First Community Health & Care C.I.C.

1-274331683

Community health services for children, young people and families

Quality Report

Forum House
Redhill, Surrey
Tel: 01737775450
Website: www.firstcommunityhealthcare.co.uk

Date of inspection visit: 20 - 22 March 2017
Date of publication: 18/08/2017

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)
1-875238883	Forum House		

This report describes our judgement of the quality of care provided within this core service by First Community Health & Care C.I.C.. 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 First Community Health & Care C.I.C. and these are brought together to inform our overall judgement of First Community Health & Care C.I.C.

Summary of findings

Ratings

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

Summary of findings

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Overall summary

We have given the service an overall rating of Outstanding.

This rating was because

- There were innovative approach to gathering feedback and provide accessible services which resulted in meaningful and continuous engagement with the public and hard to reach groups. New technology was being used successfully to reach children and young people (CYP) that may not have accessed the service through conventional means. Examples of innovations included CHAT Health (a confidential school nurse messaging service for young people aged 11-19.), Advice line (telephone advice line for parents with children and young people ages 0-19), and using social media and text messaging to stay in contact with hard to reach groups and for health promotion purposes.
- Staff were going beyond what was expected of their roles to ensure a wider involvement of healthcare providers, local organisations and agencies and the local community to meet the needs of those it cared for. We met one member of staff who had been contacted by a young person who was struggling to support themselves after leaving care. The member of staff used their own money to purchase electricity on the meter key and took the young person to a local supermarket to buy essentials until proper financial support could be arranged. The member of staff returned the next day to check all was well and then took the young person to a sexual health clinic when they confided that they might be pregnant. The staff member felt anyone would have done the same – even though they didn't know whether they would be reimbursed for their financial outlay.
- There was a very strong holistic person-centred service. It was also an outward looking culture in terms of knowing exactly what external services were available how best to access these services. Staff were empowered to build strong networks with local healthcare providers, support groups, and charities. Staff also displayed a commendable drive to continuously improve the service through innovation, balanced with meeting people's social, cultural and individual needs. This ensured that teams were creative in overcoming obstacles to delivering care.
- Children and young people (CYP) were kept safe because there were effective systems and processes to measure harm, and learn and prevent recurrence from clinical incidents. There was an open 'no blame' and inclusive culture that made the investigation and learning from such incidents a success.
- There was a very proactive and engaged safeguarding team that ensured effective management and oversight of safeguarding systems and processes. The homeless team provided an exemplary person centred service to those who were classified as homeless or vulnerably housed in temporary hostel, guesthouse, or refuge accommodation.
- The electronic records system supported a multi-disciplinary and multi-agency approach to delivering care. The records we viewed were person centred, contemporaneous and fit for purpose. They also contained evidence of parental input and took account of individual's cultural, social and diverse needs. Staff had received the appropriate amount of training to be able to do their jobs and there was adequate numbers of competent staff to ensure the service was delivered safely.
- Public feedback was unanimously positive, and there were very low levels of complaints. The quality of the service provided by First Community was recognised and much valued locally. Many parents we talked with had received personal recommendations for drop-in clinics, baby massage and other support services. CYP and their families were able to access the right service at the right time.
- The care delivered reflected national and best practice guidance and data demonstrated good clinical outcomes for those who used the service. Staff were kind, caring and went beyond what was expected of them on a daily basis to ensure every contact was a success.

Summary of findings

- The organisation provided services that reflected local need and was continuously evolving to ensure it would meet the ever-changing health and social needs of those it cared for.
- Staff were empowered to provide care that had an multidisciplinary focus and positively engaged with other services providers, councils, Clinical Commissioning Groups(CCGs)and local charities and support groups.
- Governance and risk management systems were fit for purpose. There was very good local and board leadership. Staff felt very valued and cared for, were driven and supported to innovate and improve the service.

Summary of findings

Background to the service

Information about the service

First Community provides a range of services to children and young people (CYP) in the east Surrey area with dietetics services for children provided in the north of West Sussex. First Community is a not for profit organisation that provides children's services in east Surrey. Services include early intervention, universal immunisation and screening programmes in a variety of settings including child health clinics, homes and schools.

The care delivered by the service was evidence based and reflected national and best practice guidance. This meant that Children and Young Persons (CYP) were receiving care that was deemed safe, effective and appropriate to their needs

Each team is made up of Health Visitors (HV),school nurses (SN), one Child and Adolescent Mental Health practitioner (CAMHS), one Parent and Infant Mental Health Visitor (PIMHV) andadministration support workers. First Community works with families, children and young people offering advice and information to support health, development and wellbeing. Further services are offered where additional care needs are identified. There is a dedicated health visiting and school nursing service for children, young people (CYP) and families who are homeless or vulnerably housed in a temporary accommodation.

To help us understand and judge the quality of care provided by First Community we visited a range of services including children's centres and a local school. We accompanied staff, with permission, on home visits and observed safeguarding sessions with families. We spoke with 53 staff across the service including therapists, health visitors, school nurses, Community Nursery Nurses (CNN), safeguarding team, administration staff, students, clinical service managers. We spoke with eight parents and three children who used the service and reviewed at total of nine sets of medical records. We also evaluated feedback from the service

We carried out an announced inspection of the services provided on 20 - 22 March 2017 as part of our planned programme of comprehensive inspections of independent healthcare community services.

We held focus groups with staff and visited teams either at their place of work, or within the community setting. We looked at a random sample of clinical settings across locations where we reviewed individual care plans for children, risk assessments, and a variety of team specific and service based documents and plans. We also sought feedback from external partner organisations and 11 of their staff and reviewed online feedback.

Our inspection team

Our inspection team was led by:

Team Leader: Terri Salt, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists: community nurses and matrons, a GP, community children's nurse, health visitors, school nurse, a governance lead and an expert by experience.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

Summary of findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew. We carried out an announced visit on 20-22 March 2017. During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with people who use 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

People we talked with were unanimously complimentary about the service provided by First Community. They spoke of kind, approachable and knowledgeable staff who were always ready to support and guide. They were described as "Brilliant, so calm and reassuring" or "Always seem to know the right answer to things. I can ask anything and they can tell me straight away".

It was felt that nothing was too much trouble, that the staff were not judgemental and didn't tell people what to do but helped them make their own decisions.

Good practice

- The provider holds an 'Outstanding' UNICEF Baby Friendly Award for their work to support for breastfeeding mothers.
- The child and baby "Advice Line" innovation saved local NHS partners £130,000pa as well as reducing the need for additional face-to-face health visitor support (worth £70,000pa).
- The NHS staff survey 2016 showed an engagement score of 4.04 compared to 3.79 for NHS trusts nationally – putting First Community among the best in UK for engagement.
- There was a commendable and proactive approach to understanding the needs of different groups of people and to deliver care in a way that meets these needs and promoted equality. This was most evident in the way the service met the needs of the vulnerable, Gypsy Roma and Traveller (GRT) community and refugee communities and those in vulnerable circumstances with complex social needs.
- First Community held paediatric first aid courses for staff which were extended to the community to attend free of charge. This was well attended by members of the community.
- The use of baby massage sessions to encourage mothers to attend with their babies in a non-stigmatising and socially acceptable setting was used as a contact point for staff to assess maternal wellbeing.
- There was a dedicated multidisciplinary service for CYP and families who were homeless or vulnerably housed in temporary hostel, guesthouse or refuge accommodation.
- The provider had developed an electronic school nurse service called CHAT that was based on a social media communication platform. This meant children who felt unable to access the school nursing services felt able to get the help and support they needed in a way that felt safe and protected their confidentiality. The line was continuously staffed by a school nurse and responses to contacts were very prompt.

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?

Summary of findings

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

We visited children, young people and families services in other community locations, including children's centres, schools and a travellers site. We spend time at Baby Café, at the ChatHealth and 0-19 Advice Line as well as immunisation clinics and child health drop-in centres.

We spoke with 11 patients (including children) and 53 Coostaff including health visitors, school nurses, community staff nurses, community nursery nurses, children's safeguarding team, specialist practitioners and administrative staff.

We attended multi-disciplinary meetings. We reviewed 52 feedback comment cards.

We looked at 19 care and treatment records of patients.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service SHOULD take to improve

The provider should review Health Visitor caseloads and consider whether they should be in line with the ratio recommended following publication of the Laming Report (2010) or the Institute of Health Visiting guidance.

The provider should continue to develop a system for identifying children whose parents had not completed and returned the Under 12 months Review parental assessment form as this created a potential risk that a child with potential developmental delay or other vulnerability might not be identified and supported.

The provider should consider whether families with a young child transferring into the catchment area should be offered a face to face appointment carried out in the family home to provide an opportunity for a holistic assessment and identification of risk.

First Community Health & Care C.I.C.

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 have rated the service as good.

