South Warwickshire NHS Foundation Trust

RJC

Community health services for children, young people and families

Quality Report

Warwick Hospital
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CV34 5BW
Tel: 01926 495 321
Website: www.swft.nhs.uk

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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)
RJC46	Royal Leamington Spa Rehabilitation Hospital		CV34 6SR

This report describes our judgement of the quality of care provided within this core service by South Warwickshire 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 South Warwickshire NHS Foundation Trust and these are brought together to inform our overall judgement of South Warwickshire 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?	Requires improvement

Summary of findings

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Overall summary

We found community children, young people, and family services at South Warwickshire NHS Foundation Trust good because:

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Safety performance was monitored by an electronic dashboard widely used in the NHS. When something went wrong there was a process in place to review or investigate incidents involving all relevant staff, children, young people and their families. Lessons were learned and communicated widely to support improvement in other areas as well as services that were directly affected.
- Staff took a proactive approach to safeguarding and took steps to prevent abuse from occurring, and responded appropriately to any signs or allegations. However, some therapy staff told us they had not been trained to level 3.
- Staffing levels and skill mix were planned, implemented and reviewed to keep children and young people safe at all times. Any staff shortages were responded to quickly and adequately to ensure staff could manage risks to patients.
- Risks to patients were assessed, monitored and managed on a day-to-day basis. Risks to safety from service developments, anticipated changes in demand and disruption were assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations.
- Policies and standard operating procedures were up to date and evidence-based.
- Children and young people's care and treatment was planned and delivered in line with current evidence-based guidance, best practice and legislation, including the Healthy Child Programme (HCP). This was monitored to ensure consistency of practice.
- Children and young people had comprehensive assessments of their needs, including consideration of their mental health, physical health and wellbeing.
- Children were cared for by a multidisciplinary team of dedicated and skilled staff.
- Parents were involved in giving consent to examinations, as were children when they were at an age to have a sufficient level of understanding.
- The individual needs of patients were taken into account when planning and delivering services.
- Patients and their parents were supported, treated with dignity and respect.
- Feedback from patients and families was positive and they felt supported and said staff cared about them.
- Patients and families were involved and encouraged in making decisions about their care. Staff spent time talking to children, young people and parents. They were communicated with and received information in a way they could understand.
- Complaints handling policies and procedures were in place. All complaints about the service were recorded. Information on the trust's complaints policy and procedures was available on the trust's internet website.
- All staff we spoke with told us they liked working for SWFT and there was good morale within their teams.
- Staff and managers we spoke with told us there was clear leadership at executive level. Local team leadership was well established and effective and staff said their team managers were supportive.

However, we also found:

- There was no divisional level community children's services quality dashboard or audit plan in place. Community children and young people's services were responsible for monitoring their own activities and outcomes. We found that there was a lack of performance information and no standard approach to monitoring patient outcomes.
- Some staff had not received safeguarding training to an appropriate level and may not have the level of competence to respond appropriately to safeguarding concerns.
- Different information technology (IT) systems made it difficult for staff accessing information on performance in a timely way challenging. There were also challenges in accessing laboratory results due to problems with the electronic records system.

Summary of findings

- Children and young people's needs were met through the way services were organised and delivered**.**We were told about a number of initiatives that the service was intending to do. However, we found it was taking time for action plans to be implemented.
- There was a lack of care pathway guidance for staff to ensure care was standardised across community children and young people's services. The service lacked a common pathway with a joint assessment, co-triage, by a doctor, specialist nurse or approved health professional. Referrals were reviewed by each doctor, but staff we spoke with were unaware of whether there was a SWFT protocol.
- A comprehensive service review was ongoing. However, medical staff had problems accessing performance data to assist with the redesign of services. Senior medical staff reported that this was due to not being able to access performance data, such as patients who did not attend appointments (DNA) and referral to treatment times (RTT) in a timely way. There were unclear quality measures for each service, which meant the service missed the opportunity to collate information that could assist them in reviewing services.
- There was a five year strategy to understand demand. However, there was not a standardised approach across SWFT and this had led to a lack of common dashboards and KPI's. This had been recognised by the service.
- Not all risks were identified on the risk register and so not all mitigating actions were taken.
- Staff told us there was a lack of appropriate information sharing protocols with the provider of school nursing services, and this had an impact on staff having timely access to up to date information.
- Staff reported services as being disjointed at middle management level. Staff told us community children, young people, and families services senior middle managers were not visible, even though they knew who they were.

Summary of findings

Background to the service

South Warwickshire NHS Foundation Trust (SWFT) provides community services to children, young people and families across Warwickshire. Children and young people under the age of 20 years make up 22.6% of the population of Warwickshire. 14.6% of school children are from a minority ethnic group (ChiMat, 2015).

The level of child poverty in south Warwickshire is better than the England average with 13.2% of children aged less than 16 years living in poverty. The rate of family homelessness is similar to the England average (ChiMat, 2015).

During our inspection from 15 to18 March 2016 we visited a range of community children, young people and family services provided by SWFT.

We visited the Family Nurse Partnership (FNP), at Cape Road Clinic. FNP in south Warwickshire is a voluntary programme for young first time mothers (and their partners), aged 19 years or under. They offer intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until children reach the age of two years. The FNP Programme had three aims: to improve pregnancy outcomes: improve child health and development and improve parents' economic self-sufficiency.

We visited the LAC health team at Riversley Park Clinic. The LAC team consists of a small number of specialist doctors, nurses and administrators who provide a dedicated service across Warwickshireto promote the health and wellbeing of children and young people who are looked after by the local authority. The team provide direct work to looked after children and young people plus training to health visitors, social workers and foster carers. They also work with a range of other agencies across the wider children's workforce.

We visited the community paediatrician team. The community paediatrician team are a countywide team of doctors delivering integrated medical services within the community close to home for particular groups of children and families. These include children and young people with long-term and/or complex health conditions and disability and/or social needs, especially vulnerable children.

The child development service is part of the integrated disability service (IDS). All children referred to child development services (CDS), whose families have consented, will be entered onto the IDS central database. The team include: child development advisors; paediatricians; clinical psychologists; and speech and language therapists.The team is supported by a secretary and a co-ordinator.

We visited the community speech and language therapy (SLT) team at Cape Road Clinic. The SLT team support children's speech, language and communication. Children's speech and language therapists worked with children aged 0 to 16 years. These children may experience difficulties in: using clear speech; listening to and understanding language; talking in words and sentences; social interaction; fluent speech (stammering); eating and swallowing.

We visited the north and south health visitor teams. Health visitors work in the community within a team offering support, advice to all families with children aged 0-5 years. Health visiting teams included community nursery nurses, health visitors; some teams have community staff nurses. Health visiting serviceswork closely with other agencies such as GPs,midwives and school nurses. The service offers three levels of support; universal, for all families, universal plus, for families requiring extra support, and universal partnership plus, for families needing on-going support. Health visitors offer support with: post-natal depression; sleepproblems; breastfeeding; feeding issues; speech development; concerns regarding behaviour. The SWFT health visiting service was an early implementer site (EIS) for the 'health visitor implementation plan 2011-2015'.

We visited the children's community nursing team at Exhall Grange School. The team support the care of children and young people who require healthcare outside a hospital setting. The teams care for children who have the most vulnerable health needs across Warwickshire. Children's community nursing teams design packages of care to support children and young people's individual needs; carry out health assessments of children, young people and their family's needs; provide training of health care procedures to other

Summary of findings

services to enable children and young people access to all settings; provide palliative care and symptom management; support young people through transition to adult services. The service operates Monday to Friday, 9.00am to 5.00pm.

The provision of school nursing services in south Warwickshire were tendered to an external provider in 2015, and SWFT was not responsible for the provision of school nursing.

