Virgin Care Services Limited

1-351584301

Community health services for children, young people and families

Quality Report

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Date of inspection visit: 4, 5 and 6 April 2017
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-2515712575	Chippenham Community Hospital		

This report describes our judgement of the quality of care provided within this core service by Virgin Care Services Limited. 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 Virgin Care Services Limited and these are brought together to inform our overall judgement of Virgin Care Services Limited.

Summary of findings

Ratings

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

Summary of findings

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Overall summary

We rated community health services for children, young people and families as good:

- There was a robust, visible person-centred culture. Staff within the children and young people teams always focused on the needs of children and young people and put them at the heart of everything they did.
- The feedback received for the children and young people services was excellent. Children, young people and their parents or carers spoke about how they were treated with respect and dignity and that staff were very friendly, warm, caring and professional.
- Children, young people and their parents or carers told us they were fully involved in their care and treatment. Relationships between people who used the service, those close to them and staff were strong, caring and supportive.
- Staff demonstrated high levels of care and compassion at all times during our inspection. We saw staff treating children, young people, parents and carers with dignity and respect.
- Fully embedded into services and staff was the ability to recognise the different needs and cultures of children and their families. This allowed support to be provided and reasonable adjustments to be made.
- Staff demonstrated a good awareness of their responsibilities for safeguarding children and young people. The procedures in place for supporting staff with safeguarding were robust and effective.
- Staff received regular appraisals and clinical and safeguarding supervision. Staff said they felt well supported in their roles.
- Effective multi-agency working was well embedded in practice and provided progressive outcomes for children.
- Staff demonstrated their knowledge and skills around consent consistently.
- The risk registers of individual services reflected the concerns of the staff we spoke to. Whilst risks could not always be mitigated they were discussed and staff were confident their managers were aware of the challenges they faced.
- Care and treatment was delivered in line with the National Institute for Health and Care Excellence (NICE) guidelines, with a system in place to ensure this guidance was communicated with staff. We also saw this information being shared with parents and carers.
- Staff described an open culture, where they felt confident to raise issues, and in the response they would receive.

However:

- Lone working procedures and processes to keep staff safe were not always well embedded across services.
- Staff vacancies and high caseloads were present in some services, although these were being managed to ensure safe care and treatment, there was a risk it would impact negatively on the delivery of care and staff morale.
- Not all staff working with children were up to date with their mandatory training including basic life support and the mental capacity act 2005.
- Remote working technology was yet to be developed to maintain a real time picture of services in the region.
- Benchmark targets for the healthy child programme required improvement, they were below the national average.
- The integrated therapy model was not yet fully developed or delivered. However, this was a commissioner led review and the provider was awaiting their leadership in supporting the service model going forward.

Summary of findings

Background to the service

Wiltshire Children's Community service is a business unit of Virgin Care. This business unit delivers children's services only for the county of Wiltshire. Virgin Care secured the contract to deliver these services in April 2016 for the duration of five years plus a possible two year extension. Prior to this contract five providers delivered the service and under Virgin Care they have come together under one contract, with staff being transferred under the Transfer of Undertakings Protection of Employment (TUPE) regulations.

Services provided include; health visiting, school nursing, school immunisations, family nurse partnership, speech and language therapy, paediatric therapy, community paediatrics, children's continuing care, children's community nursing, looked after children nursing and learning disability health team.

The service covers a geographical patch where the birth rate is approximately 5000 births per year. There are 402 children on child protection plans and 451 looked after children across the age range of 0-18 years. They offer a universal service to 240 schools and delivered a flu vaccine programme in 2016/17 to 12,000 children.

During our inspection, we visited clinics, staff bases and schools. We accompanied health visitors, school nurses and other staff members on community visits. We spoke with 63 staff, 26 parents/relatives/carers and 14 children. Two focus groups were held whereby 36 staff attended to talk to inspectors. We observed how children and young people were cared for, and looked at 26 care and treatment records. Policies and procedures, data and information, provided by the organisation and other stakeholders, was reviewed before, during and after our inspection.

Our inspection team

For example:

Our inspection team was led by:

Team Leader: Amy Headon, Inspector, Care Quality Commission

The team included CQC inspectors and a variety of specialists which included a management director of a health management consultancy, health visitor/school nurse, children's occupational therapist, community children's nurse and specialist learning disability nurse. An expert by experience was also part of the team and made phone calls to families to obtain feedback on the services being provided.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the core service and asked other

Summary of findings

organisations to share what they knew. We held focus groups with a range of staff who worked within the service. We carried out an announced visit on 4, 5 and 6 April 2017. During the visit we spoke with staff and people who used services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who used services.

What people who use the provider say

We spoke to 16 parents or carers who used Wiltshire Children's Community Services:

- Parents who had been supported by the health visiting teams told us "They are a real credit to Virgin Care and there's nothing they do not know and if not they will find out." "My health visitors are amazing, they have gone above and beyond for me and my children…..they were just there and still are and I can just pick up the phone." "I've had a really, really good experience. My midwife and health visitor have been very supportive. My pregnancy was not straight forward but the support I have had has been really great to help me through it." "I've been kept up-to date and involved throughout my wife's pregnancy. I'm very happy."
- Two parents told us about the speech and language therapy team "The speech and language therapy team is absolutely wonderful with [child] and knows [child] inside out….I am very grateful for the service." "I can't praise [speech and language therapy staff] enough, they do wonders with [child]." "I think they are doing an amazing job and always keep us informed."
- One parent said "The physiotherapist and occupational therapist are absolutely fantastic and I work well with them and they have [child] best interests at heart"
- A parent told us about the children's community nursing service "The nurse we currently have is amazing."
- A parent said about community paediatrics "I have been really, really happy. It is very difficult to get an appointment but the paediatrician has gone out of their way to slot us in."
- Three parents told us about the learning disability service "The [learning disability nurse] is absolutely fantastic and is amazing." "I have been very impressed with the service they have gone above and beyond what they have needed to do." "They come on time and never let me down. They are very quick at responding to telephone calls and emails." "They have really helped me with equipment and studies I didn't know of." "I have been very happy and could not praise them more highly."

Good practice

- There was a robust, visible person-centred culture. Staff within the children and young people teams always focused on the needs of children and young people and put them at the heart of everything they did. Children, young people and their parents or carers told us they were fully involved in their care and treatment. Relationships between people who used the service, those close to them and staff were strong, caring and supportive.
- The speech and language therapy team completed case load audits annually as part of clinical supervision. This was completed one to one between the therapist and their line manager and looked at case note quality and clinical decision making. The review process provided the opportunity to discuss cases and feedback directly to the therapist of both good practice and areas for development.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service SHOULD take to improve

Summary of findings

- Review lone working procedures across all Wiltshire Children's Community teams and ensure there are clear processes to follow when a lone worker perceives themselves to be at risk.
- Ensure the integrated therapy model of the Wiltshire Children's Community service is developed and delivered as soon as reasonably practicable.
- Improve performance for the healthy child programme within the Wiltshire Children's Community service towards national data sets.
- Continue to review staffing and caseloads within Wiltshire Children's Community service to mitigate any negative effect on the delivery of care and staff morale.
- Ensure training compliance is improved to reach the mandatory training target within the Wiltshire Children's Community service.
- Consider the use of recognised outcome rating scales within the learning disability health team for Wiltshire Children's Community service.

Virgin Care Services Limited

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good, because:

- Arrangements were in place to safeguard children that reflected the current legislation and local requirements. Staff understood their responsibilities and were aware of the policies and procedures.
- We saw good examples of how risks were anticipated and responded to, especially where services supported children and young people with complex needs.
- We visited clinics and observed safe and child friendly environments that were appropriately maintained.
- Records were written and managed in such a way that kept children and young people safe and protected confidentiality. These were regularly audited and where required, improvements made.
- Staffing was safe and reviewed regularly during times of high demand to ensure adequate and appropriate staffing levels.

However:

- Training compliance was below the organisation's target, in particular staff were not all up to date with basic life support and mental capacity act. The organisation were working to improve their compliance in training.
- Paper records were still used in the community increasing the risk of loss or delay in updates to patient records. Incidents had arisen where records had been misplaced during postage, however risks were being reviewed with a short term solution until electronic systems are in place.
- Some staff felt that, due to vacancies, caseloads were becoming too large and this could affect the quality of the service provided.

Detailed findings

Safety performance

- We found services were being monitored safely and effectively. We saw evidence learning had occurred

when things went wrong. A range of safety information was being monitored and fed into service improvement. This included the monitoring of incidents including medication errors.

- There had been no serious incidents requiring investigation (SIRI) reported in respect of the children and young people's services between April 2016 and February 2017.
- During the period April 2016 and February 2017 there had been no never events in respect of the children and young people's service. A never event is a serious, largely preventable patient safety incident, which should not occur if the available preventative measures have been implemented correctly
- Health visitors and school nurses told us they received regular updates on safety performance through team meetings and supervisions. This included any themes emerging from incidents reported across the services.

Incident reporting, learning and improvement

- There were clear processes for reporting incidents via the electronic reporting system. The care effectiveness team and relevant subject matter experts were responsible for ensuring learning was shared via local groups and Virgin Care committees.
- We found learning from incidents was shared across the Wiltshire business unit with incidents being discussed at manager meetings and the information being disseminated throughout the different services. The learning from reported incidents was part of the monthly team meeting agenda. Staff told us relevant information was passed to them when learning or changes to practice had been identified through the investigation of incidents. We saw information in minutes of meetings and supervision records to confirm feedback around learning from incidents was shared with staff.
- Staff found the electronic incident reporting system easy to use and were confident in completing incident forms. They were able to explain what they need to report and gave examples of incidents reported. Where staff had reported incidents they told us they had been provided with feedback in a timely manner.
- Staff were aware of the incident trends within the organisation which predominantly related to information governance. Following these incidents staff were provided with information posters on the ten golden rules for information governance and how to email securely between different servers, we saw these displayed in clinic rooms and staff bases.
- The provider reported 255 incidents between April 2016 and February 2017, 111 (43%) were near misses and 41 (16%) were not attributable to the provider; however learning would be identified and shared where applicable.
- The main types of incidents reported included information governance with 88 (34%) incidents and communication with 45 (17%) incidents. Information governance was mostly attributable to the sharing of information across different email systems and postal information governance errors. There were also instances where duplicate vaccinations had been given to children either by parents consenting twice or taking their child to the GP for the same vaccination following previous vaccination. Lessons learned included staff and GPs being vigilant about consent and messages being sent promptly between teams. Parents were contacted to reassure them about lack of harm to their children if this had happened.

