Cornwall Partnership NHS Foundation Trust

RJ8

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJ8X6	West Supported Domestic Houses	Fairview House	PL31 1LF

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall, community health services for children and young people were good. We rated all five domains as good.

Cornwall Partnership NHS Foundation Trust provides community health services for children and young people and families across Cornwall and the Isles of Scilly.

During the inspection, we spoke to 49 staff including managers, nursing staff, allied health professionals and health visitors. We also spoke with people who use the services including eight parents and staff from other organisations who work with the service. We reviewed 15 sets of patient records and observed staff providing care for children, young people and their families in a variety of settings including clinics, schools and homes.

We found

- There was an open reporting culture which supported staff to learn from incidents and improve services they delivered.
- Patient records and medications were kept securely and confidentiality was maintained at all times.
- Staff were busy but had strategies to manage their case loads safely and were supported by their managers to do so.
- Vulnerable families and safeguarding issues were given priority with safety for patients embedded in practice.
- Staff followed national guidelines to deliver effective care and worked well with other agencies to provide a seamless service for children and their families.
- Staff kept the patient at the heart of what they did and understood how they could deliver services to meet children's needs.
- Emotional support was offered to patients and their families in a way patients would be able to accept. Staff ensured patients understood their options.
- Services were planned using information from a variety of sources, to inform their decision making. Where staff identified gaps in services they worked together to provide further access for patients.
- Managers made difficult decisions to provide these services in times of financial constraint but maintained their vision of retaining staff numbers and working in collaboration with other agencies.
- Leadership teams provided good informationto staff about challenges and developments about the service although some staff felt this took a long time to filter through to them.
- Good governance procedures gave senior managers oversight of the service and how well it was performing. Systems were in place which fed this information to the local authority commissioners but was not routinely fed back to staff.

However

- We witnessed some occasions when handwashing practices were inconsistently carried out be staff.
- Some of the premises not owned but used by the service were in need of repair or decoration.

Summary of findings

Background to the service

Cornwall Partnership NHS foundation Trust has been registered to provide community services for children, young people and families in Cornwall and the Isles of Scilly since 2011. The CQC last undertook a comprehensive inspection of these services in April 2015 and found the services delivered to be good.

The trust provides a range of children's community health services. This includes:

- Health Visiting
- School Nursing
- Family Nurse Partnership
- Speech and Language Therapy
- Paediatric Community Nursing which includes Diana Nurses (for children with complex and life-limiting conditions) and epilepsy care.
- Paediatric Home Care
- Nursing Sevices in Special Schools

Over 109,000 (20%) of the population in Cornwall is made up of people under the age of 18 years. During their childhood, each of these children will be offered some sort of input from this service.These services are provided in a variety of locations across Cornwall including children's centres, health centres, clinics, schools and family homes. They are provided between Monday and Friday of each week between the hours of 9am and 6pm.

Health visiting services carry out a range of visits to babies and children under the age of five years. This varies depending upon the need and is categorised into levels of increasing need : universal, universal partnership and universal partnership plus. The universal offer usually stops at the age of two and a half years whereas the other categories will have more intensive support.

The Family Nurse Partnership is is a home visiting programme for first time young parents, aged 19 years or under. A specially trained family nurse visits the parent regularly, from the early stages of pregnancy until their child is two years of age.

School nursing services support children of school age using a range of methods. They provide health advice and promote healthy lifestyles. This includes providing 'drop ins' for children to access, clinics for booked appointments, home visits, support and training for school staff and support for parents in managing their children.

Speech and language therapists provide therapy and advice for children with communication difficulties. They provide support in clinic settings, advice for schools, parents and those close to the child.

Community nursing services provide nursing care for children who:

- have been discharged from hospital but need further support
- have complex needs
- have life limiting conditions
- are living with epilepsy

The team consists of community nurses with specialist skills and includes psychologist support. Care is usually provided in the child's home and at schools. This team also includes nurses who work in special schools. These schools provide education for children who have complex needs and are unable to access mainstream education. The nursing role is to support school staff, child and family in managing the child's medical conditions in the school setting.

Paediatric Home Care is a service that is managed within the community nursing structure but independently commissioned for specific packages of care. Staff with appropriate skills are recruited for each package of care delivered.

Summary of findings

Our inspection team

The inspection of Cornwall Partnership NHS Foundation trust was led by:

Karen Bennett-Wilson, head of hospitals inspection, supported by Michelle McLeavy, inspection manager, mental health and Mandy Williams inspection manager, community health.

The team who inspected this core service included two Care Quality Commission (CQC) inspectors, a CQC pharmacy inspector, two specialist nurse advisors.

Why we carried out this inspection

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

The trust merged with Peninsula Community Healthcare NHS Trust in April 2016 and as such we always undertake a comprehensive inspection at an appropriate time following a merger.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 25 and 29 September 2017. Before the visit we held focus groups with a range of staff who worked within the service, such as nurses, therapists. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services.

What people who use the provider say

We observed clinics and care provided in schools and in patient's homes. Patients and carers who used the service told us they found the service to be friendly and supportive. They found nursing staff to be "all nice and down to earth" giving appropriate advice showing understanding of their situation. Parents told us they appreciated having access to a variety of clinics run by health visiting staff and felt supported by them. One parent said "They're friendly and approachable, and always able to answer questions."

Parents thought nursing staff supported their children to attend school and retain their social groups by going into schools to provide treatment and care.

Parents appreciated being informed of any delays "they always phone if they are going to be late".

We saw how parents responded positively at appointments with professionals and children of all ages were engaged in their care. Children showed a positive response and were keen to have follow on appointments where necessary.

Young people who used the family nurse partnership service were engaged with the service and stated "I like the nurse who sees me. If I ring her she always gets back to me"

Summary of findings

Staff in the speech and language therapy service were appreciated for the support they offered children and their parents with comments like “They are amazing”.

Good practice

School nursing staff gave practical and tailored support to schools to ensure they were able to support chidlren’s health needs. This involved working in partnership with other professionals such as primary mental health workers as well as schools. Examples were of group work, which was provided for school staff, to identify and support their students.

Nursing staff in schools for children with complex care used the care planning documentation provided by their service to record care needs. However, this was difficult for school staff to understand. They designed care planning paperwork for these children in a format that was easy for school staff to use. This was provided for school staff in the classroom and followed a format school staff were familiar with. Children’s needs could be viewed at glance without reading through copious amounts of charts.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service SHOULD take to improve

- The service should consider options to ensure that dispersed teams have a greater knowledge of breast feeding rates in their areas, in order to be able to measure improvement or decline.
- The children’s service should consider formalising an approach to the reassessment of competencies for its staff.
- Provide assurance that staff consistently cleanse their hands and equipment used, between patient visits if there has been any contact with patients or their belongings.
- Provide assurance that all staff who store, transport or administer medicines do so according to trust policy.
- Provide assurance that patient records completed on paper and transferred to the electronic patient record system are checked as being accurate.

Cornwall Partnership NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We found community health services for children, young people and their families were safe.

