Black Country Partnership NHS Foundation Trust

TAJ

Community health services for children, young people and families

Quality Report

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Date of inspection visit: 17-20 October 2016
Date of publication: 17/02/2017

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)
TAJ	Delta House Trust Head office.		
	Brierley Hill Health and Social Care Centre		
	Kingswinford Health Centre		
	Halesowen Health Centre		
	The Sunflower Centre		
	Coseley Health and Family Centre		
	Cross Street Health Centre		
	Ladies Walk Clinic		

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated the service as good overall because:

The caseloads of health visitors were being monitored and managed well. Action was taken to ensure health visitor's caseloads were manageable, in line with national guidance. Staffing levels in health visiting had improved since our last inspection. The caseload of the Family Inclusion Team had been reduced by transferring the care of some families to other members of the health visiting team.

The equipment provided for children used at home was being maintained in line with manufacturer's maintenance requirements.

Improvements had been made to record keeping including the use of tracer cards when notes were transferred to another service.

Staff were ensuring children were safe by notifying the safeguarding team of any concerns using the trust's incident reporting system.

Assessment and care planning was based on evidence-based guidance

There was a clear approach to monitoring, auditing and benchmarking the quality of children's' services and the outcomes for people receiving care and treatment.

Staff had the skills, knowledge and experience to deliver effective care and treatment

Staff worked with other agencies in multi disciplinary teams to ensure the care children received was well co-ordinated.

Staff provided age appropriate care. They took time to interact with children and young people and their families and took account of children's individual physical, emotional and social needs.

Staff recognised when children and families needed additional support. Staff helped families to understand the treatment provided and enabled them to make decisions around the care they received. Families were involved in planning care and treatment and could access interpreters and other support when required.

The clinical commissioning group (CCG) were developing a strategy to meet the needs of local families. Clinicians and managers from the children and family service were actively working with the CCG to develop services.

The service worked with social services and education providers to meet the needs of Children and Young People in the area, particularly children with complex needs, life-limiting conditions and disabilities.

Children waited longer than the trust's target of 8 weeks from referral to treatment target but met the national waiting time standards for providing timely access to initial assessment, diagnosis and treatment

Health visiting services were meeting the targets for child development checks

Issues identified at the last inspection which required improvement had been addressed by managers in the trust.

There were good governance arrangements in place which meant incidents, audits, national guidelines and risks were discussed and the appropriate actions were taken.

The performance of the service was managed and action was taken to improve performance

Leaders had the capacity, capability, and experience to lead effectively

However,

The trust was not achieving targets for level 2 and 3 safeguarding training The proportion of staff who had completed the training had fallen since our last inspection from 88.2 % for level 2 and 93.3% for level 3 to 82% and 79% respectively. This meant 34 of eligible staff had not completed level 2 training and 31 staff had not completed level 3.

Children were referred to other teams within the trust but there were no shared records. Each service kept their own information about a child's needs. Information was held in paper records. An IT system which supported information sharing was not in place and the service could not share information with GPs.

Summary of findings

Not all services were accessible at one location for example speech therapy was not provided at the Sunflower Centre where other therapy services and the Children's Assessment Unit was based.

The pathway for the Family Inclusion Team and the access thresholds was not clear and there was a risk that some families in need might not receive the level of service they required.

The Board did not have a designated executive lead for children. A non executive lead had been identified.

A strategy was being developed with the local Clinical Commissioning group but this was not yet in place.

Senior leaders were not visible to all staff.

The trust used a system of restorative supervision but the role of this form of supervision was not clear within the trust's supervision policy. Restorative supervision was provided in addition to routine supervision for staff the trust believed needed additional support.

Summary of findings

Background to the service

The Black Country Partnership NHS Foundation Trust provides a range of community services for children, young people and families. Children living in the Dudley metropolitan borough aged 0 to 19 accessed the services. A children's assessment unit was located at the Sunflower Centre in Stourbridge. Most services were delivered from the trust's centres and clinics and in schools and family homes.

The services provided include:

- A health visiting service providing a range of clinics, support to families at home, with links to 49 GP practices
- Family Nurse Partnership supports young people under the age of 19 before and after pregnancy
- A family inclusion team supporting families with complex needs
- A haemoglobinopathy service provided by a specialist nurse for children with thalassemia and other blood conditions
- A paediatric physiotherapy service
- A nursing service for children with long term, life limiting conditions –the See Saw service
- Speech and Language Therapy services
- A Children's Assessment Unit – The Sunflower Centre based at the Brierley Hill Centre
- Paediatric occupational therapy.

There are 146 staff employed by the Children Young People and Families Directorate. Consultant community paediatricians are employed by and based at the local acute hospital.

The services are commissioned by Dudley, Sandwell and West Birmingham Wolverhampton and South Staffs clinical commissioning groups.

During the inspection, we spoke with 20 members of staff, 15 parents and five children. We reviewed 20 individual care plans for children, which included a range of clinical assessments and reviewed information provided by the trust about the service.

We last inspected children young people and family services in November 2015 when we found the service required improvement. We rated the service as outstanding for caring but requiring improvement for safety and leadership.

Following our inspection, we informed the trust that they should ensure there were suitable numbers of qualified staff to meet the needs of children and families across all children, young people and family service. The trust was also asked to ensure equipment provided to families in their home was serviced according to manufacturer's service schedule.

Our inspection team

Our inspection team was led by:

Head of Inspection: James Mullins, Head of Hospital Inspection (Mental Health), Care Quality Commission.

The sub-team which inspected this core services was comprised of one CQC inspector, a paediatric nurse and a named nurse for children's safeguarding.

Why we carried out this inspection

We undertook this inspection to find out whether Black Country Partnership NHS Foundation Trust had made improvements to their community-based children, young people and family's service since our last comprehensive inspection of the trust in November 2015.

When we last inspected the trust in November 2015, we rated the community-based children, young people and families service as requires improvement overall. We rated the core service as requires improvement for safe and well led, good for effective and responsive and outstanding for caring.

Summary of findings

Following the November 2015 inspection, we told the trust that they must take action in the following areas:

- Ensure there are suitable numbers of qualified staff to meet the needs of children and families across all CYPF services.
- Ensure all equipment is serviced as per manufacturer's service schedule.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 18 HSCA (regulated activities): relating to staffing
- Regulation 15 HSCA2008 (regulated activities): relating to premises and equipment

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?

For example:

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 17-20 October 2016. During the visit we held focus groups with a range of staff who worked within the service, such as managers, nurses, health visitors and therapists. We talked with people who used services. 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.

What people who use the provider say

Many families had been supported by the service for several years and told us that staff had always supported them well. Parents we spoke with felt involved in the care provided. However, some parents also told us they felt communication between services was not good and they had to inform staff about the care their child had received from other services with the trust.

One mother we spoke with told us they felt really well supported by the health visitors and they felt they could contact them when they needed help.

One parent we spoke with had been attending the Sunflower Centre for more than 10 years and spoke highly about the service and staff. They said, "Staff have a brilliant manner which they have adapted over the years."

Good practice

Outstanding practice

- The children's palliative care service offered respite for families and a benefits advisor provided families with support to access benefits.
- The health visiting service provided clinics in the evening to ensure families could access the service if they were working or had other commitments during the day.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust should identify a designated executive lead for children.

Senior leaders should ensure the children, young people and family service is fully supported to feel part of the organisation by leaders increasing their visibility within the service.

The trust should ensure the service has access to professional peer support for children's services.