Duty of Candour

- Staff we spoke with were aware of the Duty of Candour legislation. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person'.
- Staff spoken with were knowledgeable about the Duty of Candour and received training in this topic. Staff provided examples of when the Duty of Candour had been applied. They said they would write to families if anything had gone wrong with the child or young person's care. We saw evidence of one incident where staff had contacted the family to explain what happened and apologise.

Safeguarding

- A good practice checklist was in use to ensure staff followed appropriate steps if they had a safeguarding concern. This included: ensuring the child or young person was spoken to alone and asked about their views, observation of interactions within the family, if

there are other children or parents who could be at risk of harm, ensuring documentation was complete, compliance with child protection procedures and discussion with the safeguarding lead.

- Pathways were in place to identify and escalate concerns of domestic abuse for referral to a multi-agency risk assessment conference. Staff were very clear on the processes they should follow if there was a safeguarding concern and provided recent examples of identification and escalation of safeguarding issues. They were able to contact the safeguarding lead for support. Safeguarding contact details and flow charts were displayed in clinic rooms.
- A positive approach was taken to reporting safeguarding incidents and actions were taken as a result. Between April and December 2016, 15 incidents were reported regarding safeguarding, a combination attributable to the provider or to external providers. This included when information was failed to be shared with a child protection conference or core group meeting, inadequate recording of safeguarding concerns and action taken, and failure to follow safeguarding policies and procedures. Audits of caseloads and risk assessments were completed as a consequence of incidents reported on safeguarding practice.
- A safeguarding children and young people training strategy was in place to ensure staff were up to date with the most current practices in safeguarding. The safeguarding team provided in house training on domestic abuse and child sexual exploitation, this included female genital mutilation.
- A training compliance report for 7 April 2017 showed safeguarding children training compliance was reported as 94% for level one, 90% for level two, 93% for level three and 100% for level four. Safeguarding adults level one training was 91% compliant, however level two safeguarding adults required improvement and was reported as 76%.
- Within four weeks of commencement of employment staff were expected to complete a safeguarding induction checklist, this aimed to familiarise staff with policies, procedures and personnel within the safeguarding team, and identify safeguarding training and supervision needs.
- Staff were provided with safeguarding supervision. Between October and December 2016 74% of staff requiring one to one supervision had received it. One to one supervision was mandatory for health visitors, specialist school nurses, learning disability nurses, paediatric nurses, and paediatricians, allied health professionals who may lead child protection cases, family nurse partnership supervisor, specialist safeguarding nurses and community practice teachers. Staff were required to complete four sessions a year with intervals of no longer than four months. Family nurses received weekly supervision from the family nurse partnership supervisor.
- Allied health professionals, public health team leaders, school staff nurses and immunisation teams could request supervision from the safeguarding team on a one to one basis but received mandatory group supervision three times a year.
- An audit of quality of safeguarding supervision was completed in December 2016, measuring the effectiveness and quality of safeguarding supervision through sending a questionnaire to staff. An action plan was produced as a result of this audit which included increasing the number of multidisciplinary group supervision and facilitating smaller groups, increasing skills of supervisors and clarity on mandatory minimum requirements for practitioners.
- The head of operations sat on the local safeguarding children board enabling messages to be communicated from and to the provider.
- Health visitors routinely input into the child protection process, particularly initial child protection conferences. Attendance was prioritised and reports were provided to better inform the decision making process.
- Health visitors also contributed to child protection conferences, although we were informed that this could be problematic when invitations were provided at short notice. This impacted on reports being provided in a timely manner.
- Health visitors had received training in recognising domestic abuse and how to make referrals into the Multi-Agency Risk Assessment Conference (MARAC). Where a health visitor made a referral to the MARAC we were advised that they would prioritise attendance at the relevant meeting to share and receive information. Members of the safeguarding team also attended the MARAC and would likewise inform practitioners of any relevant domestic abuse information that might inform their interactions with their clients.
- Staff were able to advise us of how they identified safeguarding issues. For example in the learning disability team all staff we spoke to could explain how to

make a safeguarding referral. We found examples of this in the case records we examined. The team engaged with the Team Around the Child, which is a process that brings together the different agencies and family to provide an action plan to support the child.

Medicines

- We observed safe systems around the storage, administration and disposal of medication. Medicines administered were clearly recorded including batch numbers. Each record was signed and dated.
- The vaccine cool chain was well managed with fridges, cool bags and onsite temperature monitoring every hour. We saw staff noting and recording temperatures during a school vaccination session.
- Four active patient group directives (PGDs) were used for Wiltshire Children's Community services for the administration of vaccines. PGD's are written instructions to allow clinical staff other than doctors to prescribe, supply and administer medicines to patients directly. We reviewed a sample of three completed PGDs which were appropriately documented and signed.
- Immunisation nurses were trained in the use of PGDs. PGDs related to three vaccines that were in use: meningitis, human papilloma virus, and low dose diphtheria/tetanus/inactivated polio. All PGD's were produced by Public Health England and then ratified by a local PGD group. Staff were able to explain the guidelines they had to follow to ensure the safety of children receiving vaccines.
- Anaphylaxis kits were available at each immunisation session in line with Resuscitation Council guidelines. Anaphylaxis is a severe and life threatening allergic reaction which can occur after a vaccination. It therefore requires prompt treatment with appropriate medication.
- In the continuing care team non-registered community support workers were sometimes required to administer medication to children and young people. Processes were followed whereby the parents were responsible for drawing up and labelling medication so they were prepared for administration by community support workers. The aim was for community support workers to provide the least number of medications to the child, and where possible to ensure parents provided this medication to ensure consistency.
- Staff told us there was an open culture for reporting medicine incidents. A computer based system was used for reporting. Any incidents involving medicines were sent to the corporate medicines team for review. The corporate medicines team reviewed incidents involving medicines, adverse events and non-medical prescribing. All such incidents were also reviewed locally within the service
- The number of medicine related incidents were low. These included changes in medicines not being communicated by parents, parent authorisation for medicines administration, and medicines not being brought into the service by parents, or being left at school in error.

Environment and equipment

- The use of equipment kept people safe from injuries relating to sharps and clinical waste. In January 2017 an audit of sharps and waste storage was undertaken, results showed 100% compliance for sharps containers fully and securely closed when two thirds full, clinical and hazardous waste placed out of reach of vulnerable persons and stored appropriately.
- Equipment was serviced annually and we saw evidence of equipment check logs. Staff said broken or faulty equipment could easily be replaced. Staff were able to contact an external provider for equipment hire as required.
- Where clinics or services were delivered in schools, these were secure and maintained the safety of children and young people using the service. There were systems to ensure staff and visitors signed in and out when entering and leaving the premises.
- All equipment and stock, which required temperature control, was kept in a lockable cabinets or fridges and the temperature was monitored and recorded. We saw that all perishable equipment was in date.
- During our home visit with the continuing care team we observed the community support worker carrying out and recording appropriate checks of medical devices.
- We visited four health visitor clinics during the inspection and found that the design, maintenance and use of facilities and premises kept people safe. During clinic appointments, parents were advised to take their baby's nappies away with them so bins for soiled waste were not required.
- Specialist equipment needed to provide care and treatment to people in their home was appropriate and

fit for purpose. Staff had weighing scales in clinics and sets that they transported to and from their appointments. We checked three sets of weighing scales and they were clean, and calibrated within the last year.
- We reviewed stock, systems and storage, which was safe and appropriate. Once a patient's needs were assessed orders for appropriate supplies would be placed. With the parents' consent, appropriate equipment and stock were kept in patient homes.

Quality of records

- Records were written and managed in a way that kept people safe and protected. We saw evidence of a regular annual audit plan and where required, improvements made.
- Records were audited annually as part of an ongoing programme. Health records audits were completed annually, reviewing the storage and management of records, the accurate completion of records and consent. This audit identified documentation was minimal and was used to ensure a paper trail for health care plans and risk assessments.
- In the absence of electronic records, the speech and language therapy paper records regularly transfer between locations, or staff, to ensure staff had access to the relevant information to deliver care and treatment. This resulted in the record being absent from one place to be available in another. This was monitored using tracker cards which tracked where child records were. Records were sent via internal post following internal processes to ensure secure postage. Incidents had arisen where records had been misplaced during this postal process, compromising patient confidentiality. At the time of our inspection there were three incidents under investigation. The risks were being reviewed for a short term solution; however this would not be a problem once electronic systems were in place.
- An audit of safeguarding record keeping in public health teams was completed in November 2016, whereby 30 child health records were audited across 10 public health teams. An overall compliance of 77% was achieved, and areas of improvement and recommendations were made. The re-audit date was confirmed for the following year.
- There was evidence of multi-disciplinary working with therapists inputting their notes within the same recording system. Staff recorded additional information, such as allergies of children, within care records. Support and outcome plans were reviewed annually as well as updated when changes occurred.
- In the learning disability health team files were well organised with a clear structure which made it easy to locate information. We reviewed 10 files which all had up to date care plans, which were personalised and focused on meeting the identified need. Staff completed a comprehensive assessment at the initial appointment, we saw staff had completed this in all 10 files we reviewed.

Cleanliness, infection control and hygiene

- The services 2016/17 hand hygiene audit results showed 100% compliance in teams and used the World Health Organisation five moments of hygiene tool. Staff confirmed their involvement in hand hygiene audits whereby they were observed washing their hands and a check was completed using ultra violet light.
- Infection prevention control links were within the services. They were responsible for completing infection prevention control audits.
- Annually an infection prevention and control audit was completed and formed part of the corporate clinical governance RAG (red, amber, green) score card. Key clinical sites were subject to an annual environmental audit and completed as part of a service level agreement. The audit results for November and December 2016, showed only 4.89% of areas were non-compliant. The remaining areas were compliant or not applicable. Teams were able to download results and action plans were generated according to their responses.
- Specialist infection control advice was available via phone or email from a Virgin Care infection prevention control lead nurse.
- Staff were required to complete annual mandatory infection prevention and control training. Records showed 92% compliance with this training on 7 April 2017.
- Therapists used toys to interact and engage with children. Following use of toys they were wiped with cleaning wipes. However, there were no records maintained to evidence this cleaning. We were told

implementing a signing sheet of when toys were cleaned was being considered. Toys were plastic so they could be easily cleaned; we were told there were no soft toys in use as they could not be cleaned effectively.
- During home visits staff had access to appropriate personal protective equipment to protect both themselves and the child or young person from infection.
- Families spoken with had no concerns with infection control when staff provided care and treatment during home visits, they said staff always washed their hands before and after they gave the child care or treatment.