- There were systems in place to monitor safety, and processes to ensure that incidents were reported, learned from and the likely hood for recurrence was prevented.
- All staff had received duty of candour training and there was evidence that it was being applied in practice. Staff of all grades, including at executive level and the Board members, who we spoke to had a good understanding of how this applied to their roles.
- There was a robust system to ensure that people were protected from the risk of abuse. Staff from all disciplines were proactive in identifying and reporting any safeguarding concerns. There was strong leadership and good governance of any safeguarding concerns raised. Child safeguarding was a strength of the organisation.
- Medicines were stored and handled appropriately. There were robust audit processes in place for medicines management.
- First Community predominantly used an electronic records system. This was accessible by a wide range of health care professional outside of the organisation and promoted safe continuity of care. The records we viewed were accurate, up to date and fit for purpose.
- People were protected from the risk of acquiring a health care related infection because staff took the necessary precautions to protect them. The areas we visited were visibly clean and tidy.

Good

Are services safe?

- A range of risk assessments were utilised by the various clinical teams to assess and manage risk. Patients were protected from the risk of foreseeable emergencies because suitable equipment and competent staff were available.
- There was a major incident policy. Staff had received training and were able to tell inspectors what was expected of them should a major event occur.

However

Health Visitor caseloads were not in line with the ratio recommended following publication of the Laming Report (2010) or the Institute of Health Visiting guidance.

Safety performance

Incident reporting, learning and improvement

- Children and young people (CYP) experienced safe and appropriate care and treatment because there were systems that effectively monitored the quality of the care delivered.
- There were no never events reported between January 2016 and January 2017. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- We found effective processes to ensure incidents were reported, investigated and learned from.
- There was a healthy reporting and no blame culture in the organisation. Staff were encouraged to report incidents. We saw an increase in incident and near miss reporting over consecutive years but no increase in incidents resulting in harm
- The vast majority of staff we talked with felt they received appropriate feedback from investigations to prevent future recurrence. The NHS staff survey reported 95% of the staff said the organisation encouraged the reporting of errors.
- The reporting process started with staff completing a reporting template and emailing it to the Head of Governance and their line manager. Staff showed us the information reported was then entered onto a database to ensure an appropriate audit trail and to help identify any trends and themes.
- Staff were involved as much as was reasonably possible in the investigation phase to promote ownership and support learning.
- Any trends and themes and organisational learning that were identified were shared with the staff across all three core services. We saw this learning was through daily team safety huddles, in the Service Core Brief, newsletters, emails and staff meetings.
- Senior management identified and highlighted actions by the reporting of incidents and had taken steps to ensure they were addressed. Examples of action taken included study days for staff and an organisational wide 'learning from incidents' day. This event had a multispecialty approach where teams presented incidents to the audience and engaged with open debate about the learning and future prevention. External stakeholders were also invited to the learning set, so the organisation could showcase their commitment to delivering a safe service with a positive and open approach to learning from incidents. Staff were very complimentary and told us they valued this approach to learning and sharing learning in the organisation.
- We saw documentary evidence of the learning agenda and feedback from staff about this learning day.

Duty of Candour

- First Community had a Duty of Candour (DoC) Policy for staff to access. The duty of candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient's safety incident falling within these categories must be investigated and reported to the patient and any other 'relevant person' within 10 days.
- We reviewed a sample of service wide clinical incidents, patient's notes and root cause analysis and saw evidence that staff had applied the duty of candour appropriately.
- DoC training had been provided to all staff in the organisation.

Good

Are services safe?

- Staff were able to demonstrate a competent understanding of their role under the duty of candour regulations.
- We saw examples of where patients had been sent letters following incident investigations, as required under the DoC regulation.

Safeguarding

- CYP were protected from the risk of abuse occurring because staff took action to identify and prevent it from happening.
- There were appropriate policies and guidance in place for staff to follow that reflected best practice. These were readily accessible on the staff intranet. Staff spoken to were aware of the content of the policies and knew how to access them, if necessary.
- There was a Band 8 Named Nurse for child safeguarding who was also the Named Nurse for looked after children. They formed a team with two other part-time nurse specialists who formed 1 WTE, two paediatric liaison health visitors and an administrator.
- The Named Nurses role encompassed a strategic role for making arrangements under section 11 of the Children Act (2004), oversight of child safeguarding training and a supportive role for First Community staff. They were also a member of the health sub group of the Local Safeguarding Children Board and deputised for the safeguarding lead on the full LSCB.
- The child safeguarding team received clinical supervision from the designated nurse at a local CCG. The LAC supervision was provided by the designated nurse for LAC at the same CCG.
- There was a formal Safeguarding Dashboard in place that ensured good oversight of case numbers, responsibilities and service demand. A dashboard is an information management tool that visually tracks, analysing and displays key performance indicators.
- All staff had received safeguarding training at the recommended level for their designations.
- The organisations target for level 1 training was 100%. For the reporting period January 2016 to January 2017, 94% CYP staff had attended. The target was year-end.
- The Safeguarding Children level 3 compliance rate was 90% against a target of 80%.
- Bespoke level three safeguarding training had been provided for specific staff including community dentists and dietitians where the focus had been on young children who were failing to thrive. There was evidence of this being effective in identifying children at risk who might otherwise have slipped through without a referral.
- There was a good process for working with education welfare staff and the acute hospital. All home educated children who attended the emergency department were discussed at the weekly safeguarding meeting. The local authority staff were now visiting and ensuring the children were safe.
- Action plans from Serious Case Reviews were monitored at the bi-monthly safeguarding group. The board were aware of all SCRs within the area served by First Community and also monitored the progress of the action plans.
- The number of safeguarding referrals and amount of safeguarding work individual practitioners were taking on was monitored closely. Each practitioner was required to submit figures each month. This allowed trends to be identified and ensures that potential underreporting or excess workloads were considered by managers.
- Staff were aware of their role in identifying and raising a concern for those who may have been subjected to female genital mutilation (FGM). This meant that staff had the knowledge necessary to safeguard children and young people in vulnerable circumstances. There were no recorded cases of FGM identified.
- The Named Nurse for safeguarding role was broad and encompassed line management of the child safeguarding and LAC specialist staff, supporting the 0-19 staff delivery of child safeguarding training and inter agency working.
- The Chief Operating Officer was the board level lead for child safeguarding and attended the Local Child Safeguarding Board (LCSB) for example such as the Quality and Effectiveness Group and the and the Named Nurse attended the Surrey wide Neglect Group.
- The Named Nurse attended the monthly Missing and Exploited Children's (MEC) Group along with

representatives from the police, local authority, education services and health colleagues. This group considered children identified as being at risk of child sexual exploitation and worked across agencies to reduce the risks. We saw documentary evidence of these meetings.

- The Named Nurse received child-safeguarding data from individual practitioners on a monthly basis. This allowed for identification of trends and over or under reporting to be addressed.
- The LAC nurse specialist went in weekly to the local children's homes to work with home staff and directly with children to build trusting relationships, provide advice and signpost to support services. The children were able to speak to the LAC in private or to contact by telephone or text. This service was available to looked after children until they reached 25 years of age, in line with the Children Act 1989, The term LAC related to children who are in the care of the local authority for longer than 24 hours.
- The safeguarding team was very proud of the model of safeguarding supervision used by the organisation. Clinical supervision can be defined as an activity that brings skilled supervisors and practitioners together in order to reflect upon their practice. We were told operational staff who provided frontline services used to be reluctant to commit to supervision as it was very data intensive and bureaucratic. This was confirmed by the Annual Supervision Audit who found the view was widely held and so the methodology was changed. The First Community Task and Finish Group held one meeting which included staff from the electronic management information system. This resulted in a new format, based on the inter agency 'Safer Surrey' model which had been introduced by the LSCB and was far more focussed on children at risk and their families. This meant staff had a dynamic action plan following supervision and 'next steps' were clear for each child on their caseloads. In addition, this allowed supervisors to have a better oversight of individual families.
- We were told about a situation where a neglected child had been identified by musculoskeletal staff providing adult services. They had received bespoke safeguarding training. The MSK staff made a referral using the safeguarding processes. This meant that staff had taken account of a child's welfare in an adult service, which demonstrated good awareness of safeguarding issuers.
- The risks around children who had limited contact with statutory agencies were recognised and addressed. The paediatric liaison health visitors had developed good relationships with staff from other agencies. Any home educated children who attend the local emergency departments were now discussed at weekly safeguarding meetings. Where there were felt to be concerns, the local authority visited the family.
- Information about changes to policy and new guidance was disseminated by direct global email from the Named Nurse to all staff. The information was repeated by a second email sent from the central communications department. The same information was included in the staff newsletter and put on the intranet. It was also shared at both the bi-monthly adult and child safeguarding meeting and the 0-19 meeting.
- There was one serious case review involving the provider in the past two years. There were about 10 across Surrey. Information about these was disseminated by the LSCB. Staff were encouraged to attend Serious Case Reviews (SCR) workshops. The action plan from the SCR was shared and monitored through the bi-monthly adult and child safeguarding meetings. The Board was also updated on the action plan as part of the Assurance Framework.
- The First Community website provided a range of information on safeguarding process and information, including how to raise a safeguarding. Examples included an information leaflet on bruising in children who are not independently mobile.
- We saw minutes of the multi-agency safeguarding hub meetings. The minutes showed there was good attendance at the meetings and this was given priority over other work.

