WM QRS West Midlands Quality Review Service

NHS

Community Paediatric Services Peer Review Visit

Coventry and Warwickshire Partnership NHS Trust

Visit Date: 27th September 2018 Report Date: January 2019

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UKAS INSPECTION 8831

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INTRODUCTION

This report presents the findings of the review of Community Paediatric services at Coventry and Warwickshire Partnership NHS Trust that took place on the 27th September 2018. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- Community Child Health Services D3
  [Note: These were draft standards and had not been used previously in a WMQRS peer review**]**

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care which can be used as part of an organisations' Annual Governance Statement. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Any immediate risks identified will include the Trust and WMQRS response to any actions taken to mitigate against the risk. **Appendix 1** lists the visiting team that reviewed the service. **Appendix 2** contains the details of compliance with each of the standards and the percentage of standards met.

This report describes services provided or commissioned by the following organisations:

- Coventry and Warwickshire Partnership NHS Trust
- NHS Coventry and Rugby Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is NHS Coventry and Rugby Clinical Commissioning Group.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is a collaborative venture between NHS organisations to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of Coventry and Warwickshire Partnership NHS Trust for their hard work in preparing for the review and for their patience, kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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BACKGROUND

West Midlands Quality Review Service (WMQRS) was asked by NHS Coventry and Rugby CCG to undertake a review of Community Paediatric services provided by Coventry and Warwickshire Partnership NHS Trust (CWPT). The main purpose of the review was to understand the services that are provided, working arrangements with key stakeholders and to understand whether there were any gaps or duplication in service provision.

It was agreed that the WMQRS Community Child Health Services Quality Standards would be used for the review. It was the first time this particular set of standards had been used and it was agreed with the CCG and the Trust that any learning from the review would feed into the further development of the standards which would then be sent out by WMQRS for regional consultation. It is for this reason that they were still labelled as draft.

The CWPT Community Paediatrics team provided specialist care for Children and Young People. They also carried out a range of duties in relation to child protection (including referrals for assessment of injury related to alleged physical abuse or neglect, clinical input to the Paediatric Sexual Assault Service (PSAS) and advice to the Multi-Agency Safeguarding Hub (MASH)), medical advice for special educational needs, and health assessments of children in care. The role of the paediatrician involves prevention, identification, assessment, diagnosis, treatment and support. The Community Paediatricians at CWPT worked as part of a multi-disciplinary team with many other health professionals including working with other Specialist Community Clinicians, such as Community Children's nursing, Child & Adolescent Mental Health Services (CAMHS), Physiotherapists, Occupational Therapists and Speech and Language Therapists.

The team see Children and Young people aged 0-16 years of age. In addition, certain groups of young people may also be referred to the service up to 18 years of age, including:

- Children with special educational needs;
- Looked After Children (LAC);
- Children referred for an assessment of alleged Non-Accidental Injury (NAI);
- Children referred for assessment of Neurodevelopmental Disorders;
- Head injury/rehabilitation.

Young people who have a learning disability may be referred to the service up to 19 years of age.

Referrals to the team were accepted from GPs, Health Visitors, School Nurses, Allied Health Professionals, Paediatricians, CAMHS, other health professionals, social care and education, where appropriate.

The medical element of the service is provided by a team of Consultant Community Paediatricians, Specialty and Associate Specialist (SAS) doctors and Paediatric trainees. CWPT is also a teaching Trust and medical students are often present in clinics.

CWPT Community Paediatricians work with GPs and within the wider health network of therapists, nurses and mental health services. They also work with Education, Social Care and Public health services provided by the Local Authority and the voluntary sector.

The team provides services for Children and Young People with Neurodevelopmental Conditions including:

- Assessment and interventions for children with autism, Attention Deficit Hyperactivity Disorder (ADHD), Tourette's and Dyspraxia in partnership with the multi-disciplinary Neurodevelopmental team and CAMHS;
- Medical assessments for children who may have special educational needs and the health component of statutory assessments of educational special needs.

Services for Children and Young People with other developmental conditions:

- Physical disability such as cerebral palsy and co-existent learning disability and associated co-morbidities;
- Acquired brain injury and associated co-morbidities;
- Neurodegenerative and neuromuscular disorders and associated co-morbidities;

- Global developmental delay or developmental delay in specific areas;
- Less complex developmental disorders;
- Progressive conditions and associated co-morbidities;
- Inherited/genetic conditions including Neurofibromatosis and associated co-morbidities.