- There was an open culture of reporting incidents and learning was shared with teams across the service.
- Safeguarding children was a high priority for staff and training, supervision and knowledge was provided and kept up to date.
- Accommodation was appropriate for children and families to visit and action was taken if there were any risks to patient safety.
- Medicines storage, transport and administration were well managed by staff and advice was available from a paediatric pharmacist. Staff supported parents, children and teaching staff to ensure children received the correct medication, at the correct time and at the correct dose.
- Records were written in a way that kept patients safe. They were kept securely, were clear and comprehensive with care plans and outcomes completed. Records were audited for quality and actions were taken where improvements could be made.
- Staff managed and prioritised their case loads at times of high demand and when travel across the county presented additional risks and barriers.

However

- Handwashing practices were inconsistently carried out be staff.

Detailed findings

Safety performance

- The service used safety monitoring results well. Staff collected safety information which was monitored by senior managers and executive teams at governance meetings. Safety information was shared with staff and

used to improve the service. For example, infections were monitored for this service but there was no formal sepsis assessment tool in place. We saw this was discussed at meetings and an interim tool was shared with staff while a more bespoke system was developed for the community paediatric nursing team.

- Between 1 June 2016 and 31 May 2017 there had been one serious incident which involved communication between minor injury units and health visiting. This had been investigated and processes changed to improve communication systems.There were no never events reported for this service. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

Incident reporting, learning and improvement

- The service managed patient safety incidents well. Staff recognised incidents, concerns and near misses and reported them appropriately. Systems to carry out this duty were easy to use for staff. Processes were in place for individual staff to receive feedback when they reported incidents.
- Incidents relating to children's services were discussed at operation assurance group meetings, and learning passed down through line management to individual teams where appropriate. We were provided with examples of where this had occurred in relation to the mental health of new mothers and learning that had occurred following incidents that had occurred for this patient group.
- Lessons learnt from incidents were shared by email, at team meetings and at open sessions called 'Listen, Learn and Act'. Staff told us any staff member could attend these open sessions.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person'. The trust provided training and support for staff in line with trust policy. Individual support was offered when required and all duty of candour activities were overseen by locality managers. Overall the trust had applied duty of candour processes 234 times over the past 12 months none of which had applied to this core service
- Staff that we spoke with were able to describe examples of situations that would require an apology being given to patients.

Safeguarding

- The trust followed national guidance from national documents such as Working Together to Safeguard Children by providing oversight of the service, training and supervision for staff. The trust reported no external reviews or investigations relating to serious case reviews over the 12 month reporting period between 1 June 2016 to 31 May 2017. In collaboration with local authority partners, they had reviewed casesfrom between 2011 and 2015 retrospectively to identify learning points. These learning points were included in safeguarding training and included communication within health services and between agencies. Senior staff represented safeguarding at the trust board and presented annual reports, the most recent being July 2017.
- Safeguarding leads worked closely with GPs, the local safeguarding children's board and the local hospitals trust to improve communication and support offered to children who may be at risk of harm. In January 2015, CQC reviewed services for safeguarding children and looked after children and made recommendations for all agencies involved. The trust were working with their partners to take action on these recommendations. The joint focus for 2016/17 was on sexual exploitation, training and supervison. The local hospitals trust provided services for children who were looked after and staff were aware of children who were looked after who were on their caseload. We saw staff attending meetings with GPs, social workers schools and families to offer safeguarding support.
- Safeguarding referrals were monitored by the leadership team and showed that, between March 2016 and April 2017, 12 of the 67 safeguarding incidents were reported by health visiting staff. Staff we met had a good understanding of how to recognise vulnerable families at an early stage and worked with their partners in the

local authority to support these families. There were 652 children in need for the period 1 January to the 31 March 2017. We observed joint meetings where staff from the trust and local authority worked together to assess and monitor children in their care.

- A programme of audit was arranged until march 2018 and included case reviews, communication with minor injury units, use of chronologies and record keeping. Some had been undertaken and themes for improvement implemented. Staff were able to tell us of recent changes, resulting from audit, in how they follow up families of children, who did not attend or were not brought to an appointment. We saw staff contacting families, whose children had not attended an outpatient appointment. This allowed staff to assess risks to the children and offer support in helping them to have their health needs met.
- The trust provided and monitored staff training at the appropriate level if they worked with children. Training compliance figures for May 2017 exceeded the trust target of 95%. It showed 98% of staff were trained to level three safeguarding children. Staff knew when their training was due to be updated and how to arrange it.
- Staff spoke confidently about their resonsibliities to report safeguarding concerns and share relevant information. They also spoke positively about the support they received when working with families who may already be subject to safeguarding processes. Supervision was
- The electronic patient record keeping system alerted staff to any identified risks for children. Clicking on the alert icon took staff to all safeguarding information relating to a child and enabled ready access to this information.

Medicines

- The service prescribed, gave, recorded and stored medicines well. Staff followed trust policies to ensure patients received the right medication at the right dose at the right time.
- The parts of the service that handled medicines were paediatric nursing and nurses in special schools.
- Nurses in special schools trained school staff and monitored the way children's medicines were stored, prescribed and administered. Nursing staff administered prescribed medicines where necessary. Parents supplied the school with medicines and prescriptions. These were kept in locked cabinets at appropriate temperatures. Medicines that needed to be kept below room temperature were stored in a dedicated lockable medicines fridge. We saw the temperature log had been completed daily and advice was available if the fridge was outside of required temperatures. Paediatric pharmacist support was available and used by the nurses if any discrepancy was noticed. As an example, we saw nursing staff requesting pharmacy advice about a change in a child's medicines or prescription.
- Community children's nurses followed protocols to maintained safe storage and administration of medicines for children. Parents received prescribed medicines from the local acute hospital. Two nurses checked the prescription chart and medicines provided on the first visit to that patient. Any discrepancies were referred to the hospital staff that prescribed the medicines.
- Senior managers could not provide audit results that would assure themselves of how well community nursing staff stored, recorded and administered medicines. Community children's nursing staff could not recall any medicines audit having taken place. They were clear that any errors in their practise such as ommissions, would be found by colleagues but could not recall any having happened.

Environment and equipment

- The service had suitable premises and equipment and staff followed processes to ensure they were safe to use. Some of the premises, which were not owned by the trust, were in poor condition. Actions had been taken to ensure they were safe to use. An example in one area meant a sink was out of action until the landlord had acted to ensure there was no infection risk. Senior managers were aware of these risks and were liaising with the trust estates department to monitor the completion of these actions.
- Private rooms used for patient consultations were appropriately equipped. Toys were available for young children, sinks or hand gel was available for hand cleansing. Cords on window blinds were shortened to remove the risk of harm to patients from ligatures.

Good

Are services safe?

- Staff knew what equipment they were responsible for and ensured they were calibrated and maintained on a regular basis. Equipment had labels indicating when they were next due for servicing.
- Waste was removed safely from patient homes according to trust protocols. Clinical waste was segregated and disposed of at clinical bases. Bins used to dispose of sharps such as needles, were replaced before they created a risk by becoming too full.