Medicines

- Medicines were handled safely, securely and appropriately. The provider was meeting the medicine regulations.
- Staff followed published guidance about how to order, store and administer, record and destroy medication.

Good

Are services safe?

- Patient group directions (PGDs) were used by staff to enable them to give children immunisations and vaccinations. We reviewed the PGDs and saw these were reviewed regularly and were up to date. They had been signed off by the lead CCG pharmacist.
- Fridge temperatures were regularly monitored and audited. Results demonstrated good levels of compliance. This meant that drugs were stored at the right temperature to maintain their function and safety.
- Anaphylaxis kits were available where children were being vaccinated.
- Staff had received appropriate training to ensure they were competent to administer medicines.

Environment and equipment

- CYP were protected from the risk of foreseeable emergencies because suitable equipment and competent staff were available.
- Appropriate first aid kits were available. Records of equipment were easily accessible and regularly checked in line with best practice guidance.
- There was documentary evidence that staff were competent to use the equipment.
- Each centre had a named individual who was responsible for checking the first aid equipment.
- Medical devices like weighing scales were calibrated, serviced, and cleaned and compliance was audited. We saw documentary evidence of this during the inspection.

Quality of records

- Personal and medical records were managed appropriately. They were accurate, fit for purpose, held securely, and kept confidential. This meant that patient records were effectively managed and maintained.
- A new electronic records management system had been installed eight months before the inspection. Staff told us it worked better than the old system. The ability to share the records with other healthcare professionals in the community was an advantage.
- Staff had control over the templates and could design bespoke templates that reflected the work they carried out. This meant improved functionality and improved record quality at First Community.
- Where paper records were used, they were kept confidential and stored appropriately.
- The quality and completeness of the records held by First Community was audited quarterly. Data demonstrated improved compliance in all key areas. The area with the lowest compliance rate related to recording the family name on the record. However, compliance had improved from 25% to 50% in just one audit cycle. All other questions scored 85% and above.
- For Looked After Children (LAC) records were accessible by the multidisciplinary team (MDT) across the county. This ensured care continuity across the services and to help and identify and care for these who may be at risk or vulnerable. In addition this promoted improved communication between healthcare professionals and reduced communication errors.
- The family health needs assessment was in paper form at the time of the inspection. There were plans to make it electronic in the near future.

Cleanliness, infection control and hygiene

- CYP were protected from the risk of health acquired infections because staff took the necessary precautions as outlined by national guidance.
- We observed the vast majority of staff adhering to the national infection control guidance.
- This included using hand gel sanitisers, hand washing and bare below the elbow when in direct contact with children and young people, and demonstrated an appropriate hand washing technique in line with 'five moments for hand hygiene' from the WHO guidelines on hand hygiene in health care.
- However, on two separate occasions we saw two different members of staff not adhering to bare below the elbow infection control guidance. Staff were observed wearing jewellery (bracelets and rings) whilst being in direct contact with babies in a care setting.
- We saw handwashing audits were undertaken monthly with the compliance rates reported as 100%.

Good

Are services safe?

- Staff had access to an ample supply of personal protective equipment (PPE). We observed the PPE being used effectively during the majority of patient contacts we observed.
- The clinical areas we viewed appeared visibly clean. We looked at individual cleaning logs for furnishings and toys. Audit data demonstrated good compliance with the cleaning of toys and furnishings. This was in line with the Health and Social Care Act 2008: Code of Practice for the NHS for the Prevention and Control of Healthcare Associated Infections.

Mandatory training

- Staff were provided with appropriate levels of mandatory training to ensure they could undertake their roles. This meant that CYP had their health needs met by staff who had received relevant training.
- Training records were electronic and held centrally by the Human Resources, (HR) team. Senior managers had oversight of their teams' compliance rates and monitored training compliance consistently. Line managers were provided with regular reports and reminders to ensure staff training was up to date.
- Mandatory training was in place for all staff, including bank staff. Training covered a wide range of topics. Compliance at March 2017 was 72% for conflict resolution, 88% for equality and diversity, 88% for health and safety, 84% for fire safety, 94% infection control and information governance as 93%. This was measured against a year-end target of 80% of all except information governance where the target was 95%.
- Mental Capacity Assessment (MCA) and Deprivation of Liberty (DoLS) training , conflict resolution and lifting and handling training was delivered on routine service days to improve compliance.
- Training was a combination of face to face training and online modules. Staff were provided with protected time for online learning.

Assessing and responding to patient risk

- CYP were protected from the risk of receiving unsafe or inappropriate care because they had their individual needs risk assessed.
- A wide range of risk assessments were completed to manage risk. Examples included development assessments, nutritional needs, manual handling risk assessments, and those children who were subject to a child protection plan.
- Staff had access to support, guidance, and equipment to manage these risks. They also had extremely good links to other community providers and services that were regularly accessed to ensure a holistic and multi professional approach to care was achieved. Any identified risks were recorded on the electronic records system to ensure care continuity and multi professional awareness.
- If children were identified as being at risk, a face to face appointment either in a clinic or a home visit was offered.
- The CYP staff had 94% compliance with Basic Life Support training.
- Staff were provided with paediatric first aid training.

Staffing levels and caseload

- There were appropriate numbers of staff to meet the needs of the service.
- The service reported having 26.6 whole time equivalents (WTE) health visitors employed with an active caseload of 11,632 of 0-5 year olds. This was an average case load of 436 per health visitor. Whilst staff felt this was manageable and sits around the national average, it falls short of the caseload threshold was recommended by Lord Laming in 2010 in his review of child care services commissioned by the Government in the wake of the Baby Peter case. The Institute of Health Visiting recommend a ratio of 1:250.
- No agency staff were employed in the service between January and December 2016.
- Bank staff were used to support full time staff with workloads at busy times. All bank staff attended the First Community three-day induction course and there was documentary evidence they received local inductions.
- Children services had a combined workforce of 67.2 WTE and reported a vacancy rate of 2.1 WTE. Children's

Good

Are services safe?

Services had seen an increase in turnover rate in the last quarter of 2016, due to individual staff personal circumstances and uncertainty relating to service procurement.

- The sickness absence rate was reported as 5.8% as of November 2016; this was due to four staff being on long term sick leave.
- Staffing levels and caseloads were monitored and reviewed each day at the staff 'huddle' at the beginning of each shift. We observed this process during the inspection. We noted the electronic records system took account of work load and staffing levels. There was a robust audit trail of any changes or concerns raised in terms of staffing levels.
- The service provided by the homeless team had been recognised locally as a lifeline for vulnerable families and CYP. This was partly due to the teams positive networking and delivering a bespoke high quality service. At the time of the inspection, the service was seeing a high volume of referrals. The team were managing to meet people's care needs with the current established staffing numbers. However, given the success of the work undertaken, and the rise in homelessness, there was a risk that the team may not be able to provide the same level of service in the future.

Managing anticipated risks

- If a risk was identified, for example lone working, then it was recorded on the electronic records to ensure that all professionals were aware of it.
- There was a lone working policy in place and staff were aware of its content and protocols for lone working and home visits. Social media was also used to promote safety for lone workers. Staff were advised they must 'check out' at the end of each shift so the team members were aware that they had safety completed their visits. This happened at the end of every shift.
- There was regular communication with the emergency department at the local acute NHS trust. First Community staff were notified when a child accessed the emergency services. This meant that staff were able to identify any potential underlying risk and carry out a home visit if necessary.
- We were informed of an incident where a staff member on a home visit was exposed to threating behaviour and verbal abuse. Staff had been issued with a card with emergency contact numbers to call should they find themselves in unsafe situations. The staff member used the emergency contact and the police were called. This was reported as an incident, investigated, and the lone working policy was reviewed as a result. The risk to staff and the possible risk to the child were recorded on the electronic records system for all professionals to highlight the concern. All future contacts with the parents took place at a local children centre to safeguard staff.

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

- There were sufficient arrangements in place to deal with unforeseeable emergencies.
- First Community had appropriate policies and procedures for staff to follow should an emergency would occur.
- The staff we talked with explained to us what would be expected of them should a major incident occur. Staff had access to laptops and were able to work remotely if required or make their way to their nearest base in the event of severe weather conditions
- Staff had undertaken fire safety training and were able to demonstrate to inspectors where their nearest fire assembly points were.
- We saw documentary evidence of annual fire assessment and environmental audits.
- We saw firefighting equipment and designated fire assembly points. Documents we viewed showed that equipment was regularly tested and serviced.

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 have rated the service as Good.

