The Royal Wolverhampton NHS Trust

RL4

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RL4X2	The Royal Wolverhampton NHS Trust Community Services		

This report describes our judgement of the quality of care provided within this core service by The Royal Wolverhampton NHS 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 The Royal Wolverhampton NHS Trust and these are brought together to inform our overall judgement of The Royal Wolverhampton NHS Trust

Summary of findings

Ratings

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

Summary of findings

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Overall summary

We found that services were safe, effective, responsive, caring and well led. Achieving a overall rating of outstanding. The staff were enthusiastic, well supervised, compassionate and competent in their roles. During the inspection we met with managers, staff, children and parents in a range of community settings. We observed care being delivered in schools, outpatient clinics and in the patient's own home. Staff from Wolverhampton Community NHS worked with other professionals and external organisations such as Child Adolescent Mental Health Service (CAMHS) and social services. There was clear evidence that the services for children and young people were delivered in line with best practice guidance and local agreement. The staff we spoke with told us that they felt they were valued members of a professional team; they told us the patient care was first and foremost of all they did and they aspired to be the best, this reflected the trusts vision and values.

We saw robust safeguarding procedures in place supported by a flow chart. An MDT approach to safeguarding alerts was seen. Staff had received safeguarding training.

There was a positive reporting culture with evidence of learning from incidents and complaints which improved the quality and safety of services. All staff had completed mandatory training which was recorded as 90% or above; in line with the trust's target. Clinical staff had also completed specific child related training relevant to their role. From parents we heard of excellent communication between the services dealing with children and young people. We observed staff supporting children and young people in a compassionate manner ensuring they listened to them and cared for them in a respectful way; which was again confirmed by parents, young people and children who told us they felt the staff were kind, friendly, always professional and very supportive.

Environmental observations evidenced a consistently high level of cleanliness across the sites we visited. Infection control audits and cleaning schedules demonstrated that infection control practices were in place and effective. The trust supported all staff to ensure that their mandatory training was completed in a timely way and that individual training needs were addressed. Staff received regular supervision and annual appraisals; they praised the management for the level of support they were offered. We saw that during staff meetings the lone working policy had been discussed to remind staff of the risks related to their work.

The service received a low level of complaints; people we spoke with during the inspection were very complimentary about the staff and the quality of the service they received. Staff told us that early resolution of complaints avoided formal complaints being received.

The service had amalgamated with the acute service to promote a seam-free service. We heard how staff had dealt with the changes and restructuring in a positive way. We saw that the leadership of all the services was robust and senior managers were well respected; staff told us they felt fully engaged with the management and were proud to follow excellent role models.

We spoke with over 150 people during the inspection including school nurses, therapists, health visitors, family nurse partnership, physiotherapists, consultant paediatricians and administration staff. We spoke with parents/carers and young people. We spoke with young people who used the services and their parents. We observed how children and young people were being cared for. We looked at and reviewed twelve care and treatment records.

Summary of findings

Background to the service

Children and young people under the age of 20 years make up 25% of the population of Wolverhampton. 46% of school children are from a minority ethnic group, compared to an England average of 27%. The health and wellbeing of children in Wolverhampton is generally worse than the England average. The infant mortality rate is the worst in all of England.

The level of child poverty is worse than the England average with 31% of children aged less than 16 years living in poverty compared to an England average of 21%. The rate of family homelessness is worse than the England average. Children in Wolverhampton have worse than average levels of obesity: 13% of children aged 4-5 years (England average - 9%) and 24% of children aged 10-11 years are classified as obese (England average -19%).

In 2012, there were 878 acute sexually transmitted infection diagnoses in young people aged 15 to 24 years. This represents a rate of 25 diagnoses for every 1,000 people in this age range which is lower than the England average of 34 per 1,000.

Wolverhampton Children's Community Services provided a range of services for children and young people throughout Wolverhampton and surrounding areas. The services it provides included:

- Community children's nursing service
- Community paediatrics
- Child development centre
- Health visiting service
- School nursing
- Looked after children team (LAC)
- Special school nursing service
- Family Nurse Partnership, to support young parents
- Family psychotherapist
- Children's occupational therapy
- Children's physiotherapy
- Children's speech and language therapy
- Special dental service
- Audiology services
- Audiovestibular medicine
- Sexual health clinics for young people
- Nurse (youth offending team)

Services include universal health services for children and young people 0–19 years to ensure they stay healthy, safe, enjoy and achieve positive outcomes. Services are designed to promote public health such as health visiting and school nursing. Delivery and coordination of specialist or enhanced care and treatment included specialist nursing services, therapy services and community paediatric services. Together they provided coordinated care and treatment for children and young people with long-term conditions, disabilities, multiple or complex needs and children and families in vulnerable circumstances.

The majority of the community services were managed from 'The Gem Centre' but was also delivered in schools, special schools, children centres, community health centres and the patient's own home. Services were provided to pregnant women, babies, children, young people and their families.

During the inspection we observed nine clinics providing a variety of services to children and young people, offering routine services such as immunisations and specialist advice such as sexual health. We attended three home visits, three special schools, one main stream school, three health centres and two children's centres. We conducted interviews with the service managers, senior matron and staff in their teams, individually and in focus groups.