Action the provider COULD take to improve

Black Country Partnership NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- The caseloads of health visitors were being monitored and managed well. Action was taken to ensure health visitor's caseloads were manageable, in line with national guidance. Staffing levels in health visiting had improved since our last inspection. The caseload of the Family Inclusion Team had been reduced by transferring the care of some families to other members of the health visiting team.
- The equipment provided for children used at home was being maintained in line with manufacturer's maintenance requirements.
- Improvements had been made to record keeping including the use of tracer cards when notes were being used by a service.
- Staff were ensuring children were safe by notifying the safeguarding team of any concerns using the trust's incident reporting system.

However,

- The trust was not achieving targets for level 2 and 3 safeguarding training. The proportion of staff who had completed the training had fallen since our last inspection from 88.2 % for level 2 and 93.3% for level 3 to 82% and 79% respectively. This meant 34 of eligible staff had not completed level 2 training and 31 staff had not completed level 3.

Incident reporting, learning and improvement

- There were 185 incidents reported by the service between November 2015 and October 2016. Of those incidents reported the majority 95 (51%) resulted in no harm, 27 (15%) resulted in low harm. There were three incidents which resulted in moderate harm.

Good

Are services safe?

- There was one serious Incident reported to STEIS during August 2016. The incident involved a set of health visiting records lost in transit. As a result, the trust had stopped using the courier service for transporting records.
- There were also five incidents where clinical information had gone missing whilst being transferred from a local hospital where children had been admitted. At our last inspection, we found that tracer card systems for tracking the movement of medical records were not always used effectively resulting in records going missing. Staff assured us tracer cards were now used to record when patient records were transferred and the incident reports showed staff were recording the date and transfer destination.
- We saw one incident which resulted in a member of staff not being made aware of a safety alert. The incident report referred to the member of staff not receiving the safety alert through the trust's communication system. We asked staff if they normally received patient safety and other alerts and they told us their managers normally cascaded these or they were made aware at departmental meetings.
- Several incidents had been reported about the information system used by staff for recording patient activity. The incidents related to problems accessing the system and the adequacy of the system for recording information relevant to the service. Staff told us the issues had been raised and discussed with managers who were aware the IT system did not meet the needs of children's services.
- The notes of a staff meeting showed the service had discussed learning from incidents for example reducing the number of undelivered appointment letters. The new computer system did not the addresses for all the families who used the service stored on the system. Staff had to address a large number of letters manually resulting in mistakes. There were plans to modify the computer system, which would help reduce the number of mistakes. Staff were asked to check any changes of GP, mobile phone number and addresses at the initial interview with parents and at intervals thereafter.
- Staff reported incidents which occurred in patients' homes as well as incidents which occurred in the trust's clinics.

Duty of Candour

- Several staff we spoke with were familiar with the importance of the Duty of Candour requirements. The trust's incident reporting system highlighted whether an incident was subject to duty of candour. We spoke with a group of Clinical Matrons who told us they had a particular responsibility for ensuring staff followed the trust's Duty Of Candour policy and ensured this was being followed in practice. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Safeguarding

- The trust had put an effective safeguarding structure in place. Staff we spoke with had a good understanding of safeguarding procedures and policies although they felt improvements were needed for systems between agencies and sharing information and concerns with GPs.
- In the 12 month period between July 2015 and June 2016, the community children young people and family services reported six safeguarding concerns.
- One member of staff we spoke with had concerns about a child they had assessed in a school and had discussed their concerns with their manager. Their manager encouraged them to raise their concerns with the school health advisor, who had not been aware of the issues, and confirmed it would be followed up as a possible safeguarding concern.
- The trust had a target of 85% for staff receiving mandatory training. Eighty two percent of eligible staff had received level two safeguarding training and 79% of eligible staff had received level three training.
- The trust was not achieving targets for level 2 and 3 safeguarding training. The proportion of staff who had completed the training had fallen since our last inspection from 88.2%for level 2 and 93.3% for level 3 to 82% and 79% respectively. This meant 34 of eligible staff had not completed level 2 training and 31 staff had not completed level 3. Whilst the proportion of staff

completing safeguarding training had reduced from our previous inspection, the trust had increased the number of staff eligible to receive safeguarding training from 85 to 185.

- The trust provided a breakdown of the training levels by service for the period July 2015 to June 2016. These showed only 37% of staff working in the Child Development Unit at Brierley Hill had received level 2 safeguarding training. Twenty four percent of paediatric physiotherapists had not received level two safeguarding training, 60% (4 staff) had not received level three training. A specialist nurse had not received level two or three safeguarding training. Health visiting staff at Stourbridge health centre were not up to date with level two and three safeguarding training only 41% of eligible staff had completed level two training and 37% had received level three training. Only 62% of eligible staff working as part of the family nurse partnership had completed level two training, 37% of eligible staff had completed level three.
- We saw that three incidents reported by staff where communications about children at risk of abuse had not been effective. The incidents related to social services not informing staff about child protection concerns. Managers were reviewing communications with local authority colleagues to reduce the risk of health professionals not being aware when there was safeguarding concerns about a child.
- Staff were aware of the content of the trust's safeguarding supervision policy and told us they received one to one supervision every six months in accordance with the policy. Health visitors told us the safeguarding team were accessible and responsive, providing advice over the phone when they needed it. They provided one to one support for staff if the case was particularly complex.
- Staff showed us how they accessed the trust's policy on safeguarding which was available on the trust's shared drive.
- The named children's safeguarding lead for Dudley was visible and accessible. They were available to provide training and supervision for children on child-in-need plans. Staff told us social workers locally had been under pressure. This meant the children's multi-disciplinary teams were playing an increased role in ensuring staff were following child-in-need plans.
- We spoke to senior safeguarding staff including the Associate Director for Safeguarding and named nurse for the Dudley borough. The Associate Director sat on three Safeguarding Boards and chaired the trust's Safeguarding Forum, attended by the trust's named nurses and safeguarding leads. They told us all the safeguarding posts in the Trust's structure were filled. There had been a vacant post when we last inspected. They were working with the local authority to strengthen working relationships and improve communications. Plans had been developed to co-locate health and social care staff involved with children's safeguarding but these were not going ahead. However, the Family Inclusion Team leader planned to spend two days a week with the local multi agency safeguarding hub (MASH) team. This would not go ahead until the trust was able to fill the gap left in the Family Inclusion Team to minimise the risk to families with complex needs.
- The trust's named safeguarding nurses attend Quality and Safety meetings. There were 17 named nurses and leads (including the Associate Director). The named nurse for children's service received about 30 advice calls from health visitors per month which meant they were very busy.
- The named leads carried out supervision of every child on a child protection plan six to eight weeks after the child protection plan had been out in place. There was a trust database for holding information about children with child protection plans.
- Managers told us children on the child protection register were not flagged because a new computer system had been introduced. This had been identified as a risk and the trust was looking at ways of mitigating this. The plan involved the named nurse team adding and removing the flags when required.
- Referrals to social care were emailed to the named nurse team and entered on to the trust's incident reporting system. Staff could access the information on the patient administration system to check if a child was on the child protection register.

Good

Are services safe?

- There was a policy in place for escalating urgent concerns about a child. Staff followed a flow chart and the trust's policy for any concerns, which needed escalation. The Associate Director for safeguarding told us that escalation resulted in an effective response to ensure the safety of the child. Since March 2016, eight cases had been escalated resulting in decisive interventions.
- Nursery nurses were being trained to Level 3 in safeguarding and some staff had received 'train the trainer' training, enabling them to train other staff in the trust.
- The trust's safeguarding arrangements were audited twice a year involving a 'deep dive' review of child protection records to examine the action plan, actions taken against this plan and to ensure the voice of the child was being heard. The children, young people and family's team and staff more widely within the trust, discussed the learning from the audits.
- However, when we spoke to health visiting staff they told us communication between agencies was a problem on occasions. We saw from the incident log that there were three incidents where health visitors had not been informed about a child who had a protection plan or where a protection plan was being considered.