Our inspection team

Our inspection team was led by:

Chair: Jenny Leggott, Former Director of Nursing and Midwifery at Nottingham University Hospitals NHS Trust

Head of Hospital Inspections: Bernadette Hanney, CQC

The team included CQC inspectors and a variety of specialists including: CQC inspectors, paediatrician, and health visitor manager.

Why we carried out this inspection

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

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 on 15-18 March 2016.

During the visit we spoke with over 20 community staff including: community paediatricians, health visitors, community nurses, and support staff.

We talked with three children and young people who use services and five parents. We observed how patients were cared for and talked with carers and/or family members and reviewed care or treatment records. We met with children and young people who use services and their carers, who shared their views and experiences of their care and treatment.

What people who use the provider say

- Patients we spoke with were positive about the care and treatment they received.
- We viewed the community children and young people's Friends and Family Test (FFT) results for the health visiting teams and LAC nursing team. This demonstrated that in February 2016, 100% of community children, young people and families who completed the test were extremely likely to recommend the services to their friends or family; with no patients responding that they were either unlikely or extremely unlikely to recommend the services.

Summary of findings

Good practice

Outstanding practice

- Family nurse partnership (FNP) teams were outstanding in their performance management and quality assurance processes. They had a clear vision and strategy for the FNP service that was monitored via comprehensive quality performance measures.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure that all staff should complete safeguarding children training in accordance with the intercollegiate guidance document published by the Royal College of Paediatrics and Child Health (RCPCH), 'safeguarding children and young people roles and competences for health care staff, 2014.'
- The trust should ensure that appropriate information sharing protocols with school nursing services are in place to ensure staff have timely access to up to date information.
- The trust should ensure that community children, young people and family services staff have timely access to performance data to facilitate quality assurance monitoring and service planning.
- The trust should ensure that community children, young people and family services staff have timely access to information regarding laboratory results and reports.
- The trust should ensure that community children, young people and family services have clear pathways for referral, transfer and discharge.
- The trust should ensure that all risks are identified on the risk register and appropriate mitigating actions taken.

South Warwickshire 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

We found community children, young people and family services good for safe because:

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Safety performance was monitored by an electronic dashboard widely used in the NHS. When something went wrong there was a process in place to review or investigate incidents involving all relevant staff, children, young people and their families. Lessons were learned and communicated widely to support improvement in other areas as well as services that were directly affected.
- Staff took a proactive approach to safeguarding; and took steps to prevent abuse from occurring, and responded appropriately to any signs or allegations. There was active and appropriate engagement in local safeguarding procedures and effective working with other relevant organisations.
- Staffing levels and skill mix were planned, implemented and reviewed to keep children and young people safe at all times. Any staff shortages were responded to quickly and adequately to ensure staff could manage risks to children and young people who used services.
- Risks to children and young people were assessed, monitored and managed on a day-to-day basis. Risks to safety from service developments, anticipated changes in demand and disruption were assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations.

However we also found:

- We could not be assured that all staff were trained to the appropriate level in childrens safeguarding, in line with national guidance.

Good

Are services safe?

Safety performance

- Child and Maternal Health Observatory (ChiMat) 2015 found the health and wellbeing of children in Warwickshire was generally similar to the England average
- ChiMat 2015 information found that infant and child mortality rate of 3.6% in Warwickshire was not significantly different from the England average of 4.0%.
- Statistics from ChiMat 2015 found the number of children aged two years receiving measles mumps and rubella (MMR) vaccinations was 97.4% compared to the England average 92.3%; and diphtheria, tetanus, and whooping cough vaccinations were 98.9% compared to the England average 95.7%. This meant that Warwickshire's results were better than the England average.
- Children in care vaccinations were worse than the national average, at 84.8% compared to the England average 87.8% (ChiMat, 2015).
- Children achieving a good level of development after reception year was 67.2%, similar to both the England, 66.3%, and regional average, 65.1%.
- Children aged 4-5 years in Warwickshire had better, 8.6%, than the England average levels of obesity, 9.1%. 16.8% of children aged 10-11 years were classified as obese, compared to the England average of 19.1% (ChiMat, 2015).
- The number of children with one or more decayed, missing, or filled teeth, was 20%, better than the England average 27.9% (ChiMat, 2015).
- Chimat 2015 found that under 18 years old conceptions, 2.34%, and numbers of teenage mothers, (1.1%) were similar to the national average of 2.44% and 0.9% respectively.
- The community children and young people's services had recently introduced the NHS Safety Thermometer. This is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. Staff told us the NHS Safety Thermometer had provided one month's information, but had not been in use long enough to provide information over time on harm free care.

Incident reporting, learning and improvement

- The community children and young people's service used an incident reporting system widely used in the NHS. From January and December 2015 community children and young people's services reported a total of 46 incidents, including incidents in children and young peoples' homes. None of the incidents had resulted in permanent harm to children, young people or their families.
- Staff told us a serious incident review investigation (SIRI) would be completed as part of the investigation of serious incidents (SIs). There had been no SIRI's in the previous 12 months. Staff told us lessons learned from incidents were shared across community children and young people's services teams. In the case of a SIRI staff told us an action plan would be developed by community children and young people's services as a result of the SIRI's to minimise the risk of incidents being repeated.
- Community children and young people's services staff told us they understood their responsibilities to report incidents using the electronic reporting system and knew how to raise concerns. Staff confirmed that they received feedback on incidents in their own service as well as feedback from incidents in other areas of the trust. Staff and managers told us they were satisfied there was a culture of reporting incidents promptly within community children and young people's services.
- Staff told us they could monitor incidents via the electronic incident reporting system to identify themes. Staff at the Rugby community nursing team told us there had not been any recurring themes identified in the previous 12 months.
- Managers we spoke with told us incidents were discussed at monthly audit and operational governance group' meetings. Records we viewed confirmed the Rugby community children's nursing team demonstrated how information could be extracted from the electronic incident reporting system.
- Managers received safety alerts from the Department of Health's central alerting system (CAS) and would identify any alerts that were relevant to their service. Relevant alerts were forwarded to staff as an "attention" email and a text was sent to staff to ensure all staff were aware of the alert. Staff told us CAS alerts were also placed on staff noticeboards. Staff told us completed actions in response to alerts would be reported to CAS.
- Staff told us about a SWFT patient safety publication that ensured information from safety alerts, investigations, or reviews was disseminated.
- Staff we spoke with were aware of the 'duty of candour'. This is a legal duty on hospital, community and mental

health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Staff told us that community children and young people's services had not had any reason to use the duty since its introduction in April 2015. Staff told us the 'duty of candour' (DoC) was included in the trust's safeguarding training, and said the DoC had a high profile at the trust. For example, a community children's nursing service manager told us the SWFT electronic incident reporting system prompted staff when entering information to consider DoC requirements. This meant that staff were encouraged to consider the DoC in the event of incidents involving patients.