Our inspection team

Our inspection team was led by:

Chair: Karen Proctor, Director of Nursing Guy's and St Thomas' Hospital NHS Foundation Trust

Team Leader: Tim Cooper, Head of hospital Inspection, Care Quality Commission

Summary of findings

The team included CQC inspectors and a variety of specialists: who were a Medical Director, an Executive Director of Nursing & Quality, a Designated Nurse for Child Safeguarding, a Consultant Physician in Diabetes & Endocrinology, a Consultant in Clinical Oncology, a Outpatients Doctor, a Consultant in Palliative Medicine, a Consultant Orthopaedic Surgeon, a Consultant, formerly Emergency medicine, a Consultant Obstetrician & Gynaecologist, a Consultant in Intensive Care & Associate Medical Director, a Paediatrician and a FY2 (Junior Doctor), a Clinical Nurse Specialist Older People, a Staff Nurse - End of Life Care & Oncology, a Renal Specialist Nurse, a Principal Radiographer Head of Imaging and Equipment Services, a Surgery Nurse Midwifery, a Senior Staff Nurse Senior management / Nurse - Paediatrics and child health and a student nurse.

The specialists advisors who worked with our community teams had experience: Community Children's Nurse, a Senior Health Advisor for Looked after Children, a Registered Nurse - Nursing and clinical care both acute and primary care, leadership/management & governance systems, a Service Manager District nursing and two Nurses Palliative Care.

There were three experts by experience who were part of the team, they had experience of using services and caring for a person who used services.

Why we carried out this inspection

We undertook this inspection as part of our commitment to review all acute and integrated trusts by March 2016. This service was scheduled sooner because it had incorporated services from the now dissolved Mid Staffordshire Trust and we wanted to assess the impact of that. It had previously been part of the initial wave of inspections which was pre ratings which was also an consideration in scheduling this inspection.

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 02, 03, 04 and 05 June 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and non-clinical staff. We talked with people who use services both on the day and prior to the inspection during advertised listening events. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced between the dates of 08 to 19 June 2015.

What people who use the provider say

"I have been extremely impressed with the care that both myself and my son have received over the last three years. A difficult experience has been made bearable due to the excellent service provided by the team including my community nurse. She has gone above and beyond her duties, always helpful and she genuinely cares."

Summary of findings

"The care that has been provided by all the community nurses has been with compassion and of the highest standards. They offer advice and assistance not only medically but also professionally and emotionally."

"My health visitor always makes sure she asks if I am ok which has been a blessing; it shows she cares."

"I've been attending the clinic for seven years with my three children and I am very happy with the service."

"I feel listened to and staff reassure me. I like to come here as the staff explain how to take the pills."

"I feel that the process is quite confidentially respected. The staff explain things in an easy way so I understand. Think the service is located in the right place as its easy access for me and my friends."

Good practice

We saw excellent efforts being made to progress the integrated service. Scheduled meetings were being attended by all teams involved to discuss future partnership working; they continually looked for ways to maximise the service for the communities benefit and avoid duplication of work.

Children and families were seen to be treated holistically, with all issues being considered. Hard to reach groups such as travellers and asylum seekers were supported and encouraged to attend clinics and group sessions.

The Royal Wolverhampton Trust offered a Family Nurse Partnership programme which was evidence based, preventative programme for vulnerable first time young mothers under 19 years of age. Family nurses delivered a licensed programme for young girls from pregnancy until the child was 2 years of age. The programme followed a structured service model which was closely audited to ensure compliance with national FNP guidelines and FNP Programme Licence for Supervision in FNP.

The Royal Wolverhampton NHS Trust

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We found this domain to be good overall.

We saw appropriate systems were in place to report incidents within the community and there was evidence of lessons learnt from previous incidents.

Robust safeguarding procedures were in place carried out within a multi-disciplinary, multi-agency approach with trust wide governance support and review.

Compliance with cleaning schedules was seen in all areas including toys and play area equipment. Specialist equipment was issued into the community when necessary and there was a replacement and repair system in place. We observed that the staff gaining consent and ensuring confidential issues were dealt with appropriately.

Mandatory training levels were maintained at 90% or above and staff told us they felt supported, valued and protected by the lone working policy.

Vulnerable children and young people were risk assessed and managed in a multi-disciplinary, multi-agency system, ensuring appropriate review and support was in place at the earliest of opportunities. Risk assessments were individualised and discussed with all professionals involved in the case including teachers, GP and carers.

Incident reporting, learning and improvement

- There was a trust wide electronic incident reporting system. Staff we spoke with were confident about reporting incidents and gaining feedback. We saw that the system to report was easily accessible to all staff.
- There had been no Never Events reported between April 2014 and March 2015.
- Two serious incidents were reported between April 2014 and March 2015. Both related to confidentiality breeches. Lessons learnt from these incidents were demonstrated to us; a checking system was now in

Good

Are services safe?

place when notes were being sent to another department including the use of a locked bag for transporting. Patient contact details were now checked at each appointment which we observed whilst in the clinic. Health visitors also showed us that they had a locked box in their car to keep individual notes safe and avoid carrying all their notes in to a community setting or home.