Quality of records

- Individual's care records were written in and managed in a way that kept people safe. Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care within the trust.
- Patient records were kept electronically with staff needing to use passwords to access the information securely. We saw that computers were locked when not in use, and screens were not left open if unattended.
- We looked at 15 sets of patient records and found them to be comprehensively completed.
- Each specialism within the children's service had templates, which were tailored to the needs of that role. For example, health visitors were able to record the outcome of visits to new mums and babies, and record information such as weight, and domestic circumstances. Speech and language therapists were able to record information about the contents of their sessions with children together with goals that were set.
- The majority of patient records were updated in a timely way and were available for other professionals who were involved with the child's care to view. Where nursing staff used paper records when visiting patients, these were stored securely in the boot of a car during travelling times. Handwritten records were updated at the time of the child's appointment and returned to administration staff when staff next visited the administrator's location. Administration staff transferred the information to the electronic record for the child. However, it was unclear how assurance was provided that the electronic patient record was checked as accurate by the practitioner. In addition, this system created a potential delay in updated patient records being available on the electroinic system.
- Audit processes monitored the quality of records and measured compliance with trust policies. Key successes and concerns were noted and actions identified where improvements could be made. One audit showed good compliance (90%) with procedures for documenting when children did not attend an appointment. Actions were identified that could further improve the system to ensure patients remained safeguarded from abuse. Other actions had included further training for staffto improve their practice in documenting the voice of the child.

Cleanliness, infection control and hygiene

- Measures taken by staff to prevent and control infection were inconsistent. The majority of staff followed trust policies by cleaning equipment and washing hands between patient contact. Speech and language therapists, health visiting and school nursing staff did not perform any invasive procedures when caring for children. Community children's nurses provided care at a child's own home or at a clinic which may involve invasice procedures.
- Within the health visiting service, we saw that standards of cleanliness and hygiene were maintained. We observed staff using alcohol gel to cleanse hands between handling babies when soap and water was not readily available. Disposable paper towel was used to line scales used to weigh babies, and changed between patients.
- However, some staff did not clean their hands between patient visits. On one occasion there was no physical contact between patient and nurse at a home visit. On another occasion there was contact with patient clothing and the use of equipment, although non-invasive, which was not cleaned after use. Lack of consistent hand washing and equipment cleaningcould present a risk when visiting patients who are vulnerable to infection. Managers had no assurance that staff were compliant with hand hygiene practices for this service.Staff told us they attended hand hygiene training every three years as a mandatory requirement but were not aware of any hand hygiene audits having been carried out for their service.
- Toys that were available in clinics were provided by the children's centres in which they were held. We saw that

they were thoroughly cleaned by the nurses running these clinics, before being returned to storage. There were no logs to demonstrate this practice but we saw staff cleaning toys as a natural part of their role.

- The trust monitored the incidence of infections and identified themes although within the reporting period for this inspectionthere had been no health care acquired infections identified for this service.
- The trust had an aspiration that 75% of staff would take up the offer of being immunised against seasonal flu. Figures for uptake of the vaccine in 2016/17, within the children and young people's service, was 28.5%. However this figure was not solely for community health services for children, young people and familes but included mental health services' staff.

Mandatory training

- The trust told us their mandatory training data was unreliable. This was because they were combining data previously held on two systems and recording this on a new single system to provide an overview of the services training compliance. Data quality checks were still in progress but they provided us with the data they had collected. For May 2017 the data they provided at trust level showed 24 out of the 50 courses were below the target compliance rate. However, staff and their managers were aware of which training courses they needed to attend and told us they were up to date with their training. Managers monitored staff compliance and discussed training needs at one to one meetings with staff. Staff received email reminders when a course was due to expire and found the system for booking on to a course easy to navigate.
- Included in the comprehensive list of 50 modules available were fire safety, safeguarding children and adults, basic life support, information governance and manual handling. Staff training records we saw showed that these staff were up to date with their required mandatory training, with the exception of "Managing Aggression and Violence" training. We were told this was because the course was not available to book onto at the time of our inspection and managers were aware.

Assessing and responding to patient risk

- This was not an emergency service but staff followedtrust processes and were skilled in identifyingand responding appropriately to changing risks for people who used services. Patients and their carers were informed of how they could access urgent care and in what circumstances to seek further advice. Patients could contact nursing services between 8am and 6 pm each weekday and attend out of hours and emergency department services outside of these hours.
- Children were referred to community services using the Early Help Hub which was an integrated point of contact. Patient need was assessed using details on the referral form,by appropriately trained staff. If further information was required at this point the referrer would be contacted to provide this. Staff who received the referral used a triage process to assess risk and priorities those most at need. Staff made contact with children and families with information on when an appointment would be available.
- We heard examples within the school nursing service where nurses worked closely with school staff and social care services. This helped to identify deterioration in children's circumstances and the need for further support.
- Public health nursing staff were able to contact the Child and Adolescent Mental Health Service (CAMHS) if they felt a child needed more urgent emotional support. This did not always result in an appointment due to a lack of capacity within the CAMHS service but they could receive advice on how to support the child.
- Paediatric children's nursing staff reviewed patient referrals to their service and assessed the team's capacity to provide the care. Any concerns were escalated to managers. Parents were able to call the service for advice or if they had additional concerns about their child. Registered nurses used their clinical skills and judgement to assess the child'sneeds. This was carried out over the telephone in order to assess and advise if further medical help was required before they visited.
- Assessment of sepsis in a child was work in progress for the paediatric nursing team. We saw paediatric nursing staff used their knowledge and skills to assess the risk of sepsis in a patient using a national tool as guidance. Managers had recognised the need for a bespoke tool and a working group had been initiated to design this.

Good

Are services safe?

- Staff working within the family nurse partnership team had clear focus on managing and planning for potential risks of younger parents. By providing visits more often than regular health visitors these staff were working very closely with families to ensure that the support was in place to manage the challenges they faced.
- Public health nursing staff shared information to ensure children were supported when they started school. Health visiting and school nursing staff held frequent meetings to discuss children's needs who were about to start school and care plans were shared. Families were introduced to the school nursing service gradually if this was needed. For children who were receiving social care input, school nurses would attend meetings to help families to feel more comfortable with the school nursing teams.
- We saw paediatric nursing staff carried out joint visits to introduce children and families to new members of staff and ensure nursing staff had the information they needed to care for the child.

Staffing levels and caseload

- Caseloads were planned and managed to ensure that people received safe care and treatment at all times. In all of the teams we visited, staff had regular allocated time dedicated to caseload management. We were told that this time allowed for completion of outstanding tasks, and staff felt in control of their workload. However, this was not an emergency service and there was a risk that some patients may need to access care from alternative providers if nursing capacity was unavailable.
- When assessing the numbers of staff needed to carry out their duties, managers had looked at workforce planning tools. However, it was not possible to benchmark these roles as there was no reliable national comparator. Leaders within the health visiting service told us that they provided regular opportunities for staff to discuss their caseloads, and they felt confident their staff were not unduly pressured. Staff told us they were busy but not pressurised by their managers to take on more than they could cope with.
- Within the previous 18 months, leads for paediatric community nursing had assessed the numbers of nursing staff needed for the size of the population using guidance from the Royal College of Nursing. However, the number of whole time equivalent staffadvised for the service was 47 whereas figures for May 2017 showed the service had an establishment of 14 whole time equivalent nursing staff. The service lead had raised this with senior managers but there were no plans to fund further posts. Nursing staff maintained safety in their case load by assessing the team's capacity before accepting any children for treatment. These were usually children who could be discharged from the local acute hospital if care was available in the community. For example, the child may need nursing staff to administer intravenous antibiotics. Times that staff could not accept a patient on their caseload were escalated to their manager. The alternatives to having this care at home would be for children to either stay in hospital or return when their antibiotics were due.
- A workforce development review was in progress for the public health nursing service, at the time of our visit. Staff were being consulted about how they could redesign the way they provided commissioned services to be more streamlined.
- The family nurse partnership, was staffed adequately. It followed national guidelines to deliver the programme and was contracted to provide a service to 200 cases. This was split between eight nurses and was based on the increased intensity of this workload.
- The Home Care Service was independently funded to provide packages of care for children with complex needs,usually at night. Staff were recruited specifically for each package of care. Commissioners of this service would use staff from alternative agencies until the appropriate staff were in place.
- Average caseloads for health visitors were around 250, which was similar to the national average. Following the final check at two years, children were discharged if they were classed as "Universal". A "universal" case would describe a child and family with no additional needs or complications. If a family had additional needs or vulnerabilities, they would be kept on the caseload until these were resolved, or until transferred to the school nursing service aged five. This process ensured caseloads were monitored and delivered to those children and families who needed them.
- School nursing was arranged in locality teams with a mix of registered school nurses, community nurses (for