Safeguarding

- The service had a children and young people's safeguarding policy. Staff were able to explain their understanding of the policy and how they used this as part of their practice.
- Parents we spoke with told us they felt their children were safe and expressed confidence in the staff that worked with them.
- The trust's website included contact details for the safeguarding children and young people's unit and advice for parents and carers.
- Child safeguarding governance arrangements include named directors responsible for overseeing child safety. For example, the executive safeguarding lead was the director of nursing. The trust also had a named doctor for safeguarding; a named nurse for safeguarding; and a named midwifery safeguarding lead.
- Staff we spoke with told us they would liaise with the community children and young people's service safeguarding team for advice and guidance on safeguarding. Staff told us they received regular safeguarding alerts from the safeguarding team.
- Health visitors told us that relationship with the midwifery service was good and health visitors were invited to antenatal safeguarding meetings. This meant there was continuity of safeguarding both ante-natal and post-natal.
- Staff across the trust we spoke with told us work was in progress for a south Warwickshire multi-agency safeguarding team (MASH).
- The LAC team told us they had good links with the children's community safeguarding team.
- Health visitors told us they had quarterly safeguarding supervision, where safeguarding incidents, alerts and cases were reviewed.
- Staff we spoke with confirmed that they had received training in safeguarding. We viewed the staff training record for March 2016 and found 100% of eligible clinical staff were recorded as having up to date safeguarding training and 95% of non-clinical staff. However, the training record did not record what level of training staff had received or the number of staff who were trained to level 3 in line with national guidance. A service manager told us there had been some confusion about the level of safeguarding training staff required.
- Some community SLT staff told us they were trained to a level 2 in safeguarding and a band 5 play worker told us they were trained to level 1 in safeguarding. This was not in accordance with the intercollegiate guidance document published by the Royal College of Paediatrics and Child Health (RCPCH), 'safeguarding children and young people roles and competences for health care staff, 2014'. This meant there was a risk that staff may not have the level of competence to respond appropriately to safeguarding concerns.
- HV staff received regular three monthly safeguarding supervisions. If staff did not attend a safeguarding supervision their line manager was informed to follow this up.
- Staff were aware of who the safeguarding leads for the trust were and knew how to contact the safeguarding team.
- The safeguarding team told us they were in the process of rolling out training on 'female genital mutilation' (FGM). We viewed records that confirmed work was in progress to ensure staff were trained in FGM awareness. For example, the December 2015 safeguarding newsletter carried hyperlinks to a government website where staff could access information and resources on FGM.
- We viewed the SWFT lone working policy that had been ratified in June 2015 and was due for review in 2018. The community children and young people's nursing team's lone working guidance for staff involved a 'Buddy' system. This included a framework for staff contacting other staff to ensure they were safe when working in the community.
- We viewed the quarterly community children and young people's newsletter, 'Safe Steps' for December 2015.

Good

Are services safe?

This was sent to all staff via email and available on the SWFT intranet and contained the contact details for the SWFT safeguarding team as well as the safeguarding leads.

Medicines

- Training in the administration of medicines was undertaken by appropriate staff groups. All case holding health visitors were trained in community formulary, prescribing and advanced practice clinical skills.
- The community nursing team service manager told us the team had three extended nurse prescribers.
- All children with care packages had yellow cards. This was a national system for collecting information on suspected adverse drug reactions to medicines. The scheme allowed the safety of medicines and vaccines to be monitored. Staff told us the scheme had reduced transcribing errors. However, during our inspection we did not view the yellow card audits which would have provided evidence of this.
- Community children and young people's nursing teams told us they provided training for families in the administration of medicines for their children where this was appropriate to do so.
- Health care support workers were trained in medicines administration and regularly had their medicines competence reviewed.
- We viewed four children and young people's medicines administration records during home visits and found these were completed appropriately and were up to date.

Environment and equipment

- We found there were adequate stocks of equipment in community children and young people's services. In urgent circumstances, equipment could be supplied to the patient on the same day by the SWFT equipment store. Children and young people and families were informed by the equipment service if they were unable to deliver within timescales.
- The continuing care team told us where a need for a specific piece of equipment was identified that was not provided by specialist or universal services, they could provide the equipment and cross charge the cost to the clinical commissioning group (CCG).
- Maintenance and procurement of replacement equipment was planned in liaison with the SWFT equipment services team. The equipment service was responsible for the maintenance of equipment.
- Health visitors' baby and infant weight scales were regularly serviced. All health visiting staff had their scales inspected checked and calibrated in 2015.
- Staff told us they had acted on an alert from the NHS CAS in regards to subcutaneous infusion drivers by removing the identified driver extensions.

Quality of records

- Staff told us the trust used a paper based system. Paper based records were transferred via the trust's internal mail system. Staff told us they recognised that carrying paper notes around the community in their cars could pose a risk to patient confidentiality. This was not identified on the service's risk register. However, staff had access to secure record cases to mitigate the risk. Staff also highlighted that there had been no incidents involving patients' records being lost or stolen in the community.
- Managers we spoke with told us the children's community service were looking at electronic patient records for children's services and hoped to have a decision by December 2016 in regards to a suitable system.
- The children and young people's service used paper based records. Records we viewed demonstrated staff had managed children and young people's care and treatment plans appropriately. We saw that records were updated regularly and reflected the care and support received. Risk assessments had been completed to highlight any risks to children and young people's safety.
- Community children and young people's paper based records were audited annually by the FNP service, community nursing team, and health visiting teams. We viewed the results of the 2015 audit. Overall results demonstrated compliance with documentation standards. However, the report collated results and identified areas for improvement. For example, the results for signing and dating children's and young people's paper based records were 97.1%. 0.7% of the records were not signed or dated, and 2% of records

were signed and dated sometimes in the records. The audit report also highlighted learning for staff, recording "a signature and date following a contact with a client is a basic requirement, the results should be 100%".

- It is a national requirement for health practitioners to include their Nursing and Midwifery Council (NMC) PIN number on children and young people's records. The community children's services records audit results found that 62.12% of staff had recorded their NMC number. This meant that 37.9% of staff had not recorded their NMC number. The audit highlighted that this was a slight improvement on the 2014 figure which was 59.8%. However, the audit report recorded that this would be reported back to clinical leads to ensure staff took this on board, and ensure staff recorded their PIN numbers on children and young people's records.
- Staff at the FNP told us they used paper based patient records. However, electronic performance related data was collected by the FNP electronic records system, 'Open Exeter'. FNP staff told us this enabled them to adjust visits on the basis of the data collected.

Cleanliness, infection control and hygiene

- We viewed the community health services hand hygiene audit for the period January to December 2015. We saw that children and young people's community services regularly achieved 100% for hand hygiene practice.
- All staff received a staff handbook which had a reminder for staff on good hand hygiene practice. For example, washing hands when entering and leaving clinical areas.
- Overall, we found hand hygiene practice was appropriate across community children and young people's services. However, there was a lack of hand gel at Exhall Grange School.

Mandatory training

- We reviewed the March 2016 community children and young people's service records for staff training, which were broken down by clinical staff and non-clinical staff groups. We found that training had been undertaken in most instances, or arrangements had been made to attend training. For example, mandatory training for community children's and young people's clinical staff consisted of: fire training (91%), health and safety (82%), infection prevention and control (100%), moving and handling (92%), information governance (95%), emergency life support (100%), safeguarding children (100%), safeguarding adults (100%), conflict resolution training (96%), and equality and diversity training (100%).
- The mandatory training spreadsheet did not record the level of safeguarding training staff had completed, with the exception of level 2 children's safeguarding with 100% of staff having completed this. The December 2015 safeguarding children and young people's newsletter reminded staff of their responsibility to ensure they were trained to an appropriate level in safeguarding children.
- Manager's told us staff were supported to attend mandatory training within their working hours.
- Staff mandatory training was an agenda item on staff annual appraisals. Staff training needs and training records were reviewed as an aspect of their performance and development review.
- Staff told us they could request further training in addition to their mandatory training but additional training was only available to staff who had completed 100% of their mandatory training.

Assessing and responding to patient risk

- Community based staff we spoke with were able to demonstrate awareness of the key risks to children and young people. For example, safeguarding and domestic abuse.
- We found from viewing children and young people's records that risk assessments were in place to identify specific risks. Risk assessments also contained guidance for staff on mitigating risks. For example, using hoists.
- Depending on risks identified to children and young people staff were aware of how to arrange further support, by referral for specialist assessment, supply of additional equipment, or admission to hospital for children or young people whose condition appeared to be deteriorating.
- Health visitors told us they did antenatal checks at 25 weeks gestation. Universal services included a visit whenbabies were 11 to 14 days old, a visit whenbabies were six to eight weeksold, a contact whenbabies were three to four months old, and a nine month healthreview.
- The HVS offered three layers of intervention, 'universal' which was available to all parents; 'universal plus' and 'universal partnership plus' for parents who might require extra support.

