level to meet the capacity of demand in Physiotherapy, Occupational Therapy and Psychology. However Speech and Language Therapy (SALT) was not at a level to meet demand with a rapidly increasing waiting list.
- SALT caseload was 70 – 80 per person.

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

The service was rated good for children and young people.

- Policies and guidelines were accessible on the hospital intranet and were found to be current and based on nationally recognised guidance for best practice.
- Nutritional and hydration was addressed in all areas of children and young people with the department achieving UNICEF accreditation for the infant feeding.
- Multi-disciplinary teams worked well together to deliver holistic care for children and actively involving parents and carers.
- There was an effective family nurse partnership, supporting young parents.

Detailed findings

Evidence-based care and treatment

- Care and treatment for children and young people was planned and delivered in line with current evidence based guidance, standards and best practice.
- Policies and guidelines were available on the trust intranet and staff told us that the system was user friendly.
- We looked at the policies available and found them to be current, based on relevant NICE/Royal College guidelines and had clear review dates.
- There was a clear process for implementing new guidelines which were reviewed at the governance group. New guidelines were disseminated across the service through notification emails and by inclusion on the intranet. Hard copies were also available if required but not routinely available in print.
- The Healthy Child Programme policy guidance was followed by health visitors who were observed to be giving advice on baby sleeping position (to prevent sudden infant death syndrome) and providing leaflets if appropriate, discussing infant feeding, immunisation and child health.
- Health visitors also took opportunities to discuss mother's mood changes and postnatal depression risks as well as contraception.

Pain relief

- Pain relief options for labour were observed to be discussed with patients at an antenatal clinic managed by health visitors.

Nutrition and hydration

- The children's community service was level three accredited by UNICEF for infant feeding in January 2015. Accreditation was for three years with the aim of promoting healthy infant diets including breast feeding. There was an infant feeding lead employed two days a week (fixed contract) for 12 months.
- Local maternity service was not accredited for infant feeding; therefore support for mothers in relation to infant feeding was provided by the community lead.
- Breast feeding hospital initiation was 70%.This rate dropped to 42% at 10 days and 30% at six weeks. National comparative data on breast feeding shows an initiation rate of 75%. The infant feeding lead had established breast feeding drop in sessions and opened two breast feeding cafés within Peterborough where mums can get support and advice to continue breast feeding.
- Women who chose to bottle or mix breast and bottle feed were also welcome at the cafés and clinics for advice and support.
- Infant and child feeding was observed to be discussed at health visitor clinics and information about nutrition was provided.
- Two new mothers attending a health visitor led clinic told us that the information and support provided regarding infant feeding was very good.
- School nurses provided one to one sessions on a drop-in basis to discuss obesity. They reported having a good working relationship with health visitors and general practitioners in relation to obesity management.

Patient outcomes

- There was a lack of performance monitoring across the service, however these were under development and senior staff were aware of a requirement to implement a

statutory national dashboard from September 2015. Work had recently started on evaluating the information required and to put systems in place to meet the requirements of the dashboard.

- An early year's coordinator had recently started a pilot group to develop an integrated two year infant check which included nurses and local authorities. Key performance indicators were being developed. The staff were enthusiastic about this project as there would be joint working with nursery nurses playing a key role in the early year's assessment processes.
- The family nurse partnership met all of the pre-set fidelity outcome goals for recruitment of young mothers, retention of young mothers on the programme, regular attendance of young mothers at meetings and completion of the planned programme content. Fathers were also welcome to attend meetings.
- We received positive feedback from school students who had attended a drop in session who stated the school nurses were always helpful and treated them with respect. In addition a clinic was held for year nine students where they were able to discuss all health related topics including smoking cessation and drug and alcohol awareness.

Competent staff

- Staff employed within all areas of the children and young people services were appropriately qualified.
- Newly employed staff attended a trust induction, local induction and observed experienced staff undertaking procedures such as vaccination programmes and child assessments prior to undertaking these procedures. However there was not an established standardised competency framework in place to measure or record competencies.
- Staff told us there was support for training and attending conferences but this was limited due to budgetary constraints. Some staff attended local networks such as palliative care, cystic fibrosis and oncology.
- Training was available for allied professional groups although funding was limited. Speech and language had a budget but other therapy staff including occupational therapy, physiotherapy and psychology had no specific funds for training. Additionally workload limited the opportunity to attend training outside of the trust.
- Appraisals were well managed with 91% of staff having had appraisals within the last twelve months and dates set for those outstanding. All staff said their appraisals were up to date and personal development plans completed.

Multidisciplinary working

- There was good evidence of multidisciplinary working. We attended a multidisciplinary team meeting (MDT) for children with complex needs. This was led by a consultant paediatric clinical Lead and attended by nursing and allied professionals. Clear plans of action were agreed for the children presented.
- Parents or carers were invited to tell their 'experience story' and involved in all aspects of care planning.

Transition

- The MDT also discussed services for some patients aged 16 plus. There were no commissioned services for 16 – 18year olds and therefore this client group did not have automatic access unless already known within the care system. This had resulted in transition being managed in an ad-hoc way with young people receiving limited help through the transition into adult care.