schools) and school nurse assistants. Each team covered two secondary schools and the feeder primary schools for the area.Vacancy rates in school nursing were low and varied between teams. In May 2017 there were 3.8 whole time equivalent vacancies out of an establishment of 36.7. Staff had been recruited to the permanent roles but not all were in post when we visited. The trust could provide no bank or agency data for this service although staff told us they had temporary staff allocated to their team who were working on a bank basis. This had filled many of the shifts that were waiting for permanent staff however, we had no measure of how many were left unfilled.

- Staff in all areas told us they were busy but managed their caseloads by prioritising patients with the greatest need.
- There were enough speech and language therapists to manage their caseloads safely. Within the speech and language therapy service, patients were allocated according to location with therapists working in set geographical areas, and around set schools. Leaders had oversight of the caseloads of their therapists, and this was discussed regularly with them. The introduction of the entry and exit criteria had greatly improved their ability to manage their caseloads. Therapists told us that although they were busy, they felt their caseloads were manageable and they felt supported.

Managing anticipated risks

- The service anticipated risks that seasonal fluctuations might present. Nursing staff were allocated a caseload within a region wherever possible. This was to reduce the amount of miles each nurse travelled and prevent delays in times of heavy traffic such as in the summer holidays. Should a nurse be delayed they would call the patient to inform them.
- When travel was limited further such as in extreme winter weather nursing staff would work from bases closest to their home. Patient and families with greatest need would be identified and contact made with them. Nursing staff would liaise with colleagues to ensure patients and families had their needs met. This included safeguarding conferences which would be attended using electronic conference calling if the nurse was unable to attend in person.
- Staff provided information for parents and school staff to support decisions on when they should seek further medical help for their child. We saw a publication given to a school regarding minor childhood illnesses and how they should be treated.
- School nursing staff provided information for each of their schools to highlight the risks relevant for the changing seasons. For example, sun care in the summer and flu vaccinations in the autumn.

Major incident awareness and training (only include at service level if variation or specific conerns)

- The policy for major incidents was available for staff to view and included action cards indicating priorities and staff activities. Staff told us they had completed forms for the trust identifying any additional skills, abilities and competencies. This was to enable the trust to allocate tasks to suitably able people in times of crisis.

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 found the community health services provided for children, young people and families were effective.

- There was a clear, strong and thoroughly embedded emphasis on providing services that were evidence based and reflected current guidance.
- The health visiting service was consistently exceeding it's 90% target for the completion of core contacts for babies and young children.
- Multi-disciplinary working occurred routinely and across specialisms, organisational and geographical boundaries. We saw how this led to a more effective service for chidren and families.
- There were clear and effective pathways in place for referral, transfer and discharge of children and families. We saw how this ensured work was targeted and effective.

However,

- There was a lack of knowedge across dispersed teams about the prevalence of breast feeding in these areas, only that it was "low".

There was no formal process in place to reassess competencies once they had been initially achieved.

Detailed findings

Evidence based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. Senior managers met regularly with commissioners of the service to agree and report on performance of the service.
- Staff used pathways and assessments which followed guidelines from the National Institute for Health Care and Excellence (NICE). This included pathways for continence in children, epilepsy and diabetes.
- School nursing staff and health visitors delivered care which followed the Healthy Child Programme. This is a national programme of interventions designed to be delivered around the individual needs of a child and its family. Activity was monitored and reported to senior managers and commissioners. Health visiting staff saw children at key points in their development. This included visits before birth (antenatal), new birth, six to eight weeks, 12 months and two years of age. For the period between 1 Apriland 30 May 2017 monitoing showed the mandatory visits were above the trust target of 90%.
- The Family Nurse Partnership (FNP) is a home visiting programme for first time young parents, aged 19 years or under. The FNP programme is underpinned by an internationally recognised robust evidence base, which shows it can improve health, social and educational outcomes in the short, medium and long term, while also providing positive economic returns. A specially trained family nurse visited the parent regularly, from the early stages of pregnancy until their child reached two years of age. We were given examples of where this had provided positive outcomes for the families who received care from this service. We heard about the Family Nurse Partnership supervisor attending a professional meeting, which was also attended by a former recipient of the service who had completed education and was achieving positive career goals
- School nursing staff met with senior staff in each school within Cornwall and the Isles of Scilly to develop a school health profile. This identified what health support was required for that year and included but was not limited to, information regarding children with social needs, safeguarding issues, health promotion and children with medical conditions. The local target set by commissioners was that 95% of schools should have this profile completed by the final quarter of each year. For the final quarter of 2016 each region had achieved between 80% and 95% for this target. Managers had reviewed the reasons for not achieving this target and had put actions in place to improve the target for 2017. Staff who needed help inputting information to the audit process were supported and encouraged to arrange visits earlier in the year.

Good

Are services effective?

- School nursing staff worked in partnership with the local authority to deliver the national child measurement programme. This intervention was used as an opportunity to inform parents of how the school nursing service could support them, and to promote healthy lifestyles for families. Information was anonymised and shared with the local authority and with the national programme.
- The service carried out additional audits to measure how they were performing. This included training for school staff regarding management of children with anaphylaxis. Anaphylaxis is a life threatening allergic reaction which needs immediate action. An audit of training showed that 100% of schools who requested the training received it from the school nursing team.
- We observed speech and language therapy sessions that used evidence based tools to assess the needs of children in this area. A comprehensive recording system of the outcomes of these assessments, informed their care plans moving forward.
- Within the speech and language service we saw examples of care plans that were informed by evidence based guidance, and these were achieving outcomes for children. These care plans identified needs and set goals in accordance with this guidance, and the achievement of these goals was monitored and recorded within the child's records.
- Within the children's service, there was an "evidence based practice" group. The role of this group was to research the latest guidance relating to a designated topic and to feed this back to staff within the service. For example, this group had looked into the most recent research around selective mutism and this was being added to the agenda for discussion at an upcoming development day within the speech and language therapy service. This process provided assurance that the work of staff within these services was based on recent guidance and research available to practitioners.
- At the time of our inspection, the service had achieved level three accreditation under the UNICEF Baby Friendly Initiative. This programme aims to train health professionals in hospitals, health visiting services and children's centres to support mothers to breastfeed and help all parents to build a close and loving relationship with their baby irrespective of feeding method. However, at local level, leaders were not able to tell inspectors what the breastfeeding rates were within their teams. We were told they sat at around 50%, but not any timescales for these, for example what age babies these figures were taken for. Therefore these service could not be assured of the breast feeding rates within these areas, or benchmark them to measure for improvement or decline.

