# Review of compliance

| Cambridgeshire Community Services NHS | |
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| **Region:** | East |
| **Location address:** | The Priory, Priory Road, St Ives, Cambridgeshire PE27 5BB |
| **Type of service:** | • Acute Services<br>• Community healthcare service<br>• Diagnostic and/or screening service<br>• Rehabilitation services<br>• Dental service<br>• Long term conditions services<br>• Hospice services<br>• Doctor's treatment service |
| **Date the review was completed:** | May 2011 |
| **Overview of the service:** | Cambridgeshire Community Services NHS Trust became the first specialist NHS Community trust created in England, in April 2010. The trust took over the running of the majority of services previously operated by Cambridgeshire PCT.<br>The trust, which employs over 2,800 staff, provides a wide range of health and social care services to people across Cambridgeshire from six hospital locations and a large number of |

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| | community locations. |

# Summary of our findings
for the essential standards of quality and safety

## What we found overall

We found that Cambridgeshire Community Services NHS Trust was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out the review, what we found and any action required.

## Why we carried out this review

We carried out this review to check whether Cambridgeshire Community Services NHS Trust had made improvements in relation to:

- Safeguarding people who use services from abuse
- Staffing

This was because the trust stated it was not compliant during preparations for registration in April 2010. At that time, the trust had developed action plans to ensure it reached compliance with Outcome 7 by the end of September 2010 and Outcome 13 by the end of March 2011.

## How we carried out this review

We reviewed all the information we hold about this provider and requested that the trust send us an update of their action plan to achieve compliance, with some supporting evidence. Upon receipt of the action plan we requested a range of additional information.

## What people told us

During this specific review we have not spoken directly with people who use this service about these essential outcomes.

## What we found about the standards we reviewed and how well Cambridgeshire Community Services NHS Trust was meeting them

**Outcome 7: People should be protected from abuse and staff should respect their human rights**

- Overall, we found that improvements are needed for this essential standard.

**Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs**

- Overall, we found that improvements are needed for this essential standard.

## Action we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

**What we found**
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

# Outcome 7:
# Safeguarding people who use services from abuse

## What the outcome says

This is what people who use services should expect.

People who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

## What we found

**Our judgement**

**There are major concerns** with outcome 7: Safeguarding people who use services from abuse

**Our findings**

**What people who use the service experienced and told us:**

We did not speak with anybody who uses the services during this review.

**Other evidence:**

At registration in April 2010, the trust declared non compliance with outcome 7 in respect of adult safeguarding. The trust supplied us with an action plan that indicated that, by 30 September 2010, it would complete a number of actions to strengthen safeguarding practices. Actions proposed included:

- the establishment of an internal safeguarding board to oversee development
- scoping staff's training needs and commissioning relevant training
- the development of an audit programme to understand staff awareness
- raising staff awareness of reporting systems
- the development of a clearer safeguarding strategy and operational plan.

By 30 September 2010 the trust had set up an internal safeguarding board, which had revised the safeguarding strategy and had developed a detailed safeguarding operational plan. We were also provided with examples of initiatives undertaken to raise the profile of reporting mechanisms for safeguarding concerns.

A project had been completed to look at training requirements in line with the competencies required for the individual staff group's roles and responsibilities. However, by the anticipated compliance date the trust had not fully finalised arrangements for the delivery of staff training. The trust told us that this related to the decision that all staff will be trained in a standardised format meaning a higher than originally anticipated number of individuals to be trained, or retrained, in safeguarding awareness. This had led the trust to rethink how the training should be delivered and to a decision to offer this training through an electronic learning format. The trust is currently finalising details regarding the provider and the format of the training. More in-depth safeguarding training is to continue being delivered by the local authority and arrangements are in place for this training.

In August 2010 the trust also undertook an audit of staff awareness and experience of safeguarding practices. The audit focused on 200 staff members from a representative cross section of the organisation. While the audit achieved a very good response rate, the findings of the audit indicate poor outcomes in respect of staff awareness about safeguarding practice, reporting mechanisms and level of training. Only 57% of respondents could confirm that they had received any form of safeguarding training in the previous three years. 31% of staff stated they were not confident in knowing what their responsibilities are in respect of safeguarding. Numbers of staff confirming that they had reported safeguarding concerns were noted to be 5% less than those confirming they had witnessed matters of concerns. Not all respondents were confident regarding how they could locate further information or who the safeguarding leads were. Few respondents were able to provide a reasonable definition of a vulnerable adult or state all categories of abuse.

A further information request was made to the trust to clarify how many staff had received any level of safeguarding training in the previous three years. The trust did not have a system in place to immediately confirm these details. However, following discussion with its existing training provider, the trust was able to confirm overall figures for 2007 to November 2010. This told us that less than half of the existing staff had received basic safeguarding training in the previous three years. The trust has since confirmed that it aims for all staff to have received this training by August 2011.

In February 2011 we were made aware of an incident that had occurred in October 2010 where staff had failed to report and manage a child protection concern in a timely and appropriate manner. Following this, we have been provided with a report of the investigation undertaken by the trust. This included a number of recommendations for improved child protection. These recommendations included:

- improved training and supervision processes
- clarity regarding individual staff groups' responsibilities
- job rotation to allow for experience of managing child protection issues
- development of an on call safeguarding rota
- improvements to transfer procedures.