Services for Children and Young People with other conditions

- General community paediatric assessment and diagnosis of children identified as in need of the service including children with non-acute physical health difficulties
- Specialist paediatric assessment and support to the continence service
- Health promotion activities
- Contribute to multidisciplinary and multiagency networks that are involved in screening programmes
- Support to immunisation services
- Assessment, diagnosis, treatment and management of long-term medical conditions that cannot currently be cured but can be controlled with the use of medication and other therapies, such as epilepsy and general neurology
- Medical advice for the assessment and management of children with emotional and behavioural difficulties and neurodevelopmental difficulties
- Palliative care services in partnership with the Community Children's Nursing Service and the Lead Paediatrician for Palliative Care for Coventry and Warwickshire
- Training to students, medical staff and other health professionals

Services for vulnerable children and families

- Initial Health Assessments of children taken into the care of the Local Authority
- Medical assessments for children who have a plan for adoption and adults who seek to adopt
- Advice on health concerns related to safeguarding, adoption and fostering
- Assessment, and support for children from marginalised groups such as asylum seekers and refugees
- Safeguarding medical assessments (physical abuse and neglect)
- Assessments for Child Sexual abuse (forensic and historic)

Reviewers heard that Coventry is noted to be one of the fastest growing cities in the UK. According to the '*End Child Poverty Coalition*[1]'there were an estimated 32.8% of children in poverty after housing costs and in two electoral wards, more than half of the children live in poverty. The most recent census (2011) showed that 39% of children were from BME backgrounds – which is higher than the national average in England. Historically, Coventry has a higher than average rate of children who are in Looked After Care.

It is against this background that the Community Paediatric team provide services.

[1] **End Child Poverty Coalition** - **End Child Poverty coalition** was set up in 2001 by a group of UK children's charities, social justice groups, faith-groups, trade unions and others concerned about what they considered the unacceptably high levels of child poverty in the UK. It was established as a charity in 2003 with a single goal - to eradicate child poverty in the United Kingdom. In 2010 it was removed from the Charity Commission's register,[1] and it is now hosted by the Child Poverty Action Group

PLEASE NOTE:

1. There were significant issues with the number of reviewers who were actually available to attend on the day of the review. Eight reviewers were booked for this review. However, one withdrew the week before, one withdrew two days before, two the day before and one on the morning of the review. This meant that only 3 reviewers (plus 2 WMQRS representatives) were there on the day of the review. The issues were discussed with the Coventry and Warwickshire Partnership NHS Trust team, and a decision was taken that the review should go ahead with the resources available and a revised timetable, along with provision for a member of the review team to make necessary phone calls.

   A further evidence review therefore took place on the 9th October to ensure that a thorough review of the evidence presented had been completed. In addition, some further discussions with key stakeholders took place on the telephone after the review day.

2. In addition, there was some confusion on the day of the review regarding the scope of the review. The initial request from Coventry and Rugby CCG was for a review of Community Paediatrics. However, the Quality Standards used (as agreed with the CCG and Coventry & Warwickshire Partnership Trust) were Child Health standards which inevitably focussed on some broader aspects of the community child health service.

   The report reflects the findings of the review team, based on the confirmed and now shared understanding that this was a review of Community Paediatrics and not the wider community child health services.

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General Comments and Achievements

The Community Paediatric team prepared for the review extremely well and showed a high level of commitment to the review process. Specifically, the Background Information report and Self-Assessment provided was extremely comprehensive. In addition, the team invited a wide range of people from their multi-agency partners to meet with and talk to reviewers during and after the review in order to share their own views on the services provided.

The review team was impressed with the honesty of the CWPT team, who were very open in their interactions with the review team. They demonstrated a high level of respect for each other and were clearly committed and passionate about providing the best possible care for their patients. This commitment puts the team in a strong position to take on board the feedback and recommendations from this review to further improve patient experience and outcomes.

Specifically, the review team heard that the Community Paediatric team worked well with a range of internal and external partners, that they were able to offer more appointments than recommended for their population based on the 'Covering all Bases'[2] model. In addition, they were providing Initial Health Assessments for Looked After Children within 13 days of notification of coming into care for more than 95% of children - which is well above the national average.