Pain relief

- Where relevant children had their pain assessed using an appropriate method for their age and development. Tools were used such as numbers from one to 10 and smiley faces to indicate what level of pain children were experiencing. We saw how a child, school, parents and nurses worked together to control a child's pain. Pain control was discussed between the professionals and parents at the meeting and treatment was documented in the care plan. Staff were able to review amounts of pain relief provided and assess effectiveness of the treatment.

Nutrition and hydration

- Nurses supported parents, schools and other professionals to provide nutrition and hydration for children in their care. Nursing staff had received additional training so they could support families with feeding devices where oral nutrition was not possible and this was recorded in the child's care plan.

Technology and telemedicine

- The service used technology to improve the effectiveness of their service. Smart phones had been provided which had improved the ability to connect to the internet. Staff used these to connect their laptops when away from the office and to show children useful 'apps' that would support their health issue.
- Nursing staff sent text messages to parents and children as appointment reminders.

Patient outcomes

- Information about the outcomes of people's care and treatment was routinely collected by the speech and language service. Care plans were updated after each contact, with details of goals achieved and new ones

set. These fed into the outcomes set for children, and were recorded when achieved. This enabled therapists to hold a clear record of the outcomes achieved by children in their care.

- The family nurse partnership team routinely recorded outcomes for the families in its care and fed this data back into a national database for analysis. This provided the team with the information they needed to measure their outcomes in relation to those of similar teams nationally. For example, information from the most recent data showed that the family nurse partnership team had reduced the number of children who were taken into care. The figure, within this cohort, of 2.2% of children being taken into care was better than the national average of 3.3%.
- However, the public health nursing service did not routinely collect all information about its performance in relation to the healthy child programme. We were told that for the areas where this information was not collected, this was because these programmes were run by the public health, with the children's services only carrying out the tasks within it. This included much of the national child measurement programme. The service received data about its performance in these areas, when they asked for it, but this was not routinely passed to them.
- The health visiting service was achieving in excess of 90% key contact visits at all stages with the highest number for the six to eight week check, at 95%. Additionally, the service was carrying our visits at between three and four months and 15 months of age. Completion of these visits stood at 86% and 96% respectively.

Competent staff

- Staff had the right qualifications, skills knowledge and experience to carry out their roles. Although not all staff were specialist children's nurses, a process was in place whereby through induction, new staff undertook a series of competency assessments to ensure they were able to complete their tasks safely. However, once competencies had been achieved, there was not a formal process in all teams for these competencies to be reassessed on an ongoing basis.
- Learning needs for staff were identified through regular supervision and appraisals. Staff told us they felt supported to ask for training, and that they had been given opportunities to develop. In recent months, staff had been given the opportunity to attend multi-agency training provided by the local authority. This training was well received by staff who stated it was of a very high standard.
- Within the service, staff attended a twice yearly performance review. For speech and language therapy this was informed by the information gathered about their clinical performance as well as the quality of the records they kept. The approach aimed to refine the discussion to the developmental possibilities for each staff member, and was referred to in the interim supervisions. We were told that this also informed a constructive approach to performance management and allowed performance to be improved and monitored in a more supportive way.
- A system of clinical supervision by peers had been developed for staff and was appreciated as positive support.

Multi-disciplinary working and coordinated care pathways

- Care was delivered in a coordinated way when different teams were involved. This included both internally and externally to the trust.
- Within the children's service, the electronic patient records system enabled staff from different areas to access each other's notes and gain full insight into the care of patients. For example, we observed a speech and language therapy session with a child who was also subject to ongoing involvement from the health visiting team. Effective sharing of information enabled the therapist to have full knowledge of the whole child and to take this into account in their treatment.
- Within the family nurse partnership, two nurses sat with the local authority family assessment team. (FAST). This allowed for a much more efficient and timely channel of communication between both health and social care professionals. It also allowed for the sharing of expertise and knowledge, improving the effectiveness of both teams.
- We saw numerous examples of multiple professionals working together to support children and families, where communication was open, timely and effective.

We attended a GP liaison meeting with the health visiting and school nursing teams. This meeting provided an opportunity forstaff to discuss a set caseload of children based within a GP practiceand update each other on the progress of those children. Staff told us they felt that this worked very well as a mechanism for optimising the support offered to children and their families.

- The speech and language service held a clear, evidence based criteria for acceptance into the service and worked with other services to support children who did not meet this criteria. For example, health visiting staff supported toddlers with early speech problems but were supported by speech and language therapists.
- Within health visiting teams, each staff member had a link with a local nursery. The purpose of this link was to provide advice and support to nursery staff looking after children, but also as an alternative way to connect with parents. We heard of an example whereby a nursery had a number of children still in nappies. The health visiting team were able to provide a group session to a number of parents about potty training, which potentially saved a number of separate contacts for the team at a later date. It also provided an avenue into the service for children who may have been discharged from the health visitor caseload.
- Care was co-ordinated by school nursing staff who liaised with main stream school staff to assess and provide the most appropriate care for children. Discussions were held each academic year to assess the nursing support the school needed based on children's needs and how this could be offered.
- School nursing staff worked with colleagues from other teams and agencies to support children of school age. We heard of programmes delivered in schools which included working with mental health workers and teaching staff to identify how children could be supported with anxiety issues.
- School nursing staff could receive advice form colleagues in the Child and Adolescent Mental Health Service (CAMHS) and from primary mental health workers. Thise was often to support children who were waiting for appointments with CAMHS.
- Nursing staff who supported schools for children with additional and complex needs liaised with school staff and therapists to identify the needs of individual children. Nursing staff wrote care plans, shared these with scool staff, made arrangements for school staff to receive appropriate training in medical needs of the child and liaised with parents to ensure information was up to date. Nurses we spoke with planned to streamline their processes by attending the education and health planning meetings for each child.
- Children who received care from community paediatric nursing services were under the overall care of padiatricians from the local acute trust or other specialist areas. Community paediatric nurses were clear about who to contact and were able to access support from paediatricians when they needed to. If were any problems with prescriptions, for example, they could refer directly back to the paediatric service in the acute hospital for advice and support.

Referral, transfer, discharge and transition

- Staff worked together to assess and plan ongoing care and treatment in a timely way. This included movement between health visiting and school nursing teams, as well as across services such as speech and language therapy.
- A pilot project saw school nurses and health visitors providing one service for children aged 0 – 19. They also shared line managers and worked more closely within set geographical areas. We were told that this allowed for smoother transition between services and a greater understanding between teams.
- Processes were followed at times of transition for children. Health visiting and school nursing services had a process of handover when the child was starting school. This ensured staff were aware of issues and could support the family and schools appropriately. The epilepsy part of paediatric nursing started a nationally available programme for transition to adult services when the child reached 14 years of age.
- Information was shared with children's GPs after an episode of care and when children were discharged from their caseload.
- Referral into speech and language services was governed by a clear criteria. This provided assurances that suitable referrals were made and the service was offered to children who were suitable for interventions.

Good

Are services effective?