Mandatory training

- Training was provided for all staff to ensure they were competent to perform in their roles. Staff said training was easily accessed and of good quality.
- There was a list of mandatory training. The organisation's target for mandatory training was 100%. Training compliance against total work force dated 7 April 2017 overall was 88% compliant. This included basic life support (83%), conflict resolution (80%), deprivation of liberty safeguards (86%), mental capacity act (74%), health and safety awareness (91%), Safeguarding Children Level 3 (96%) and moving and handling non-patient role (93%).
- Mandatory training was delivered through classroom based learning and electronic learning. Staff told us they were given the time to attend training sessions and since the introduction of electronic based learning it had been easier to complete training. However, some staff reported there was lack of classroom based learning available in some parts of the region which caused delays in updating training.
- A corporate induction and local induction policy created a structure where all staff, whether temporary or permanent were effectively and appropriately introduced to the organisation. All new members of staff were invited to attend a corporate induction programme on their first day of employment.

Assessing and responding to patient risk

- There was a training and development team who were responsible for providing training to ensure staff had the correct skills to treat children. We observed a clinical skills training session for seizure management where seven people attended, six people were external to the organisation and from schools where children were based, and one was internal who was a community support worker from the continuing care team. Following a training presentation each trainee was assessed in practical situations using mannequins and situations were made specific to the child the person cared for. The Virgin Care employed trainer was clear about how to handle different situations and discussed how to assess and respond to different risks which may present, providing questioning and challenge to the trainees.
- Within the continuing care team we observed completion of risk assessments, for example manual handling risk assessments. We were provided with an example of how a moving and handling process had been devised with a physiotherapist to ensure the young person was being moved safely both for the young person and the staff members involved.
- The continuing care team were able to contact the on-call nurse 24 hours a day, seven days a week. This enabled non-registered community support workers and parents/guardians to contact a registered nurse for advice.
- Health visitors undertook assessments of children at all stages of early development in line with mandatory requirements, they also conducted assessments at the request of concerned parents where a parent was concerned about a child's possible developmental delay. We saw how a health visitor visited the family at home to hear of those concerns and undertake an assessment that could better inform a potential referral to speech and language services or a paediatrician. When the assessment could not continue due to the child and their sibling becoming upset, the health visitor made a repeat appointment with the parent at the next available and convenient time and location. This is important work to identify need at the earliest opportunity so potentially vulnerable children are appropriately assessed and signposted to therapeutic interventions where necessary, but also to support concerned parents and carers.
- Health visitors routinely made clients aware of the Wiltshire Improving Access to Psychological Therapies (IAPT) service and appropriately referred clients with gained consent. The short term interventions offered by the service included; psychological therapy in relation to low mood, depression, social anxiety and stress. This was offered to mothers who might be living with short term psychological disorders following birth.

Good

Are services safe?

- Health visitors provided mothers with the opportunity to undertake an assessment following birth known as 'how are you feeling' questions. This was a perinatal mental health screening tool completed in conversation with expectant and new mothers across Wiltshire. A score following completion of the assessment advised both midwives and health visitors how best to proceed in ensuring appropriate care and support could be provided, such as making a referral to mental health services via the perinatal mental health pathway.
- We witnessed a health visitor undertaking a new birth assessment at the family home. We saw how the practitioner explained the reason for the assessment to both the mother and father of the new-born child and recorded their actions in the mothers 'red book' records that she kept. The assessment included a hearing test which could identify speech and language needs at an early stage of the child's development. This was important work to identify potential developmental issues at the earliest opportunity.
- During the assessment the health visitor explained processes and at the end was required to offer and explain a large number of information forms and feedback processes. We spoke with the mother concerned who told us, "It's a bit too much information really, especially at such an early stage. I already had a lot of information given to me at the hospital and everyone wants me to feedback on my experience. It's a bit over the top really."
- Health and care plans developed following on from the assessment process were also seen to be SMART (specific, measurable, achievable, realistic, and timed) with clearly defined goals, roles and responsibilities and expected dates for completion or review. This meant that oversight of developmental and health related issues could be better monitored and reviewed at the annual health assessment review for the child, or before if required.
- Clinic sessions had a variety of leaflets available for parents to understand the signs and symptoms of sepsis. Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. Common signs and symptoms include fever, increased heart rate, increased breathing rate, and confusion. Staff we spoke with said they received information about sepsis but had not received any official training.
- We saw health visitors explain the signs and symptoms of meningitis to a parent during a new birth visit. This was to enable the parent to recognise and respond if the child was suspected of having meningitis so the right care could be sought in a timely way.
- The learning disability health team undertook risk assessments if the child or young person was not known to services or if they identified a risk in the patient's record. The team ensured children and their families were aware of who they should contact in an emergency, particularly out of hours when the service did not operate, this was recorded as part of the positive behaviour support plan. We saw evidence of this in the case files we examined.

Staffing levels and caseload

- Staffing was planned in line with service specifications and service activity. Consideration would be given to the National Institute for Health and Clinical Excellence (NICE) safer staffing community guidance when published. For example the school nursing caseload weighting was based on number of schools, the population, mileage and safeguarding requirements for children. A caseload weighting tool was also used in the health visiting service reflecting geography and transient population, this allowed staffing levels to be safely adjusted to ensure appropriate staffing. The learning disability team were not using a recognised staffing tool, the staffing was based on the number of staff in post when the service was redesigned, merging a community team and inpatient service.
- In December 2016 vacancy rates were running at 10% for clinical staff and 7% for non-clinical staff. The higher vacancies included 3.29 whole time equivalent (WTE) staff in school nursing, 3.17 WTE staff in health visiting, 2.61 WTE paediatricians and 3.69 WTE staff in integrated therapies.
- The community paediatric team consisted of consultant community paediatricians, speciality doctors and an attention deficit hyperactivity disorder practitioner. There were comments from parents about the lack of paediatricians in the service. The team was a mixture of substantive doctors and agency locums whilst the provider recruited to permanent posts.

Good

Are services safe?

- Agency and bank usage was low across the organisation. Between April 2016 and February 2017 on average 3.3 WTE clinical bank staff, 0.73 WTE clinical agency staff, 1.28 WTE non-clinical bank staff and 8.13 WTE non-clinical agency staff were used each month.
- Health visiting caseloads averaged 380 preschool children per health visitor.
- Family Nurse Partnership caseload was 67 cases per nurse (licenced for 100 caseloads).
- Speech and language referral rates varied across the academic year. For example between the beginning of April and end of June 2016 (quarter one) the service saw 771 referrals, July to end of September 2016 (quarter two) 350 referrals and October to end of December 2016 (quarter three) 514 referrals.
- Paediatric therapy referral rates included 144 referrals in quarter one, 114 in quarter two and 148 in quarter three.
- Community paediatrics referrals 433 in quarter one, 583 in quarter two and 572 in quarter three. With a caseload of approximately 2,000 in total at any one time for the whole service.
- The children's continuing care team had approximately 18 children with packages of care. Packages varied dependent on needs of the child and agreement at complex needs panel.
- Children's community nursing active caseload was 185 children including ten oncology cases and 15 cystic fibrosis cases seen under a service level agreement with a local acute trust. Referral rates were 13 for quarter one, 12 quarter two and 13 quarter three.
- The average number of children or young people on the learning disability service case load was 25.
- There were 451 looked after children in total. This caseload was split as follows: under-fives were seen by the health visitor, five to 11 year olds were seen by school nurses and 11-18 year olds were seen by looked after children nursing service.
- Vacancies, high caseloads and challenges with recruitment were included on service level risk registers. The risks within the delivery of school nursing service and community paediatrics was included on the business unit risk register as this was a higher level risk. The organisation was working to mitigate the risks of vacancies and high caseloads. For example large caseloads were included on the risk register for speech and language therapy. Actions were being taken to recruit and regularly review capacity levels. Bank or agency staff were used to fill gaps in staffing to meet the demands of caseloads.
- The family nurse partnership risk register included insufficient staffing levels, added December 2016 where they were working at 35% staffing capacity. As a consequence, two family nurses were recruited and there was a phased allocation of caseloads between February and May 2017.
- The learning disability health team had a 33% vacancy with three vacancies, one registered nurse post and two support worker posts. These posts were in the process of being recruited to.
- Workforce vacancies and challenges in recruiting to occupational therapy was included on the therapies risk register. Recruitment and use of agency staff was being reviewed to fill these posts.
- There were concerns raised around staffing within the health visiting teams due to gaps in the rota through staff on maternity. Staff told us that management had been working with them to cover unforeseen absence, and had taken all available measures to address the concerns. We saw evidence of risk assessments and thresholds were in place for interventions at each level of universal, universal plus and universal partnership plus. Staff were able to confidently tell us how they did this.
- There was risk that health visitors were not always able to undertake pro-active work with their clients as staff felt there were high caseloads which were compacted by current vacancies and maternity leave within the organisation. We were further advised that when staffing levels were below establishment managers would undertake a risk assessment of work priorities and as part of this process one of the actions might by that universal antenatal visits were temporarily suspended. This meant that opportunities for health visitors to routinely assess the home environment for risks were reduced at the pre-birth stage. Subsequently important questions in relation to domestic abuse might not be asked at a recognised stage in pregnancy when risk of abuse was recognised as being heightened. We were aware that where risk had been identified these cases would be a priority and so targeted antenatal visits would continue.

Good

Are services safe?

Managing anticipated risks

- Patient safety alerts were received from the central alerting system and reviewed by the care effectiveness team or pharmacy lead. Relevant alerts would be sent out to service managers for cascading to teams.
- Risk assessments would be completed when staff worked alone. Any locations which were perceived to be a risk area would be identified within case records and on electronic systems if in use. Verbal communication was required between other teams to inform of these risks in the absence of linked electronic systems.
- Information entered onto the risk register for health visitors showed sub optimum staffing levels for the Avebury and Salisbury city teams. Parts of the risk reduction plans were to re-deploy staff from other areas, staff told us this happened frequently whilst recruitment was in progress.
- The continuing care team had flow chart documents to follow in the event of an emergency, for example if no electricity was available. This ensured staff responded appropriately in these situations so the child or young person was not put at risk.
- In the event of adverse weather decisions would be made on the safety of staff to provide care and treatment to children and young people and cancellation of care packages, home visits and appointments would be made dependent on access and children and young people's needs. The service had access to partnership four by four vehicles as agreed by the local Emergency Planning Resilience Forum.