- The care delivered by the service was evidence based and reflected national and best practice guidance. This meant that Children and Young Persons (CYP) were receiving care that was deemed safe, effective and appropriate to their needs.
- First Community had implemented a live performance dashboard that staff could access at any time. This promoted ownership and responsibility of the team performance, facilitated the celebration of success, but easily identified areas for improvement.
- All staff were actively engaged in activities to monitor and improve quality and outcomes. There was a dedicated audit lead in place and a healthy audit culture had been developed in the service.
- Staff were actively encouraged and supported to continuously develop their skills and knowledge. Staff were competent to undertake their roles.
- Staff, teams and services were committed to working collaboratively and have found innovative and efficient ways to deliver more joined-up care to people who used services. This included strong links with other health care providers, local charities and support groups. They embraced new technology to improve the quality of the service.
- There was a holistic approach to planning people's discharge, transfer or transition to other services, which was done at the earliest possible stage.
- The electronic record system was effective and enabled the easy sharing of information needed to deliver effective fully integrated care and provide real-time information across teams and services.

However

- At the time of the inspection there was no system in place for identifying children whose parents had not completed and returned the Under 12 months Review parental assessment form. This created a potential risk that a child with potential developmental delay or other vulnerability might not be identified and supported. It is recognised that the provider had already identified this gap in their provision and was addressing it.

Families with a young child transferring into the catchment area were offered a face to face appointment but this was not carried out in family home so was a missed opportunity for an holistic assessment and identification of risk.

Evidence based care and treatment

- Children and Young Persons (CYP) received care and treatment which reflected best practice and national guidance. For example, around immunisation of young children, Looked After Children (LAC) (NICE LGB19) and the Children Act 1989.
- There was an organisation policy and procedure for the dissemination, implementation and monitoring of National Institute for Clinical Excellence (NICE) guidance and Public Health England (PHE) immunisation updates. Two Quality Improvement Facilitators were employed to monitor and review published guidance and liaise with relevant clinical staff accordingly.
- The policies available to staff promoted the social and emotional wellbeing of children and young people and provided guidance for staff to meet objectives outlined in the public health outcomes framework for England, 2013–2016.
- First Community provided the Healthy Child Programme (HCP) to all children and families during pregnancy until five years of age. The Healthy Child Programme for the early life stages focused on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.
- We saw targeted 'Under 12 month reviews' were in place. Staff used the national 'Ages and stages

questionnaire' to assess development. These questionnaires were sent to parents to complete. Those not meeting the expected milestones were sent an appointment for a face to face appointment.

- However, we asked if there was a system to identify those who did not respond to the questions. Staff told us that there were no monitoring processes to identify this cohort of parents. First Community were aware of this, and were developing a system to ensure this group of non-responders could be engaged with as they were potentially those children at most risk.
- Services such as the School Entry Health Review, vision screening, twelve month and two and a half year reviews, and National Child Measurement Programme were all being delivered ways reflecting national guidance pathways.
- The service had achieved Unicef Baby Friendly initiative and received an Outstanding award. This baby friendly accreditation was based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services.
- Health visitor teams were using a maternal mood assessment in line with NICE guidance. (NICE Postnatal care quality statement 10 'Women who have transient psychological symptoms ('baby blues') that have not resolved at 10–14 days after the birth should be assessed for mental health problems).
- We observed anticipatory NICE guidance being discussed with parents during the inspection.
- Staff meetings were held regularly and used to actively promote NICE guidance and relevant training.
- A family parent led health assessment tool ('new birth') was used by the service. Parents we talked with felt actively involved in the assessment process. This meant they were made aware of the national screening tools and development benchmarks for their baby.
- All children in school years 1 and 2 were offered flu vaccination through a nasal spray. This was an extension of the national flu immunisation programme for children and based on national guidance.
- There was evidence that Public Health England (PHE) immunisation policies were reviewed at immunisation boards quarterly to ensure the service reflected best practice guidance.

Pain relief (always include for EoLC and inpatients, include for others if applicable)

- We saw staff discussing pain relief and symptom management with parents who were given appropriate information on how to manage pain.

Nutrition and hydration (always include for Adults, Inpatients and EoLC, include for others is applicable)

- CYP had their nutrition and hydration needs considered by the service.
- We observed staff providing best practice guidance and general advice for breastfeeding mothers. For example, mothers were given advice on milk intake and nutritional need.
- There was a baby weighing support group which parents could access.
- First Community provided 'Introducing Family Food Workshops' for parents. These covered a wide range of information including the introduction of new foods and giving baby a healthy start.
- There was ample information and support provided on the importance of healthy eating in families.
- Children were weighed as outlined in national guidance and there was access to paediatric dietitians, if required. Paediatric dietitians had identified a rise in referrals for children who suffered food allergies. In response to this, they had set up a baby weaning group which ran every six weeks and which was well attended.
- First Community promoted the national Health Exercise Nutrition for the Really Young (HENRY) programme. This meant that the service was promoting a national initiative that encouraged parents to give their children a healthy start in life and help prevent child obesity.

Technology and telemedicine (always include for Adults and CYP, include for others if applicable)

- First Community had embraced technology and telemedicine.

Good

Are services effective?

- Initiatives included ChatHealth, an Advice Line and text messaging, using social media platforms to get information to hard to reach groups and the general public.
- ChatHealth was a web-based text messaging service, which young people of secondary school age could use to access confidential advice from a school nurse.
- 'Advice line' was a telephone advice line that was staffed by health visitors and provided advice and signposting to parents of children aged 0 to 19. Data demonstrated that these initiatives had a significant positive impact on the service, and services provided by other stakeholders as well as the local community.
- Staff used tablet devices to obtain feedback at the point of contact in the community. This had the advantage of capturing feedback from those who may not normally take the time to give feedback via other means. It also meant that the opinions of hard to reach groups were captured more effectively.

First Community was trialling an electronic 'red book' also known as the Personal Child Health Record which is a national standard health and development record given to parents. This trial was to assess the prospect of improved record keeping, and care continuity for children

Patient outcomes

- There were systems and process to ensure clinical outcomes were measured and improved upon. This meant the organisation was able to demonstrate the care it was delivering was fit for purpose and meeting the needs of those who used the service.
- We observed First Community had a proactive audit culture with a dedicated audit lead to promote audit effectiveness and better impact monitoring. A comprehensive guide on how to undertake clinical audit was available for staff.
- All missed appointments (DNAs) by phone, personal letters or have a face to face follow up with a home visit or clinic attendance.
- Breastfeeding audits and bottle fed baby audits were undertaken every three months using the UNICEF Baby Friendly standards for health visitors. UNICEF supports breastfeeding and parent infant relationships by working with public services to improve standards of care. The audits demonstrated good performance and consistent service improvement in areas that required further input. Each result in the audit was reviewed and feedback provided to staff. Staff gave us examples of feedback received which included written notes saying "Thank you and well done" to staff on areas that were meeting and exceeding the targets as well as notes of encouragement where the result was not as desired.
- Other examples of audit included Parental Experience of Service BFI in children's centres. Data showed the service was exceeding the 70% national benchmark in all areas. Out of the 12 questions asked, 10 scored 100%. The two questions that achieved 70% (which met the national average) were marked for continued improvement. The audit tool was based on the nationally recognised UNICEF UK Baby Friendly Initiative Audit Tool.
- Data demonstrated good immunisation uptake, for example childhood flu was reported as 64% for years 1 and 2, Human papilloma virus (HPV) 86% for year 8, tetanus, diphtheria and polio (Td/IPV) had an uptake of 75% and meningococcal ACWY (MenACWY) as 79% for year 10, and a MenACWY catch up for year 11 as 78%.
- An annual emergency hormonal contraception (Emergency Contraception) PGD Audit 2016 was undertaken. Data demonstrated 100% compliance rates for all questions with the exception of one. That question related to documenting a nurse signature on the records. A score of 95% was achieved, which was well within the acceptable limit.
- ChatHealth performance and contacts were regularly audited to identify trends, themes and learning. For example, contact themes identified by the service was, eating disorders, sexual health, domestic abuse, body confidence and emotional issues.

Competent staff

- CYP and families had their care needs met by competent staff.
- Staff were able to access additional training to ensure they could develop personally and meet the changing needs of those they cared for.
- First Community has set an annual year end appraisal compliance rate at 100% .The compliance rate was reported as 94% at the time of the inspection.

Good

Are services effective?