- 30 incidents were reported to NRLS in the past 12 months of which 27 were 'no harm', two 'low harm' and one 'moderate harm'. 14 of these incidents were reported as documentation issues (including electronic & paper records, identification and drug charts). No other trends were identified as each incident was an isolated case. Incidents related to equipment or medication not being available on discharge from hospital, vaccinations issues, communication and documentation issues.

Duty of Candour

- We heard examples of where the management had spoken with families when unsatisfactory situations had occurred. For example, the previous breach of confidentiality and immunisation incidents had been discussed with those involved. Explanations had been given to demonstrate that practices had changed to avoid such an occurrence happening again and an apology was given.

Safeguarding

- We found evidence of robust safeguarding procedures in place. Safeguarding alerts were investigated with a multi-disciplinary, multi-agency approach with trust wide governance support and review.
- 93% of staff had completed level two safeguarding children training and 76% had completed level three safeguarding children. 100% of those staff that required level four training had completed it; the remaining staff were either booked in to complete their relevant level of training or was currently not at work.
- Staff involved with safeguarding aimed to have fortnightly supervision with their manager, however this sometimes this was monthly due to time pressures. We were told on several occasions that the managers were always available to discuss cases and offer immediate support. The manager of family nurse partnership told us that they received weekly supervisions which we saw were diarised.
- We were shown the child protection flow chart which had been developed by the trust. This described staff member responsibilities and duties, action to take if there were concerns and who to contact for advice.
- We saw guidance notes and minutes of the bi-weekly 'family nurse partnership' tripartite safeguarding meetings. It was at these three way meetings that the family nurse, supervisor and named nurses discussed safeguarding cases. During this time serious case review findings, local knowledge and services were discussed.
- Most of the staff involved with safeguarding cases had received safeguarding supervision sessions which ranged between two and six weekly depending on the severity of the cases.
- The 2014/2015 annual review and quality account showed that local audit included a review of safeguarding supervision; the safeguarding supervision policy was to be amended to reflect national guidance.
- Community staff described to us their system whereby they let centre based staff know there whereabouts and how long they would be in line with the lone working policy. Risk assessments in the community were completed holistically, considering the patients home environment, historic information and issues such as pets and the location. Where necessary staff worked in pairs.

Medicines management

- We reviewed medication storage and handling during the inspection. We saw variation in the way medication was handled within the community, with no clear guidelines for staff to follow.
- We found that staff in the community carried medication in cool bags. The temperatures of the refrigerators in the community settings were checked and recorded daily.
- We saw that emergency drugs were available and 'in date' in the clinics. At the Pendeford Dental Clinic staff had difficulty in finding the emergency drugs, however these were eventually located.

Good

Are services safe?

- We saw that the community children's nursing team working in special schools had clear guidelines for the administration of medicines in the school setting. The team were responsible for safe storage, documentation, and disposal. Specific training had been given where necessary and involvement of the dietician was available for tube feeds and oral feeding concerns.

Safety of equipment

- We saw completed cleaning schedules for clinics and department equipment; toys and play area equipment were also included.
- We saw that electrical 'safety test' stickers were sited on equipment. Maintenance support and replacement were available when necessary.
- Bariatric and specialist equipment was located throughout the community settings. Health visitors, school nurses and family nurses had individual sets of baby weighing scales to ensure appropriate weight monitoring and the prevention of delays in recording. We saw that recently purchased scales were in place to issue to new members of the health visiting team.
- We identified firefighting equipment was correctly stored and maintained. Fire doors were clear of obstruction and well sign posted.
- We looked at first aid boxes in some settings and found them to contain suitable level of equipment.

Records and management

- All the records we reviewed were easily accessible when requested, yet stored securely.
- Managers described how they attended local governance meetings with community colleagues, which promoted MDT learning from incidents and complaints.
- Records were seen to be consistently well written, dated and signed. There was evidence of parental consent and parental involvement. Through case tracking we saw a child's care plans which had clear goals and outcomes including documented explanations for carers and teaching staff.
- We saw that compliance in the 'community documentation audit' had improved in the quarter three. For example 'Does every page for paper records or every entry for electronic records of the current attendance/admission include the patient's identification (NHS number)?' scored 100% and 'Are all entries legible?' scored 100%. The sexual health team scored 100% in all areas of the audit.

Cleanliness, infection control and hygiene

- During the inspection the areas we visited were clean and tidy with easy access to hand gel and hand washing facilities. Signs were posted around the clinical areas reminding staff and visitors to wash their hands. Foot operated waste bins were available and in good order.
- The May hand hygiene assessment had recorded an overall compliance rate of 93%.
- Staff were able to describe the trusts infection control procedures and we saw that guidance was available. When asked for, cleaning schedules which were made available which were fully completed. In all the areas we inspected there was cleaning schedules for toys and play areas; including a ball cleaning machine for the ball pool in the soft play area at The Gem Centre.