Major incident awareness and training

- There was a business continuity plan for Wiltshire Children's Community services. This included child death rapid response service, paediatric on call service and provision of community paediatric nursing team and children's continuing care team. Information was included on actions required in the event of contingencies for example major incident affecting a partner organisation, infection disease outbreak or severe weather. Each service also had their own business continuity plan identifying hazardous activities.

Good

Are services effective?

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

Summary

We rated effective as good, because:

- We found people's needs were assessed and care and treatment was delivered in line with evidence based guidance and current legislation.
- Care plans were up to date and focussed on meeting the identified need, staff linked care plans to relevant guidance.
- Evidence showed that staff had the right qualifications, experience and knowledge to perform their roles safely.
- Staff received regular supervision and appraisals to ensure they were well supported.
- We saw evidence of positive and proactive multidisciplinary working across the region's teams including other professionals and organisations. We observed care being delivered that was co-ordinated and the required services were involved in assessing and planning care and treatment.
- Staff sought consent to care and treatment in line with current legislation and guidance. Consent was clearly documented, and processes were well embedded in practice.

However:

- Remote working technology was yet to be developed to maintain a real-time picture of services in the region.
- Performance for the healthy child programme remained below national averages when benchmarked against regional and national data sets.
- Records were not easily available for all staff to see in a timely manner, resulting in some patients having to tell their story more than once.

Detailed findings

Evidence based care and treatment

- Best practice from evidenced based guidance was regularly reviewed and implemented. The National Institute for Clinical and Health Excellence (NICE) guidance published on the NICE website was reviewed by the care effectiveness team on a monthly basis and a log maintained. Relevant guidelines were reviewed and assessed and presented to the Quality Care Effectiveness and Safeguarding Committee for approval, this was then cascaded to staff. A quarterly NICE guidance report was prepared identifying which guidance had been implemented for Wiltshire Children's Community Services. Recent NICE guidance audits included health care records and environmental audits.
- Speech and language therapy services used evidence based guidance and research to deliver communication approaches. These included narrative therapy, the Derbyshire language scheme, colourful pictograms and intensive interaction Hanan programmes. Staff were aware of guidelines from the Royal College of Speech and Language Therapists for example guidelines on working collaboratively and involving the family and the child, and research and discussions for care pathways. In the speech and language therapy team, one member of staff was allocated two sessions a week to look at current research to ensure the service was up to date.
- Relevant and current evidence based guidance; standards, best practice and legislation were identified and used to deliver care. Health visitors gave information to families in line with the Department of Health guidance to reduce sudden infant death syndrome and the NICE Quality Standard, such as quality standard 37 safer infant sleeping. The latest research was discussed in line with NICE guidance and the world health organisation. This included the benefits of breast feeding, immunisations, guidance on not smoking, guidance on car seat sleeping and the use of pacifiers. We saw how the health visitors discussed with their parents what this was so parents could make informed decisions.
- We saw how the health visiting service worked across services and organisational boundaries for babies and children 0 to five years and their families, to improve public outcomes. The service delivered the healthy child programme (HCP) which was the early intervention and prevention public health programme that lies at the heart of the universal service for children and families. At a crucial stage of life, the HCP provides an invaluable opportunity to identify families that are in need of additional support and children who are at risk of poor outcomes. The HCP offered every family a programme

of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices – all services that children and families needed to receive if they were to achieve their optimum health and wellbeing. As part of the HCP we attended two new birth visits where we saw how the health visitors discussed the role of the health visitor and frequency of visits, contact and clinic details, emotional support and assessment, monitoring and development of the infant. We observed in both visits how the health visitor explained the importance of the Personal Child Health Record (PCHR) and that it needed to accompany the child on any visit or intervention. The health visitor explained its purpose and what the growth centiles meant and how the screening and immunisations programmes worked.

- Care of a looked after child was delivered in line with NICE guidance (Public health guideline 28) recommendation 16 and 17. We attended a home visit and saw how the child's development was monitored and assessed. We saw how the foster parents were supported by the health visitor and attachment issues were discussed.
- Advice was given in line with latest NICE clinical guidance for post immunisation administration of medication. For example, the health visitor advised not to routinely give paracetamol and ibuprofen to prevent fever at the time of vaccination. However, if post immunisation pain and fever developed then it was safe to do so and a new mother was advised to purchase child paracetamol and have it ready in case it was required.
- Speech and language therapy services signposted parents and carers to videos on the Wiltshire children's services website. For example videos on communication language. This helped deliver clear information to families. We were told there were plans for further videos particularly for older children.
- Within the learning disability health team staff were linking care plans to best practice guidance such as NICE for autism and behaviour management and we saw evidence in care plans of this. We also saw that the team had linked the continence care pathway to NICE guidance.
- The learning disability team did not use a rating scale to record the outcome of their interventions. However, staff recorded a success criterion in the care plans, which they could refer to when identifying the effectiveness of the intervention. The service also sent out a questionnaire asking how effective the child or young person found the service.

Pain relief

- Children and young people's pain levels were assessed and appropriate pain relief was administered in a timely manner. We saw evidence in patient records where pain management had been carried out during visits and pain relief had been administered accordingly.
- Staff demonstrated a range of methods in assessing pain by asking children and young people with verbal communication skills to rate their pain using words and pictures. Those children who were too young or unable to communicate verbally had their pain assessed using non-verbal cues, body language, facial expressions and posturing.

Nutrition and hydration

- Links were established with external nutrition specialists to provide support and guidance to staff. The continuing care team could contact nutrition specialists if they had problems with specialist equipment for delivering nutrients to children and young people or required training in the use of the equipment.
- We observed, during a new baby visit, how a health visitor stressed the importance of maintaining a healthy diet. Reminders of increasing calorie and fluid intake was discussed with a mother who was breastfeeding and advice given on the avoidance of caffeine.
- We saw evidence that a child's daily food intake was recorded in care notes as well as regular checks on weight being completed.
- Staff completed joint visits with dieticians, who worked for an external healthcare provider, if this was assessed as required to meet the child or young person's need.

Technology and telemedicine

- The lack of technology was identified as a challenge for the provider and on occasions reduced their effectiveness and at times inconvenienced services. Wiltshire children's community service was largely paper based with no mobile working. This resulted in the inability to access the internet or manage ordering supplies when not working at a base location. The introduction of technology and mobile working was being considered for the near future.

Good

Are services effective?

- Speech and language therapy services had access to a video link, this was an effective way of using technology to communicate with both schools and families without the requirement for travel for either parties involved.
- Staff told us that they were supplied with mobile phones for remote working and all staff were aware of the forthcoming improvements to the IT systems. This will have the potential to allow staff to securely access local protocols and procedures as well as report incidents when working remotely.

Patient outcomes

- Information about the outcomes for children and young people's care and treatment was routinely collected.
- The service benchmarked the delivery of the Healthy Child Programme by comparing performance to regionaland national data sets. The data we reviewed for quarters two to four 2016-2017 were as follows: new birth visits were above regional averages but slightly below national averages. Six to eight week visits were below national and regional averages. One-year review (by 12 months) had improved and in quarter four was 74.9% which was above the regional but slightly below the national target of 75.3%. One-year review (by 15 months) remained below regional and national averages. Two and a half year reviews remained consistently below national and regional benchmarking data.
- We received data for breast feeding prevalence at six to eight weeks after birth from September 2016 to February 2017. When we compared the data sets to the England average of 43.2%.they were consistently above this national average.
- Therapists set targets for schools, once the schools had achieved these targets they contacted the team for review. Targets were also sent home to parents.
- We found good examples of outcomes for families engaging with health visitors. Practitioners were supported and encouraged to work with families at risk of disengaging from the service. This approach was benefiting outcomes for vulnerable children and families.

Competent staff

- Staff were appraised annually and the majority of staff received a mid-year review. Mid-year compliance identified staff had received their appraisal across the public health nursing and specialist services with 100% compliance. Compliance was at 97% for integrated therapies, 85% for school nursing and 76% health visiting.
- We reviewed three completed appraisals, the appraiser devised a plan for the following year that covered training and support for the member of staff. If there were concerns about staff performance, the clinical lead addressed them and plans to support the staff were developed, we saw evidence in personal files to confirm this.
- Support for revalidation was provided through teaching sessions, making national guidance available and a designated email account for queries.
- There were specialist roles for speech and language therapists. Specialists provided support to staff. Children could be referred to specialists to ensure staff with relevant expertise delivered care and treatment.
- Speech and language therapy teams received clinical supervision every four to six weeks from their line manager. Template clinical supervision forms were used to ensure relevant areas were covered to support staff, for example staff wellbeing, safeguarding concerns, and successful or challenging cases to discuss. We saw evidence for one therapist of completion of regular clinical supervision forms.
- We spoke to staff who had been working for the organisation for less than one year, they spoke positively about the induction process and felt they were provided with multiple shadowing opportunities and support to ensure they were competent in their role.
- There was a training team who delivered regular training sessions to those who worked with children with complex health care needs. This was delivered to community support workers as part of the continuing care team, new nurses, student nurses and carers. They were provided with a comprehensive induction programme including clinical skills and competencies and their professional accountability. Training included anaphylaxis, seizure management, enteral feeding and respiratory. For non-registered Virgin Care staff within the continuing care team competencies were signed off by the training team or nurses once staff demonstrated their competency in the area. Between 1 April 2016 and 31 March 2017 the training team delivered 277 seizure sessions, 75 anaphylaxis and severe allergy sessions and 172 enteral feeding sessions.

Good

Are services effective?

- The service told us the health visitors were given annual updates on the 'health needs of Looked After Children (LAC)'. These updates were run as bi-monthly sessions which allowed for new starters to attend. Attendance was monitored and reported centrally by the LAC designated nurse. Sessions covered:
  - Health needs of LAC
  - Health needs of asylum seekers
  - Sexual health assessments
  - Undertaking holistic health assessments and care planning and use of appropriate tools
- We reviewed the file of one community support worker within the continuing health care team; they were signed off for competencies, for each child for whom they provided care and treatment, on an annual basis.
- Staff told us there were lots of opportunities for development available regardless of the seniority of the staff grade.
- Staff reported that there were good training opportunities. The provider had sent all nurses in the learning disability team on a Sleep Scotland course to enable them to promote healthy sleep in children and young people through sleep awareness, sleep counselling and education. The team identified this course as the service worked with children and young people with sleep issues.