Medicines

- None of the children, young people and family teams prescribed medicines and there were no medicines stored in the clinics used by these services.
- Staff were aware of the trust's medicines management policy, which was available on the trust's intranet site the policy was due to be reviewed in 2018.
- Parents and carers were responsible for administering medicines at home.

Environment and equipment

- The Sunflower Centre was a temporary base for children's assessment unit (CAU). There were three treatment rooms, plus a sensory integration room and a soft play room. The service had moved from the acute hospital in September 2015 to this temporary location but the intention was to locate services together with other professionals to provide a full assessment and development centre. The trust had not yet identified a site.
- The Child Assessment Unit within the centre was child-friendly with attractive wall decorations, mobiles suspended from the ceiling and furniture suitable young and older children.
- Therapy staff told us children were provided with the equipment they needed within three to four weeks. They described how they worked closely with the local clinical commissioning group to order equipment needed at home. The CCG usually accepted the therapist's assessment and ordered the equipment. However, children's palliative care staff told us they had difficulty obtaining specialist beds and a head teacher in a school told us a child had grown out of an item of equipment before it was delivered. Therapy staff also told us there were long waits for wheelchairs currently 14 months. The wheelchair service was provided by the local acute trust and staff referred children to be assessed but they often had to chase up referrals and the delivery of the wheelchair.
- At our last inspection, staff told us equipment provided by the paediatric physiotherapy department for use in patient's homes was not always checked according to the manufacturers 'recommendations. The trust had changed the arrangements for maintaining equipment shortly before our previous inspection. The physiotherapy service manager told us they had reviewed the arrangements since our last visit and they were confident all equipment provided to families by the service was checked according to the new standard operating procedure developed by the trust.
- We saw the standard operating procedure (SOP) which had been developed by the trust for ensuring the paediatric physiotherapy service effectively maintained equipment provided for children to use in their home. The SOP was signed off in July 2016. The procedure described the process to be followed for purchasing and checking equipment. Equipment provided for pre-school children was checked six monthly and annually for school age children. Children's records contained copies of the signed service loan agreements. A log of all equipment loan agreements was completed for each piece of equipment issued, which recorded when

maintenance checks were carried out. We saw records of completed equipment inspection checklists, which showed when equipment had been checked. There were inspection checklists based on manufacturer's guidelines. There was a nominated medical device lead for the children, young people and family's directorate who was responsible for ensuring the service complied with guidelines and procedures. New staff who joined the service received training on equipment ordering and the maintenance policy as part of their induction programme.

Quality of records

- The trust carried out regular records audits. We saw the results of audits which had been carried out each quarter between July 2015 and May 2016. The audits showed areas for improvement which included recording care plan reviews. Sixty three percent of records showed a care plan review had been carried out, 27% of records did not include a contact telephone number for the family.
- We reviewed 20 sets of child health records from a range of services including health visiting , physiotherapy, occupational therapy, speech therapy and the Seesaw palliative care service. We found these contained assessments of children's needs and a clear care plan. Records followed the standards required by the nursing and midwifery council and were dated and signed.
- Health visiting records did not have a clear statement about parental responsibility. For example we saw one child lived with foster parents the social services department had parental responsibility for the child but this was not clearly stated. It was not clear who could provide consent for example for immunisations.
- Blood screening results were missing from one set of records. When we asked, the health visitor about this they told us they always checked the results at the six week check. They told us the results were sent to the family. It was not clear how the service picked up if any conditions had been identified by the test.
- Staff told us the process for transferring health records had improved and was audited. They said records were no longer transferred insecurely. A courier collected the records and staff had to sign for their receipt.
- Records of visits to the child's home we reviewed were comprehensively documented, dated and signed. Care plans contained advanced care plans highlighting the child and their family's wishes.
- Safeguarding information was recorded on a yellow form which was easily identifiable in the child's paper records.

Cleanliness, infection control and hygiene

- We observed staff wash their hands after examining each child although we also there were no prompts displayed in treatment areas to remind parents to wash their hands after they changed their child's nappy.
- Infection prevention and control audits were carried out every three months for community children, young people and family (CYPF) services. The results showed the majority of services were achieving 100%. Community CYPF services had identified Infection prevention champions who were responsible for keeping up to date with infection control policies by attending trust infection control leads meetings. They were responsible for feeding back information to their teams to ensure staff understood changes in infection control practices.
- We saw the results of quarterly infection control audits undertaken in June and August 2016 for all areas in children's services. The audits reviewed compliance with the trust's bare below the elbow policy, hand hygiene and adherence to the trust's sharps policy. The audit measured staff's knowledge about the '5 moments for hand hygiene' and monitored how clean sinks were and staff's access to personal preventative equipment, hand gels and paper towels. The results of the audits showed high levels of compliance 100% in all the areas used by the health visiting, physiotherapy and occupational therapy service. The child assessment unit had achieved 100% for the first quarter dropping to 92% in the second quarter. The trust had recorded this as resulting in moderate concerns. All other areas including for example the palliative care service had achieved 100%.
- Staff cleaned the toys in the Sunflower Centre regularly as shown by the cleaning schedules.

Good

Are services safe?

- Staff had access to personal protective equipment (PPE) and we observed staff using gloves and aprons when they were treating children. Staff also adhered to the trusts bare below the elbow policy.

Mandatory training

- The trust provided us with information about mandatory training rates for the period between July 2015 and June 2016. At our last inspection, the trust had intended levels of safeguarding training to reach 95% by December 2015. However, the most recent figures showed they had not achieved this or the current internal target of 85% for level 2 or 3 children's safeguarding.
- The target for mandatory training at our last inspection was 95%. The trust had revised this to a target of 85% across all mandatory training courses.
- At this inspection, a larger number of staff were eligible for mandatory training courses for example safeguarding.
- Mandatory training included a one day annual mandatory training day training in conflict resolution, patient moving and handling, paediatric basic life support, promoting safe and therapeutic services (PSTS), safeguarding adults and safeguarding children levels and 3.
- The annual mandatory training day had been completed by 92% of eligible staff , 79% had completed conflict resolution training, 91% had completed moving and handling patient handling, 91% had completed paediatric basic life support. 82% had completed safeguarding children level two and 79% had completed safeguarding children level three.
- Staff told us they attended mandatory training days and completing on line training. They said managers supported them to complete training during the working day or attend courses.

Assessing and responding to patient risk

- We reviewed eight sets of records in the children's palliative care (Seesaw) service and saw children's needs had been assessed and care plans were in place. There were assessments for moving and handling, nutrition, sleep, development and medicines. Records of visits to the child's home were comprehensively documented, dated and signed. Care plans contained advanced care plans highlighting the child and their family's wishes.
- Urgent medical attention could be accessed by contacting the combined acute and community paediatric team based at the local acute hospital or via the child's GP.
- Children with complex needs living in the community received a multi-disciplinary assessment and review. Their care was monitored by a multi-disciplinary team involving physiotherapy, occupational therapy, paediatricians and paediatric nursing staff.

Staffing levels and caseload

- The trust had reviewed the health visiting service and were working towards fully meeting the recommendations of the National Health Visitor Plan published by the Department Of Health in 2011. Five health visitor posts had been converted into nursery nurse posts as a result. Nursery nurses were supervised by health visitors to provide support to families who required a community or universal level of service. Some health visitors we spoke with told us they had concerns about the changes which had not yet been fully implemented. They felt the main reason for the changes was to reduce costs. We discussed this with managers who told us the changes were being made following a carefully considered review of the health visiting service.
- The target caseload for each health visitor was 350. The average caseload at the time of inspection was 355 cases. The service tried to ensure health visitors did not have more than 15 universal partnership plus cases (UPP). This was the level of service provided to families with the most complex needs. Managers told us the UPP cases were allocated across teams regardless of geography to ensure all four teams shared the management of complex cases equitably across teams.
- Staff and managers told us the caseloads of health visitors were reviewed monthly. Health visitor's caseloads were weighted according to the complexity of individual cases.
- The caseloads were discussed at a local level within the local teams and with the Service Manager. A quarterly

monitoring tool was completed for the generic health visitors. The family inclusion team was monitored monthly due to the transient nature of this cohort of children and their families.