- Supervisions were well established and well attended by all staff we talked with. Compliance rates for supervisions as reported in quarterly December report was 77% with 23% of staff recorded as not engaging in the process. This was noted as an increase on the previous quarter score of 86%. We were told the reason for the increase in non-compliance was the recruitment of new staff members and maternity leave.
- Supervision record books were developed for staff to record details of their supervisions and their personal progress.
- Staff were provided with a range of supervision options to choose from, for example groups sessions, reflective logs, clinical specialist supervision/ peer supervision, action log and an option to mix sessions. Staff preference was monitored quarterly, and data demonstrated staff preferred group sessions.
- We saw clinical supervision group facilitators attended a four day course in 2016 to enable them to undertake their roles. There were twenty three active facilitators in the service.
- The CAMHS nurse had supervision with other CAMHS nurses from a neighbouring mental health trust.
- Preceptor meetings (preceptorship meetings provide a specific learning experience and training for less experienced staff) were held every six weeks for year, staff felt these were beneficial to them.
- Staff were encouraged to work with other specialists to understand their role which enabled them to provide a better understanding of CYP. A nursery nurse told us they had spent time with the CAMHS service to ensure they could meet the needs of those with a mental illness.
- Staff had the relevant qualifications and memberships appropriate to their position. There were systems which alerted managers when staff's professional registrations were due and to ensure they were renewed. These were demonstrated to us.
- Staff were supported to ensure they could partake in the Nursing and Midwifery Council (NMC) revalidation requirements. Staff we spoke with who had already been through the process told us they were fully supported by the organisation and their managers.

Multi-disciplinary working and coordinated care pathways

- There was a strong emphasis on multidisciplinary (MDT) and multiagency working in the organisation. This meant CYP had access to numerous healthcare professionals with the necessary knowledge, skills and experience to ensure high quality diagnosis, treatment and care. Staff demonstrated a good knowledge of how to access the services they need for the CYP they come in contact with.
- MDT working was promoted at every level of the organisation, from floor to board. The records we viewed demonstrated MDT working was happening continuously. Staff were encouraged to actively engage with community partners to ensure the service could provide the best holistic care possible. Examples of this engagement included liaising and attending meetings with the maternity and obstetrics team, child health teams, perinatal mental health teams and community midwifes.
- We observed therapists worked closely with the nursing teams, GP colleagues and referrals for external support being made during the inspection.
- Staff provided many examples of how they worked with other members of the multidisciplinary team to be able to meet the needs of children and their families.
- This included positive working relationships with GPs, NHS services and professionals and social services. This meant that CYP using the services benefited from this approach to care and had access to a wider range of support and services.
- We observed the organisation had close and valuable links with the housing department, social care services, and the homeless team, local charities and support groups.

Referral, transfer, discharge and transition

- There were appropriate referral, transfer, discharge and transition arrangements in place.
- The organisation used a continuum of need assessment tool. This made sure that each person involved in a patient's care was aware of the level of need and support of the patient.

Good

Are services effective?

- Transfers into the service were risk assessed and provided with a face to face appointment in a clinic setting. This may be a missed opportunity to risk assess the CYP in their own home setting.
- There were policies and procedures in place to make sure that as children transferred from health visiting to school nursing once they commenced school that relevant and important information was passed to the receiving clinician. The integrated medical records system meant there was effective communication between teams and external organisations and practitioners.

Access to information

- Electronic records were used to ensure continuity of care between First Community staff and other community health care professionals.
- Staff were able to access current guidelines, policies, procedures via the intranet which had recently been redesigned to improve functionality. Staff feedback during the inspection was positive about the changes that had been implemented.
- Staff had built an extensive range of knowledge about local health services and pathways, charities and support groups which were of benefit to those they cared for. This meant staff were able to provide appropriate signposting to service users which supported them in addressing their wider needs.
- We observed the service used paper records in some areas. We noted data from home visits was not captured at the time of the interaction. Records were recorded retrospectively at the end of the day by the clinician onto the electronic records system. This may cause a risk to quality and continuity of patient's records, as no paper records were being used as an interim measure. However, this risk did not relate to the homeless team, where the success of this service relied on trust and informality. Staff making notes during visits may raise suspicion and damage positive relationships formed.
- Children who moved to the local area were offered face-to-face appointments to ensure robust information gathering and personal review.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- There were systems in place to gain and review consent from children and their parents or guardians. We observed consent being obtained and recorded throughout the inspection. For example, immunisation data showed consent was recorded for each child and monitored on the school nurse dashboard.
- Staff used 'Gillick competencies' and followed the Fraser guidelines to determine whether a child was mature enough to give informed consent.
- Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent is a term originating in England and is used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.
- Compliance with consent guidance was continuously audited and demonstrated good levels of compliance.
- Staff had the necessary training to obtain consent and understood their roles to ensure compliance with the Mental Capacity Act 2005. Data showed staff had received consent and Mental Capacity Training (MCA) and Deprivation of Liberty Safeguards (DoLs) training.

Outstanding ☆

Are services caring?

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

Summary

We have rated this service as Outstanding because

- People were truly respected and valued as partners in their own and their families care.
- Feedback from Children and Young Persons (CYP) and parents who used the service was entirely and enthusiastically positive. We were told about several situations where staff went way beyond the usual expectations of their role to ensure that services were meeting people's individual needs. The staff's formidable commitment to make people's lives better, even if it meant they had to step outside of their job descriptions, was highly commendable. Every staff member we spent time with displayed a compelling caring and supportive nature that was much appreciated by those who used the service. This culture was encouraged, recognised and much celebrated in local teams and in the wider organisation.
- Staff recognised and respected people's personal, cultural, social and religious needs. We saw evidence of innovative and effective working with hard to reach groups such as Looked After Children who had left the care system for supported lodgings or who were living alone as young adults. The work with homeless families or those living in fragile housing situations was exemplary and liable to expand beyond the team's ability to cope within the current resources was at risk of becoming a victim of its own success.
- Friends and Family Test data demonstrated very high levels of satisfaction with the service which received scores of 100% continuously.
- There was a very strong holistic person-centered service. It was also an outward looking culture in terms of knowing exactly what external services were available how best to access these services. Staff were empowered to build strong networks with local healthcare providers, support groups, and charities. Staff also displayed a commendable drive to continuously improve the service through innovation, balanced with meeting people's social, cultural and individual needs. This ensured that teams creative in overcoming obstacles to delivering care.
- CYP and their parents felt involved in their care and were able to influence their care and treatment plans. Staff empowered people to have a voice and to realise their potential. In addition, they ensured they advocated for those who felt unable to do so.
- People's emotional and social needs were highly valued by staff and were embedded in their care and treatment. Whilst this was evidenced across the service, it was most striking and a prominent feature of the work undertaken by the homeless team.

Compassionate care

- People who used the service were very complimentary about the staff and would recommend the service to their friends and family. Friends and Family Test data demonstrated a good response rate and suggested 100% of those who's used the service between April 2016 and December 2016 would recommend it to others.
- During the inspection, we met parents who had accessed drop-in clinics and baby massage sessions because of personal recommendations.
- Examples of the comments we received were: "I can ask the staff anything at any time", "The staff are marvelous", "They have given me so much help and support".
- The staff we met were very committed to their roles and ensured people got the best service that could be delivered.
- We observed staff demonstrate good communication skills and deliver helpful advice in a way that was easily understood. This included using open questions that encouraged dialogue. The interactions we saw reflected a kind, caring and individualised approach, which promoted dignity and mutual respect.
- There were many examples of staff going beyond what is expected of them to ensure people felt cared for.

Are services caring?

- We were told about one young adult who had used the online CHAT service to get help. They were reportedly unwell and had no food, no money for the electricity meter and no heating. They were identified as a Looked after Children (LAC) by staff. The staff member immediately visited the young adult at home, put money in the electricity meter, shopped for food, contacted the LAC's GP and arranged for the young person to be seen at another specialist service. The member of staff did this without thought for their own personal financial cost. The staff member was driven by the needs to provide and care for the LAC who was in a vulnerable, situation even if some of the concerns were outside of their and remit.
- We were told about one year 10 student who was continuously anxious about having immunisations. Staff worked on a one to one basis with the child until they felt ready to have them. The student was pleased they had been supported to overcome their fear of injections and phoned their parents straight away to share the achievement.
- Another example was about a particularly vulnerable refugee family who were homeless and had who had an 18 month old baby. Due to their immigration status, they were unable to work and had no recourse to public funds. The family had a budget of £30 a week for food and necessities. The health visitor (HV) from the homeless team worked tirelessly with the family to ensure they had the support they needed. This included sourcing clothes, regular food bank vouchers and food parcels. When a trusting relationship had been established, one of the adults disclosed information to the HV about their past, where they suffered unimaginable abuse. The HV submitted a referral to a charity which provided support for victims of torture and continued to work with the adult to prepare a graphic chronological transcript of the abuse that had been disclosed. This was to ensure expert medical and psychological assessments and support could be obtained.
- Other stories contained details of the additional support provided to the Gypsy, Roma, Traveler (GRT) community which included advocacy with housing and other services where there was limited literacy, the provision of food bank vouchers, and when benefits were delayed, referrals to housing and benefit support as well as applications to local charities for grants for school uniforms. There was evidence of referrals for developmental assessments and applications for funded nursery places for GRT toddlers. This was to help promote their social skills and overall development. The homeless team also provided packages of care for GRT mums, to promote safety, healthy eating and establishing sleep routines and manage behaviour.
- We saw staff wore name badges and introduced themselves by name on each contact we observed.