Access to information

- Written information and signage was noted to be in English language only.
- Information in languages other than English was readily available and downloaded from the internet when required.
- The hospital intranet provided a user friendly source of access to information on a wide range of subjects.

Consent

- Consent to care and treatment was obtained in line with legislation and guidance, including the Children's Acts 1989 and 2004.
- Staff demonstrated gaining consent consistently and fully explained all procedures to children using appropriate language.
- Family Nurse Partnership (FNP) provided a service for pregnant young people less than 19 years of age. Consent was required from the young person's parent or guardian if they were under 16 years. The FNP team told us that this had not been problematic with any of their clients but they could utilise Gillick competence if

required. This is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

- Parental consent was acquired for all interventions either verbally or signed and recorded in the medical notes.

Good

Are services caring?

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

Summary

The service was rated as good for caring.

- Staff were passionate about the service they provided to community children and young people.
- The service planned and provided safe individualised care using a family friendly inclusive approach.
- Confidentiality was maintained in an age appropriate way using Gillick guidelines to determine children and young people's rights and wishes.

Detailed findings

Compassionate care

- Care was provided in a consistent and compassionate way across the community children and young people's service.
- Staff of all professional disciplines expressed a determination to treat patients and their carers holistically and respected the many cultural differences of the catchment area.
- Those using the services provided told us staff were friendly, helpful and treated them with respect.
- Two young parents being supported by the family nurse partnership told us that the team 'treat you like an adult and respect your wishes' and 'they are really helpful, supportive and show you the right path.'
- Friends and Family test results for Cambridge and Peterborough NHS Foundation (CPFT) Trust give an improving picture with 53% recommending the trust to family and friends in January 2015 increasing to 57% in March 2015.

Understanding and involvement of patients and those close to them

- The community children and young people service supported the involvement of patients and carers in service planning; this was evident at parent story telling during MTD meetings and through observed conversations between community staff and patients of all ages.
- Children were spoken to appropriately and full explanations given regarding procedures.

Emotional support

- Emotional support was provided by health visitors who were observed to give patients time to discuss their concerns and anxieties.
- Self-help groups had been initiated using the Crispin Day approach – 'Empowering parents, empowering communities' this involves teaching parents to be able to cascade information to other parents in peer groups.
- The Solihull approach, an on-line parenting courses aimed at guiding emotional development in children was also promoted.
- The infant feeding lead provided emotional support to new mums.

Requires improvement

Are services responsive to people's needs?

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

Summary

The service was rated as requires improvement for responsive because:

- There were long waiting times following referral in some services, especially speech and language therapy. Service provision had not increased in line with the population increases in recent years.

However:

- New young parents were particularly well supported by the family nurse partnership initiative and health visitors who tailored home visits to meet individual needs when needed.
- Translators were frequently used during consultations and staff reported that access to interpreters was not difficult to arrange if required. Written information taken from the internet was printed off and supplied as required.

Detailed findings

Service planning and delivery to meet the needs of local people

- The Family Nurse Partnership (FNP) was well established in Peterborough. The FNP is a home visiting programme for first time young mothers, aged 19 or under. A specially trained family nurse visited young mothers regularly from early pregnancy until the child was two. Participation in the programme was voluntary for young mothers. The family nurses were working closely with other health and social care professionals, using joint visits to provide a co-ordinated multidisciplinary approach.
- Speech and language therapy (SALT) service was unable to meet the demands of the local population. There had been an increase in demand for SALT services. There was up to 12 months wait for new referrals. However urgent referrals were seen within one week. This was identified on the risk register. The trust had notified local commissioners in April 2015 of the demand, capacity and delivery concerns of the service. Staff told us they were proud of the team and that they worked additional unpaid hours (one to one and a half hours each day) to try and meet demand, but were unable to do so. This was supported by information provided by the Trust which indicated that referral to treatment time in 2013/4 was 98% but by quarter three 2014/15 this had reduced to 48%. Patients on the waiting list had increased from 12 to 313 during this same period. This information was also reflected in the paediatric SALT team meeting minutes from March 2015.
- SALT staff were supported by their manager but there was no planned increase in funding and there was therefore an increasing risk both to the service and staff.
- Community nurses were managing to maintain a referral to treatment of 98% but were unable to take direct referrals from the children's ward of the local hospital to support the discharge of patients requiring intravenous therapy. This was not reflected in the figures supplied. The team had averaged a constant referral rate of 50 patients per quarter.
- Occupational therapy services for 0 to 19 year olds had strict waiting list criteria and were able to see patients within the eight to twelve week criteria.
- Commissioners had recently stopped the provision of constipation and eczema clinics which were previously held on a Saturday morning. Referrals for this service were returned to the General Practitioner (GP) for local management.
- There was an active multidisciplinary team approach to referrals into the children and young people's services. Those requiring urgent intervention were identified through this process.