Multi-disciplinary working and coordinated care pathways

- The integrated service being provided promoted multidisciplinary working and coordinated care pathways.
- A children and young people's training team provided training using a multidisciplinary / multiagency training model to support inclusion of children with complex health care needs in all Wiltshire services. The service provided 761 carer sessions and provided support and bespoke training to staff within external organisations for example special schools, district specialist centres and short break settings.
- The community paediatric team held joint clinics with colleagues, therapists and external child and adolescent mental health services.
- There were link speech and language therapists allocated to schools and nurseries. We were told by staff this had been successful to build relationships with the schools and nurseries to ensure continuity of care. Nursery staff told us they felt supported by the speech and language therapy service. We observed collaborative processes between the school and speech and language therapists, reviewing a child's social story and discussing changes to support the child.
- Examples were provided where different teams had worked together effectively keeping the child at the centre of what was done. One example was how a safeguarding concern had been identified by a therapist; they reported the concern and communicated with the health visitor who completed an unannounced welfare visit.
- The clinical lead for training and development worked with the local authority and commissioners to develop a document to identify the needs of children, this pathway was developed for children's needs in settings to ensure a co-ordinated approach.
- The continuing care team worked with external providers to include the local authority safeguarding teams and end of life provision services. Staff said inter agency communication had improved for example when families moved from out of area in to Wiltshire.
- We observed a child development multidisciplinary team clinic where a Virgin Care occupational therapist worked in conjunction with a paediatrician and physiotherapist to deliver care and treatment to children.
- Strength and Difficulty Questionnaires data was provided to the Looked After Children (LAC) health team who then passed on that information to paediatricians for use in informing the initial health assessment process. This meant that consideration was given to information taken directly from the child or young person which helped paediatricians assess their emotional and mental health which contributed to the plan of what care and support they required.
- During our review we witnessed a psychologist led meeting with all four family nurse partnerships where individual cases were discussed in depth and decisions made as a group on how best to progress the cases. One particularly complex case discussed evidenced strong information gathering practice by the practitioners concerned in relation to the safety and vulnerabilities of the child and potential risks posed by a family member. The evidence gathering process had been well documented and accordingly a decision was taken to

undertake a Common Assessment Framework (CAF) assessment of the family and to further make a referral to children's social care via the Multi-Agency Safeguarding Hub (MASH).

- We found the family nurse partnerships engaged well with partners across the health landscape, including health visitors and midwives. Where, for example, a young expectant mother was identified by a GP, psychologist or midwife, at the pregnancy booking stage, then they could, with consent, be referred to the service using a recently developed referral form. This included provision for the person making the referral to identify if the young person had made other family members aware of the pregnancy, if they were subject to child protection measures, are there any identified mental health issues and who does the young person currently live with. This information is important for the family nurse partnership to engage well with the expectant mother at an early stage and be aware of any issues that might otherwise affect engagement with them.

- The learning disability team reported good working relationships with other children's teams. They had regular meetings where they discussed the child or young person on their caseloads and identified the links each team member had with other services. For example, the family support panel, continence clinic and the child and adolescent mental health service learning disabilities forum. They also discussed service development. All team members attended group safeguarding supervision meetings with other professionals including psychologists and occupational therapists. The service reported that their patients were usually under the care of a consultant paediatrician. However, if the team needed to access support from a psychiatrist, or other mental health professionals, they referred to the local children's and adolescence mental health service.

Referral, transfer, discharge and transition

- Each team had processes to receive and review referrals. It was important to build relationships with referrers to ensure the relevant information was sent so not to delay the referral process. We saw evidence of comprehensive referral forms completed for therapy services, for example from schools, nurseries or paediatricians.

- When discharging children from the continuing care team this would be completed in a step down approach reducing the amount of contact with the child gradually before stopping the package. For children transitioning to adult services this would be completed by the children's community nurse or social worker with shadow shifts and joint working.
- There was a transition document identifying the transition pathway for paediatric speech and language therapy to adult speech and language therapy. This ensured strategies were in place to support the young person during their transition. The processes for transition were unique to each child and required consent from the young person to continue receiving intervention. Joint visits could be implemented when a young person moved from a child to an adult service.
- Statement of Educational Needs and Disabilities (SEND) reforms have enabled paediatricians across Wiltshire to better 'let go' of cases that they might have previously held where young people transitioned into adult services. Participation in Education Health and Care Planning (ECHP) processes meant that children living with those additional needs were better assessed and their needs met by multi-agency partners and schools. This also meant that those children and young people had their needs met by the most appropriate practitioners identified to provide care and support to them.
- There was a dedicated unaccompanied asylum seeker pathway into the looked after children's (LAC) team with joint clinics held with children's social care. The LAC designated nurse attended initial health assessments to pick up on any issues that might require further immediate action. They followed up the assessment 12 weeks later, generally in a face-to-face meeting with the young person to further ensure required outcomes were being met and again pursue any developing areas of concern. Where child and adolescent mental health early intervention work was considered necessary, this was arranged via the dedicated LAC child and adolescent mental health practitioner so the vulnerable child was offered appropriate care and support at the earliest opportunity. This was good practice, meeting the needs of often traumatised young asylum seekers, who might be difficult to engage with.
- Care leavers across Wiltshire were provided with a comprehensive health passport on leaving care which was initially developed in conjunction with young

people on the care leaver's council. A recent change was suggested by the new provider which, during review it was partly rejected by those young people on the care leaver's panel and by the LAC health team. As a result, a revised passport was being developed which will, again, be presented to the care leaver's council before it is implemented.

- The current health leaving care passport can be completed by the young person from age 14 and includes, where available, information pertaining to their birth weight, blood type, personal details, GP detail, health information and summaries and information about how to manage emotional health and wellbeing, anxiety, stress and depression and drug and alcohol use.
- We saw how staff dealt with a potentially difficult conversation with a young mother who had declined involvement of the Family Nurse Partnership Programme (FNP), yet required multi-agency input. We attended a team around the child (TAC) meeting where more than one agency was involved in providing additional support to the child and mother. We saw how the health visitor and the mother worked together to plan a slow withdrawal and eventual discharge of the extra support which the family had needed.

Access to information

- There remains a challenge across health services in Wiltshire to ensure that children, young people and parents and carers only have to tell their story once. The use of IT across multi-disciplinary services remains limited with a heavy reliance on paper records. This meant that some information might not be easily shared in an efficient and timely manner and there was the potential for records to be fragmented and incomplete. Practitioners we spoke with told us that they are aware of parents, carers and indeed children and young people telling them of their frustration that they sometimes have to tell their story or circumstances more than once when being provided with care and support by those multi-disciplinary teams. It is hoped that the implementation of better IT services across Virgin Care Services will negate this need.
- Speech and language therapy received detailed information about a child within the referral. If this information was not thorough the referral would be returned to obtain further information.
- All reports, letter and targets within therapy services were routinely sent to parents, schools and GPs where applicable to ensure the team around the child were well informed.
- Educational health care plans and reports were completed and sent to relevant professionals.

Consent

- Staff showed an understanding of relevant consent and decision making requirements of legislation and guidance. Staff were aware of the needs to ask for consent and for this to be appropriately recorded.
- Therapy services always obtained parent or guardian consent. We saw evidence of signed consent in nine records and in all appointments observed during the inspection. Consent was also obtained to talk and write to other healthcare professionals.
- Staff spoken with were knowledgeable about the Fraser Guidelines and Gillick competence. Fraser guidelines refer to a legal case which found that doctors and nurses are able to give contraceptive advice or treatment to under 16 year olds without parental consent. The Gillick competence is used in medical law to establish whether a child (16 years or younger) is able to consent to their own medical treatment without the need for parental permission or knowledge. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were familiar with the principles of Gillick and had used this to include the child or young person, where possible, in the decision making regarding their care.
- We inspected care plans where consent was clearly recorded. For example, there was clear documentation of the parents' consent in regards to assessments, treatment and sharing of information with other healthcare professionals.
- Staff were aware of what to do in situations where gaining consent was more challenging. We observed young people being asked for verbal consent on the day of their immunisations and observed them explaining the procedure and understanding the associated pressure of the children's peers. For example if a child was nervous they wouldn't want their fear or uncertainty to be exposed to their friends.

Good

Are services effective?

- Staff spoken with had a good understanding of the Mental Capacity Act. There was a policy in place that staff could access.

Outstanding ☆

Are services caring?

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

Summary

We rated caring as outstanding, because:

- We observed high levels of attention to building strong relationships between staff and children and their families.
- Staff were highly motivated to provide care which was kind and dignified.
- Staff put quality and compassionate care at the forefront of everything they did. Considering not only the child they were treating but the child's family, recognising the support and care required.
- The feedback we received about care was overwhelmingly positive. Children, young people and their parents or carers spoke about how they were treated with respect and dignity and that staff were very friendly, warm, caring and professional.
- There was a robust, visible, person-centred culture where care was individualised. Staff always focused on the needs of children and young people and put them at the heart of everything they did.
- Staff took time to effectively interact and involve the child and their family, empowering people to have a voice and be partners in their care. Children and parents told us they were fully involved in the care and treatment.
- During our inspection we observed excellent communication by staff to children, young people and their families.
- Staff were respectful of people's needs and took in to account personal, cultural, social and religious needs. People's individual preferences and needs were reflected in the care being delivered.
- Staff were experienced in responding to non-verbal communication from young children and were able to change their approach to make the child feel as comfortable as possible.
- It was embedded in staff practice to provide emotional support to children and their families. We observed staff going beyond the extra mile to ensure this support was in place.

Detailed findings

Compassionate care

- We observed consistently across all services compassionate care being provided to children and their families. Staff were passionate and motivated to provide quality care with the child at the centre of what they did.
- Staff were observed to introduce themselves and their role to parents/guardians and children if it was the family's first appointment.
- Staff positively interacted with children, engaging them with the use of toys and verbal communication whilst ensuring safe play. All the children we saw interacting with staff showed pleasure in seeing the staff member and it was clear that a bond of trust had been built between staff and child.
- The staff we met spoke respectfully of the children and young people and their parents/carers. They were able to give examples of the needs of the children or young people they worked with and how they had assisted in meeting them.
- We spoke with 16 parents over the phone who were extremely positive about the care being provided to their child, parents told us there was a good rapport with staff and their children were treated with respect and dignity. Parents said healthcare professionals were very dedicated and provided good support and advice.
- It was positive to learn from one parent how much they had gained in confidence through the support from their healthcare professional. Two people had received very good support regarding identifying problems with their child's sleep patterns, one healthcare professional was said to go above and beyond and the second healthcare professional we were told was amazing.
- Practitioners were said to show excellent skills in identifying underlying causes and in relation to the families and children suffering with sleep deprivation the difference the service had made upon their lives was fantastic to hear. We were told the health visiting service was sensitive, empathetic and accessible providing a timely service, we heard how they helped and supported vulnerable families through very difficult periods in their life. Other comments included:

Outstanding ☆

Are services caring?