- Team leaders were able to respond flexibility to demand and support teams as necessary to cover sickness and other absences because they did not formally carry a caseload.
- Health visiting teams had been reviewed with some qualified health visiting posts being replaced by band four nursery nurses. Managers told us they had reviewed the teams to provide greater flexibility in how the teams worked and to identify cost savings. They told us they were confident the new model where qualified staff supervised the band four nursery nurses provided greater flexibility in how staff worked. Health visitors developed children's care plans and nursery nurses were being responsible for providing the support described in the plan.
- At our previous inspection we found one specialist health visitor carrying a complex caseload of 96 cases and we were concerned that these children and families could not be adequately monitored and managed to protect them from abuse an avoidable harm. Following our inspection the specialist health visitor's caseload was reviewed and 23 cases were transferred to other health visiting teams. The specialist health visitor was due to be seconded to the local authority multi-agency safeguarding hub (MASH) two days per week. Managers had advertised for a replacement however, we noted the post was at a lower grade and included responsibility for the care of the next infant (CONI) training. This is a statutory role which provides support for families where there has previously been a baby death.
- Health visiting teams had been reviewed to increase the number of nursery nurses and reduce the number of health visitors. The teams were designed to provide one nursery nurse for each for the four geographic locations served. Nursery nurses would be able to provide contact that is more direct for example baby massage sessions and community development work such as the "Let's get kids fit" courses to tackle the high levels of obesity in the area. Health visitors would assess babies and supervise nursery nurses. Health visitors would be freed up to concentrate on more complex families and safeguarding issues. The changes were in the process being implemented. Most staff were positive about the changes but some staff told us this was a cost cutting exercise and would result more pressure being placed on health visitors.
- We saw lack of access to psychology had been identified as a risk on the children young people and families risk register. The service was concerned the impact that lack of psychology resource might have on the future viability of the children's assessment service. Children who required support from psychology were managed by the paediatricians in the acute trust were they could access psychology.
- The service's risk register also highlighted pressures on the haemoglobinopathy specialist nurse who was contracted to work for 22.5hrs per week covering antenatal clinics, screening meetings, neonatal home visits, patient caseload management, delivering staff training and management of the service. A business case was being developed to bid for an additional post.
- The SeeSaw team provided non clinical support in the absence of the haemoglobinopathy specialist nurse
- The Current post holder has restricted leave planning due to cover and therefore this has an impact on work life balance and potentially increases the likelihood of fatigue/sickness. Managers were in the process of creating business case to recruit another staff for cover.

Managing anticipated risks

- A risk register was maintained which contained an assessment of the risks faced by children and young people's services. The minutes of the Children, Young People and Families Quality and Safety Group showed risks were reviewed monthly. There were 21 risks identified on the register in total. The risks included issues about IT systems and communications between teams for example the midwifery and health visiting teams. Staffing pressures were also highlighted resulting in bids being developed for additional staffing where required. Each risk had a responsible manager identified. Progress to address or reduce the risk was monitored monthly. The risks, which had been resolved by the action plan, were highlighted as being completed whilst the ones, which were off track, were highlighted as being escalated. Six of the 21 risks identified had been closed.

Good

Are services safe?

- We saw examples of patient risk assessments for physiotherapy, occupational therapy, speech therapy and the palliative care service which had been carried out and recorded in patient's records. These were comprehensive and re-evaluated. The palliative care service also carried out nutritional assessments.
- All the risks identified had actions identified for reducing the risk and monitoring the risk. Concerns were escalated to senior managers where required. For example we saw concerns about communications between midwives and health visitors were being reviewed in joint meetings between the Health Visiting and Midwifery service a practitioner, team leader and service manager. The risk had also been escalated to more senior managers to resolve the issues at an organisational level. New birth visits were being monitored against numbers of antenatal notifications received.
- The See Saw palliative care service were not always notified when a child was admitted to hospital. This meant there was a risk children might not receive continuity of care. Staff told us once the risk had been identified discussions had been held between the Children's Ward Outreach Team (CWOT) and See Saw Team to discuss specific cases. This had resulted in improved communication between the services with hospital staff now contacting the See Saw team to notify them about a child's admission and to arrange their discharge. The service level agreement and standard operating procedure (SOP), describing the standards the services aimed to achieve, had been developed as a result. The risk register showed the SOP had not been signed off and the risk had therefore been escalated to ensure the necessary agreements were in place.

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 rated effective as good because:

- Assessment and care planning was based on evidence-based guidance.
- There was a clear approach to monitoring, auditing and benchmarking the quality of children's' services and the outcomes for families receiving care and treatment.
- Staff had the skills, knowledge and experience to deliver effective care and treatment
- Staff worked with other agencies in multi disciplinary teams to ensure the care children received was well co-ordinated.

However,

- Children were referred to other teams within the trust but there were no shared records. Each service kept their own information about a child's needs. Information was held in paper records. An IT system which supported information sharing was not in place and the service could not share information with GPs.
- Not all services were accessible at one location for example speech therapy was not provided at the Sunflower Centre where other therapy services and the Children's Assessment Unit was based.
- The pathway for the Family Inclusion Team and the access thresholds was not clear and there was a risk that some families in need might not receive the level of service they required.

Evidence based care and treatment

- The health visiting team and nursery nurse team achieved the UNICEF's stage three baby friendly award in 2015. The baby friendly awards were designed by UNICEF to provide parents with the best possible care to build close and loving relationships, and to feed their baby in ways which will support optimum health and development. By achieving stage three, the service had attained the highest level of recognition. To achieve the award, the trusts pre-school services were externally assessed 10 baby friendly standards. The assessment included interviews with mothers about the care they received.
- The physiotherapy service used the gross motor function assessment score for children with cerebral palsy and followed CPIPUK guidance which are the standards developed by the chartered institute of physiotherapists for treating children. The service also contributed to a regional programme for hip migration. Consultant medical staff reviewed the results remotely to identify children who needed treatment.
- Other national guidelines were being followed, such as Promoting the Quality of Care of Looked After Children and Young People, and Special Educational Needs and Disability Code of Practice
- Schools were provided with a progression tool developed by a national charity, experts in the field of speech and language therapy, which was also used as a screening tool at referral.

Pain relief

- The manager of the SeeSaw service told us they assessed children's pain but were not using a particular scoring tool.
- We saw written description of children's pain, the medicine or therapy being used to provide pain relief.

Nutrition and hydration

- Care and treatment was planned and delivered to meet the nutrition and hydration needs of children. Children's nutritional and hydration needs were all assessed and if they needed support from the nursing or speech therapy team. The information was included in the relevant section of the care plan. We saw example of care plans where children required advice about swallowing and where enteral nutrition was being provided. The advice was based on national guidance and we saw examples of nutritional needs for example a child with cystic fibrosis which were discussed by the multi disciplinary team.

Good

Are services effective?

Technology and telemedicine

- Managers told us they were developing a paper for the board highlighting the IT and information sharing needs for children's' services in response to the problems identified by staff following the implementation of the new patient administration system.