The action plan since supplied by the trust indicates that one of these actions, in respect of improved training, will not be completed until September 2011.

We have since requested further information from the trust regarding the levels of child safeguarding training that staff had completed. The trust has supplied evidence that indicates that, while 82% of staff had received basic training, only 63% of staff have received level 2 training and 69% of staff have received level 3 training, where appropriate to their role. This does not meet the requirements set out in 'Working together to safeguard children' (HM Government 2006), which sets out the standards for staff training in child safeguarding. This requires all staff working in healthcare settings to receive basic training, those with infrequent contact with children to receive level 2 training and those working predominantly with children to receive level 3 training.

**Our judgement:**

Overall we found that improvements are needed for the trust to meet compliance with this essential outcome.

Not all relevant staff had undertaken awareness training in adult safeguarding.

Not all relevant staff had undertaken child safeguarding training in line with the requirements and responsibilities of their role, as set out in national guidance.

An incident has occurred where staff had failed to report and manage a child protection concern in a timely and appropriate manner. We are concerned that a recommendation in respect of improved child safeguarding training, made following investigation of this matter, will not be completed until September 2011.

# Outcome 13:
# Staffing

## What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

## What we found

**Our judgement**

**There are moderate concerns** with outcome 13: Staffing

**Our findings**

**What people who use the service experienced and told us:**

We did not speak with anybody who uses the services during this review.

**Other evidence:**

At registration in April 2010 the trust declared non compliance with outcome 13 in respect of staffing levels for a number of services. The trust was not meeting required staffing levels within the special care baby unit and acute paediatrics service, for its health visiting service and for the district nursing service. The trust supplied us with an action plan that indicated that by 31 March 2011 it would complete a number of actions to meet staffing levels for each service and become compliant with the outcome.

During this review we asked the trust to complete a self assessment and further action plans detailing the work it would complete to become compliant. The trust was also asked to supply information regarding how it was managing risks created by a lack of staff during this interim period.

At October 2010 the trust confirmed that it had redeveloped the care pathway for paediatric care and had successfully recruited sufficient staff within the acute paediatrics service. The trust also evidenced that a long term strategy had been put in place to retain and recruit further staff.

At October 2010 the trust also confirmed that recruitment work was underway to attract sufficient staff to the special care baby unit. In the interim, the service had been reduced by two beds to ensure that there were sufficient staff to safely manage the service. The trust confirmed these actions had been fully supported by the regional neonatal network and contingency arrangements were in place to ensure that, where required, the children received a service from adjacent neonatal services. However, the trust has subsequently supplied further information that indicates that it is not yet meeting the standards for staffing set out in the British Association of Perinatal Medicine guidelines (August 2010), as it was not always able roster sufficient specialist nurses for the 10 beds currently being operated.

The trust has been subject to a performance notice, set by the commissioning primary care trust in February 2010, as it was not meeting national outcome measures for health visiting. Since then the trust has undertaken a large number of initiatives to recruit sufficient numbers of health visitors. This transformation project has included sponsorship of trainee health visitors and recruitment drives to attract staff from other areas, as well as measures to reduce the non clinical elements of health visitors' workloads. At February 2010 the vacancy rate has been more than halved and the trust remains hopeful to have achieved full recruitment by 31 March 2011. In addition, the trust is now meeting national outcome measures for health visiting.

While the trust has confirmed that a process has been put in place to manage demand for district nurses and a transformation programme is in place, the information supplied by the trust in respect of actual vacancy rates has been inconsistent and therefore the actual deficit remains unclear.

**Our judgement:**

Overall we found that improvements are needed for the trust to meet compliance with this essential outcome.

There are currently insufficient specialty nurses available within the acute paediatrics service to ensure that there are always sufficient specialist staff on duty within the special care baby unit.

The trust has confirmed that there is a process is in place to manage demand for the district nursing service. However the trust has not evidenced that it has a clear plan in place to ensure there are sufficient district nurses available by 31 March 2011.

# Action
we have asked the provider to take

## Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

| Regulated activity | Regulation | Outcome |
|---|---|---|
| Treatment of disease, disorder or injury<br>Surgical procedures<br>Diagnostic or screening procedures<br>Nursing care<br>Family planning | **11** | **7** |
| | **How the regulation is not being met:**<br>Not all relevant staff have undertaken awareness training in adult safeguarding.<br>Not all relevant staff have undertaken child safeguarding training in line with the requirements and responsibilities of their role, as set out in national guidance.<br>An incident has occurred where staff had failed to report and manage a child protection concern in a timely and appropriate manner. We are concerned that a recommendation in respect of improved child safeguarding training, made following investigation of this matter, will not be completed until September 2011. | |
| Treatment of disease, disorder or injury<br>Surgical procedures<br>Diagnostic or screening procedures<br>Nursing care<br>Family planning | **22** | **13** |
| | **How the regulation is not being met:**<br>There are currently insufficient specialty nurses available within the acute paediatrics service to ensure that there are always sufficient specialist staff on duty within the special care baby unit.<br>The trust has confirmed that there is a process is in place to manage demand for the district nursing service. However the trust has not evidenced that it has a clear plan in place to ensure there are sufficient district nurses available by 31 March 2011. | |

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

# What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions**: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

## Information for the reader

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