"The speech and language therapy team is absolutely wonderful with [child] and knows [child] inside out….I am very grateful for the service"

"The physiotherapist and occupational therapist are absolutely fantastic and I work well with them and they have [child] best interests at heart"

"I can't praise [speech and language therapy staff] enough, they do wonders with [child]"

"I've had a really, really good experience. My midwife and health visitor have been very supportive."

"My health visitors are amazing, they have gone above and beyond for me and my children"

"The [learning disability nurse] is absolutely fantastic and is amazing."

"I have been very impressed with the learning disability service they have gone above and beyond what they have needed to do."

- The friends and family test feedback tool was launched by the provider in July 2016, in line with NHS England requirements. Between July and September 2016 98% of responses said they were likely or extremely likely to recommend the service to their friends and family. Similarly, between October and December 2016 96% were likely or extremely likely to recommend the service.

Understanding and involvement of patients and those close to them

- Relationships between staff and the child and their families appeared strong, ensuring children and their families were fully involved as partners in their care and treatment. Staff took time to interact with children and their families and ensured their understanding.
- We saw evidence of children being involved in planning their care, helping to devise and make alterations to care plans.
- During speech and language therapy appointments the therapist provided targeted child specific advice and involved parents in care planning and seeking their views. Concerns were summarised to parents but positive feedback was also given including praise for the child's strengths. One parent said about the speech and language therapy team, "They are doing an amazing job and always keep us informed."
- We observed a speech and language therapy triage assessment clinic appointment. The therapist clearly explained the purpose of the appointment and checked the parents understood. The parents were provided with time to speak and provided background information and the therapist engaged during this conversation. The therapist was clear giving information about the normal child development in terms of speech and language in line with their age. Examples were provided to ensure parents understanding.
- A speech and language therapy assistant told us about how they had been encouraging parents to attend sessions with their child and improve parent engagement. Letters were sent to the parents informing of their child's appointment within school and nursery settings and explaining to the parents their attendance at this session would be beneficial to both them and the child.
- Speech and language therapy groups at a special school involved the young people when setting standards for the group, they were also encouraged to help with planning and outcomes of the group.
- The occupational therapist discussed child priorities with the child directly and explored options with them.
- The continuing care team ensured parents signed an agreement of care for the benefit of the family and the staff member to ensure it was clear the responsibilities and expectations. It also ensured staff had appropriate provision, for example toilet facilities and access to water and hot drinks during their time in family homes.
- Staff recognised how some of their clients were socially isolated and we saw how they were given information and encouraged to attend local groups such as breastfeeding and mother and baby groups. Health visitors and community nursery nurses (CNN) also identified that extra visits may be required should that client have limited communication skills, or find it difficult to access local clinics. The health visitors encouraged fathers to be involved with all aspects of care and discussed with them how they could sign up to an app specifically for fathers.
- During one home visit two nurses were in attendance. This was to not only assist each other with the procedure if required but also to distract and entertain the families other children. We observed the nurses were welcomed by the children and offered to help with

their sibling's procedure by chatting and reading to their sibling. Staff recognised care went beyond the direct care to the child but also to provide care and support to the child's family.

- Staff in the learning disability team were able to give us examples of how they had engaged the child or young person to develop care plans. Staff had recorded this in the 10 care plans we reviewed. The care plan was signed by the appropriate person to show that they agreed with the care plan. Staff advised us that they worked throughout the care process to agree changes with the child or young person, parent or carer.
- Staff provided information about other services and treatment to families, this was provided in an appropriate format. For example, easy read. We saw evidence of the information shared with families in the files; parent/carers confirmed this during telephone interviews.

Emotional support

- Parents were able to talk about worries and concerns with staff, staff responded to these concerns and provided appropriate emotional support to the child and their families.
- We observed the sensitive nature of a therapist when delivering difficult information to a parent.
- One parent told us the continuing care team were "really good and took time with us and was very empathic" during a difficult time of transitioning a child to receive care support in the home. The lead nurse built up a relationship with the child to enable smooth transition.
- We observed one nurse supporting a family who were due to move out of county. It was the parents who required the emotional support as they were worried about the continuity of care for their child and having to re-establish the close relationships that had developed between them over the course of the child's palliative treatments.
- We observed how staff carried out assessments to check the emotional wellbeing of their clients and spent time talking to them about the signs and symptoms of depression, what to do and who to contact.
- The health visitors told us that post-natal depression could affect people from any socio-economic and cultural background. We saw how the health visitors went out of their way to visit patients in the community when a clinic appointment would have been the norm. The health visitors recognised how isolated some families were that moved to the area and whose partner/spouse was in the military. They recognised how it was difficult for some to get to clinics for various reasons and health visitors would phone and visit those clients that they felt were socially and emotionally isolated.
- The health visitors discussed that if the mother did experience a change in mood then she was encouraged to contact the health visitor and we saw how work mobile numbers were given to those mothers who were potentially at risk due to social isolation. They were also told that 'listening visits' could also be provided for those new mothers that were struggling.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good, because:

- There were examples of proactive responses to events or changes within the local population.
- In the majority of services, the 18 week referral to treatment time target was consistently being met.
- The 'you said, we did' evidenced examples where the service was responsive to the needs of people using the service.
- The family nurse partnership was a proactive and developing service within Wiltshire.
- Wiltshire Children's community services ensured children and young people coming into care had good and timely access to Child and Adolescent Mental Health Services.
- Staff took time to learn about their patients and their family's cultures, religions and beliefs.

However:

- The integrated therapy model was not yet fully developed or delivered in line with the recommissioned service. However, this was a commissioner led review and the provider was awaiting their leadership in supporting the service model going forward.
- Occupational therapy in the South of Wiltshire had 27 children or young people over the 18 week referral to treatment time.
- Parents told us about their difficulties and delays in accessing the community paediatric service, however the organisation were proactive in their response to the large waiting list inherited which they had decreased dramatically since acquisition.

Detailed findings

Planning and delivering services which meet people's needs

- The 'you said, we did' scheme evidenced examples where the service was responsive to the needs of people using the service. It was used to review feedback ('you said') and then make changes to the service ('we did') based on this feedback to improve. For example a health visitor morning clinic was moved to the afternoon due to changes to the venue, this was not popular for people using the service and as a result a new venue was sought. Another example was a family requested their community nursing appointment would be best in a clinic rather than at home as this was easier for them, this was arranged and provided with a joint appointment with speech and language therapy.
- There was an agenda item in team meetings to identify any action the team had taken relating to the "you said, we did", meeting minutes documented changes made from feedback. For example in the learning disability team they had extended the time between appointments to allow treatments to be more effective and had devised bespoke social stories for the child or young person.
- There were numerous examples of how different services were flexible to meet the needs of people.
- Services planned to deliver their care and treatment in locations or settings which were suitable for the child and their family. We observed staff asking parents the days and times which would be best for appointments. Children were seen in environments they were familiar with, where they were more settled, which was less disruptive for the child and enabled a more accurate assessment.
- Speech and language therapy services operated under a link model, this ensured the same staff were in the same setting to enable relationships to be built with school and nursery staff and with the children and their families. One parent commented how their child had benefited from the same therapist since the start ensuring continuity with the direct care provided but also the school, home and therapist working consistently together to support the child.
- Speech and language therapy services provided a telephone advice line Monday to Thursday for one hour each day. One parent told us how they had used the advice telephone number and they were given helpful tips on how to communicate with their child. The advice line was used for parents and health visitors and could be used for general advice or to clarify referral processes. The advice line was audited to see who was accessing it and the purpose of the phone call.
- One parent spoke highly of the weekly speech and language local group called 'opportunity group', they

said "it is really really good and opens up access to support". The paediatrician also visited this group every three months enabling parents to access support and request individual appointments with the paediatrician. The child was able to be in a regular familiar setting which is less daunting for them. The parent said "they are really good at signposting" for example they were assisted with accessing a specialist dentist and a continence advisor.

- The integrated therapy model including occupational therapy and physiotherapy was not yet fully developed or delivered within Virgin Care. This was a commissioner led review and the provider was awaiting their leadership in supporting the service model going forward. This impacted on physiotherapy services which had been subcontracted for one year to acute trusts to ensure children and young people were still being cared for and treated. A transfer of physiotherapy services in the north of Wiltshire, to Virgin Care, took place the week of our inspection. Physiotherapy services in the south had not had the transition agreed. Pathways were therefore unable to be implemented in line with recommissioned service and there were inconsistencies with delivery of integrated therapy across Wiltshire.
- The training and development team were commissioned to deliver training to non-registered staff in educational and leisure settings, to support children health care needs. Approximately 900 staff were trained each year. This enabled the team around the child to be knowledgeable and confident to support the needs of the child they cared for.
- There were examples of proactive responses to events or changes within the local population. For example a child death had occurred in the local area as a result of adrenaline not being administered in a timely way. A school nurse then delivered sessions to children in secondary schools to ensure their understanding of their own or their friend's adrenaline delivery equipment.
- Looked after Children (LAC) nurses undertook their own emotional health and wellbeing assessments on children and young people in their care so that there was no over-reliance on the point scoring structure of the strength and difficulties questionnaire process, to provide a more holistic approach to the assessment process.
- The Family Nurse Partnership (FNP) provided additional support to young families (mothers aged 19 years and under) across Wiltshire from pregnancy through to their child reaching age two. The two and a half year programme was structured and required commitment from the young mother or family to meet with the FNP practitioner on a two weekly basis and complete the nationally accredited programme.
- The FNP in Wiltshire had been in place for two and a half years and was only just seeing some of the earliest participants in the programme graduating. The course was pro-active in engaging with those young families to ensure that by education, training and the formulation of positive practitioner/client relationships that there were better outcomes for vulnerable children whose needs might not be otherwise appropriately met.
- A challenge for the LAC team was the increased number of unaccompanied asylum seeker children coming into the area, who required universal blood screening. This was based on the requirement from the Kent dispersal team who had responsibility for the children. There was a recognised need to develop a robust pathway to engage with GPs in the blood screening process and further ensure that a future plan was in place once the screening results were received so that continuing care could be provided and roles and responsibilities clearly defined.
- The LAC health team provided training to foster carers at events held every quarter. In conjunction with partners from child and adolescent mental health and education, training was provided that included; the reasons for certain types of questioning in review health assessments, the child's journey through the care system and the relevance of health to the looked after child. Training events also sometimes took place at weekends to better meet the needs of carers who had other commitments during the working week.