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. The electronic patient record system used by staff in the children's service provided a platform for all information about children within the service to be stored and accessed by relevant professionals from within the trust.
- Staff spoke highly of the efficacy of the electronic patient record system they used to be able to share and store information. This worked particularly well when children had attended the minor injuries units run by the trust. Information around these attendances was uploaded by administrators onto the electronic system and was therefore available immediately.
- We observed staff working closely with colleagues from the local authority, GPs and schools to ensure they had complete information about the children in their care.

Consent

- Staff understood and demonstrated how they gained consent from children and their parents in a variety of circumstances.
- Nursing staff followed national guidelines in cases where children refused treatment, were unable to make their own decisions or were less than 16 years of age. This included assessing whether children were able to understand the consequences of their decisions and using Fraser Guidelines for children requiring sexual health advice.
- Children who had communication difficulties were supported to understand and give or refuse their consent by using physical prompts.
- We observed parents being asked for consent for their details to be entered onto a system that was used by the children's service as a whole.

Good

Are services caring?

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

Summary

We found the community health services provided for children, young people and families were caring.

- Staff understood how conditions affected children and those close to them and made every effort to ensure they were involved in making decisions about their care.
- Staff gave time to all their contacts to ask questions and express their concerns, dealing with responses sensitively and in an age appropriate way.
- Children and those close to them were offered emotional support using a range of methods and staff used their skills and knowledge to provide suitable options for care.
- Independence was encouraged for children to allow them to access school and manage their conditions as effectively as possible.

Detailed findings

Compassionate care

- Staff treated children and those close to them with respect, compassion and dignity. They took the time to interact with children at each contact. We saw health visitors interacted with siblings when carrying out new birth visits, and often remembered them from previous involvement.
- School nursing staff and community children's nurses ensured there was private space for children and their parents to be seen. This gave them privacy to express their concerns.
- In clinics we saw that the health visiting team had rearranged the area to ensure there was a private area for parents to ask questions or for mothers to breastfeed if they wished. This was done in response to feedback from families who had attended clinics.
- We observed calm meetings with new mothers, and gentle questioning aimed at getting an understanding of an individual's situation.
- Children were spoken to with sensitivity and additional visits were arranged for children in order that they could feel safe to contribute their views.
- Parents were offered alternative appointments to allow them to talk about sensitive issues without upsetting their child.
- Parents and children were given information in a clear way and were reassured by staff if they felt anxious. Time was given for any questions parent or child may have.
- We saw how young children were engaged in the process of being measured and how the information was kept confidential and they did not feel judged.

Understanding and involvement of patients and those close to them

- Staff ensured that children and their parents understood options of care and were able to make their own choices. Children were spoken to by staff in a suitable way for their age and development.
- We saw how staff often recognised when people who used services needed additional support to understand the care being offered to their children. In baby clinics, we saw that parents were not rushed and were encouraged to ask questions in a safe environment. Staff took the time to explain options to parents, as well as to help them to understand potential outcomes for their children.
- We observed staff routinely signposting people who used services to places they could find support or further information. For example, a younger mother was informed about a baby group specifically set up charitably for parents under the age of 23.
- Staff took the time to explain information to parents. When explaining evidence based guidance, they ensured this was understood and clearly delivered. Parents responded positively to this and were confident to ask questions
- Where parents and children attended appointments together staff involved them in the care of the child. Children were included in the conversation and parents were helped with advice on how to collect information that would inform their next consultation. For example keeping a diary.

Good

Are services caring?

- Parents or guardians of children receiving a service from the speech and language team were sent a new copy of their care plan each time it was amended or updated so they were clear about the goals set within it.
- Staff were sensitive to the communication needs of children and supported them to contribute their views with non-verbal cues and drawing pictures or writing them down.

Emotional support

- Staff offered emotional support to children and their parents in a timely way. Methods of support varied depending on the individual needs. For example information about clinics that would support the carer, appointments with psychologists for families of children with complex or life-threatening conditions.
- The family nurse partnership team worked closely with young families to help them build positive relationships with their baby and understand their baby's needs. The intensive involvement of these nurses provided young parents with the emotional support needed to manage the challenges they faced.
- Parents told us that they found the health visiting team friendly and approachable, and they enjoyed the service they received from them. They said they trusted the advice offered and this gave them confidence in caring for their children.
- Children, families and carers were provided with information to support their independence. Parents were signposted to other organisations including social media groups that could provide support for them.
- Children were supported to maximise their independence. This included those with complex needs where school staff were provided with the information and training they needed to care for the child. Nursing support was available for any concerns about how support should be offered.
- Children were offered emotional support and helped to access other organisations that could provide further help.

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 found the community health services provided for children, young people and families were responsive.

- Managers and staff used available information to plan the services they delivered. This included information from the local authority, schools, patients and their carers.
- The needs of vulnerable patients were prioritised.
- Teams worked collaboratively to provide care for patients where there were gaps.
- Teams provided timely access to their services and managers monitored this.
- Patients with additional, complex and alternative needs were supported to access services they needed.
- Staff were clear about the complaints procedure and managers maintained an oversight of these with actions taken as necessary.

However

- Some of the premises not owned but used by the service, were in need of repair or decoration. Managers were aware of this and were taking steps to action this although options were limited.

Detailed findings

Planning and delivering services which meet people's needs

- Leaders within the school nursing and health visiting teams attended regular contractual meetings with commissioners, where discussions were held about services. However, although we were told that at these meetings the service could raise questions, the final say about the services they were being funded to provide lay with the commissioners and managers had limited influence in these discussions. Additionally, the public health nursing service within the trust had been tasked with making cuts of £700,000 within the current financial year. This had meant that managers had had to write a business plan outlining how and where these savings could be made. This had resulted in the strategy to provide 0-19 services across localities, as well as other cost saving measures aimed at protecting direct service delivery whilst cutting unnecessary expense.
- Information about the needs of the local population was used to inform how services were planned and delivered. Information was shared by and with the local authority to provide evidence of the services that were needed in each region. Teams were based geographically to minimise travel time, and allow for a more efficient planning of caseloads.
- School nursing services planned their services in consultation with the schools in the county. Information was fed back about the reasons referrals were made to them. This information was not always fed back to the nursing staff but they responded to their own observations by offering further support to children in schools. This often involved supporting children who were waiting for an appointment with the Child and Adolescent Mental Health Service.
- Budget cuts had prompted senior managers to make difficult decisions on how to provide the service within their financial limitations. They had decided to maintain their workforce numbers and look at alternative ways of saving money. One such decision was to remove the supply of bedwetting alarms for children. As an alternative, staff were directed to signpost parents to other agencies that could supply these alarms but parents would need to pay for their use. Staff expressed concern that not all parents would be able to afford this and the child's bedwetting would not be treated. However, managers abided by their decision to withdraw the provision of the bedwetting alarms.
- Within health visiting teams, a mix of qualified health visitors, community nurses (for health visiting) and nursery nurses worked together to manage caseloads of varying complexities. This allowed for qualified health visitors' expertise to be utilised efficiently, whilst families assessed as having less need were often seen by paediatric community nurses or nursery nurses.
- Demand for speech and language therapy was high, and this was managed with a clear, evidence based entry

criteria. This meant that children requiring their services were able to access it, without excessive waits, and were the most suitable for the type of service on offer. For children who didn't meet the entry criteria, the service was able to suggest alternatives, for example health visitor led groups for toddlers.