Patient outcomes

- There was a clear approach to monitoring, auditing and benchmarking the quality of children's' services and the outcomes for people receiving care and treatment.
- A new infant feeding advisor had recently been appointed replacing a member of staff who had retired. New staff received a two day induction on breastfeeding and existing staff had a half day training update annually. The children's centre supported parenting courses provided by a national charity. The service organised breastfeeding buddies to support mothers who were breastfeeding.
- The family nurse partnership evaluated the effectiveness of the service. As part of the evaluation, the team monitored the outcome of their interventions.
- The children's palliative care service monitored their performance against a range of key performance indicators. These included contacting the family within two days of referral and a home visit if required within 10 days. Advanced care plans developed and in place, reviewed every 12 months.
- The occupational therapy service used an adapted version of the Canadian Occupational Therapy Performance measures for older children who were supported to identify their own goals and self-assess their progress towards those goals.
- The children's occupational therapy service had developed a range of feedback questionnaires for evaluating their service. The results were evaluated to assess if children had enjoyed the session and parents were asked to provide their observations. One parent had commented that their child did not want to attend the sessions in the beginning but that they now really looked forward to them. The questionnaires assessed children's' views and their parents and carers.
- Health visiting figures provided by the trust showed 95% of children received a 6-8 week review. Ninety five percent of children received a 12 month review by the time they were 12 months old and 95% of children received their two year check when they should. The service identified the reasons for children not receiving the checks for example because they were in hospital or had not attended their appointment.
- The trust's target for babies to receive a face to face new birth visit from a health visitor within 14 days was 95%. The trust achieved the target between March and June 2016 and in the three months June to September 2016.

The target for mother's breastfeeding at three to six weeks was 36%. Figures provided by the trust showed the highest levels between October 2015 and June 2016 was just above 30%.

Competent staff

- Matrons told us they ensured training was tailored to meet the needs of staff working in the community, which required a different emphasis than in-patient services.
- Therapy staff told us the trust provided them with protected time for continuing professional development.
- We spoke with five therapy staff. One member of staff described the induction training they had received which lasted for six weeks. They said they had also had a mentor during their first six months in post whose role was to support and assess their competencies.
- Health visitors working in the community were supported by four community practice tutors.
- All occupational therapy staff were up to date with mandatory training and training attendance was monitored. The manager had identified two members of staff on maternity leave to ensure their training is not missed. Managers received notification when a member of staff had attended a training course.
- The occupational therapy team had a training budget for non-mandatory training and the team decided on the priorities for further training. Sensory integration training provided to new starter as a vacancy fell available. The trust were supporting three occupational therapy staff to attend specialist children's training events provided by the college of occupational therapy.

Good

Are services effective?

- Staff were appraised annually with six month reviews. Staff told us they areas for training and development. Staff were asked to bring in their continuing personal development portfolio to ensure that all activities had been logged.
- Staff within children's services received regular supervision. There was peer supervision for more senior staff in addition to formal supervision meetings provide by managers. Staff had supervision meetings with their managers approximately every six weeks. Peer supervision focused on clinical good practice. Staff attending these group supervision meetings choose a topic and each member of staff took a relevant case to discuss with the group.
- The trust provided information about appraisals for staff groups for the 12 months between July 2015 and June 2016. One member of staff in the family inclusion team and one speech therapist had not had an appraisal. Nursing staff within the health visiting and primary care teams had all had an appraisal (100%)

Multi-disciplinary working and coordinated care pathways

- Multi-disciplinary meetings (MDTs) with consultant paediatricians were held on the second Wednesday of every month. Children's needs were reviewed by the MDT to develop a care plan and decide which therapies needed to be involved.
- Health visitors were aligned to GP practices. Health visiting staff told us this helped communications between GPs and the health visiting teams. Health visitors attended GP practices monthly MDT meetings when children with safeguarding concerns were discussed.
- Health visiting staff told us there was good professional team working in place with the midwifery team who were based in the local acute trust. Health visitors offered contact at 28-34 weeks gestation and there was an agreement in place with the midwifery service to share information about families, needs. We saw examples of information which had been shared with health visitors in four sets of records we reviewed. These showed that families with the greatest need were being highlighted allowing health visitors to make contact early and offer support. Health visiting staff were trained in promotional guide interviewing for use at antenatal visits and at six week checks. Two health visitors told us they did not always use this approach and preferred contact with families to be led by parents and carers.
- A tracer card system had been introduced for all antenatal bookings within the family nurse partnership team. Previously health visiting staff had not always been aware of mothers who were being supported by the FNP team.
- The health visiting service was in the process of introducing a new integrated two year review for universal families. The new approach was being piloted in five areas. The review took place at the child's nursery with the parent or carer present. Nursery nurses were leading the initiative which reduced duplication. The assessments were undertaken jointly with colleagues from education.
- Staff told us cross boundary working was challenging. Health visiting teams worked across local authority boundaries and the school health service was part of a separate provide organisation based in Shropshire. Ante natal bookings with hospitals in other areas were not always notified to the health visiting team. There were no arrangements in place for hospitals in other areas to notify the health visiting service about families living in the area.
- GPs and health visitors were not able to communicate electronically or share records of children who might be at risk. Staff told us about an eight month old baby who was seen by a GP in the Sandwell area. The child had attended the accident and emergency area but there was no communication with the health visitors. A nursery nurse had telephoned the health visiting team to make them aware the family lived in their area.
- The children's palliative care team met weekly to review their caseload, discuss new referrals and update the team on individual cases.
- The trust had a Commissioning for Quality and Innovation CQUIN in place for multi-disciplinary working with GPs. Therapists copied their assessment reports to GPs but felt things could be improved if they could share electronic records with GPs. The Clinical Commissioning Group CCG was exploring the development of a multi-specialty community provider. Children young people and family's staff were working with the CCG and

education partners to develop joint plans for children's services in the community. This included developing support for families locally where children were attending specialist schools or services outside the Dudley area.

- Staff and managers told us health visitors were being asked to organise and chair case review meetings for children because of pressures on the social services team. The service had identified this as a risk on the their risk register.
- A pathway to identify autistic spectrum disorder ASD in children up to the age of five was finalised in August 2016. The service wanted this pathway to be very clinically driven and to keep paediatricians on board as well as involving parents. Parental feedback was used to develop the pathway.
- The Children's Assessment Unit provided a multi-professional assessment of pre-school children referred to the services by consultants at the local hospital. Children with socio-communication difficulties received a multi disciplinary assessment and a home visit. Nursery nurses carried out observations. Psychology, speech and language therapy, occupational therapy and physiotherapy assessments were recorded as required. The service also worked closely with the Specialist Early Years Team (Education) who contributed to the assessment.
- Referrals to the service were handled effectively. There were clear criteria in place for referrals and the service worked in partnership with the education service, school health services and social workers to ensure children and young people received a swift response and a service which met their needs.
- A new referral pathway to the child and adolescent mental health service had been developed and was being implemented. This meant staff within the children and young people's community team would be able to make referrals and reduce the length of time children waited to access the child and adolescent mental health service.

Referral, transfer, discharge and transition

- A parent told us services were not joined up and relied on parents to inform each department about what was happening. They said they had made a complaint and a physiotherapist was now involved in co-ordinating their child's care plan.
- The nursery nurse team reviewed children who were on the waiting list. The directorate's clinical psychology post was vacant. The service had arranged for a psychologist in the acute trust to see some patients. They agreed to prioritise children who were due to start school shortly
- Services could refer internally within the children and young people's directorate rather than discharging the child back to their GP.
- Physiotherapy referrals were triaged weekly according to need. The service was working on reducing waiting times by moving to a team diary rather than individual therapists holding their own diaries.
- Health visitors were concerned that the school nursing service did not have the child health records for children who started school aged four. Health visitors were responsible for children up to the age of five and transferred their records to the school nursing service when they were five. The school nursing service was provided by another trust and health visitors had no way of knowing which children were at school. Managers had identified the problem and were working on a solution. They were no aware of incidents which had occurred as a result.
- There were clear referral protocols in place for children and young people who required access to specialist services for example neurology or orthopaedics.
- Staff discussed plans from the age of 16 for young people whose care transferred to clinical teams caring for adults. We saw examples of transition plans in children's' records.
- Children's services worked closely with GPs participating in practice multi-disciplinary to plan the care provided for vulnerable children including children being discharged from the children's community service.