Equality and diversity

- Staff were respectful of family cultural needs and preferences. For example we observed staff removing shoes when entering homes.
- Staff told us they took time to learn about their patients and their family's cultures, religions and beliefs and took steps to understand their needs leading up to and when at end of life. Staff spoke at length with families regarding their wishes and made every effort to ensure they were respected. Part of this process involved discussing any potential issues with coroners to avoid any delays or confusion.

Good

Are services responsive to people's needs?

- In records examined within the looked after children's team we saw due consideration given to children's religious and cultural beliefs. For example, in one case examined we saw how an unaccompanied asylum seeker from Afghanistan's religious beliefs were well documented, including how important their reading of the Koran was to them in their daily life and how this should be recognised by practitioners in their interactions with them.
- Teams were able to access information in different languages and in easy read or other accessible formats if required.
- An ethnic minority achievement service provided by the local council was available for children and families where English was not a first language. The service could be contacted to provide translation services or joint visits could be completed. Additionally, staff had access to a language line for translation services.
- In speech and language therapy services there was a care pathway for bi-lingual children with English as an additional language to ensure these children were appropriately flagged and resources were available for communication.

Meeting the needs of people in vulnerable circumstances

- Pathways were in place for unaccompanied asylum seeking children. The pathway made sure that the child or young person was monitored throughout their time in care. When the Looked After Children (LAC) team saw these children and young people, it was always in the presence of a qualified interpreter. The team ensured the child or young person had been registered with a GP, attended dental and vision assessments and taken part in the accelerated childhood immunisation programme. The team contributed to a study day for health professionals aimed at addressing the needs of unaccompanied children and young people seeking asylum in the UK.
- Staff ensured care and treatment was delivered which was individualised for each child. Staff were made aware of children with additional needs, for example communication difficulties, and made adjustments accordingly.
- The learning disability team had developed social stories were a character that is familiar to the child or young person (such as a favourite TV character) would go through the same treatment.
- Wiltshire Children's services ensured children and young people coming into care had good and timely access to Child and Adolescent Mental Health Services support if they had identified mental health needs. All children aged three years and over on first entering the care system had an assessment of their mental health.
- Health review assessments for the zero to five year age group were undertaken by health visitors. Public health school nurses then undertook reviews of children aged five to ten years with children aged 11 to 18 and those complex cases being undertaken by the LAC health team. We reviewed health assessment notes which were seen to be comprehensive, highlighting physical and dental health, emotional and behavioural development, any issues whilst in their current placement, and any developmental or educational concerns. The resultant health care plans were also seen to be detailed and clearly articulated the child's voice and goals in life and how those goals needed to be met.

Access to the right care at the right time

- The community paediatrics team had inherited a long waiting list from previous providers, this significant backlog was unanticipated when transferring the service. Many children and young people on the transfer were over 18 week beaches and some were over 52 week breaches. Plans were put in place to address the issue and the waiting list dramatically decreased from 1600 to 700 children and young people with no 52 week waiters. Between September 2016 and February 2017, there was an average wait of 11.1 weeks for first appointment. An average of 93% of patients, per month, were seen within 18 weeks referral to treatment time.
- The occupational therapy team saw on average 68.7% per month of patients within 18 weeks of referral time between September 2016 and February 2017. At the time of our inspection the occupational therapy in the North of Wiltshire were achieving their referral to treatment targets with no breaches. However, in the South of Wiltshire there were 27 children or young people over the 18 week referral to treatment target resulting from inherited waiting lists from a previous provider. We were told recent recruitment had ensured the team in the South was fully staffed and they were implementing a triage system to address any outstanding children to manage the waiting lists.
- The physiotherapy service was meeting 18 week referral to treatment targets through a service level agreement.

Good

Are services responsive to people's needs?

- For speech and language therapy services the average time to first appointment between September 2016 and February 2017 was 8.5 weeks. The average per month referral to treatment time achieving less than 18 weeks was 99%. Speech and language therapy services had an internal target of eight weeks referral to treatment time. Staff kept a close eye on breaches.
- Speech and language therapy services were currently reviewing their reporting of referral to treatment times. In March 2017 45 children or young people had breached 18 weeks, however it was identified only eight were genuine breaches the remaining were data errors due to changes in systems which staff were not familiar with. There was potential these eight genuine breaches were also due to data errors.
- In the learning disability team the maximum wait from referral to first visit was six weeks. The teams target was to have seen all referrals within 13 weeks, which they achieved. The team was flexible with appointments and would make appointments outside the operational hours of 9am to 5pm. They usually visited families at home and at educational or other day placements. If a child or young person or parent/carer did not attend an appointment, they would make three more appointments before discharging the child or young person. Staff told us that they always consider the safety of the family if they missed appointments and consider safeguarding referrals. Staff told us they would only cancel appointments when necessary and would reschedule at that time. They would advise the child or young person and parent/carer if the appointment was going to run over time. Parents/carers we spoke with confirmed this.
- The percentage of appointments or contacts where the patient did not attend (DNA) including home visits was monitored. This was particularly higher for children's community paediatrics with an average of 9% DNAs per month between September 2016 and February 2017. In the same period physiotherapy saw an average of 9% DNAs.
- In therapy services children who did not attend appointment were provided with a second appointment, if they consistently did not attend appointments health visitors or GP's were contacted to follow up with the family.
- We spoke to two parents who told us they did not have any problems with accessing therapy services to include speech and language therapy, occupational therapy and physiotherapy. They had relevant contact details should they need advice.
- We received feedback from parents about the lack of paediatricians in the service and difficulties and delays in accessing the paediatric appointments, however it was commented by some parents how this had since improved and despite initial problems when the service moved to Virgin Care they could now access paediatricians via emails and telephone calls. One parent shared concerns about going to great lengths to arrange an attention deficit hyperactivity disorder (ADHD) clinic appointment and the difficulties they had to contact someone from Virgin Care via telephone.
- Parents also fed back, with respect across a number of the children's services their difficulties in contacting the service via telephone.
- The recent Wiltshire child and adolescent mental health transformation programme has established dedicated child and adolescent mental health LAC support to those looked after children who required mental or emotional health assessment or support. This meant that those vulnerable children and young people received appropriate assessment and support in a timely way.

Learning from complaints and concerns

- Staff told us they would encourage families to complain if they expressed any concerns and would support them with the process. An 'how to complain' leaflet could be provided to families.
- Learning from complaints was fed back in the team meeting and via individual supervision if required. We saw that there was an agenda item in the team meeting to address learning from complaints.
- There were eight complaints received between April and December 2016. Three for community paediatrics, three for health visitors across three different teams, one for speech and language therapy and one for occupational therapy. The provider recognised learning from these complaints. For example a complainant was unhappy about information being shared with other professionals, as a result a consent form was implemented to ensure parents or guardians and young people, where Fraser competent, signed to agree who they consented to appointment letters being sent to.

Good

Are services responsive to people's needs?

- There were 40 concerns received between April and December 2016, of which 31 were with regards to the paediatric service for poor communication and waiting times (a concern is any verbal expression of dissatisfaction and does not require the same formal process as a complaint). Customers were unable to get through to the central number for community paediatrics because it was engaged; there were also queries with regards to transfer of patients caseloads since the new contract and confusion over how to access the service. The provider reviewed these concerns, they reviewed the telephone line and ensured the central number was free to take queries and outgoing calls were made on mobile telephones. They sent letters to all children who had been transferred to Virgin Care. Plans were in place for further advertisement.
- The continuing care team provided an example of a complaint received about community support workers turning up at the wrong house, as a result a text system had been implemented sending the initials of the child to each community support worker to ensure they were at the correct location on their shift.

Good

Are services well-led?

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

Summary

We rated well-led as good, because:

- Staff spoke positively about local management and leadership.
- There was evidence of the vision across the different services.
- There was a robust process in place to identify and manage risks at a service and business unit level. Risks were being regularly reviewed and mitigated.
- Teams linked in to the provider's governance systems and discussed key performance indicators in team meetings.
- Staff turnover was low and retention was good.
- Staff said they received regular communication locally and corporately from Virgin Care and felt well informed.

However:

- The lone working processes were not always well embedded to ensure risks were managed across all services. There was a lack of personal safety devices or safe word usage to promote staff safety.
- Policies were still being aligned between the five organisations that joined together under one Virgin Care contract.
- There were challenges with the current estates and information technology availability.

Detailed findings

Leadership of this service

- Overall, the head of operations provided leadership, with service lead managers responsible for each service line. Service leads felt well supported by the head of operations.
- There were effective governance arrangements. Information was regularly monitored to provide a holistic understanding of performance, including safety, quality and patient experience.
- Staff were positive about local management and said they were visible, approachable and accessible. Staff felt valued and supported.
- The executive team were visible and proactive and staff at all levels saw this.
- The local leadership team we found to be coherent and well versed on the services challenges and risks.
- A local review of leadership had been undertaken to ensure right staff, right skills, and right place since taking on additional local regional contracts.
- Staff reported that there was opportunity to get training in leadership. Virgin provided its own course, accredited with the institute of leadership and management.

Service vision and strategy

- There was evidence of the vision across the different services, which were included within service provision documents.
- The five year road map set out the vision for Wiltshire children's service. This was displayed in staff areas. Staff said they were kept informed of upcoming changes within the road map.
- The provider recognised challenges they faced with their current estates, the plan for the development of the hubs would enable the redesign of services and allow improvements to information technology. The hubs would be main clinics located at strategic locations across the county. Some staff were anxious about this move and felt unprepared, whilst other staff felt this would be a positive change.
- Staff we spoke with were aware of the corporate values and said they were linked to their personal development reviews and appraisals. We reviewed three appraisals and saw that the clinical lead reviewed staff member's performance against the provider's values.
- The integrated therapy team's vision was to provide an integrated therapy service to enable sharing of knowledge and understanding between physiotherapists and occupational therapists ensuring the most appropriate therapist working with the child at the right time. This was currently not in place with subcontracted work for physiotherapists and processes between the North and South occupational therapists not yet aligned. The service manager told us they were not as far ahead as they would like due to staffing issues and estates uncertainty. There was also a vision to create therapy assistant posts to improve the skill mix within the team.