- All staff we spoke with had a clear thorough understanding of their local populations, the demographics and the challenges they faced. They also had clear understanding of which facilities were on offer in local areas and used this knowledge to signpost families and children.
- However, facilities and services were not always appropriate for the services that were delivered. Services were provided in many areas not owned by the trust.These were mainly schools, children's centres or health centres. This meant they were able to be offered in age appropriate surroundings for the children in their care, in the heart of their communities. These buildings were often dilapidated and in need of redecoration, however as they were not owned by the service, they had limited abilities to address this issue, with no suitable alternatives.

Equality and diversity

- Services were planned to take account of the needs of different people. We saw that the Family Nurse Partnership specialised in providing an enhanced service for younger parents. Additionally, we saw that a clear understanding of the status of each family ensured they received a service that met their needs.
- We witnessed interactions with families for whom English was not their first language. Staff explained things clearly and took the time to ensure they understood what was being communicated. This seemed to be a naturally well embedded practice. We were told that there was access to translation services if the need arose, and staff knew how to use this.
- All the areas we visited were accessible for people with physical disabilities and where children could not attend clinics they were seen in their homes.

Meeting the needs of people in vulnerable circumstances

- We saw how arrangements worked, to enable access to services for children and families in vulnerable circumstances. Health visitors with a higher proportion of vulnerable families within their caseloads, tended to have fewer cases in total. This meant that they had greater capacity to meet the additional needs of these families.
- The children's service worked closely with the local authority to provide a rounded service to families in vulnerable circumstances. By keeping abreast of the whole situation that may be affecting such families, staff were able to offer a service that was joined up with other agencies to meet need.
- The electronic patient record system used by the children's service, contained provision for all staff to be able to see at a glance, any information about children. This included any additional needs or vulnerable circumstances.
- We saw how nursing staff engaged with children with complex needs, physical and learning disabilities and helped them to communicate their choices.
- School nursing staff were aware of the children who were looked after in their schools and would liaise with the specialist children looked after team if there were any issues. This team was managed by an alternative provider.

Access to the right care at the right time

- People had access to timely care and treatment. The referral system used a single point of access called the Early Help Hub. All referrals were assessed by a professional in the hub and directed to where the most appropriate care could be given, or redirected if it was an inappropriate referral. Advice could also be given to parents at this stage which might prevent an unnecessary appointment. The system was spoken of in positive terms by all staff. Staff told us the referrals they received were appropriate and more fully completed with relevant information for the care needed.
- The speech and language service held targets of 13 week waits from referral to treatment. At the time of our inspection, it was achieving this target in 90% of cases. Systems for managing referrals centred on a triage system whereby referrals that were accepted were sent to individual therapists. Triage occurred within two

weeks of being received by the service. Therapistsmanaged their own waiting lists and reported waiting times to managers who maintained oversight of the waiting list.

- School nursing and the paediatric nursing service assessed any referrals they received and allocated them according to greatest need. Contact was made within five days of the referral to arrange appointments.
- The speech and language service held a clear, evidence based criteria for acceptance into the service and shared . The referral process into this service was clear to everyone that we spoke with, and enabled the team to assess fully the suitability of the referral into the service. Speech and language therapists worked with health visitors to enable them to carry out assessments as part of the two year developmental review. It was at this point that most referrals to the speech and language therapy team were made and they developed a group named "toddler talk". Children were able to access services to help with the development of their verbal skills, designed by, and quality assured by speech and language therapists, but delivered by health visitors.
- Parents told us they were kept informed of any delays to the service and given a guideline of when the nurse would be able to attend.
- Families were able to have access to support at the time they needed it by having open access to the paediatric nursing service. Advice was offered on a telephone call and could prevent unnecessary visits.

Learning from complaints and concerns

- People who used services knew how to make complaints and raise concerns. Opportunities to raise concerns were provided via an electronic system that they could access both in clinic settings and remotely. Leaders within services were then able to access this information and respond appropriately. There had been very few complaints for this service but managers told us of the process and how they had supported staff in response to complaints about staff attitudes.
- Numbers of complaints for children's services were low compared to other areas within the trust. However, we learned of clear processes in place that enabled learning to be cascaded to teams.

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 found the community health services provided for children, young people and families were well led.

- Leaders used their skills and knowledge to create an open culture with effective lines of communication and engagement for their staff at all levels.
- Leaders understood the challenges of providing good quality care in times of expenditure cuts and made difficult decisions.
- The strategy of working in partnership with other organisations and streamlining service delivery contributed to the trust vision of integrating with the local authority services.
- Staff felt supported and encouraged to act on their ideas to improve services for children and their families.
- Feedback from children and their families was encouraged and used to make improvements where possible.

However,

- Some staff reported that they felt they were not properly consulted about change, and had a feeling of being "done to".

Detailed findings

Leadership of this service

- Leaders had the skills, knowledge and experience to carry out their role. We met with leaders in a variety of teams who were working effectively and had the skills to do so. At the time of our inspection, two locality managers had oversight of the six localities in the area providing school nursing and health visiting services, divided into East and West Cornwall.
- There were structures in place beneath the locality managers that enabled effective leadership to be in place at each stage down to the staff on the front line. A range of meetings and events helped staff to feel part of their local team and of the wider service for children and families.
- Different specialities within the children's service were led by managers who were accessible to dispersed teams. Within the public nursing services, locality managers led teams based in geographical locations. This meant they had a greater understanding of what was going on closer to front line services. This also meant they were able to act as a conduit for information to be passed up and down varying levels of staff.
- Staff were clear about their roles and understood what they were accountable for. We spoke with numerous staff who were clearly able to describe how their role fitted within the larger team and in turn the wider trust. Staff were clear about who their managers were and the different ways in which they could access them.
- Leaders within the speech and language service undertook an element of clinical practice. They felt this allowed them to keep in touch with their staff, the children who used the service and the challenges that were faced. These leaders all spoke passionately about how much they enjoyed their clinical role, and benefitted from the patient contact this provided.
- Leaders understood the challenges to good quality care they faced and were working hard to address these in a difficult climate. Funding for public health nursing was being reduced by £700,000 in the current year. The cost improvement programme had created pressures within these services, which were being addressed by leaders at the time of our inspection. Leaders had made a decision to retain staff numbers and were investigating alternative ways of working in order to provide good quality services within constrained budgets. Money saving options were to withdraw the provision of bed wetting alarms. and consulting with staff on how they could increase efficiency of their roles.
- Within the family nurse partnership, leaders were aware of the stresses the role could place on staff and worked hard to support their wellbeing.
- Staff told us that leaders were visible and approachable. Leaders spoke of an emphasis on ensuring that they were available to staff when needed.

Good

Are services well-led?

- Staff felt supported by their managers with one comment of "I think they are brilliant bosses, the best I've ever had". Staff with home commitments were able to work flexibly and new starters were supported with managing their caseloads. However, some staff felt they were 'done to' and not properly consulted about change. They felt they had been slotted into roles because of their banding and needed further support to increase their skills and help them meet additional demands of the change in their role.