Good

Are services safe?

- The HVS worked closely with early years staff in children centres and early years settings for the HCP review at age 2-2.5 with early year's foundation stage assessments for pre-school children.
- Staff in the LAC team were not meeting statutory national requirements for the assessment of children looked after. Staff told us LAC were assessed every six months. Looked after children were not receiving their first health assessment and a health plan by the time of the first review of the child's care plan, four weeks after becoming looked after. Staff and managers told us this was due to delays caused by the local authority and not due to SWFT. Managers told us they were in communication with the local authority to resolve the issue. However, this was not identified on the service's risk register.

Staffing levels and caseload

- Overall we found there was a stable workforce at SWFT community children, young people and families' services, and a low rate of staff turnover. Staff in general reported that they had manageable caseloads.
- We viewed the local caseloads spreadsheet for community nursing. We found that the south community nursing team had 5.6 whole time equivalent (WTE) band 6 nurses and 3.4 WTE band 5 nurses. The north team had 3.4 WTE band 6 nurses and 2.6 WTE band 5 nurses. The education locality team had 2 WTE band 6 nurse and 0.94 WTE band 5 nurses. The play locality had 2 WTE band 5 nurses and 1 WTE band 4 staff. The community nursing team was supported by 24.7 WTE band 4 nurses and 2.8 WTE band 3 nurses. The team also had 2.9 WTE locality managers, and 3.9 WTE lead nurses.
- Community children, young people and families' physiotherapy's overall caseload was 1155. This broke down as 492 in the south team, 145 in the east team, and 517 in thenorth team. The average caseload across the service was 60 cases for every WTE physiotherapist.
- Community children and young people's occupational therapy's (OT) active caseload in the south team was 282 and in the north team it was 333. The total of WTE OT clinical staff which includes OT core, OT traded service and OT's on fixed term posts was 15.3. In addition there was a WTE 0.6 practitioner who was employed by the local county council working with the team and managing adaptation referrals.
- The total of WTE for support staff OT assistants and OT technicians, who held a case load was 3.9.
- Staff at the north community nursing team told us they had the highest rates of sickness absence in the service. Staff said this was due to complex work, but also due to staff being encouraged to take sickness absence if they had any signs of infection. Staff said this ensured patient safety and also ensured staff did not work when they were feeling unwell. However, staff did concede that high levels of staff absence could leave the team short of staff and place extra stress on the team.
- Overall, rates of staff turnover were low. For example, the FNP and child health medical north team had no vacancies in the year March 2014 to April 2015. Staff told us figures had remained low up to 2016. Most staff we spoke with told us they liked working for SWFT.
- Health visitors told us the service's own staff would work as bank workers and this alleviated the use of agency or locum staff.

Managing anticipated risks

- The community children and young people's nursing team had a framework in place to ensure information which could affect staff working in the community was cascaded. This involved staff having named members of staff they would contact. Staff told us the framework had been used recently to inform staff of areas affected by flooding.
- Staff working in the community on their own used a signing in and signing out system when they left the office, as well as a 'buddy' system to ensure their safety. Staff carried mobile phones to ensure they could contact, or be contacted by, the office or their 'buddy' in an emergency.

Major incident awareness and training

- SWFT had guidance for staff on dealing with a major incident. Community teams had business continuity plans in place in regards to inclement weather.
- Some community staff told us they were unaware of how community services would be utilised in a major incident.

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.

We found community children, young people and family services good for effective because:

- Children and young people's care and treatment was planned and delivered in line with current evidence-based guidance, best practice and legislation, including the Healthy Child Programme (HCP). This was monitored to ensure consistency of practice.
- Children and young people had comprehensive assessments of their needs, including consideration of their mental health, physical health and wellbeing.
- Children were cared for by a multidisciplinary team of dedicated and skilled staff.
- Parents were involved in giving consent to examinations, as were children when they were at an age to have a sufficient level of understanding.

However, we found that:

- Different IT systems made it difficult for staff accessing information on performance in a timely way challenging.
- Staff in the LAC team told us there were problems accessing laboratory results due to problems with IT access on the SWFT electronic records system. Staff told us this meant staff had to spend time following up results.
- There was no community children's services dashboard or audit plan in place. Community children and young people's services were responsible for monitoring their own activities and outcomes. We found there was no standard approach to monitoring patient outcomes.

Evidence based care and treatment

- Staff at the community children's nursing team told us policies were approved by the children's policy approval group. The group would formulate policies for all activities.
- SWFT was an early implementer site (EIS) for the 'Health Visitor implementation plan 2011-2015: A call to action, 2011.' This was part of the government's agenda to introduce an evidence based approach in health visiting. The objective was to provide high quality support for families and children by expanding health to tackle population health issues and deliver better health outcomes. Children's community nurses we spoke with told us the EIS had increased the resources available to the health visiting service.
- Health visitors delivered the Healthy Child Programme (HCP) for pre-school children, which was designed to offer a core, evidence based programme of support, starting in pregnancy, through the early weeks of life and throughout childhood. Health visitors were the gateway to other services families needed. For example, we viewed the SWFT 'Safeguarding Children' policy; this had been approved on 15 April 2015 and was due to be reviewed in April 2018.
- Community children and young people's services had a range of standard operating procedures available to provide guidance for staff. These included: 'intermittent catheterisation', this is a safe and effective way of managing patients with urinary retention or incontinence; 'tracheostomy', this is an opening created at the front of the neck so a tube can be inserted into the windpipe to help patients breathe. Standard operating procedures were up to date and had a review date. They also carried the National Institute for Clinical Excellence (NICE) guidance that underpinned the practice area, and hyperlinks to the policy that had informed the procedure to enable staff in accessing the original documents.
- New guidance from NICE or the Royal Colleges was a standard agenda item of the 'audit and operational governance group'. This was a monthly meeting attended by community service leads.
- We viewed a range of policies on the SWFT intranet. We found the policies were in date and had review dates. For example, the SWFT domestic abuse policy had been approved in December 2015 and was due for review in December 2016. The policy had a list of references for staff as well as links to external organisations including the National Society for the Prevention of Cruelty to Children (NSPCC).
- Health visitors demonstrated how care for children and young people requiring long term ventilation was based on the West Midlands Quality Review Services (WMQRS), Quality Standards 2015. WMQRS was a

collaborativeventure by NHS organisations in the West Midlands to improve the quality of health services by the provision of evidenced based practice standards across the region.

- Staff at Stratford-upon-Avon health visiting service told us about the SWFT preceptorship programme for newly qualified staff. However, staff told us they did not have any staff who were on preceptorship at the time or our visit as eligible staff had completed their preceptorship.
- Health visitors had achieved level 3 UNICEF 'Baby Friendly' accreditation for breastfeeding. The Baby Friendly Initiative is based on a UNICEF and the World Health Organization (WHO) global accreditation programme. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care
- The quarterly community children and young people's newsletter, 'Safe Steps' contained hyperlinks for staff on new safeguarding policies. For example, the December 2015 had links to guidance on the Warwickshire neglect strategies guidance on 'bruising in non-mobile babies' and government guidance on 'what to do if you're worried a child is being abused'.

Technology and telemedicine

- Staff told us they used the SWFT electronic information system, to record patient contacts, but not as a patient record system. Staff said SWFT were looking at systems of mobile working for community staff as this would improve staff access to patient information.
- Staff at Stratford-upon-Avon children's community team told us there was a working party looking at suitable electronic records systems for community children and young people's services.