Mandatory training

- Mandatory training records showed that almost all the staff was 100% compliant. Where compliance had not been met records showed that one person had not received the training in most circumstances due to sickness. The recording system highlighted the member of staff in red which ensured their training needs were addressed when they returned to work.
- We saw that the health visitors, school nurses and family nurse partnership staff had received specific training and updates which related to their role and responsibilities. This data was recorded as being fully completed including specific competencies such as medication administration.

Assessing and responding to patient risk

- We saw 'children in need of protection' documents which clearly stated the action to take when concerns were identified, who to involve, how to raise the referral and who to liaise with. The trust clearly displayed the contact details of the 'named nurse safeguarding children' and the 'named doctor safeguarding children' in clinic areas and on display boards.

Good

Are services safe?

- Infant mortality was reported as the worst in England. The trust was working closely with public health, city council, current providers, health professionals, GP and schools to raise awareness and approach the issue in a joined up way. Health promotion was delivered in schools and outpatients and smoking cessation groups had been further developed. A monthly mortality review meeting was held where cases were reviewed and discussed. Currently the statistics were static with no reduction in cases which was a key priority for all partners; we saw a 15 point action plan (2015/16) had been written to strengthen local understanding and awareness.
- We saw processes in place whereby parents or carers of children who missed outpatient's appointments had been followed up with either a telephone call enquiry from the clinic, the health visitor or the GP to check the reason for non-attendance. This ensured the reason for the fail to attend was addressed and further appointments attended.
- Formal arrangements were in place to deal with the management of a child identified to be at risk. Multi-disciplinary meetings were minuted to ensure a strong support network was in place for the safety of the child.

Staffing levels and caseload

- 32 staff worked in the community children's nursing team including two band 8 paediatric nurse practitioners and a band 7 family psychotherapist.
- The 2014 caseload mapping exercise identified higher than recommended caseloads for the health visitor team. An implementation plan was put in place and the team was increased to; 68 health visitors, 10 band three's HCA's, and four band four nursery nurses work in the integrated team along with 32 student health visitors.
- 29 community children's nurses offered a seven day service. During the week the staff worked between 08.30 and 17.00 and offered a reduced service at weekends. Visits were planned around the families need, with an initial telephone call to arrange the convenient time. Some visits and treatment were carried out in school when appropriate.
- Family Nurse Partnership staffing was one band eight supervisor, four family nurses and one quality support officer. The current caseload of 48 was within a programme to recruit up to 102 clients.
- School Nursing Workforce was one band eight school nursing manager, one (1 WTE) band seven assistant school nurse manager, one band seven (0.71 WTE) community practice teacher, seventeen (12.03WTE) band six team leaders, six (4.2WTE) band five school nurses, four (2.84 WTE) band three school nurse assistants, two (1.8 WTE) band three sexual health assistants and four band two (2.4 WTE) records and administration clerks.
- At the time of the inspection there were 95 schools within the catchment of Wolverhampton School Nursing Service. There were plans to open a further five schools in the next academic year.

Managing anticipated risks

- A wide range of risk assessments were in place to assess and manage individual and identified team risks. Issues such as unknown address changes for children were time consuming for the staff to identify the person's new address. We were also told that the current geographical caseload review was to be managed with care to avoid any 'risk identified' cases being overlooked or lost in the handover phase.
- We were told that there was currently 777 looked after children (LAC) in the community of Wolverhampton.
- Staff told us and we saw that multi-agency planning meetings that took place to safeguard children and young people. A wide range of healthcare professionals, teachers and carers attended these meetings where individual cases were assessed and reviewed; care records and relevant documentation was put in place including consent and action plans.

Major incident awareness and training

- In the event of a major incident, non-essential services within the community would cease and staff would be mobilised to alternative locations. Community staff would then be assigned to relevant duties as stated in the business continuity plan. For example the community children's nursing team would action

Good

Are services safe?

'admission avoidance' or 'earlier discharge' where possible. Staff we spoke with told us they were aware of the policy and procedure which was covered in induction.

Good

Are services effective?

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

Summary

We found this domain to be good overall.

We saw that the multi-disciplinary approach of the community team enhanced the service for the children, young people and families in the local area. Each team followed national and local guidance whilst adhering to the relevant policies and procedures of the trust.

We saw documentation which gave assurances that staff competencies were checked, annual appraisals were completed and regular supervision undertaken. A strong ethos of multi-disciplinary work was evident with clear referral pathways and support networks. Parents told us they valued the professional attitude and supportive nature of the community staff they had been in contact with.

Transition services were in place with recognised developments required as the service grew; a diabetic transition clinic was now established to support users and their families. We saw evidence that gaining consent was a necessary part of the teams work and one that was carried out at every opportunity.

2014/15 audits were now completed, for example 'food allergy in children' was compliant and 'autism' was partially compliant; an action plan had since been completed. 2015/16 audits included eating disorders and type one diabetes.