Service vision and strategy

- The children's service had a clear vision and strategy, which supported the trust vision of integrating with local authority services across the county. At the time of our inspection, a new way of providing services to children aged 0-19 was being piloted in one locality. This involved joining together a health visiting team, and a school nursing team, managed jointly through a single leadership structure.
- Since its introduction, the project had been amended and adjusted using feedback from those working within it and so staff were actively involved in its development. The plan was to expand the service to other localities across the county. Additionally, the development of the service in this way was regularly discussed in teams with progress updates communicated to staff

Governance, risk management and quality measurement

- Governance frameworks based on national standards of good practice supported the delivery of good quality care for children.
- Performance information collected was based on targets set nationally and commissioners. This included visits for babies at key points by health visiting staff and measurement of children at reception age and school year six. Managers reviewed this information at departmental meetings and reported monthly to the trust board. These figures were provided to the commissioner but were not routinely fed back to staff. Senior managers told us they could access this information and could feed it back to staff through clinical development and team meetings although this was not done on a regular basis.
- Where performance did not meet identified targets actions were put into place to improve outcomes. For example, school nursing services did not meet a target of having created school health profiles. Actions to start planning these meetings earlier in the year were monitored by locality managers.
- A programme of internal audit was undertaken for the service and we saw actions had been taken where further improvement had been identified with further monitoring planned. One such improvement was in communication systems between services for safeguarding children.
- Risks for the service were placed on a risk register. Staff were aware how to access this and if the risk could not be managed locally would be escalated to senior manager and trust board level. Risks were rated as red, amber and green and reviewed at identified timescales depending on the actions. We saw that safeguarding children risks had been reviewed and actioned with greater focus on training and supervision for staff. Staffing was placed on the risk register for the trust as a whole and did not specify children's nursing teams. However, there was a workforce review in progress to identify staffing needs of the service.
- Managers were fully aware of cost savings and the impact this could have on deliver of the service. It was not a feature of the risk register but we heard outline plans for actions if further savings were imposed on the service.
- The service worked in partnership with other organisations to provide holistic services for children. This included the local acute hospital trust, local authority, safeguarding children board and schools. These were managed using a range of regular meetings to discuss how they could improve systems further. This was evident with safeguarding processes to learn from each other in how to communicate about vulnerable families and informing community paediatric nursing services about planned discharges from hospital. Where packages of home care nursing services were required, these were managed using contractual agreements.
- Feedback from families who use the service was regularly discussed at department and board meetings with updates of any actions taken by staff. The service received few complaints, most of which could be managed locally. Compliments from families were escalated and responded to by the associate director who sent personal thanks to the staff member or team.

Good

Are services well-led?

Culture within this service

- Staff told us they felt respected and valued. Managers and leaders that we met with demonstrated clearly that they respected and appreciated the work of their staff. Communication was open and clear, with managers operating an "open door" policy for their staff.
- Individuals and teams were empowered to make suggestions about how their service could be improved. We saw that within the speech and language service, the team were able to amend the format of their care plans to better meet the needs of the children it supported.
- We saw examples of how action could be taken to address behaviour or performance that was not consistent with the vision and values of the service. The speech and language service used a bi-annual performance review to address any issues at the earliest opportunity, as soon as there were signs that performance may be dipping. We were told that this was a more supportive way to manage issues, and staff reported that they felt supported to manage their own performance. The capability policy was used effectively to improve performance in a supportive way.
- We saw a service that was clearly centred on the needs and experiences of people who used it. Locations and times of baby clinics had been designed to maximise convenience for local families. Some ante natal groups were being run in the evenings to allow parents to attend who weren't available during the day.
- Staff spoke confidently about how they worked together to ensure the safety of their colleagues when lone working. A lone working procedure was effective at ensuring staff were safe and their whereabouts known. In some teams this involved calling into a central number, to report they had arrived or left a particular appointment. In others, staff also contacted staff within their own teams to report in and out. Offices had clear boards that detailed staff's plans for the day and were used as a reference point by managers and colleagues.

Public engagement

- People's views and experiences were gathered routinely to shape and improve services. We saw numerous examples of changes that had been made to services following feedback from patients. For example, in one of the baby clinics we visited, the waiting area had been moved into a separate room, so that parents and babies could be seen more privately, and in a calmer space.
- In another example parents had described their frustrations about the difficulty of getting through on the phone to a health visitor for advice. As a result of this, at the time of our inspection a central advice line was in the process of being set up, which would have a dedicated staff team to take these calls and respond to parents.
- Parents and children were given the opportunity to feedback on their experiences at clinics or after episodes of care, using computers that were set up for the purpose. Alternatively, they were given information about how they could do this on line or by posting feedback forms from home. A link person within each team held responsibility for collating this feedback and passing it to leaders. They also acted as a link back to front line staff about the outcomes of this. In areas where there were low numbers of responses, link staff encouraged their colleagues to routinely offer feedback opportunities.
- The paediatric nursing team consulted with a charity local to Cornwall, to engage with views of parents when making any changes to the service.

Staff engagement

- The public health nursing service was undergoing a period of reconfiguration at the time of our inspection, with one area acting as a pilot for this change. Managers spoke of team days, and meetings at which point information about the progress of this project could be shared with teams. Staff we spoke with said they felt fully informed about the changes, and had been offered the chance to feedback their thoughts.
- Staff were aware of processes that supported their views being taken to and from trust board meetings. However, the processes were often lengthy and messages often became misinterpreted before they were officially shared at team meetings. Detailed minutes were shared with staff who were unable to attend and further communication in the form of staff newsletters for each

Good

Are services well-led?

part of the service were distributed. The newsletters were designed as easy to read headlines to inform staff who could access more detailed information when they were able.

- Within the speech and language service, we saw that leaders met regularly to discuss progress and feedback information based on what had been imparted to them by their teams. Staff within these services said they felt informed about the performance of the service and that they would be listened to if they wanted to make suggestions.
- Staff at all levels had a clear understanding of the challenges facing the children's service, and were aware that these were clearly recognised at management level. Staff were confident that managers had an understanding of their concerns, and that they did their best to support them with these. For example, a recent drive to improve efficiencies around mileage expenditure had meant a rethink about how work was managed for staff. It was recognised however by managers that this was not always possible, and staff said they did not feel unduly pressured by this.

Innovation, improvement and sustainability

- Nursing staff told us of a number of occasions when their ideas had been transformed into action. Community children's and Diana nurses had been challenged by the number of miles travelled across the county. Diana nurses were separately funded and cared for children with life-limiting conditions. This had led to nursing staff demonstrating the mileage covered by them and reorganising the community paediatrics and Diana nursing services to work jointly across geographical areas to increase capacity of the team.
- Nursing staff had developed documentation that supported patient consultations to ensure no issues were missed.
- School nursing staff in special schools supported school staff to manage children's complex needs independently of the school nurse. Nurses in schools for children with complex care used the care planning documentation provided by their service to record care needs. However, this was difficult for school staff to understand. They designed care planning paperwork for these children in a format that was easy for school staff to use. This was provided for school staff in the classroom and followed a format school staff were familiar with. Children's needs could be viewed at glance without reading through copious amounts of charts.
- School nursing staff had embraced the change in commissioning that allowed them to vary their offer to schools. For example, where 'drop ins' were unsuccessful, alternative methods of support and engagement were offered such as groups work for staff and school students around identifying and managing anxiety.