Patient outcomes

- There was no community children, young people and family services dashboard or audit plan in place. Community children and young people's teams were responsible for monitoring their own activities and outcomes. We found there was no standard approach to monitoring patient outcomes. This made it difficult for children and young people's outcomes to be benchmarked and monitored across community children and young people's teams.
- Staff at the community children's SLT team told us they audited patient outcomes, but that audits were ad hoc.
- The FNP team's FNP programme included a national framework for measuring how well the programme was being implemented in context of the Core Model Elements or 'Fidelity Goals' that cover core aspects of the programme's delivery andimplementation. They were designed to enable the FNP teams, commissioners and provider organisations to measure the successful implementation of FNP and support continuous quality improvement in delivery. Staff told us the 'Fidelity Goal' outcomes were monitored by the FNP National Unit, and as a result the team knew what their performance targets were. Staff added that the team's objectives were monitored by the FNP National Unit quarterly advisory boards as well as the annual FNP National Unit review.
- The FNP's 'Fidelity Goals' covered four main areas: recruitment and enrolment, retention of clients, amount of programme received (also known as dosage which was measured by visits); and programme content received (measured by thespread of content delivered in each of the programme's domains).
- The SWFT FNP team were meeting or had met the enrolment goals of: at least 60% of young mothers being enrolled on the programme before the 16th week of pregnancy and 100% no later than 28 weeks; 100% of enrolled first time mothers were within the specified age bracket; 75% of eligible young mothers who were offered the programme were enrolled; and each nurse enrolling 25 families within 12 months of recruitment commencing. Staff told us the National Unit were the main auditors for the FNP team.
- The health visiting service delivered the full HCP from to five years, with a focus on working across services for children and their families to improve public health outcomes. The HCP offered every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices.
- We viewed a spreadsheet the health visiting service had produced for the local authority in relation to the health visiting services 'activities and outcomes'. For example, the spreadsheet recorded that 45% of infants were breastfed at six to eight weeks. This was better than the England average in the infant feeding survey 2010, published 2012, where the rate was 24% (results from the 2015 survey were unavailable at the time of inspection).

Good

Are services effective?

Competent staff

- All community nursing teams had a consultant nurse to supervise clinical practice. The SWFT north community nursing team told us they received safeguarding supervision three times a year, as well as clinical supervision every eight weeks.
- The trust's health visitors were all trained in health visiting. Staff we spoke with told us all the work of the health visiting service had to come from an identifiable evidence base. Staff described how they could access the trust's policies and procedures on the trust intranet. The health visitors' clinical lead at the south team told us they did a clinical round with every health visitor annually, where they accompanied staff on home visits and observed their practice.
- Staff at the LAC team told us they linked to the British Association of Adoption and Fostering (BAAF) regional groups to share best practice. The December 2015 issue of the safeguarding children's newsletter informed staff who worked with looked after children that they must ensure they met the required competency requirements by accessing their correct level of safeguarding children training.
- The December 2015 safeguarding children's newsletter also carried a reminder to staff in regards to LAC supervision and training. The newsletter informed staff that this was available for health visitors and family nurses, and could be accessed via the electronic learning and development records system, and that a range of dates and venues were available throughout the year. Health visitors we spoke with confirmed that they had attended LAC training.
- FNP staff received a range of supervision, including clinical supervision, quarterly safeguarding supervision, monthly business meetings and team training days, where staff developed their practice skills or reviewed information from the National FNP programme. FNP staff told us supervision in the team was protected time. Staff told us this had fostered an innovative culture which had been recognised by SWFT and as a result they were a model of supervisory practice for the health visiting teams. FNP staff said supervision for health visitors had improved as a result of the work the FNP was doing in regards to supervising staff.
- Staff at the FNP told us they were revalidated every year on interventions. If staff did not pass their revalidation they were offered further training. Staff told us their supervisors revised their practice standards every three months.
- Staff at the FNP showed us their job descriptions. Staff told us they worked in accordance with their job descriptions. Staff said the job description was extensive as it was based on the FNP nurse description from the FNP National Unit.
- Health visitors told us they were under regular performance monitoring as a result of being an EIS. The EIS is national roll out of improved ways of working for health visitors. SWFT had seven health visitors who were fellows of the institute of health visiting. For example, the Stratford-upon-Avon team manager did an annual clinical round to assess staff competence.
- Community children's nursing teams had bi-annual clinical skills days for both nurses and support workers. These were training days for staff to look at clinical practice.
- Health visitors told us they had good access to training opportunities. This included core training, for example in using the health visitors' developmental tool and training in domestic abuse awareness. Health visitors had an annual conference; this was a development day that included training, reflection and future developments for the service.
- Community children and young people's support workers were known as 'carers'. Support workers told us at a focus group that they received regular three monthly group supervisions and these would take place at a designated support workers home.
- Staff had access to the Coventry and Warwickshire children and young people's competency framework; this was an e-learning competency system that had replaced paper based competency assessments. The aim of the framework was to enhance the training and educational experience of nurses and care staff of all levels by delivering a high quality interactive on-line system. Staff told us the system was useful in maintaining skills and knowledge. Staff told us the e-learning involved a workbook and was reviewed annually.
- We viewed the community children and young people's spreadsheet for staff who had received an annual appraisal. We found that the percentages of staff who

had received an annual appraisal met the Trust target of 90%. For example, the record indicated that 100% of clinical staff had received an annual appraisal and 93% of non-clinical staff.

Multi-disciplinary working and coordinated care pathways

- A member of the safeguarding team staff told us about a multi-agency risk assessment conference (MARAC) they had attended during our inspection to ensure risks regarding a person who used services were appropriately assessed. Staff told us they attended MARAC's in Rugby, the south and north areas of SWFT on a monthly basis.
- Health visitors had a monthly liaison meeting with midwives. They also visited children's centres fortnightly to discuss families who were supported by both the service and the children's centre.
- Health visitors we spoke with told us they considered multi-disciplinary working as strength in the service. Health visitors gave examples of their relationships with GP's, schools and children's centres. All GP's had a named health visitor.
- Staff at Stratford-upon-Avon children's community team told us they had good relationships with the perinatal mental health team and the drug and alcohol team as they were in the same building. Staff said if they had any queries the adult specialist teams were accessible and helpful.
- The safeguarding team told us a multi-agency safeguarding hub (MASH), was due to be launched in April 2016. This would be a single point of access for all professionals to report safeguarding concerns.

Referral, transfer, discharge and transition

- Staff at community children and young peoples' services told us integrated community health services were arranged into 'locality teams', with the aim of ensuring children, young people and their families received a seamless service during referral, transfer, discharge and transition.
- We viewed a range of community children's, young people and families services care pathways including: cystic fibrosis (this is an inherited condition in which affects the lungs and digestive system and can cause problems with breathing and digestion), and transitions for young people with life limiting conditions. Transitions are pathways that help young people move between children's and adult services. However, these were models from other organisations. For example, the cystic fibrosis care pathway was from the cystic fibrosis trust, and the 'stepping up' transitions care pathway, a 'guide for young people with life limiting conditions', was a pathway from 'Together for short lives'.
- We viewed the SWFT 'continuing care' pathway. This provided a care pathway in regards to assessing, planning, and implementing care for children under the age of 18 years, who needed support with complex care packages that might involve education and the local authority social services department.
- Health visitors told us the children and young people's hospital wards were good at notifying them of babies and pre-school children who were discharged home. Health visitors said SWFT had a paediatric liaison nurse so that community staff would have someone they could liaise directly with at the hospital to speed up transfers, discharges, and transitions.
- Health visitors told us they worked closely with families and the local authority for children who were being adopted.