Access to information

- We met with a group of staff who worked with children, young people and families who told us, "IT is one of our

bugbears". They said the system was used for recording all patient contacts for example home visits and patients attending clinics and to record progress against key performance indicators (KPIs). They said the system was slow and did not hold any clinical information.

- Information from the old computer system was moved across to the new one but staff told us some records were missing and some children could not be found on the new system.
- A new IT system had been implemented two months prior to the inspection but staff working in child health felt the system was not suitable for their service. The previous system used by the trust was no longer supported by the IT supplier and all the trust's services had moved to the system now being used by the children's service. Staff told us they had been assured the current system was only temporary and they would move on to a new electronic record system being developed by the trust's IT department.
- There were records of incidents which had been reported about problems transferring confidential patient information from between sites in the trust and the local acute trust. This service was provided by an external company and staff told us they had to check all patient information transferred had been safely received.

Consent

- We observed a therapist discuss consent to share a child's details. They explained who they would share the information with and the purposes of sharing the information. The parent was invited to ask questions if they needed any clarification before giving their consent.
- Obtaining consent was covered in staff induction training and as part of mandatory training. If staff were seeing a child for example in their school without a parent being present then they were required to have formal written consent. Staff told us they recorded consent to share information within health and with education.
- The service used national guidance for example the college of occupational therapy (OT) guidance for assessing the capacity of 14-18 year olds to consent to treatment. Staff asked children between the age of 14-18 whether they would like information about their care sent to them or to their parents. Staff told us they tried to involve children in making decisions about their treatment as soon as they were capable of understanding the treatment.
- This meant there was a valid process in place for consent to treatment for children and young people who were under 16, which involved them in decisions about their care or from a person with parental responsibility where the child cannot give or withhold consent.
- Staff ensured that children were seen as children first and foremost, with their individual physical, emotional and social needs recognised and responded to. Staff told us they reviewed care plans to ensure the individual needs of the child were clearly identified.
- Another parent told us they had been very anxious during their pregnancy because they had previously had a late miscarriage and a child who had died. They told us they had received a lot of support from the hospital and the trust's child health team and reassurance. Health visitors contacted them by telephone to find out how they were and to provide reassurance. They said they often spoke with different health visitors and they would have preferred to have more continuity.
- We observed a therapist sensitively provide advice for parents. They described the research findings relating to the use of baby walkers.
- Children's and young people received assessment and treatment according to their needs, which were age appropriate. The Family Nurse Partnership (FNP) service supported young expectant mothers up to the ages of 19 and their babies up to two years of age. Staff we spoke with told us about the challenges of supporting young mothers and the commitment of the team to meeting their needs.

Understanding and involvement of patients and those close to them

- We observed therapy staff assessing children in the Sunflower assessment centre and saw they provided safe and compassionate care. Carers and parents were involved in discussions about children's assessment and treatment. We also observed staff involving children and young people in discussions about their care in the Sunflower assessment service and in other services for example physiotherapy and occupational therapy.

Good

Are services effective?

- Staff communicated effectively with children and young people and checked that they understood their care, treatment and were encouraged to ask questions.
- Staff told us the family with guidance from staff chose the key worker if the child had specialised needs.
- Another parent told us how good they thought the gym club was. This was the result of a collaboration between schools and the physiotherapy service. They said it worked well because it allowed children and young people to work together in groups and motivate each other. They said the sessions ran outside school hours which meant the children did not miss out on school.

Emotional support

- We observed a therapist carry out an assessment on a child. They asked the child's parent to describe their understanding of their child's condition and what they hoped would happen during the assessment. The therapist acknowledged the parents anxiety and provided reassurance. They explained clearly what they planned to do during the assessment and explained each stage of the process and what they were looking for. We spoke to the parent afterwards and they told us they felt involved and happy with the information they had received.
- Children and young people were supported to access, maintain their education, and maintain their social networks. Staff from the children's services team carried out assessment and treatment in the child's school to reduce the time they spent away from the classroom and friends.
- Advocacy was available for looked after children who were supported by social workers. Children and young people could access advice and support outside the service providing their care.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Staff provided age appropriate care. They took time to interact with children and young people and their families and took account of children's individual physical, emotional and social needs.
- Staff recognised when children and families needed additional support to help them understand and be involved in their care and treatment accessing interpreters and other support when required.
- Staff empowered children, young people and families by providing information and support to enable them to make decisions around the care they received.

Detailed findings

- We spoke with five parents in the Olive Hill Children's Centre who told us they liked attending and thought the service was very child friendly. They were able to wait with their child in the play room where the children were able to play together. Parents told us they also enjoyed the opportunity to meet other parents. We observed health visiting staff consultations with three families and found staff were respectful and considerate. We found staff were supportive and encouraging, sensitive to families' needs.
- There were no private facilities for mothers who wanted to breastfeed. When we asked staff about this they said mothers did not mind and were happy to breastfeed in the room.
- We observed one child having a boot fitted to assist with their mobility. There was a good rapport between the parent and therapist who offered to write a summary report to their local scout group to help with the child's involvement with the group.

Compassionate care

- Staff ensured that children were seen as children first and foremost, with their individual physical, emotional and social needs recognised and responded to. Staff told us they reviewed care plans to ensure the individual needs of the child were clearly identified.
- Another parent told us they had been very anxious during their pregnancy because they had previously had a late miscarriage and a child who had died. They told us they had received a lot of support from the hospital and the trust's child health team and reassurance. Health visitors contacted them by telephone to find out how they were and to provide reassurance. They said they often spoke with different health visitors and they would have preferred to have more continuity.
- We observed a therapist sensitively provide advice for parents. They described the research findings relating to the use of baby walkers.
- Children's and young people received assessment and treatment according to their needs, which were age appropriate. The Family Nurse Partnership (FNP) service supported young expectant mothers up to the ages of 19 and their babies up to two years of age. Staff we spoke with told us about the challenges of supporting young mothers and the commitment of the team to meeting their needs.

Understanding and involvement of patients and those close to them

- We observed therapy staff assessing children in the Sunflower assessment centre and saw they provided safe and compassionate care. Carers and parents were involved in discussions about children's assessment and treatment. We also observed staff involving children and young people in discussions about their care in the Sunflower assessment service and in other services for example physiotherapy and occupational therapy.
- Staff communicated effectively with children and young people and checked that they understood their care, treatment and were encouraged to ask questions.
- Staff told us the family with guidance from staff chose the key worker if the child had specialised needs.
- Another parent told us how good they thought the gym club was. This was the result of a collaboration between schools and the physiotherapy service. They said it

worked well because it allowed children and young people to work together in groups and motivate each other. They said the sessions ran outside school hours which meant the children did not miss out on school.

Emotional support

- We observed a therapist carry out an assessment on a child. They asked the child's parent to describe their understanding of their child's condition and what they hoped would happen during the assessment. The therapist acknowledged the parents anxiety and provided reassurance. They explained clearly what they planned to do during the assessment and explained each stage of the process and what they were looking for. We spoke to the parent afterwards and they told us they felt involved and happy with the information they had received.
- Children and young people were supported to access, maintain their education, and maintain their social networks. Staff from the children's services team carried out assessment and treatment in the child's school to reduce the time they spent away from the classroom and friends.
- Advocacy was available for looked after children who were supported by social workers. Children and young people could access advice and support outside the service providing their care.
- The children's palliative care team (The SeeSaw team) told us they supported the whole family and were there to provide advice. They were also able to provide respite care in a local children's hospice to enable the family to spend time together or provide break for carers.