Evidence based care and treatment

- The trust policies and guidance were based on national guidelines and best practice.
- Paediatric services offered a specialist service for non-acute general medical and developmental problems in childhood. This included a diagnostic service for children with developmental delay or learning difficulties, care for children with chronic or complex disabling conditions and palliative care for children with long term conditions. Following national guidelines special clinics were held for enuresis (bedwetting), paediatric audiology (hearing) and growth abnormalities. Joint clinics with CAMHS for children with Attention Deficit and Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorders (childhood autism) were also available. Advice was given for childhood immunisations and child health surveillance. Medical advice was given for children with special educational needs, looked after children and for child protection.
- Health visitors currently used the Benson Model; a strategic planning methodology which empowered community nursing services to objectively plan and manage the workload, caseloads and inform change. The model profiled the local population and enabled development of a validated local service programme. Key metrics and a robust, transparent framework informed decision making, strategic development and communications between the trust and commissioners.
- Health visitors and school nurses lead and delivered the Healthy Child Programme (HCP). The HCP is the early intervention and prevention public health programme that lies at the heart of universal services for children, young people and families. A series of reviews, screening tests, vaccinations and information to support parents gives their child the best chance of staying healthy and well.
- We saw that NICE guidelines for epilepsy were being followed in a school setting. Each child had a named community nurse linked to their mainstream school. The named nurses ensured that teachers had the necessary updates, relevant training and updated the individual care plans.
- The RWT Family Nurse Partnership (FNP) programme commissioned by NHS England until October 2015 delivered an intensive, evidence based, preventative programme for vulnerable first time young mothers, from pregnancy until the child was 24 months. From October 2015 the programme was due to be commissioned by the local authority. The performance of this newly introduced licensed programme was audited continuously to ensure compliance with national FNP guidelines and FNP Programme Licence in FNP. Currently an expected caseload of 48 was managed by four full time staff and an analytic/administrative

support person, with the capacity of the team being 102 clients. Recent evidence written in The Lancet (a general medical journal) showed that the FNP programme reduced the amount of maltreatment and child neglect.

- The LAC health team delivers direct clinical contact, advice and support to looked after children, their carers and social workers to address all health issues unique to this group. The team was closely linked to the safeguarding children team and community paediatric services. The team consisted of a designated doctor, a named nurse and a team administrator for LAC. They worked closely in partnership with social care and CAMHS professionals to help LAC remain healthy both physically and emotionally. The team arranged, co-ordinated and undertook statutory health assessments in accordance with Department of Health Statutory Guidance.
- The health visitors were currently awaiting the results of level three accreditation for UNICEF UK 'Baby Friendly' status.
- We observed the approved 'puberty talk' being presented by the school nurses as part of The National Healthy School Programme. The National Healthy Schools Programme ensured a range of outcomes in respect of improvement in health and reduced health inequalities; greater social inclusion; raised achievement of children and young people; and increased working between health promotion providers and education establishments.

Nutrition and hydration

- We saw guidance policies in place in the school setting relating to nutrition and hydration, including individualised eating and drinking guidance for teachers to support children with healthy choices.
- School staff demonstrated that they followed prescribed enteral feeding regimes which they had been trained to undertake.
- Children who were at risk of obesity had access to advice from a dietician and weight monitoring when necessary.
- Additional training from the breastfeeding and infant feeding teams supported the health visiting teams to deliver breastfeeding drop-ins across the city including children and family centres and health centres.

Approach to monitoring quality and people's outcomes

- Data supplied showed that diagnostic testing for audiology was carried out within 14 days of referral. Children requiring hearing aids were fitted within seven days and a consultant review would take place within 28 days. No children's clinic had been cancelled during the previous 12 months; 20% of appointments resulted in a did not attend (DNA). When appointments were missed the parent or carer were telephoned to reschedule another appointment. Monthly governance meetings were held to review waiting times.
- Currently health visitors had seen 97% of primary visits and quarter four breast feeding initiative was recorded as 47%. 12 month check data was recorded as 67% with 12,911 face to face contacts recorded for quarter four (January to March 2015). There were 630 six to eight week checks carried out during quarter four.
- We saw that the immunisation audit of 2014 was fully compliant; including anaphylaxis pack checks, consent gained and liaison with the school.

Competent staff

- There had been 92% attendance at the conflict resolution training including violence and aggression (NHSLA).
- Staff supervision and appraisals were well managed in all areas; the trust supported staff who requested further support or training including degrees and study at master's level.
- The health visitors senior team had completed the 'train the trainer' training to ensure staff training was continuously updated and was currently at 97% compliance. We heard examples of using a 'safeguard' board game and 'key word' cards for discussions during supervision and in weekly team meetings.
- Staff were given role relevant training such as domestic violence, baby massage; immunisation update and health check knowledge.

Multi-disciplinary working and coordination of care pathways

- All the teams we met and spoke with described a multi-disciplinary approach to the success of their work. They were proud of their positive working relationships in

sometimes difficult situations and a reasonably new integrated service. Staff celebrated their achievements and input into a wider health agenda at regional, national level including the workforce development plan for health visitors which had been acknowledged by NHS England to be a working document.

- The local authority and the integrated community staff were looking at a best practice model of working to maximise the service outcomes and avoid duplication of their work. We heard that the community and parents, carers and families were reported to be very grateful of the integrated working and support they received. Parents told us they appreciated the staff looking after them and offering advice and much needed support.
- The diverse community were reliant on the care pathways being robust with a fully integrated team of professionals working together. We observed a one to one soft play session undertaken very proficiently by a physiotherapist assistant; whilst the physiotherapist supported the mother with other issues giving them advice and support.