Good

Are services well-led?

- Speech and language therapists worked as a training and collaborative move, skilling up the team around the child. Their vision moving forward was to use more innovation and different ways of working.

Governance, risk management and quality measurement

- The organisation were still embedding the governance process and aligning policies from the five joining organisations, some policies were awaiting approval.
- Governance was arranged at a business unit level and fed up nationally to the Virgin Care Board and back down to the business unit. Service level team meetings were held regularly and fed into the Wiltshire Children's Senior Management Business Meeting which was held monthly and reported to Virgin Care Executives, Virgin Care Clinical Governance Committee and subsequently the Virgin Care Board.
- The Quality, Care Effectiveness and Safeguarding Committee, held monthly, was chaired by the head of operations and attended by service managers, quality assurance manager or their deputy, and the named nurse for safeguarding children or their deputy. The committee was accountable to Virgin Care Clinical Governance Committees.
- A local business unit infection control and medicines management meeting was held which fed in to the Quality, Care Effectiveness and Safeguarding Committee. The head of operations also attended the Wiltshire Safeguarding Children's Board.
- Teams fed into the provider governance system by providing information on agreed key performance indicators. For example, time to first appointment, discharges, face to face and non-face to face contacts. Teams received feedback relating to the governance system in their team meetings and developed actions to address any issues.
- There was a robust process in place to identify and manage risks at a service and business unit level. Service level risk registers and an overall business unit risk register were maintained. Identified risks were proposed by senior managers or escalated if risk rated above 12 at service level; risks were presented to the Quality Care Effectiveness and Safeguarding Committee for approval and were regularly reviewed within this committee. Approved risks were added to the business unit risk register. Senior managers took ownership of risks and reviewed and updated monthly.
- We reviewed service level risk registers and it was evident risks were being regularly reviewed and mitigated. However, the paediatric service, looked after children, school nurses and therapies risk registers did not have clear ownership or review dates.
- The business unit risk register included seven management risks and one concern, these risks were reviewed monthly. The concern was with regards to the premises used at a local acute trust and the impact on health and safety compliance, staff morale and information governance requirements. An estates strategy and plan was in place with commissioners to address this.
- The quality dashboard was shared at senior management team meeting to allow management to review performance.
- Representation was provided from each service at the quality care effectiveness and safeguarding committee and senior management team meetings.
- Staff felt information was cascaded up and down through the governance structure. At service level, team meetings were held and staff felt well informed at these meetings and were able to bring ideas and share learning.
- Internal service reviews were completed to look at the quality of service provisions, this was started in December 2016 and the process was being embedded across the business unit. We reviewed examples of completed reviews and subsequent action plans; there was an aim to review in six months. Staff were enthusiastic about this process and it allowed areas of improvement to be identified.
- Quality assurance of looked after child processes across Wiltshire was good. We examined recent audits of initial health assessments, review health assessments and health action plans. The process included ensuring that the voice of the child or, where younger children were concerned, the child's lived experience were evident in the files and further that ensuing health action plans were SMART. Where it was considered that further development was required then individual practitioners would be contacted so that those developmental areas could be addressed.

Good

Are services well-led?

Culture within this service

- Staff said there was an open and supportive culture within teams. Staff knew how to access the whistle blowing policy and felt that they could use it without fear of victimisation.
- Staff reported feeling positive about work. They were passionate about their roles and the ability to engage with children and make a difference. They felt their individual teams were supportive and enjoyed their work environment. However, some staff felt that the caseloads were getting large and this may affect team morale.
- Staff turnover between April and December 2016 remained low, at 1% at the end of December 2016. The Virgin Care target for sickness was 4% and Wiltshire was running at 3% sickness absence at the end of December 2016.
- Managers said therapists were resilient and dedicated and worked hard for children and their families, going over and above to provide care and treatment with children and their families coming first.
- Lone working procedures were not consistently implemented across different services. It was difficult to ascertain how lone working risks were being managed in all areas. Staff were all aware of the requirement to accurately maintain their electronic calendars so colleagues knew where they were, although management did comment on how staff sometimes needed reminding of this. Systems to call and confirm arrival or departure when lone working was in place in some teams. However, other teams these were not prevalent. Within the continuing care team it was reliant on the parents escalating to the on-call telephone number if a staff member did not arrive.
- Staff were not always aware of a safe word to use should they have trouble and need to discretely call for help. There were no personal safety devices used to initiate a response if a lone worker felt they were at risk. The organisation told us they were looking to implement a mobile system across different teams whereby staff location could be tracked. During our inspection a senior management team meeting was held, we were told at this meeting code words were discussed and a code word had been decided and was being disseminated to staff.
- The learning disability team had lone working procedures in place to keep staff safe. This included each member of staff having a buddy who would check they had returned from a visit and contact them if they had not. Staff were expected to call an out of hours number if they had a visit outside of regular working hours. The service could also use an app to track staff members work smart phones. We saw minutes to team meetings, which showed the team discussed lone working and the clinical lead reminded staff of the protocols.
- Staff said Virgin Care Services were good at publicising and promoting successful work by staff and teams which was positive for personal achievement and team morale.
- All senior managers consistently and openly told us how motivated and energised they felt since working for Virgin Care Services as the new provider. A lot of emphasis was placed on this and how they felt listened to and valued. Staff reported good support was on hand from the corporate team and other regional Virgin teams. They told us this was reflected in the views of staff.
- Staff told us there was a no blame culture and incidents were seen as an opportunity to learn. Staff felt comfortable and confident in reporting them.
- Management spoke highly about how well their teams worked together and were incredibly proud of the culture and the support that had been established since the start of the contract in 2016.

Public engagement

- Patients and the public were engaged and involved. Their views were captured and acted upon to shape and improve the service.
- The friends and family test was used to capture feedback from people who used the service. The provider aimed to improve services through the use of feedback comments and displayed these via 'you said we did' notices, and shared the learning within team meetings. The provider could evidence changes made as a result of feedback left by people who used the service. For example one parent called a community children's nurse to inform them that during a stay in a hospice they had found a manual handling system that worked much better for the child. The community children's nurse made contact with a representative of the product and this was available to order and had been ordered for the patient.

Good

Are services well-led?

- Services were using the 'you said, we did' process whereby feedback was obtained from parents, carers or children and young people and changes made. For example the speech and language therapy services displayed in clinic rooms the 'you said, you wanted to know how to help your children at home' and 'we did, we have put our videos on our website'. These supported speech and language needs.
- The provider recognised the importance of the voice of the child, young person and families to inform the way services were designed and assess the care being provided. There was a Wiltshire children, young people and family's engagement plan for 2016/17. This set out engaging with partnership organisations and attendance at meetings enabling comments and information regarding the services being provided to be gathered.
- Wiltshire Children's Community services was an active member of the group planning a Wiltshire Youth Summit which aimed to bring young people across the county together and inspire and motivate them to become involved in voicing their views as users or potential users of healthcare services.
- The family nurse partnership service obtained feedback through service user satisfaction surveys and through focus groups.
- Good links had been established between paediatricians and the Wiltshire parent carers association. The group actively engaged with paediatricians in a pro-active way to highlight early where issues might arise pertaining to the care of looked after children. For example, practitioners we spoke with told us that there were no real issues with regard to children transitioning into adult services who needed to take equipment as provided by children's services into the equivalent adult service.
- The service was aiming to launch the national programme "CHAT health" in Wiltshire in 2017; this allowed young people to confidentially text to ask for help about a variety of issues or to book an appointment with a school nurse.
- There was recognition of the need to allow 'hard to reach' groups to access services, and work was being done with partnership organisations to ensure these children young people and families could be engaged.
- The family nurse partnership service engaged well with their client group by obtaining feedback and suggestions for service design. Clients were invited to take part in regular meetings with practitioners and managers and also to complete family and friends feedback cards and 'how's it going between us' feedback. This ensured that services continued to be developed in a way that best suited the needs of service users.

Staff engagement

- A bi-annual survey 'have your say' was run and included the friends and family test question required by NHS England. A survey was completed in Wiltshire in May 2016 and all staff were asked to participate. Actions were identified as a result of these surveys.
- The Wiltshire Partnership Forum was used to provide a local consultative mechanism to discuss and address local issues and encourage employee participation and engagement. The terms of reference identified meetings to be scheduled six times per year. We reviewed meeting minutes from December 2016 and January 2017. December 2016 saw attendance from the head of operations as the chair, the head of workforce and six staff, of which one was a service level manager. In January 2017 there was attendance from the head of operations as chair and seven staff. From review of meeting minutes the Wiltshire Partnership Forum appeared well structured discussing people and service updates and understanding any challenges front line staff were experiencing or any gaps in information being cascaded to staff. Actions points were identified and revisited at subsequent meetings.
- Staff said they received regular communication from Virgin Care and felt well informed. For example they received newsletters and had access to the staff intranet.
- A number of staff commented how they appreciated compliments being fed back to them.
- Staff in the speech and language therapy teams told us they were always listened to, a list was maintained which staff were able to add to of suggestions for innovation or improvements to the service. They felt their ideas were taken on board and changes made. For example they were looking at a process of acknowledging referrals which staff had raised as an area for improvement.

Innovation, improvement and sustainability

- The 'Wiltshire Splitz support service' is a registered charity delivering support services to women and young

people experiencing the trauma of domestic abuse. Health visitors would, with appropriate consent, refer mothers to the service for additional advice and support as well as making appropriate referrals to the Multi Agency Risk Assessment Conference (MARAC) where domestic abuse was identified.

- Virgin Care Services utilised the You Said, We Did methodology for all theirservices every month. This was used proactively to improve care. Some examples of how feedback from children, young people and their families influenced their services in Quarter 3 were as follows

"You said" Parents requested information on managing sleep for children and young people with learning difficulties at the Wiltshire Parents Carers Council Event on 13th October.

"We did" The team used Sleep Scotland materials to provide an informative presentation to 20 parents on managing sleep. Excellent feedback received.

- The service were working with representatives from Wiltshire council to engage the parents of children who were being educated at home or outside of Wiltshire County Council area, to ensure they had knowledge of Virgin Care services and ensured they could access health services. Wiltshire Children's Community service were currently working with external partners on ensuring leaflets about information sharing and consent were clear and to explain why certain information, such as compliance with the accessible information standards is collected. From feedback received from families, this was a particular issue for some ethnic minority families.