Good Practice

The review team identified the following areas of good practice:

1. Reviewers saw that there was an effective epilepsy pathway in place. This service had good integration with the acute Trust and was delivering short waiting times and timely interventions for patients.
2. The review team were shown a YouTube video that had been developed for patients and their parents & carers. The video introduced the service to patients and told them in advance of what to expect from their clinic visit. This was seen as a good example of improving the patient experience – particularly for children and their parents & carers who may have been anxious about attending an appointment.
3. Reviewers heard that the Community Paediatric team had good working relationships with colleagues at the main acute Trust – University Hospitals Coventry and Warwickshire NHS Trust (UHCW). Reviewers heard from representatives at the acute Trust that community paediatricians were accessible to acute paediatricians who also described the joint clinics and joint guidelines that had been developed between the two teams.
4. Reviewers felt that the facilities at the City of Coventry Health Centre, where the main clinics are located, were impressive. The clinic area was modern, bright and airy and provided a positive and welcoming environment for patients and their families. Reviewers met a Health Care Assistant who completed pre-clinic checks for children (measuring weight and height etc), in a room equipped with toys. This was seen as an important stage to provide a relaxing environment for children whilst they waited for their appointment. There was a well-equipped gym area for physiotherapy and a room equipped with video equipment for undertaking interviews.
5. Reviewers heard of a number of joint clinics which had been established between the Community Paediatric team and other specialisms including: physiotherapists; Trauma & Orthopaedics (with a surgeon from University Hospitals Coventry & Warwickshire); Neurology clinics with Birmingham Children's Hospital and a neurology transitional clinic. They also hold joint clinics with the regional genetics service. These were felt to be good examples of joint working and examples of improving the patient experience in terms of seamless care.

[2] **Covering all Bases** – Royal College of Paediatrics and Child Health - September 2017 is a suite of documents providing an evidence-based toolkit for planning the paediatric element of modern community child health (CCH) services, including public health and statutory services for safeguarding; child death reviews and the care of looked after children and those with special educational needs or disabilities.

6. The Community Paediatric team was co-located with child and family health services and other community services at the Paybody building in Coventry. Reviewers heard that having the teams in the same building helped to improve communication between teams which was positive for improving patient pathways.
7. Reviewers heard that the Community Paediatric team operated a flexible approach in their appointments. Patients were offered appointment times and lengths to meet patient need. Specifically, reviewers heard that phone consultations were also being offered to some patients which was seen as a good initiative for improving access by patients to clinical staff.
8. Reviewers saw and heard from the Safeguarding and Looked after Children teams about a training and competency framework for nursing staff which was also identified by reviewers as an example of good practice.
9. Reviewers were impressed with the quality framework for Looked after Children which provided a comprehensive set of KPIs for monitoring the service and the outcomes being delivered.
10. The review team heard from the CAMHS and Learning Disability teams regarding the positive mentoring and supervision that the Community Paediatricians provide to medical trainees in these other specialties.
11. Reviewers were impressed with the health assessment for Unaccompanied Asylum Seekers. This was seen as very comprehensive and a good example ensuring that the health needs of this patient group can be identified, and appropriate interventions implemented.

Immediate Risks

No immediate risks were identified by the review team

Concerns

1. **Service specification**

   Reviewers were concerned that the Community Paediatric service specification had not been reviewed since it was published in 2010. In the intervening period, the population of Coventry had increased considerably as had the underlying demographics of disease. In addition, new national guidance, including the Royal College of Paediatrics and Child Health 'Covering all Bases' and 'Facing the Future3'had been produced. The service specification therefore needs to be reviewed urgently to ensure that the services that are being commissioned and provided reflect national best practice and the needs of the population of Coventry.

2. **Feedback from service users**

   Reviewers saw that there was some feedback from patients and their parents & carers specifically regarding the Community Paediatric service (as separate from the other CWPT Community Child Health Services) including Friends and Family Test. Reviewers also heard that some patients and their parents & carers had been involved in the interview process for the consultant paediatricians. However, reviewers felt that more could be done, and this was evident in the discussions that reviewers had with parents & carers during the review who expressed that this was the first time they had been asked about their experience of the service. It is important that the service consider the views and experience of patients, parents & carers in order to shape its future design and ensure that it meets the needs of its population.

[3] **Royal College of Paediatrics and Child Health: Facing the Future** (originally published in 2015 now updated in 2018): Standards for children with ongoing health needs provides a vision of how paediatric care can be delivered to provide a high-quality service that meets the needs of infants, children and young people with ongoing health needs.

3. **Clinical Letter delays**

Reviewers saw clinical letters that had been completed months after the clinic had taken place. They also heard from parents & carers that there was a significant delay between the clinic appointment and receiving a letter to confirm next steps. This was a concern for reviewers as this was impacting upon the patient experience and potentially causing a delay in their treatment pathway. The review team heard that there were some issues with administration and clerical support for Community Paediatricians and felt that this should be reviewed to ensure that letters were written and communicated in a timelier way and that Community Paediatrician time was being used more effectively.