Referral and transition

- Transition services were set up to support children in schools and clinics throughout the city. The local authority supported the teams with transition pathways with the early year's teams. The consultants met with parents/carers and the child to discuss their feelings about transfer to the adult programme of support and attendance at adult clinics. Children with complex needs were supported up to 19 years of age and children with acute needs were supported up to 18 years of age. For example 100 children were currently supported with epilepsy and will all be introduced in to the transition service.
- We found that referral arrangements were in place for those children and young people moving between services. The community team had made strong links with local support networks such as Birmingham children's hospital consultants and specialists.

Availability of information

- Currently the integrated service and multidisciplinary partners did not have a fully integrated IT system. Plans to bring a more joined up service was under discussion and progress had been made for health visitors with the imminent introduction of hand held 'record keeping' devices.
- Reports, patient notes and care plans were shared securely via NHS.net. Paper copies of care plans and reports were stored in locked cabinets in locked offices,

Consent

- To assess whether a child was mature enough to make their own decisions and give consent staff used 'Gillick competencies' and 'Fraser guidelines'.
- Parents we spoke with told us they were always asked for verbal consent and sometimes written consent depending on what the treatment of care was. We saw consent to treatment in school nursing records and included in care pathways and documentation.

Outstanding ☆

Are services caring?

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

Summary

We found this domain to be outstanding overall.

We evidenced high levels of dignity and respect being shown to patients, families and between staff. Patient understanding and involvement was at the forefront of all community work and we heard examples of excellent transition work and special needs support being offered.

There was much positive interaction with the diverse community including young people and children with special needs. The school nurses and community children's nurses supported teaching staff and carers within school settings and the child's home. Children's nursing service referred children to specialist services for emotional support and advice when the circumstances required greater input than they could offer.

Staff told us they felt well supported by the management during day to day work and during difficult times; we saw that emotional support was offered as part of supervision with opportunities and time available for specialist support when necessary.

Dignity, respect and compassionate care

- People we spoke with told us they felt that the staff they had been in contact with were friendly, compassionate and non-judgemental. One person told us the staff were approachable and gave them time to express their concerns; they were confident that they would be shown respect, receive the right guidance and ongoing support.
- We heard many examples of staff being supportive to parents and children during sensitive times. Parents told us on several occasions that the health visitors and family nurse had given them time to 'open up' and share their concerns and worries. They told us they thought this was above and beyond what was expected of them and they praised the staff for this dedication and the amount of time offered. We heard where one family thought they required little emotional support, however once they had begun to talk to the therapist they realised they had hidden anxieties which had affected their experience.
- Between February 2014 and March 2015, the school nursing service received 10 compliments; some of these related to teaching in schools, support to multi-agency support teams, diligent work in safeguarding and parents' coffee morning support in school.

Patient understanding and involvement

We observed sensitive interactions with parents and children during clinic sessions, during therapy and whilst on home visits. The staff met with children at eye level and spoke with a gentle voice to gain their trust. The appointment time was centred on the child where they were asked questions initially, with the support of the parents when needed. It was evident that children enjoyed attending clinics, playing with the wealth of toys and they were seen to be comfortable and relaxed with the staff attending to them.

- We observed the community children's nurses explaining care and care plans to a family in a respectful way, gaining their understanding and increasing their confidence. Parents told us that the staff would explain things until they understood; they were never made to feel stupid.

Emotional support

- We heard examples of parents being supported during the delivery of bad news when a child's life limiting diagnosis had been given. The psychotherapist offered emotional bereavement and support to families and staff in the community. Working alongside the Child and Adolescent Mental Health team (CAMHs) when required, they told us they were continually reflective of their practice to look for ongoing improvements. We saw a wealth of thank you cards had been sent to the clinic to show gratitude and praise for the support they had given, which although 'difficult' at the time, parents and families spoke of the benefits and value of the time spent together.
- We saw many example of emotional support being given during the inspection. One example we saw, to reduce a mother's anxiety whilst her child was receiving

a hearing test she observed through a two way mirror. This gave her the assurance her child was safe yet gave the child the confidence to attend the session independently.

Promotion of self-care

- We saw that clinic staff and teachers promoted children to become independent where possible. Invitations to attend the clinic consultations on their own were encouraged as part of the transition work into adult clinics and senior school. Information leaflets were available in many formats including pictorial and simple text.

Good

Are services responsive to people's needs?

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

Summary

We found this domain to be good overall.

The service was responsive to the diverse community and difficult to reach groups. The community nurses, health visitors, school nurses and family nurse partnership worked with other health professionals to give a seamless service in a timely manner. Parents and carers we spoke with told us they had been well supported by the staff and felt they were treated with respect and listened to in sometimes difficult circumstances. Therapy services provided support to the nursing team by assisting with interim therapy sessions and key worker roles.

Timely referral put children at the centre of the teams work and they sought guidance and advice to maximise the child's experience and outcome. A low level of complaints had been received which was explained by many of the teams as a reflection of their strong working relationships and their drive to offer an responsive service to local children, young people and families.