Understanding and involvement of patients and those close to them

- The feedback we received demonstrated people felt involved and very much part of planning the care they received.
- Staff were encouraged to engage with any organisation that would be of benefit to those they served. For example, the local housing department, social services, local charities and support groups, the local NHS mental health trust and other healthcare professionals.
- The homeless team recognised the large GRT community that it served and worked closely with the community, local GRT representatives from other educational and local authority's to ensure it could meet all the healthcare needs of this group. This had included providing training days for First Community and the local NHS trusts to help staff understand the culture and health needs of the community.
- The service had arranged a Mother's Day themed drop-in sessions with the assistance of a local charity which provided a 'goodie bag' for all the mothers who attended.

Emotional support

- There were appropriate systems that provided emotional support for parents, children and young people Service.
- Emotional support was provided by the nurses, therapists, and ancillary workers.
- We observed the homeless team listening to one person's emotional concerns regarding their social

situation and addressing their stress. The nurse had taken it upon herself to liaise with the local housing services to stay informed and provide reassurance and support in this case.

- The CAMHS nurse was integrated in to the school nursing team and there was also a Parent Infant Mental Health practitioner who provided emotional support at the organisation.
- Staff told us baby massage was used not only as a therapy for babies, but also as an opportunity to engage with the parents and assess their emotional needs.
- There was a wide range of information provided in paper and on the organisation's website which promoted the importance of good emotional health.
- Staff were also able to refer and sign post to external organisations for emotional support, if required.

Outstanding ☆

Are services responsive to people's needs?

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

Summary

We have rated the service as outstanding because

- Staff were going beyond what was expected of their roles to ensure a wider involvement of healthcare providers, local organisations and agencies and the local community to meet the needs of those it cared for. There was an exceptionally proactive approach and truly holistic approach to assessing, planning and delivering care and treatment to the CYP who used the service. This went beyond asking the standard questions and focused on a deep understanding of the individual needs and preferences of individuals and groups. This was most evident in the care delivered to hard to reach and vulnerable groups, for example Gypsy, Roma, Travelers (GRT), refugees, the homeless. There was an impressive staff ethos and drive to make every contact count in the most challenging of situations, which was balanced with ensuring best practice, was followed.
- People were able to access services in a way and at a time, that suited them. The team's flexible approach to texting and social media use meant the service could respond in real time to people's individual needs. This was most effective within the homeless team as people's social situations and locations changed frequently. The service had embraced a pioneering way to reach those who felt unable to access the service through conventional means. This included using CHAT Health, a chat platform for school aged children and an advice line for parents with children between 0 and 19 months. Both incentives resulted in progressive and effective health care delivery. The advice line reduced the need for GP and health visitor (HV) face-to-face appointments and evidence suggested had a significant cost reduction for the service and other partner organisations. In addition, using text messages and social media for communication and health promotion purposes. This meant health advice and support was available to a cohort of school age children who felt unable to access a face-to-face service because of the possible social stigmas attached to seeing the school nurses.
- People's individual needs and preferences were central to the planning of care. The parents we talked with during the inspection felt very much involved in devising care plans and felt able to make informed choices that reflected their individual needs. The services were flexible, provided choice and ensured continuity of care.
- The service was delivered in a way that met the needs of those living in vulnerable circumstances. One young mother-to-be was homeless and slept on various friends' sofas throughout her pregnancy. The social instability meant that staff had to keep abreast of numerous location changes to ensure this young woman received the care she needed. Staff were proactive and used text messaging to arrange home visits to friends' houses and carry out welfare checks. This was an example of the service adapting to the ever-changing needs of one vulnerable individual and providing invaluable support and care.
- There were effective processes to take account of comments and concerns. People who used services were confident the organisation would respond positively to any concerns raised. Data demonstrated there were very low levels of complaints in the service. No complaints were escalated to the Parliamentary Health Service Ombudsman (PHSO), this demonstrated good local resolution.
- A Child and Adolescent Mental Health Services (CAMHS) nurse worked alongside the health visiting and school nursing teams. The CAMHS nurse carried a small caseload and provided additional support and advice to the teams who required mental health oversight.

Planning and delivering services which meet people's needs

- First Community adapted its services to meet the needs of its demographics, because local healthcare needs were continuously assessed and reviewed through engagement with local stakeholders, service commissioners, and public feedback.

Are services responsive to people's needs?

- First Community held paediatric first aid courses for staff which was extended to the community to attend free of charge. This was well attended by members of the community.
- Staff had embraced modern technology to improve services and meet people needs. This had a direct impact on children who did not want to access face to face services, as well as those with changing social needs. For example, the homeless were able to access the service in a way they were not able to do so with a conventional healthcare model.

Equality and diversity

- The service addressed the care needs of hard to reach groups, for example, travellers, refugees, asylum seekers and ethnic minorities groups.
- There was a band 7 nurse who led the homeless team. In addition, the organisation had a link nurse for the Gypsy, Roma, Travelers (GRT) and refugee communities. Link nurses are part of a system that shares information and provides formal, two-way communication between specialist teams and nurses in the clinical area.
- Staff had recognised a need for training to help understand the equality and diversity of vulnerable groups and had an organisation wide study day that was extended to other local organisations. The staff we talked with told us that this study day was well attended and very informative.
- There were good examples of continuous engagement and communication with local travellers. Examples of this included a social media group, quarterly newsletter, and text messaging.
- Staff were able to provide information in different languages for ethnic minority groups if required.
- Translator services were available and being used by staff.
- Buildings were easily accessible for people with limited mobility or who relied on a wheelchair to move around.

Meeting the needs of people in vulnerable circumstances

- There were systems to ensure the service could meet the needs of Children and Young Persons (CYP) who were vulnerable as a result of their circumstances.
- The Looked after Children (LAC) team supported 'looked after' children, to improve their health and life chances; provided holistic and health educational approach to health assessments; and contributed to strategic planning to raise the profile of children and young people within the care system.
- There was a dedicated health visiting and school nursing service for CYP and families who were homeless or housed in temporary hostel, guesthouse or refuge accommodation.
- There was multidisciplinary team structure to ensure it was able to provide a wide range of skills and expertise. The team consisted of a Specialist Community Public Health Nurse (SCPHN), a Community Staff Nurse and Community Nursery Nurses.
- The homeless team identified children with poor dental hygiene in a women's refuge. In response to this, they arranged for a dental nurse to visit the refuges to give practical help and advice to families.
- The homeless team had developed strong and productive links the local council, education boards and GRT and refugee support groups.
- They had also established strong and trusted links with the GRT community to ensure they could meet their health needs. This collaborate working had seen the successful design of a traveller specific health information leaflet. Relationships with the GRT community were strong with the First Community staff being seen as welcome and respected visitors.
- The homeless team identified the organisation would benefit from specific training on how best to meet the care needs of the GRT and hard to reach individuals in the community. A study day was designed and provided to the entire organisation. The day included training on how to meet this group's health care needs, but also provided invaluable information about the culture and beliefs, communication styles and the importance of making every contact count. GRT representatives from the local area attended. Staff we talked with gave positive feedback about the training day.
- The homeless team received feedback from the GRT community which related to the care they received from

another local provider. The team acted upon the feedback and provided learning and development opportunities for the organisation with the aim of improved patient experiences for the GRT community.

- The homeless team worked in collaboration with the GRT community and local representatives to design a vaccination information leaflet that was predominantly picture based which overcame obstacles relating to literacy. Through using this leaflet and through positive engagement, the team had a significant impact on the community which resulted in a high demand for the HPV vaccine. The lead GRT nurse had received training in administering immunisation and provided a mobile service to the local sites. This approach also had a major impact on the take up of other vaccines. The programme was so successful the team want to extend it to other hard to reach groups for example LAC and home educated children.
- First Community were advocating the new national campaign to promote language development and improve children's life chances. There was ample information made available to parents in the children's centre. We also observed the Community Nursery Nurses (CNN) providing advice and support during the drop-in sessions about the safe and moderate use of electronic devices.
- We observed mums being given appropriate advice which was communicated in a way they would easily understand. Staff provided a wide range of information leaflets to the mums who used the service. This included information on safe sleeping, breastfeeding and flat head syndrome.
- Paediatric dietitians identified a rise in referrals for children who suffered food allergies. In response to this, they set up a baby weaning group which occurred every six weeks and was well attended.
- We heard about one young mum who was homeless and slept on various friends' sofas throughout her pregnancy. The social instability meant that staff had to keep abreast of numerous location changes to ensure this young woman received the care she needed. Staff were proactive and used text messaging to arrange home visits and carry out welfare checks. This was an example of the service adapting to the ever-changing needs of one vulnerable individual and providing invaluable support and care.
- The school nurse teams provided sexual health advice and support and emergency contraception.
- We observed staff use role modelling and positive reinforcement effectively during homes visits to empower the parents to do the same. Positive reinforcement can be defined as a technique used to modify children's behaviour by reinforcing desired behaviours.
- The organisation's website had plenty of health and wellbeing information for people to access. For examples, '5 reasons to have your child vaccinated', 'potty training', 'feeding baby', 'tummy time', 'baby massage', 'behaviour issues', 'post-natal depression', smoking cessation etc.
- There was also a strong emphasis on providing information especially for dads. Examples included post-natal depression, emotional wellbeing, pregnancy, birth and beyond.