Access to the right care at the right time

- Due to a transient population related to local work availability there was a risk of missing children within the system. There was an action plan in place to identify how many children may be missing. This was a collaborative plan with health and local authority reviewing records and attendances at clinics and GPs.
- FNP could demonstrate that they met all the fidelity rules which include competent staff and appropriate referral systems to access the service.
- Allied professions provided a service Monday to Friday.
- Community nurses provided a seven day 24hour service using a rota and on-call system.

Meeting the needs of people in vulnerable circumstances

Requires improvement

Are services responsive to people's needs?

- The family nurse partnership (FNP) was successful in meeting individual's needs. We spoke with two young mums in receipt of this service who were very positive about the help and advice given stating that they had been treated with respect and given good advice. The FNP had a flexible approach and will visit mums at home if required, but actively encouraged attendance at sessions such as baby massage and yoga for additional peer support.
- Obesity in children was higher than the national average with 21% of children recorded as obese in the 10 – 11 year group (National average 18%). School nurses and health visitors were actively involved in providing dietary advice and held one to one drop-in sessions for children at secondary school.
- A health visitor was observed to be interactive with parents actively listening and being led by the parent regarding needs. This included a sensitive approach to cultural differences and social difficulties seeing individuals in their homes if they were unable to attend clinics.

Equality and diversity

- Provision of information in languages other than English was limited. We were told that information was downloadable in other languages on the internet and leaflets would be provided to individuals in their own language as needed. One person said access to information was not difficult and the nurses provided all the information needed.
- Translators were booked regularly. Family members were only very occasionally used if appropriate. However, health visitors never used family members following the outcome of a serious incident. Children were never used for translation purposes.
- Language line translation was used although this was not always found to be convenient.

Learning from complaints and concerns

- Complaints and concerns received were discussed at the monthly staff meetings.
- Staff told us that local resolution when a concern was raised was the norm. There was an ongoing complaint in relation to the closure of a care facility. This had identified problems in communication with the families involved and lessons had been learnt for handling any similar situation in the future.
- There was information about how to make a complaint in person, by telephone, email or post as options. The trust had an up to date complaints handling policy.

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

The children's and young people's service was rated as good for well led.

- Staff throughout the service reported an improvement in management culture over the last 18 months and said that managers were visible and accessible both in person and through intranet contact. There were clear governance arrangements and staff understood their responsibilities in relation to incidents, complaints and safeguarding.
- Children and young people services across Cambridge and Peterborough health and social care were undergoing a transformational change under the system wide transformational Board. Local authorities were trying to work together to provide consistency across the regions. This had raised the priority for the service, supported by the Chief Executive.
- There was little evidence of performance monitoring to establish levels of achievement or to identify areas in need of improvement. Local service specifications were being developed to ensure that comparative data was available from September 2015.This meant that the service was currently unable to monitor its performance against national targets.
- There were lone working devices for staff visiting patients. These were in the form of GPS lanyards and mobile phones to track lone workers. Staff demonstrated how this worked, but mobile signals were not always good.

Detailed findings

Vision and strategy for this service

- Staff throughout the service reported an improvement in management culture over the last 18 months and said that managers were visible and accessible both in person and through intranet contact.
- Following a transition period the directorate was developing a vision and strategy for the service utilising good practices from the two recently amalgamated regions of Cambridge and Peterborough.
- Staff spoken with were not aware of any local or trust wide vision but spoke of the recent service amalgamation and the need to work together in a unified way.

Governance, risk management and quality measurement

- There were good governance arrangements and staff understood their roles and responsibilities with regard to governance. There was evidence of two way cascading of information.
- There was a non-executive director champion for the children's service who was actively involved and visible within the directorate taking part in executive visits.
- The senior directorate manager regularly attended staff meetings to answer staff queries and provide a team update.
- There was little evidence of benchmarking with similar sized services and populations across the country.
- The directorate was working on putting in systems to meet the requirement of a data collection dashboard due to be implemented in September 2015.

Leadership of service

- Staff spoken to were very positive about the chief executive, were able to name him and told us that there had been personal visits to the service both at the hospital based sites and in the community. Staff told us that there was support and praise given for their hard work.
- Senior management within the directorate was viewed as proactive with an experienced clinical lead and senior manager.
- Staff told us they were listened to and felt valued in their roles. Managers understood the service and any problems specific to the service.

Culture within the service

- Teams within the service, including community nurses, health visitors, school nurses and therapy staff, worked well together in their teams and were mutually supportive during periods when staff were on leave or off sick.

Good

Are services well-led?

- Communication between the different disciplines was good.

Public engagement

- There was active involvement and listening to the 'patients' voice' as was evident in multidisciplinary meetings.
- Patients and their families were asked for and provided feedback on the care they received, including the use of Friends and Family Test surveys.

Staff engagement

- Nurses from within the service had presented at a national nurses day.
- Staff told us they felt directorate and trust senior management teams listened to their views through regular one to one meetings, team meetings and staff surveys.

Innovation, improvement and sustainability

- There was a pride across the service for national initiatives provided.
- There were national initiatives within the children and young people service which had been accredited and were effective. These included the family nurse partnership and the UNICEF infant feeding program.