Planning and delivering services which meet people's needs

- Local authorities (LAs) in England collect and record information on young people's participation in education or training, which the Department for Education uses to estimate the number and proportion of young people not in education, work or training (NEET) in each LA area in England. The local authority NEET figures provided an annual estimate, based on average figures for November to January each year. Wolverhampton has 3.5% less young people NEET than the England average.
- The health visiting team visited mothers to introduce the service and identify any possible needs. They also completed a postnatal visit at 10 to 14 days. The families visited the clinic for advice and to have the baby weighed. All the health visitors were nurse prescribers which ensured timely treatment if needed, for example emollients.
- We attended a home visit to a child with complex needs. This demonstrated that the service met the needs of the child and the family both health wise and psycho-socially.
- To ensure continuity of care we heard that physiotherapists who were working with a child in the community would attend the ward when a child was unwell and admitted to the hospital.
- We evidenced that early access to therapies was responsive to the need of the child. For example, a child had not been receiving effective therapy whilst they had moved out of the area which had caused their condition to worsen; on their return to the area the special needs (early years) team leader organised their care very quickly so they could access therapies and their condition improved greatly.
- We saw many information leaflets and booklets available for parents that included clinic times, support networks, self-help group and contact details. Parents were seen picking up leaflets in children's centres, for example a timetable for April to July which showed the weekly groups, times and what each activity offered. Advice leaflets relating to safety in the home, simple first aid advice and healthy homes were distributed to parents or available to picked up at the children's centres.
- The community team supported parents and carers to attend the clinics and receive the support to promote healthy lifestyles and friendship networks. To avoid too much disruption parents were offered 'stay and play' sessions for younger siblings whilst their older sibling was at nursery; this time encouraged toddlers to become more confident, meet new friends and join in fun activities.

Equality and diversity

- RWT Family Nurse Partnership (FNP) programme used literature in different styles to ensure the clients understood the information.

Good

Are services responsive to people's needs?

- The community staff had access to translation service when necessary. Translators were booked in advance to ensure they attended clinic appointments and home visits.
- Access to sexual health services was available for all young people in the city. All clinical staff had received level three safeguarding training. This training included all relevant subjects including trafficking and female genital mutilation (FGM). There was a referral mechanism to refer any FGM victim to the trust to be seen by a consultant and identify a child a risk.
- There was evidence of recent input from the safeguarding team in relation to assessment of young people using the sexual health services.
- The service addressed the care needs of hard to reach groups such as travellers, refugees, asylum seekers and ethnic minority groups. We saw that interaction with the diverse community was a key role for all community staff. Health visitors met with travellers and asylum seekers where possible, taking time to understand their cultures and individual needs and concerns. One father we spoke with told us he thought that the clinics were a waste of time to start with, but he now attended with his son and stayed for the stay and play session. He had met other parents and enjoyed the interaction; he also said he had learnt useful information which had helped him.

Meeting the needs of people in vulnerable services

- We saw a referral pathway in place for children with significant development delays which detailed the referral process and access to the review process. Between September 2014 and May 2015 197 multi-agency referrals were seen by the referral panel. Following the review meeting the child could be offered support in their own home, they may be invited to attend a specific group at the Gem Centre or be reviewed in their school setting or local children's centre. The parents may be offered a key worker who would see the child on a regular basis demonstrating the 'team around the child' model.
- We saw feedback from a training session which had been arranged by the occupational therapists at The Gem Centre; attendees had praised the staff for the content of the workshop. Following this training some professionals had changed the way they worked with children to promote motor skills which made some school activities more effective.

Access to the right care at the right time

- Currently the integrated service and multidisciplinary partners did not have a fully integrated IT system. Plans to bring a more joined up service was under discussion and progress had been made for health visitors with the planned introduction of hand held 'record keeping' devices.
- Contents of reports, patient notes and care plans may be shared verbally at multi-disciplinary meetings as required within confines of data sharing standards. Paper copies of care plans and reports were stored in locked cabinets in locked offices.

Complaints handling (for this service) and learning from feedback

- Staff told us that the low level of complaints was a reflection of their strong working relationships with the children, young people and families of Wolverhampton. They told us that people's concerns rarely escalated to a formal complaint as the teams responded quickly to the issue and resolved concerns at the earliest of opportunities.
- Six complaints were received during the previous 12 months and were all responded to and now closed. The staff told us they prided themselves on giving an excellent service and where possible attempted to address any complaints at the time; avoiding formal complaints being received.

Outstanding ☆

Are services well-led?

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

Summary

We found this domain to be outstanding overall.

All the staff we met and spoke with embraced the trust vision and strived to be the best. Patient feedback was requested and we saw examples whereby this had promoted service improvement. There were clear governance structures which reviewed workforce issues, incidents and complaints.

We saw good arrangements for referral and transfer from this service to others who lead on key elements of the patients pathway. We saw good arrangements in place for working with stakeholders and especially with Local Authorities. Transition arrangements for children were well coordinated and covered age ranges up to 19 years old; we saw that worked across boundaries and organisations.