Access to information

- Staff across community children, young people and family services told us information technology support could be a problem. Some staff told us there was a "patchwork" of different IT systems and this made accessing information on performance in a timely way challenging.
- Staff at the LAC team told us there were problems accessing laboratory results due to problems with IT access on the SWFT electronic records system. Staff told us this meant staff had to spend time chasing up results. This was not identified on the service's risk register. Staff told us they had reported the problem, but the problem had persisted.
- Health visiting staff told us there had been problems gaining access to information on children they were working with, due to a private company that had taken over school nursing services in south Warwickshire not releasing information in a timely way. Managers told us they were in communication with the school nursing service provider in regards to devising information sharing protocols.

Good

Are services effective?

- All staff received a SWFT staff handbook. Some of the staff we spoke with showed us their staff handbook, this signposted staff to information to SWFT policies on the intranet, including safeguarding and whistleblowing, as well as an explanation of serious incidents.

Consent

- The community children's nursing team told us consent to share information and consent to provide care and treatment to children and young people was recorded and reviewed annually.
- Parents were involved in giving consent to examinations, as were children when they were at an age to have a sufficient level of understanding. Staff were aware of the Fraser guidelines and Gillick competence, this is a decision whether a child or young person aged 16 years or younger, is able to consent to their own medical treatment, without the need for parental permission or knowledge. Staff told us they would always speak with young people and encourage them to involve their parents when appropriate but would respect the rights of a child/young person deemed to be competent to make a decision about their care or treatment.
- We observed how staff explained procedures to children in a way they could understand. We attended home visits with health visitors where we observed a number of examples of staff asking for permission before providing care. A parent told us, "They always ask permission."
- The children's community nursing team and health visitors told us they had received training in consent and this had included the Fraser guidelines and Gillick competence.
- All the parents and carers we spoke with told us they felt involved in their child's care. We saw that staff spent time with children, young people and their parents to ensure they understood their care and treatment.

Good

Are services caring?

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

We found community children, young people and family services good for caring because:

- Children and young people and their parents were supported and treated with dignity and respect.
- Feedback from children, young people and families was positive. Children, young people and their parents were treated with kindness during interactions with staff and relationships with staff were positive. Children, young people and families felt supported and said staff cared about them.
- Children and young people were involved and encouraged in making decisions about their care. Staff spent time talking to children, young people and parents. They were communicated with and received information in a way they could understand. Staff responded compassionately when children and young people needed help and supported them to meet their basic personal needs. Children and young people's privacy and confidentiality were respected at all times.
- Parents spoke highly of the care children and young people received and told us they felt involved in their children's care. We observed examples of compassion and kindness by staff. Staff spent time with children, young people, and their families in their homes and in clinic environments to make sure they understood their care and treatment.

Compassionate care

- We observed compassionate care delivered by staff across community services. Staff were seen to be very considerate and empathetic towards children, young people and their families, and other people. Staff demonstrated a good understanding of children and young people's emotional wellbeing. Children and young people's social and emotional needs were valued by staff and embedded in the care and treatment community staff provided. There was a strong visible person-centred culture. For example, we observed a health visitor talking to a parent about their family. It was apparent from the conversation that the health visitor knew the family and was aware of their needs.
- Throughout our inspection we found the approach staff used was consistently appropriate and demonstrated consideration and compassion for the child or young person. Staff interacted with children, young people and their relatives in a respectful and considerate manner. A parent told us about their health visitor, "They always treat me with respect and dignity. The health visitor has been brilliant."
- The trust had rolled out the NHS Friends and Family Test (FFT). We viewed the results for community children's services for February 2016. Comments from parents included, "Health visitors genuinely care about children and their development"; and "My health visitor is very helpful and caring"; and "My care is always thorough. Everything is always covered, I completely trust them."

Understanding and involvement of patients and those close to them

- The community children, young people and families nursing team gave each new patient an information folder. This included information on what the team did and the hours the team worked. The folder also carried information on: the named nurse for the child or young person; the standards of care children, young people and families could expect from the team, including information on; community play specialists; education facilitation; and rheumatology services. There was a section in the folder to record useful contact details.
- The community children, young people and families had a fridge magnet they distributed to families and the families of staff with the on-call telephone number. This was a handy way for families to access the contact details of the on-call nurses.
- The community children, young people and families' service had a bi-monthly communication group that met to discuss how communication with children, young people and families could be improved.
- The community children's nursing team offered training to parents in medicines administration and feeding. The team had also worked with the parents of children receiving large ventilator packages of care to assist them in understanding the care their children were receiving, and why qualified nursing staff would need to take the lead in providing the ventilator care.
- We saw a health visitor providing appropriate advice and information to a parent on breast feeding during a home visit.

Good

Are services caring?

- FFT comments from parents included, “I'm really impressed with all the help and advice given. Any questions I have are always answered”; and “My child was given the best possible treatment when needed and was treated with dignity and respect all the time. I was given proper advice and suggestions whenever I was concerned about my child's health”.

Emotional support

- We observed staff providing emotional support to children, young people and relatives. Staff we spoke with were aware of the emotional aspects of care for patients living with long term conditions and provided specialist support where this was needed. Relationships between children, young people, parents and staff were strong, caring and supportive. Relationships with children, young people and their families were highly valued by community children, young people and families’ staff.
- We saw a health visitor ask a parent about how they were feeling during a home visit. The parent had been experiencing ‘low mood’ and told the health visitor that this had now lifted. The health visitor was supportive and sensitive in discussing family relationships and emotional support with the parent.

Good

Are services responsive to people's needs?

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

We found community children, young people and family services good for responsive because:

- Patients' needs were met through the way services were organised and delivered**.** We were told about a number of initiatives that the service was intending to do. However, we did find it was taking excess time for action plans to be implemented.
- Individual patient needs were taken into account when planning and delivering services.
- Complaints handling policies and procedures were in place. All complaints to the service were recorded. Information on the trust's complaints policy and procedures was available on the trust's internet website.
- Overall we found there was good access to childrens and young people's services.

However, we also found:

- Medical staff had problems accessing performance data to assist with the redesign of services. Senior medical staff reported that this due to not being able to access performance data, such as patients who did not attend (DNA) appointments and referral to treatment times (RTT) in a timely way.
- There was a lack of care pathway guidance for staff to ensure care was standardised across community children and young people's services. The services lacked a common pathway with co-triage by a doctor, specialist nurse or approved health professional. Referrals were reviewed by each doctor, but staff we spoke with were unaware of whether there was a SWFT protocol.

Planning and delivering services which meet people's needs

- Work was in progress on a business plan, 'the big picture', to standardise the community children's and young people's services approach. We viewed the proposals for the standardised approach. However, staff we spoke with told us they were aware that changes were in the pipeline, but said they did not fully understand the reasoning for changes in the service. The trust told us that the process involved service managers and team leaders at the time of inspection, and they were ensuring the proposals were 'fit for purpose' before engaging staff. Staff thought the changes were due to tendering processes, whilst managers told us changes were related to the sustainability of services.
- We viewed the 'children, young people and families – work programme review 2016-17', this clearly outlined the objectives for the community children and young people's service and the schedule for implementing the work programme. The review would include a review of children's paediatric services with the objective of ensuring an equitable distribution of services across south Warwickshire. The work programme review recorded that service specifications were in place as well as key performance indicators (KPIs). The target for completion of service specifications and KPI's was July 2016.
- The Clinical Lead for Community Paediatrics told us community children, young people and families services were starting to review the service. However, the Clinical Lead for Community Paediatrics told us this was proving difficult as they did not have access to performance data, such as patients who DNA appointments and RTT in a timely way. The Clinical Lead for Community Paediatrics told us they had requested the data from the electronic data management team but had not received this, even though staff were putting data into the system.
- The Clinical Lead for Community Paediatrics told us that children who did not have autism spectrum disorder (ASD, a condition that affects social interaction, communication, interests and behaviour), were not subject to a common pathway with co-triage by a doctor, specialist nurse or approved health professional. Referrals were reviewed by each doctor, but staff we spoke with were unaware of whether there was a SWFT protocol. A staff member told us both acute and community referrals went through a common gateway, a single point of access. However, this could result in inequalities as children would be seen in their locality and may not be seen by the most appropriate professional.