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 rated responsive as good because :

- The clinical commissioning groups were involved in planning services. Clinicians and managers from the children and family service were actively working with the CCG to develop services to meet the needs of the local population.
- The service worked with social services and education providers to meet the needs of Children and Young People in the area, particularly children with complex needs, life-limiting conditions and disabilities.
- Children waited longer than the trust's target of 8 weeks from referral to treatment target but met the national waiting time standards for providing timely access to initial assessment, diagnosis and treatment
- Health visiting services meeting targets relating for child development checks

Planning and delivering services which meet people's needs

- We spoke with one family who told us the physiotherapy and occupational therapy had all worked well but they had hoped all the services could be accessed at the Sunflower centre. They said their child needed further sensory tests and they were surprised that they would have to be seen somewhere else. The trust had developed standards for time the health visiting service responded to referrals and these were audited. We saw the results of quarterly audits carried out between July 2015 and May 2016. The results showed the health visiting service had responded to all urgent referrals (100%) on the same day or next working day. The audit also showed that 90% of health visiting notes were transferred within the trust's two weeks standard and direct contact made with the HV team in the receiving area where the child had a child protection plan in place.
- The service worked closely with the local clinical commission group to plan children's services. This was informed by the local joint strategic needs analysis which identified the health needs of children living in the borough.
- Another parent said services were not joined up and relied on parents to inform each department about what was happening. They said they had made a compliant and a physiotherapist was now involved in co-ordinating their child's care plan. Another parent said they felt as if their child had been abandoned by the OT service. They said they had no goals for their child's treatment and felt they needed to review the care being provided.
- Families were courage to use any of the baby clinics held by the trust regardless of where people lived. Health visiting clinics were held in a range of clinics, GP surgeries and Children's Centres. Evening clinics were held in two locations from 5-7pm.
- The health visiting service ran 'mop up' clinics for families who had not attended their two year child development appointments. Families were offered another appointment if they did not attend their first appointment and a mop up clinic appointment if they did attend the second appointment. There were two evening clinics for families who were unable to attend during the day.
- A complex needs nurse supported children in schools and three healthcare workers also assisted children in schools. Staff told us initially there was a lack of clarity about the role of this nurse which had been resolved through discussions within the trust and with partners in the education sector.
- A meeting was held in the evening to discuss the needs of children who were starting school. We spoke to one parent who told us they had been reassured when the service explained how they could support their child at school.
- One parent we spoke with had been attending the Sunflower Centre for more than 10 years and spoke highly about the service and staff. They said, "Staff have a brilliant manner which they have adapted over the years."

Good

Are services responsive to people's needs?

- The service responded to feedback. Staff told us the new signs in the Sunflower Centre were the result of feedback from patents who said they were unsure they were in the correct place when they arrived.
- Families also commented that they have found the first meetings with professionals daunting, so key workers have a planning conversation beforehand to find out what will make the parents feel most comfortable (e.g. offer to talk on their behalf if this is what the families want).
- The physiotherapy and occupational therapy service were based in the same building and worked closely to assess and respond to children's needs. They carried out .a joint telephone assessment involving health professionals from both services. Following the assessment, they discussed which service could provide the most appropriate care.
- Occupation therapy and physiotherapy staff worked together to support children with cerebral palsy. Joint visits were also undertaken with speech therapists if a child in school had difficulty eating and swallowing.
- Multi-disciplinary meetings were also held with staff from the children and adolescent mental health service for children who had a mental health and physical condition and for children with a learning disability.
- Occupational therapy and physiotherapy staff worked with a local football club to provide children with access to football in the summer months.
- The physiotherapy service organised bike riding sessions during the summer for children who had problems with co-ordination.
- Families were encouraged to choose a key worker to support them. They could choose a key worker from any of the services involved in providing a child's care.

Meeting the needs of people in vulnerable circumstances

- The Family Inclusion service specialised in supporting families in vulnerable circumstances for example asylum seekers or families suffering from domestic abuse.
- We spoke with the manager of the family nurse partnership a service developed to support young people expecting a child. The service prioritised young people aged 17 and under. Antenatal visits were provided in schools and colleges for young people in education. At our previous inspection, health visitors told us they were not always aware families were being supported by the family nurse partnership. When we spoke to staff at this inspection they told us this was now resolved and communication with the health visiting teams was good. Some young people occasionally dropped out of the programme and it was important they could be followed up by the general health visiting service.
- The family nurse partnership team worked closely with the local voluntary organisations who were able to provide support for young mothers and families.

Equality and Diversity

- Staff told us it was not always easy to access interpreter services and they had to ensure these were booked in advance of making an appointment.

Access to the right care at the right time

- The health visiting service provided several drop in sessions in Children's' centres and clinic. Families were able to see a health visitor if they had any questions or concerns. Families were greeted by a family support worker who encouraged families to use the services available in the Centre. One mother told us they had attended a talk about weaning which they had found out about by attending the children's centre. They told us they had found this really helpful.
- The children's palliative care service worked with local hospitals and specialist providers enabling children to return home. The service tried to respond the same day to families. The service was provided five days a week from Monday to Friday but they were able to access respite care at week-ends. Staff told us they ensured families knew how to access support at night and week-ends. They also trained families to support their child for example administering their medicines. The service worked with a children's hospice at home service and told us about the care provided for one child who was being transferred to this service. The service did not provide care at the end of life. The children's palliative care service worked with the voluntary sector to enable families to access benefits advice. An advisor worked with the team 12 hours a week.

Good

Are services responsive to people's needs?

- There were 142 children on the speech therapy waiting list and the average waiting time was eight weeks. The longest wait for a small number of children was 18 weeks.
- Children waited14 weeks to be seen by the occupational therapy service.
- The average waiting time for physiotherapy was eight weeks. Waiting time for the gait clinic had increased to 16 weeks. The physiotherapy service also had urgent referral criteria which meant some children were seen within five working days for conditions such as Obstetric Brachial Plexus Lesions. Senior clinicians triaged referrals and urgent referrals were prioritised.
- The proportion of children who did not attend their scheduled appointments was 5.8% for occupational therapy, 7.7% in physiotherapy and 8.7% for speech and language therapy. The service planned to send appointment reminders to patients by text...
- Waiting lists in physiotherapy were monitored across localities and telephone assessments were carried out to assess the urgent of a child's condition. Pre re-school children and those who had undergone surgery were prioritised.
- The speech and language service pre-school team worked as one team across clinics and localities which meant they adopted a flexible approach to meet clinical requirements. If referrals increased in a particular clinic then additional sessions were allocated to minimise waiting times. Looked after children were prioritised for initial assessments. The service provided additional sessions in the summer months to ensure children starting school in September were seen. Parents, nursery and school staff were provided with resources and strategies to use at the first assessment. This meant children were supported whilst waiting for specific speech and language therapy.
- The occupational therapy service had developed a protocol for prioritising new referrals. The protocol stipulated that the most urgent referrals were to be seen within seven days, the second category for prioritisation were seen as soon as possible and the third and least urgent category were seen in date order. The most urgent category included children referred by social workers because of concerns about non accidental injury, children who had undergone acute treatment for example following a road traffic accident. The protocol was reviewed every two years.