All the staff we spoke with were well supported by their manager; they felt they offered a high quality service and were valued by the multidisciplinary team. The teams had received a wealth of positive feedback from families, schools and people who commissioned the service.

The community team supported parents and carers to attend the clinics and receive the support to promote healthy lifestyles and friendship networks. To avoid too much disruption parents were offered 'stay and play' sessions for younger children.

The community teams were innovative and passionate about the service they provided for example the health visitors' involvement in the workforce development plan had been acknowledged by NHS England to be best practice.

Service vision and strategy

- Children's service annual plan was linked to the trust vision and values and aimed to provide an equitable and efficient service. Working parties had been set up to look at areas for development such as 'risks of core groups' and 'review of the current screening tool'.
- Staff we spoke with about the trust told us about 'striving to be the best' as described in the trust vision and they were enthusiastic to achieve it.
- The Gem Centre philosophy was 'Team around the child' and had been nationally recognised for its collaborative work and the development of local services. Following a review of the services nationally, a review team member stated that the 'special needs' early years' service was "The best example in the country of key working for disabled children under five".

Governance, risk management and quality measurement

- The team demonstrated that they had an effective process in place for carrying out clinical audits. Action plans were in place which related to the findings of the audits and achievable time scales were noted. Any concerns were taken seriously and fed up to board level.
- The community children's monthly integrated governance report documented incidents and trends, health records check and complaints,
- We saw good pathways between this service and referral to other services.
- We found evidence of a clear governance structure and positive reporting culture including use of key performance indicators, workforce issues and learning from incidents and formal complaints.
- We saw the most recent risk register that displayed clear lines of responsibility and accountability and identified the current risks to the service.

Leadership of this service

- All the staff we spoke with felt they were well supported by their line manager. They told us that they had confidence in the senior management team and the staff were complimentary about the board.
- We saw good relationships between the service and local authorities and other key stakeholders.

Culture within this service

Are services well-led?

- It was evident that there was a positive, open culture within the community CYP service. Staff showed dedication and commitment and there were examples from people who received the service of staff 'going that extra mile'.
- Staff we spoke with were proud of the service they delivered and the positive outcomes for children, young people and their families. Staff told us they felt listened to and valued by the trust. We heard many managers described as having an 'open door' policy.

Public and staff engagement

- Staff told us that they were encouraged to feedback any comments or concerns they had to any senior manager.
- Staff told us about 'Chat Back' an interactive survey method which they could link in to demonstrate a real time view about what it was like to work at New Cross.
- We saw that a school headmaster had written to the school nursing manager to commend the team of community staff working at or attending the school. The letter ended saying, "The support of your team is greatly valued". Additional evidence was provided by the youth offending team. They had consistently and effectively worked together with RWT for more than 12 years with the support of a seconded school nurse. The school nurse was seen as an integral part of the service delivery working with individual, vulnerable people; assessing their risk and reviewing their progress.
- Families and young people told us they were encouraged to leave feedback on comment cards, the hospital website or service specific surveys.
- We saw examples of service improvement driven by some patient feedback. For example evening clinics and home visits were arranged to fit in with family/working life. Also community nurses visited schools to avoid children missing school through attending hospital appointments.
- The Department of Health and Public Health England (2014) recommended that commissioners needed to ensure that providers demonstrated a robust service for children and young people including targeted commissioning such as the Healthy Child Programme (2009). An example of this assurance was the school nursing service client feedback (September 2013 to July 2014). Surveys were completed in six areas; the school nursing service, immunisation sessions, drop ins, vulnerable young people's teaching groups, parent groups with the parents of children who attend the Share Group in a special school and Youth Offending Team (YOT). Results were positive with a reasonable return in most areas. 82% of girls reported they knew where to get immunised, 86% of those gave positive feedback and 14% gave negative feedback. Negative comments included the injection hurt, they were scared or they felt dizzy.

Innovation, improvement and sustainability

- Handheld devices were in the process of being issued to each health visitor to move away from carrying paper records in the community. This integrated working project aimed to be completed by September so that bespoke records for CYP data set and NHS England would be in place.
- The trust was currently awaiting the results of level three accreditation for 'Baby Friendly' status.
- The continual multidisciplinary working resulted in the overall success that had been achieved by the teams. We saw examples whereby some of their achievements had been recognised regionally and nationally, for example 'Paving the Way' document by The Challenging Behaviour Foundation.
- The workforce development plan for health visitors had been acknowledged by NHS England to become a a model of best practice, good leadership and service development.
- The community staff had introduced 'Hello my name is' cards to ensure parents, carers and staff have their contact details.
- The community team supported parents and carers to attend the clinics and receive the support to promote healthy lifestyles and friendship networks. To avoid too much disruption parents were offered 'stay and play' sessions for younger siblings whilst their older sibling was at nursery; this time encouraged toddlers to become more confident, meet new friends and join in fun activities.
- The audiology clinic had started a weekly playgroup for children with hearing deficiencies; children, parents and carers met people in the similar situation as themselves

Outstanding ☆

Are services well-led?

which promoted greater understanding and reduced anxieties. Consultants and teachers of the deaf attended sessions, they presented literature and gave advice in a relaxed atmosphere.