Access to the right care at the right time

- The people who used the service had access to the right care at the right time. For example, those who were referred to the Parent and Infant Mental Health Visitor (PIMHV) waited less than six weeks for a one to one appointment or intervention. The Royal College of Psychiatrists suggest good PIMH services should ensure pregnant and postpartum women are "fast tracked", assessed within four weeks and effectively treated within three months of referral in line with NICE guidance. This meant that First Community was exceeding the suggested timeframe for mothers receiving appointments for one to one appointments or intervention.
- The 'Every Child Counts Regional Audit of the Child Health Promotion Programme – Health Visiting and School Nursing Service March 2016' suggested a regional average compliance rate of 86% for new birth visits within 14 days. First Community continuously performed above the projected target by achieving a compliance rate of 89%.

Outstanding ☆

Are services responsive to people's needs?

- Monthly averages of 112 antenatal contacts were completed by 28 weeks. This meant First Community was meeting the National Heath Visiting Core Service Specification benchmark of ensuring babies received the review within the set timeframe.
- Data demonstrated the service was exceeding the national targets of 65% set for 12-month reviews by achieving a compliance rate of 67%. This meant that the service was meeting the required targets and ensuring babies received a review in a timely way.
- The health visiting service achieved a compliance rate of 70% for two and a half year reviews, which exceeded the national average of 65%.
- Evidence we viewed showed 59% of babies were recorded as being totally or partially breastfed at 6 to 8 weeks, with 93% of babies having their feeding status assessed.
- The enuresis service received 109 referrals annually. An enuresis (bed-wetting) support service was provided at First Community. Face to face appointments were offered and packages of care put in pace for children and their families. This included enuresis support and advice, referrals to other children's services and often, referrals for the family to access additional support. An easy to read information booklet was available for parents. We saw additional information was available on the First Community website.
- Health visitor teams were using a maternal mood assessments in line with NICE guidance. Data demonstrated a 38% increase in the number of reviews completed in January 2017 when compared to the previous year.
- The service had established a proactive approach to care for babies who were identified as tongue tied (is where the strip of skin connecting the baby's tongue to the floor of their mouth is shorter than usual and makes feeding difficult). First Community had worked with a local NHS provider to establish a direct referral pathway. A GP referral was not required as staff could refer directly to the trust. This meant appointments were received in a timely manner. In addition, the service provided additional support with breastfeeding for mothers after the baby had been treated.
- The school nurses identified a cohort of children who did not feel confident to access the nursing service directly. In response to this, they developed an electronic school nurse service called CHAT that was based on a social media communication platform. This meant children who felt unable to access the school nursing services felt able to get the help and support they needed in a way that felt safe and protected their confidentiality. A school nurse continuously staffed the line and responses to contacts were very prompt. We saw evidence of how the service sensitively addressed young people's concerns and ensured these children had access to the care, treatment and emotional support they needed.
- There was an advice line in operation for parents of children aged 0-19 years old. This was in response to identifying east Surrey had a significantly high number of children attending emergency departments for minor ailments. The service received 154 calls in January 2017, 96 requested general information, 21 required feeding advice, nine related to sleep management, eight requested behavioural problems, five for parental advice, five for minor illness information, four related to immunisation advice, two requested toileting advice, two needed education advice and two for home safety advice. An audit of the advice line was able to demonstrate significant savings to the local health economy.
- Comments received about the advice line included "Being able to get an immediate response and knowing someone is on the end of the phone makes all the difference" , "I think that the advice line is brilliant", "I know I've someone to talk to" and "A useful resource to help you through the confusing world of babies".
- We attended a community drop-in clinic during the inspection. We met a parent who attended to discuss concerns about their child's speech development. The staff provided advice and reassurance and made a referral for the child to have a full assessment of their development needs.
- Whilst visiting clinics, we saw various information leaflets and posters displayed advising parents. This included giving babies vitamin drops, smoking cessation and safe sleeping.

Outstanding ☆

Are services responsive to people's needs?

- We observed staff providing mums with safer sleeping advice during the inspection. We also observed staff providing mums with breastfeeding information and offering the support of a breast feeding counsellor.
- A wide range of support and advice services were provided by the service, examples included smoking cessation, healthy eating parenting guidance, boundaries and stimulation, sexual health, domestic abuse, alcohol and substance misuse, family Illness, parenting advice. The people we talked with during the inspection told us they knew how to access information about the services provided.
- Baby massage sessions were provided to the community and we saw these were well attended. Staff told us these were beneficial for the babies, but also provided staff with an opportunity to assess the parent's emotional wellbeing and the chance to provide additional support if necessary.
- During the inspection, we became aware that an external provider's premises which had a baby clinic booked for the afternoon, was being closed for the day. This was not communicated to the health visitor team. The provider of the premises requested the clinic be cancelled as there was no receptionist available. Staff in the CYP service did not want to cancel the clinic with no notice. A member of staff was identified to work in the reception area which ensured the clinic was able to continue as planned. This demonstrated a positive and flexible attitude of staff to ensure service provision.

Learning from complaints and concerns

- There were policies and procedures to deal with comments and concerns.
- Staff were aware of these procedures and were able to demonstrate learning from such reporting. An example of this was one parent who missed an appointment with the health visitor due to a communication break down. Text messaging was used as an easy way to confirm appointments with this parent for further contact.
- No complaints were escalated to the Parliamentary Heath Service Ombudsman's (PHSO) which indicated good local resolution between January 2016 and January 2017.
- There was a strong emphasis on local resolution to any concern or comment received.
- We reviewed a sample of organisation complaints during the inspection to get an overview of how complaints were handled. The quality of the investigations, response tone and learning was consistent.
- This meant that the service was learning from comments and complaints and as a result improving the quality of care it provided as well as preventing recurrence.
- Service users we spoke with told us they were extremely happy with the service provided by the nursing team. They were confident their concerns and comments would be taken seriously and investigated without bias.
- Staff were encouraged and empowered to facilitate local resolution of any concerns raised before they became complaints.
- Trends and themes from complaints were regularly reviewed at board level and triangulated with serious incident data.
- The clinical governance manager reviewed all complaints and categorised them by trend and theme.
- The Chief Operating Officer reviewed every complaint when they were received, and signed off all the written responses.

Outstanding ☆

Are services well-led?

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

Summary

We have judged the service as Outstanding.

- First Community Health had a clear vision and strategy that was well understood and support by staff. Staff were involved in its design and committed to its successful implementation. Staff were loyal to the organisation and excited by, and welcomed the challenges ahead in terms of having a bigger impact on care provision to a significantly larger demographic.
- There was appropriate and effective governance, risk and quality measurement processes. These were widely understood by staff and influenced practice and service delivery. Staff were given direct access to outcome dashboards so they could share the success and identify areas for improvement.
- Morale in the organisation was exceptionally positive. Teams were engaged and worked cohesively to deliver the service.
- Staff felt overwhelmingly valued, highly respected and were driven to share their initiatives and service strengths with a wider healthcare economy. Senior managers and board members were highly visible, very approachable and lived the 'floor to board in 5 minutes ethos'. There was a systematic approach to improve care outcomes, tackle health inequalities and obtain best value for money. Examples of this included the advice line, CHAT line and using Community Nursery Nurses (CNN) in the drop-in clinics instead of health visitors, and direct referrals to the local NHS Enuresis Service.
- The service had systems in place to capture the views of the people who used their services. There was a strong commitment to ensuring the service captured the views of all and that harder to reach groups were able to provide feedback.
- The data we reviewed was entirely positive. Teams were continuously capturing feedback with hard to reach and vulnerable groups which can be a significant challenge to organisations.
- There was a unanimous feeling that every individual member of staff counted and was valued, regardless of their role or position. Staff felt they could genuinely effect change and have a positive impact on the service delivered and the teams they worked in. The staff survey demonstrated very high engagement scores and work satisfaction scores. Data also suggested staff were highly likely to recommend the service to others.
- Staff did not want to wait to be told what they should improve; they wanted to be at the forefront of innovation and service improvement. There was a very refreshing and consistent 'can do' attitude that ran through the service at all levels. Staff told us they wanted "good care to be rolled out nationally" and felt confident in their ability to influence the Children and Young Persons (CYP) national agenda. Innovation success was widely celebrated and actively encouraged. Modern technology was being used effectively to meet the needs of the service and as a real time communication method for staff.