Good

Are services responsive to people's needs?

Equality and diversity

- Staff we spoke with told us that children and young people's cultural and religious needs were assessed as an aspect of their' initial assessments. The patient's records we viewed included specific information on children's cultural or religious needs.
- The trust communications team could provide information documents in other languages, large print, Braille and audio format upon request. Staff told us that where the service did not have high demand for information in other languages; patients could request information and receive it quickly from the trust's communications team.
- Staff told us people who did not use English had access to a face to face interpreting service as well as a telephone support interpreting service.
- The SLT team had a number of initiatives to engage families with English as a second language. This included working with children's centres to identify families at risk of isolation due to language barriers.

Meeting the needs of people in vulnerable circumstances

- A clinical lead health visitor told us the service were in the process of reviewing the learning disability provision at community children and young people's services. They told us staff were engaged in a working party to look at pathways for children with a learning disability.
- A health visitor had adapted a tool for parents who had learning disability as an aspect of the Baby Steps programme. This is an NSPCC ante-natal programme that helps vulnerable parents cope with the pressures of having a baby. The tool looked at how the parents processed information to enable health visiting staff to assist the parents understanding of how to care for a child.
- The LAC team told us they had experienced problems in accessing information to plot patient's journeys due to limited access to IT systems. Staff at the team told us the "talk of going paperless" had not come to fruition.
- The child development service (CDS) assessed pre-school children suspected of autism. The team included staff with specialist skills in autism including; consultant paediatrician, clinical psychologist, specialist speech and language therapist, child development adviser and lead consultant pre-school teachers. Children and parents attended appointments over a five-week period. At the end of the assessment there was a discussion attended by all the professionals involved, and parents meet the CDS team to discuss the assessment, conclusions, recommendations, any diagnosis given, and to plan care where the outcome of the assessment indicated that a child needed support.
- Children and young people with additional needs, for example, due to hearing or visual impairment had this recorded in their care records.

Access to the right care at the right time

- Overall we found there was good access to services with health visitors meeting their referral to treatment times (RTT).
- There was a single point of access (SpA) based in Rugby for community children and young people's services. Referrals were faxed to the SpA. Referrals would be sent by the SpA to the appropriate team based upon postcode. The SpA was administrative and did not triage. Staff at the SpA told us triage was completed by the team the referral was forwarded to. Staff said all referrals were forwarded to the appropriate team on the same day or within 24 hours.
- Data submitted by SWFT stated that the maximum waiting time community children's SLT was 18 weeks, but this was for "low priority" patients. The data did not indicate what percentage of children were seen within 18 weeks.
- The RTT performance for integrated specialities paediatric occupational therapy met 100% of its target in 2015. However, the rate in March 2016 was 83.3%, which did not meet the trust target of 90%.
- The community paediatrics team had not met the SWFT target RTT in 2015. 84.6% of children and young people were seen within three days, against a target of 90%.
- There had been improvements in the number of LAC receiving initial health assessments in the previous 12 months. Over 90% of eligible children had received a LAC in the appropriate timescale from January to March 2016. This exceeded the SWFT target of 85%.
- The LAC team were not meeting the 28 day target for health reviews. However, this was due to delays caused by the local authority in sending information on LAC. We saw that the senior management team had an action plan in place to monitor the 28 day target as part of the 'children, young people, and families work programme 2016-17'.

Good

Are services responsive to people's needs?

- From September to December 2015, health visitors completed 1287 face to face new birth visits. 87% of these were seen by a health visitor within the target of 14 days.
- The community children's nursing team 'standards of care' set out the standards of care children and young people could expect from the team. This included all new referrals being seen within five working days from referral.
- The FNP had a flowchart that clearly explained the discharge process for children who were being discharged or transferred to universal services or to another community team, or for children who were being discharged out of the county to a different authority.
- The FNP conducted a comprehensive annual review in 2016. This recorded that 63% of parents and children had received 80% of their visits, this was slightly better than the national average of 57%; in toddlerhood 40% was below the national average of 57%. The review recorded that the FNP team were reviewing delivery of the programme in toddlerhood and visits might be an area of change in the proposals from the National Unit.
- The FNP annual review reported activity in pregnancy in the previous 12 months in infancy as 79% of clients achieving 65% of visits, this was better than the national average of 58%. In toddlerhood 55% of children achieved 60% of visits this was slightly worse than the programme average of 60%.
- 95% of children were seen by community nurses within the standard five days.

Learning from complaints and concerns

- SWFT had complaints handling policies and procedures in place. All complaints to the service were recorded. Information on the trust's complaints policy and procedures was available on the trust's internet website.
- Community children and young people's services had one formal complaint in the previous 12 months. Actions taken to address the complaint were recorded on the complaints log.
- Information for children, young people and families about services included information about how to raise concerns or complaints and information about the patient advice and liaison service (PALS). Most parents we spoke with were aware of the complaints procedure. Staff we spoke with told us they would direct a young person or parent to PALS if they wished to make a complaint.
- Staff we spoke with were aware of the trust's complaints policy and of their responsibilities within the complaints process. Formal complainants were directed to PALS; informal complaints were logged. However, managers we spoke with told us they would always try to resolve an informal complaint from parents, children or young people immediately. Staff were aware of complaints parents, children and young people had raised about their service area and of what was done to resolve the complaint.
- Managers told us action to be undertaken following the investigation of a complaint was identified and discussed with the child, young person and parents. Line managers fed back learning from complaint investigations at team meetings. We viewed the community children's services complaints log and saw that action plans in response to complaints were in place, and the completion of actions was monitored.

Requires improvement

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.

We found community children, young people and family services requires improvement for being well led because:

- The service had a five year strategy to understand and meet demand. However, there was not a standardised approach across SWFT and this had led to a lack of common dashboards and KPI's.
- Staff told us and meeting minutes we viewed acknowledged that there was a lack of performance information in community children, young people, and families' services. However, this was not included on the risk register.
- Community children, young people, and families services was undergoing a comprehensive review. However, in not having a clear quality measures for each service the service was missing the opportunity to collate information that could assist them in reviewing services.
- Staff told us there was a lack of appropriate information sharing protocols with the provider of school nursing services, and this had an impact on staff having timely access to up to date information.
- Staff told us community children, young people, and families services senior middle managers were not visible, even though they knew who they were.

However, we also found that:

- All staff we spoke with told us they liked working for SWFT and there was good morale within their teams.
- Staff and managers we spoke with told us there was clear leadership at executive level. Local team leadership was well established and effective and staff said their team managers were supportive. However, staff reported services as being disjointed at middle management level.

Service vision and strategy

- We viewed nurse management meeting minutes, 2 October 2015. The meeting had been attended by the team leads from across community children and young people's services. The need for the service to have a vision had been discussed. However, it was unclear from subsequent meeting minutes, in December 2015 and February 2016, whether there had been any action in regards to the vision for children's services, and no updates recorded in the minutes.
- Most staff were aware of the overarching SWFT vision and values as these were published in staff handbooks and publicised on the intranet.
- The 'Big Picture' strategy was in development to provide a framework by which each service manager and team lead could systematically review quality and identify their local priorities. However, staff had not yet been consulted on this so were unaware of the local vision for children's services.
- SWFT had a five year plan, 2014 to 2019 for children's services. The strategy objectives were "to deliver a sustainable local acute, surgical and community children's services providing care closer to home with no gaps in service provision." The strategy had identified the need for SWFT to understand capacity and demand and highlighted the need for dashboards and KPI's.
- We viewed the services 'business team meeting' minutes, 4 September 2015. We saw that standardising approaches across south Warwickshire had been discussed at the meeting. The meeting highlighted that north and south Warwickshire had different approaches in terms of commissioning of services. The general manager highlighted at the meeting the need to have some common models around resources, needs analysis, practice, referral pathways with access to provision based on need. We saw that work was in progress on the standardisation agenda and a work programme was in place for 2016-17. However, according to the children, young people and families – work programme review 2016-17' a strategy group was not due to review the children and young people's strategy until April 2016. Work was in progress, but the process had taken eight months from the date of the meeting and over 18 months since the five year plan had been launched.