Learning from complaints and concerns

- The Trust received six complaints about the children young people and family service in the 12 months between July 2015 and June 2016. The highest number of complaints related to the Speech and Language service. One complaint was upheld. The nature of the complaints ranged from communications issues to concerns about treatment. Children, Young People and Families received 43 compliments during the same period. Speech and language therapy and the children's development centre received the highest number of compliments.
- Staff told us the Matrons were visible to patients and families and were able to resolve problems and save complaints being escalated.
- Matrons had an over-arching responsibility for complaints and concerns. They told us they telephone complainants and arrange face-to-face meetings. They checked that the duty of candour was followed where appropriate.

Good

Are services well-led?

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

Summary

We rated well-led as good because:

- Issues identified at the last inspection which required improvement had been addressed by managers in the trust.
- There were good governance arrangements in place which meant incidents, audits, national guidelines and risks were discussed and the appropriate measures were put in place.
- The performance of the service was managed and action was taken to improve performance
- Leaders had the capacity, capability, and experience to lead effectively

However,

- The Board did not have a designated executive lead for children. A non executive lead had been identified.
- A strategy was being developed with the local Clinical Commissioning group but this was not yet in place.
- Senior leaders were not visible to all staff.
- The trust used a system of restorative supervision but the role of this form of supervision was not clear within the trust's supervision policy. Restorative supervision was provided in addition to routine supervision for staff the trust believed needed additional support.

Service vision and strategy

- Managers acknowledged that much of the emphasis over the last 12 months had been on addressing issues in the child and adolescent mental health service. Managers were working with the local clinical commissioning group to develop plans for the service's future. The strategy and vision was under development in partnership with local commissioners.
- Service managers met with GPs from the clinical commissioning group in a clinical quality review group where staff were able to present a patient story.
- A strategy for the service had not been developed. However, the service was involved in discussions with the local clinical commissioning group about the future organisation of services and was working with a specialist provider on a programme of pathway transformation to provide more specialised care closer to home.

Governance, risk management and quality measurement

- A Quality and Safety group was responsible for managing the quality of care provided to children and young people. We reviewed the notes taken during these meetings and found they discussed incidents, audits, national guidelines and the service's risk register
- The children young people and families quality and strategy group reported to a trust wide quality and strategy group. The minutes of these meetings showed issues in children's services were monitored and discussed. The trust wide quality and safety group included representation from the medical and nursing directors as well as the director responsible for the service. The group discussed safety issues identified in the clinical quality dashboard such as incidents, safeguarding and risks.
- The Quality and Strategy Group monitored the number of incidents which had been reported and had noted the number reduced in comparison to the previous year. The rolling 12 month average of number of incidents reported each month was 29 and a total of 20 incidents were reported during August 2016. The group discussed whether the number of incidents had reduced or if incidents were not being fully reported. The group agreed to stress the importance to staff of reporting all incidents as being key to effective governance.
- Children young people and family services maintained a risk register which was review and updated monthly. Two risks had been escalated to senior managers because staff in the service was unable to resolve them and the risk register showed they were off track.

Leadership of the service

Good

Are services well-led?

- There was a non executive lead for children's services. The Director Of Nursing provided clinical leadership for all clinical services including children and young people's services. There was no designated executive lead on the Board for children's' services.
- A group director who also managed the services provided for people with a learning disability managed children, Young People and Family services. Day to day the service was managed by a general manager who also managed the child and adolescent mental health service.
- A matron provided clinical leadership for the CYPF and CAMH services. Heads of service were responsible for managing physiotherapy, occupational therapy, speech and language therapy and nursing services.
- The physiotherapy service manager was the lead allied health professional for therapies. Staff told us their managers were approachable and kept them informed about changes affecting the service. They told us managers had previously felt remote and disinterested in services but this had improved over the last twelve months.
- The trust had introduced matrons across all services to strengthen governance.
- There were clear lines of accountability for safeguarding children and support for children and looked after children.
- We met with a group of the trust's Matrons including the Head of Nursing for Children Young People and Families. The Matron's told us they ensured that the nurse's' voice was heard by senior managers and the trust board, improve links with outside agencies and allied health professionals.
- The trust were working on a sustainability plan and managers in children's' services told us they were involved

Culture within this service

- At our last inspection we found there was a disconnect between senior managers and other staff. Senior managers had not supported the health visiting team with additional resources to manage a caseload which had quadrupled over the preceding 12 months
- At this inspection service heads and other managers told us they felt more involved but some front line staff felt things had not changed significantly. Some staff told us the matron and senior managers were not visible and they were unsure whether children's community services were regarded as a priority by the organisation.
- We spoke with a group of five health visitors who were passionate about what they did for families but they said some of the enthusiasm had gone out of the service. They felt they had lost autonomy and the impact of budget cuts and reduction in the number of children's centres had all had an effect. They described concerns about the loss of links with school nurses and felt that no longer being GP practice based meant families could no longer knock on the door for advice. They felt the new structure had taken them out of the communities they served.
- However, they also said they saw the value of the relatively new team working which enabled them to share work within and across teams and provide mutual support.
- Children's community nursing staff said the presence of matrons helped counterbalance the financial focus of service managers and ensured there was an appropriate focus on quality and safety.
- One member of staff told us community staff sometimes felt professionally isolated. There were no professional rotations in a place to support staff retain and develop new skills. They said older staff had often maintained professional networks regardless of previous service re-organisations. They said it was an issue for younger staff working in a predominantly mental health trust. We discussed this with managers who told us they were aware of staff's concerns and had made progress over the last twelve months to support and promote the role of children's services.
- Staff followed the trust's a lone worker policy to ensure staff working alone or in disperse teams were safe. We saw staff signed in and out on a whiteboard and showed where they were going when they were on home visits or visits to schools.

Public engagement

- The service encouraged families to provide feedback using 'Have your say cards requesting feedback on the

service. The cards could be completed and submitted using feedback boxes in key locations such as the Sunflower Centre. Staff told us they acted on the feedback received for example by making the entrance to the Sunflower Centre more family friendly. There was no reception desk at the Centre and families were not sure they were in the correct place. When we arrived to inspect the Centre estates staff were in the process of applying new welcome materials in the entrance which had been designed for the service with pictures of sunflowers.

- Friends and family test results for the period August to October 2016 showed that 96.2% of families who responded would recommend the service to friends and family.
- Staff told us the team were very supportive and managers were approachable.

Staff engagement

- There was a monthly health visitor forum. Staff told us this had been chaired by health visitors in the past but was now led by a manager and some staff felt less positive about being involved as a result.
- There were multi-disciplinary team meetings every six weeks. The agenda was open and was on line so staff could add in topics they would like discussed. Incidents, audits, risk assessments were always discussed and they agreed how to spend funds that had been donated to the service.
- Sickness rates were similar to the national average at 4.0%. These had reduced in June 2016. Turnover rates had increased in May and June 2016 to 2% but the rate was consistently better than the national average of 4%. Vacancy rates had increased from 6% to 8% in May and June 2016. The highest number of vacancies was in the health visiting teams in Dudley Central and North and children's palliative care team. However, the numbers were small, 3.48 staff in total.

Innovation, improvement and sustainability

- The physiotherapy service had developed plans for treating children with complex musculo-skeletal conditions. Staff who provided the service would be trained to prescribe medicines.
- A gait clinic had been developed to allow children with gait abnormalities to be assessed. Health visitors had received training to refer children to the service.
- Managers told us they were introducing a patient feedback questionnaire which asked about six areas: communication, compassion, commitment, courage, care and competence (6 Cs) The questionnaire asked families to provide any examples where the community nursing team had adequately supported the family or if they could have provided more support. The feedback questionnaire also asked families to comment on areas where the service had made a difference to the care of the family.
- The service was working with a major acute hospital on a transforming care programme which involved community teams developing more specialist care in the community closer to the children family home.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.