Service vision and strategy

- We saw an appropriate vision and strategy for the CYP service at First Community Staff felt involved in its development and were committed to its implementation.
- Staff told us about an 'uncertainty' moving forward as a new and major contract was due to commence in April 2017. However, they were adamant that they would 'overcome the challenges it would throw at them' and would continue to deliver the services to the highest standards possible.

Governance, risk management and quality measurement

- There were systems and processes to measure and monitor the quality of the service because there were systems and processes in place to identify, manage, and assess risks.

Outstanding ☆

Are services well-led?

- The governance structure at First Community was functioning well, had the confidence of staff, and was well understood.
- There were six sub groups (infection control and prevention, clinical quality and effectiveness, safeguarding adults and children, research and development, health and safety, and information governance). Each of these groups then reported to the integrated governance committee who in turn reported to the board.
- Information flowed well between the various boards and staff members. Communication systems consisted of a combination of verbal team and individual feedback and briefs (a formal briefing tool call the 'core brief'), meeting updates, staff newsletters and intranet.
- Governance and performance management systems and processes were proactively reviewed and reflected best practice.
- There was a governance lead who had complete oversight of all the incidents in the services. Trends and themes were analysed to prevent recurrence and learning from these were widely shared.
- We found very effective use of the service of risk registers. Risks were RAG rated. RAG can be defined as a method of rating for risks based on Red, Amber (yellow), and Green colours used in a traffic light rating system. Risks were regularly reviewed at service and board level, and staff were aware of the risks relevant to their services. Staff were fully informed on the risks on the register and were able to provide details on how the risks were being mitigated.

  Staff were able to escalate concerns to the risk registers and felt able to influence how risks were managed and monitored. An example of this was a period where there was a high number of staff on maternity leave. Whilst the vacancies were backfilled by a temporary workforce, staff felt strongly that the staffing risk was recorded on the departmental risk register. This was discussed with senior managers and added to the register, despite the risk being mitigated.
- First Community had electronic live performance dashboards. Staff had their own log-ins and were actively encourage to log in to review their achievements and areas for improvements. Staff were using this facility not only to drive up standards but to get a sense of achievement from what their teams achieved.
- There was a positive culture and approach to audit in the organisation. Staff were complimented when they performed well and encouraged to make improvements when appropriate.
- Complaints trends and themes were reviewed at board level and linked to Serious Incident (SI) data to ensure robust risk management and learning.
- First Community held an annual quality improvement day that was attended by staff and external Stakeholders. All the presentations were benchmarked against the CQC key questions inspection of safe, effective, caring, responsive and well led.
- Managers and service leads (band 6 and above) were provided with quality Improvement training. Topics covered included 'what is governance and why does it matter?'

  'governance across public and private sectors', 'governance, risk, and assurance within the NHS', 'assuring the quality of care', 'the pivotal role of clinical audit', 'clinical audit: What it is and how to do it', 'clinical audit in First Community - the policy, strategy and process, roles and responsibilities', 'National Institute for Clinical Excellence (NICE): The role of NICE' and 'NICE in First Community, the policy, process, roles & responsibilities'.
- Clinical staff also received quality improvement training which covered had a slightly reduced content.

Leadership of this service

- We found evidence of strong leadership at all levels of First Community.
- Members of the executive board and senior managers were highly visible, approachable and perceived as part of the CYP team.
- Staff told us about the 'flat hierarchy' that was perceived as pivotal to the inclusiveness culture they experience. They also told us that the lack of a perceived hierarchy made them feel very valued and an important part of the service.

Outstanding ☆

Are services well-led?

- First Community CH had a 'floor to board in 5 minutes' approach for staff to escalate concerns. Board to floor in 5 minutes was a concern escalation process used by the organisation. It meant that senior concerns could be raised with board level management within 5 minutes of a concern being raised. Staff told this that this communication system worked effectively.
- There was a values based framework that was developed by, and well understood by staff. It contained a very impressive perspective and guidance for difficult conversations which was presented in a way that was easily understood.
- Feedback from staff about the senior and board level management was entirely positive.
- We saw evidence staff had daily huddles and regularly staff meetings with standing agenda items.
- The leaders of the service lived the values of the organisation. We saw how they reacted towards more junior staff, how they supported and acknowledge staff ideas and the respect that staff had for them.

Culture within this service

- There was a very open, non-hierarchical and positive culture both within children's services and across the wider First Community.
- Staff felt extremely valued at all levels of the organisation. The flat board structure and floor to board communication method meant staff were engaged with the strategy and goals of the organisation. They also demonstrated a genuinely positive, endearing and infectious upbeat and inclusive attitude towards their work.
- There was trust between the staff and the leadership, which meant staff, felt they could share their ideas and suggestions openly. It also meant that there was ample good will amongst teams. The leadership proactively nurtured and supported staff to think 'outside the box' to impact service delivery. Evidence of these innovations has been mentioned elsewhere in the report.
- There were various examples shared earlier in the report of staff going beyond what was expected of them to ensure that the CYP using their services regardless of any obstacles that may present. This was evidence of a very patient centred service being delivered by staff who were completely committed to their roles.
- Staff described First Community as a flexible organisation. We were given examples of this, such as staff being offered sabbaticals to travel as a way of retaining staff. The chief executive (CEO) worked part time and staff we talked with had working hours that empowered a healthy work life balance.
- The staff were actively involved in the new CEO's induction to the organisation.
- There were staff representatives from each team that met with the board regularly to voice the opinions of staff. We saw documentary evidence of this process.

Public engagement

- There were systems for members of the public to express their views on the service. We saw numerous posters encouraging people to provide feedback. The tools used were adapted from different cohorts and included feedback forms for children.
- We also saw the results of the last patient survey for CYP displayed in the health centres we visited.
- Various communication methods were used to gather feedback about the quality of the service. This included emails, text and social media.
- Staff worked closely with local charities to ensure they could access additional resources for their clients.
- The service engaged with various young carers associations and youth groups in the locality.
- Communication methods with the public included emails and texted invitations to course and events. Feedback we received from the public about the methods used was positive.

Staff engagement

- The organisation's staff survey reported very high levels of engagement. An overall engagement score of 4.1 was reported and was higher than the 3.8 score achieved to similar organisations.

Outstanding ☆

Are services well-led?

- Eighty five percent of health visitors and 63% of all other staff (school nurses, community nursery nurses, administration staff) were satisfied with opportunities for flexible working patterns.
- All health visitors 93% of all other staff said they knew who their managers were.
- All health visitors and 95% of all other staff had not experienced discrimination from patients/service users, their relatives or other members of the public.
- All health visitors and 93% of other staff reported having an appraisal or review in last 12 months.
- A slightly lower 85% of health visitors and 73% of other staff would recommend First Community as a good place to work and 95% of staff felt trusted to do their job.
- However, areas for improvement were noted in terms of staff input to decision making and staffing levels.
- Only 43% of HV staff and 36% of nursing staff felt able to meet the conflicting demands within their time at work. Only 30% of HV and 27% of nursing staff felt there were enough staff in organisation. An action plan was in place to address the areas were scores fell below the desired targets.
- Staff were able to provide feedback via numerous methods, including at regular supervision sessions, team huddles and through staff representatives.
- First Community had a Freedom to Speak Up Guardian in post. Guardians have a key role in helping to raise the profile of raising concerns in their organisation and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled. Staff were aware of who the guardian was and the various ways to make contact should they need to.
- Staff were actively encouraged to engage in quality improvements and to bring new initiatives to the organisation. At the annual quality improvement day, staff were asked to vote for the best initiative to receive a small voucher as a token of gratitude from the executive board.
- The organisation had an awards programme to recognise and reward staff recognised staff achievement.

The organisation had a Council of Governors who were elected staff representatives who together fed information into the governance structure and assurance framework. They had specific responsibilities enshrined within the organisation's Articles of Association and were involved in recruitment of executive directors and organisational policy

Innovation, improvement and sustainability

- Significant work had been undertaken to improve outcomes for hard to reach groups. The success of initiatives pioneered by the homeless team was attributed to the self-determination, relentless hard work, patience, and constant networking. The trust built between staff and these groups had a major part to ply in the success of the bespoke the service provided.
- ChatHealth – was an innovative instant messaging facility run by the school nursing team to provide advice and signposting for children.
- Advice line – a phone service provided advice and sign posting to parents of children between the ages of 0 and 19 years of age.
- The use of social media communication 'apps' to ensure that lone workers on various sites are effectively communicated with and safe.
- The provision of a paediatric Child and Adolescent Mental Health (CAMH) practitioner and Parent and Infant Mental Health Visitor (PIMHV) to work alongside the 0-19 CYP Service
- Child health drop-in' sessions were an initiative led by 0-19 Community Nursery Nurses. The initiative proved so successful, it had become an integral part of the service.
- An easy to understand 'Introducing family foods' information leaflet.
- Paediatric dietitians had identified a rise in referrals for children who suffered food allergies. In response to this they set up a baby weaning group which runs every six weeks and is well attended.