Requires improvement

Are services well-led?

- The FNP, on the 17 March 2016 annual review clearly reviewed the work of the service in the previous 12 months and created a strategy with a documented action plan for the service in 2016/17. As a result FNP staff had a clear local vision and strategy.

Governance, risk management and quality measurement

- We could not identify a clear approach to monitoring, auditing, or benchmarking across community children, young people and family services. For example, staff told us they had found accessing information for a community children and young people's services review on DNA and cancellation rates difficult, due to being unable to get information from the electronic data system.
- We viewed minutes from the 'audit and operational governance group', dated from July 2015 to January 2016. We saw that the meetings discussed incidents and complaints on a regular basis, as well as audit activity and safeguarding children. However, with the exception of a 'NG 26 Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care audit' and a LAC report, we did not see any evidence in the minutes of any specific discussions of community children, young people, and families services or actions in response to discussions at the meetings being followed up at subsequent meetings.
- Business team meeting minutes, 8 January 2015, recorded that children, young people and family services had attended an electronic patients records meeting. At the meeting there was an analysis of community children, young people and family services requirements in comparison to the electronic records systems the service were using. At the meeting it was acknowledged that the electronic systems that were in use were "not the best solution for children's services". Discussions and staff consultations about a replacement system were in progress, but there were no decisions in regards to a replacement system.
- With the exception of the FNP service, we did not see an audit plan for community children, young people and family services. The SLT team told us audit activity was ad hoc. In the business team meeting minutes, 6 November 2015, it was recorded that senior managers acknowledged that systems needed to be introduced to get "better information from health visitors" and SLT to achieve better outcomes. However, in not having a clear audit plan or quality measures for each service the community children, young people and family service was missing the opportunity to collate information that could assist them in monitoring the success of services or identify where improvements might be required.
- A risk register was in place to identify the key concerns for the service. The risk register was linked to the trust's corporate objectives. The risk register had been regularly reviewed and updated and actions taken to mitigate risks in previous quarters had been recorded on the risk register. However, some staff we spoke with had identified risks in regards to access to performance information, laboratory results, and information from the school nursing service provider. These were not included on the risk register and meant that mitigating actions were not taken.
- There was a governance framework in place. We viewed a flowchart that clearly set out the community children, young people's and families' governance meetings and how these fed into the SWFT boards meetings.
- FNP teams were outstanding in their performance management and quality assurance processes. They had a clear vision and strategy for the FNP service that was monitored via quality performance measures.
- Staff and managers told us there had been issues with school nursing having been tendered to a private provider in September 2015. Managers told us the trust had not realised that informal practices that had existed when school nursing was part of SWFT would need to be formalised and work was in progress to formalise protocols with the private provider. However, staff told us this had led to information not being released in a timely way when requested by community children, young people and family services and the problem had not been resolved. Senior manager's told us discussions with the provider of school nursing services about information protocols were ongoing. However, the risk was not identified on the service's risk register.

Leadership of this service

- The trust chief executive officer (CEO) had worked for the trust for a number of years. Managers across community children's services spoke positively about the CEO and senior management team. Staff knew who the CEO was and felt they were approachable. Staff and

managers we spoke with told us there was clear leadership at executive level. Managers told us they had attended staff briefings with the CEO and said they could request one to one meetings with the CEO.

- Local team leadership was well established and effective and staff said their team managers were supportive. Team leads we spoke with appeared knowledgeable about children, young people and their families' needs, as well as their staff needs. However, there was a disjoint between senior managers, local managers and staff. For example, some staff told us there had been recent changes in the structure of community children and young people's services resulting in additional layers of management . Some staff told us they had not met the general manager of community children, young people, and family services, who had been in post for 12 months, although they knew who they were.

Culture within this service

- Staff across community children, young people, and family services told us they were anxious about service tendering. Some staff told us they thought service were more business focused. A staff member told us, "We don't know where we might be or who we might be working for in a year."
- Some staff told us community children, young people and family services was introducing a more patient outcomes based model and this involved a culture change in the service. However, some staff thought the service had over-reacted to the tendering of school nursing services to a private provider and had adopted a managerial approach in response, even though staff we spoke with conceded that community children, young people and family services needed to find ways of being more cost effective.
- Staff at the FNP told us they felt respected and valued, and added that being commissioned by Public Health England made them feel valued.
- The community children and young people's services assistant director told us the high level of 'no harm' incidents reported by community children and young people's services reflected that the service had an "open, reporting culture." Staff we spoke with told us the culture of community children, young people, and family services were open.
- Staff we spoke with told us they liked working for SWFT and there was good morale within their teams.

Public engagement

- Community children and young people's services engaged with the public through the NHS FFT. This had been introduced in community children, young people, and family services in January 2016. We viewed the FFT results for community children and young people's services for February 2016 and found services consistently achieved 100% in regards to people who used the service being extremely likely to recommend services to others.
- The SLT team had a number of initiatives to engage children and families in service planning. This included a 'Time to talk'; this was a countywide initiative to promote early intervention and support to prevent children falling behind with their speech and language.
- Managers told us how young people had been involved in interview panels for new staff. This involved young people having lunch with job candidates.

Staff engagement

- Managers told us there had been two consultations with staff in regards to the specific requirements for a children's electronic patient records system to ensure any system children's services adopted was fit for purpose.
- Staff at a community services CQC focus group told us they received a monthly newsletter, 'E-pulse', via email. Other regular staff communication and engagement forums included a blog on the trust's intranet where staff could ask questions and other staff and managers could provide answers.
- Some community children, young people, and family teams produced their own newsletters. For example, we viewed a newsletter, 'What's occurring'; these were newsletters where staff would volunteer to review a typical day in their working lives. We saw the December 2015 newsletter reported on 'a day in the life' of a health care support worker. Staff told us this enabled staff to understand the roles of other members of the service.
- The safeguarding team produced a quarterly newsletter which was distributed to community children, young people, and family staff. For example, the December 2015 edition had a flowchart for the Warwickshire Safeguarding Children's Board, this provided guidance

for staff on the reporting procedure where there were safeguarding concerns for children or young people. The newsletter also carried the names and contact details of the SWFT safeguarding lead professionals.
- Manager's told us they had recognised staff needed support during tendering processes and were working with the SWFT clinical psychology team to identify methods of supporting staff wellbeing during the process.

Innovation, improvement and sustainability

- The community nursing team had launched a team of 'home support volunteers'. These were volunteers that provided support for families in their own homes. This included: befriending, practical support in the home; community support groups; and transport to appointments.
- The community nursing team were piloting a two year project called 'Short Lives'. The project would provide volunteer support for vulnerable families. The community nursing team had held a volunteers open day at various sites in south Warwickshire with the aim of attracting suitable volunteers.
- Physiotherapy had introduced the 'Moves' programme. This identified children who might benefit from a programme of exercises. This involved children and their families in improving children's motor skills.
- The occupational therapy team had introduced a 'Sensory Integration' initiative, offering specialist assessment for children experiencing sensory difficulties.
- Eight of the SWFT health visitors had been awarded Fellowships of the Institute of Health Visiting (FiHV). Launched in May 2014, the Fellowship scheme set out to identify and acknowledge exceptional health visitors who have made a real difference to health outcomes for children and families in England.