4. **Team Vacancies**

Reviewers noted that there were a number of vacancies within the Community Paediatric team. They also heard that, as a consequence, the existing team were routinely working in excess of their contracted hours to deliver services. Reviewers were concerned that, against the backdrop of changes to the local demographics which is significantly impacting upon demand, that this is not sustainable. The level of vacancies and use of locums is putting pressure on the existing team and means that some members of staff are having to cover more than one statutory role.

5. **Documentation Control**

The evidence seen by reviewers showed that whilst team policies were clearly in the Trust standard format, other documentation was not following a document control structure; the reviewers were uncertain that all documents they saw formed part of a coordinated approach to healthcare. Many documents were out of date and some significantly (2011). This may be as a result of pressures on the team identified above. However, it is important from a safety and quality perspective that documents are dated so that staff are following the latest national guidance and best practice.

6. **Lack of robust guidelines**

Reviewers saw a number of clinical pathways in the form of flowcharts. However, they were not supported by evidence of robust guidelines specific to CWPT Community Paediatrics that provided additional information regarding how the pathway was developed, roles and responsibilities of key individuals, monitoring and review. Some of the pathway flow charts offered represented the Paediatric component of a wider MDT pathway but the wider MDT pathway was not provided. The review team were advised that clinical guidelines as far as possible were aligned with those of the local acute hospital and were available for reference on the Acute Trust website. Robust guidelines, which reflect the local context and are explicit to CWPT, should be available in order to ensure that best practice is being followed and that staff are clear about their own roles and responsibilities as well as their routes of escalation.

7. **Autism Spectrum Disorder assessments – long waits**

Reviewers noted that referral rates for Autism Spectrum Disorders (ASD) are high and that the waiting list continues to rise. This was also highlighted by parents who the review team met. This maybe as a result of the team vacancies highlighted above. Reviewers were advised that the ASD waiting list is reviewed with commissioners on a regular basis. However, the provider and commissioners should continue to work together to ensure that this pathway is reviewed to identify improvements for patients and their families.

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FURTHER CONSIDERATION

1. Reviewers heard from colleagues at CWPT, UHCW and others that the Community Paediatricians were very accessible in and out of hours although the Trust is not commissioned to provide an out of hours community paediatric service. However, these arrangements appeared to be informal between colleagues. Consideration should be given to ensuring that these arrangements are formalised which may help relieve the current pressures on the existing team.

2. Reviewers heard that the team did ask for patient feedback, however, this was limited to Friends and Family Test, 360-degree feedback for appraisal and Paediatric Sexual Assault Service (PSAS) feedback. The parents & carers who the review team met with did not feel that they had been asked for detailed feedback. The team would benefit from obtaining detailed and regular feedback from patients and their parents & carers to shape the future design of services. The Community Paediatric team did confirm that an action plan to address this had been developed. The team may wish to consider seeking support from colleagues in the Trust to ensure that efficient and effective ways of capturing user experience are employed.

3. Reviewers were unsure as to whether issues raised (complaints and concerns or otherwise) that were resolved locally were captured in the data discussed at the Safety and Quality group. This should be included to ensure that a comprehensive picture of feedback is available on which to make service decisions.

4. Reviewers heard from some parents & carers that they did not feel their own needs and well-being were being considered and that support for their personal needs was not offered. Parents & carers felt that the support that they were benefitting from had been achieved through looking at what was available and relationships that they had made themselves. The team should consider whether there is anything more that they can do to ensure that the needs of parents & carers are being recognised and met.

5. Reviewers saw that there was a range of patient information available for patients and parents & carers. However, the parents & carers that the review team spoke to said that they were not aware of the information. This may be perception or may be dependent upon the particular pathway that there were on. Consideration should be given to reminding staff that the information is there and should be proactively shared with patients and their parents & carers.

6. Reviewers heard from staff that access to interpreters was not always timely and suggest that consideration should be given to reviewing whether this aspect of patient experience could be improved.

7. Reviewers heard that the Universal Services (including Health Visiting and School Nursing) had been transferred to another provider – South Warwickshire NHS Trust. It is important that the impact of this is fully considered and understood so that services can be integrated and that the full range of patient interventions is communicated and understood across all relevant teams.

8. The review team saw that there was process in place for regular multi-disciplinary Quality and Safety meetings where complaints and incidents were reviewed. However, there was no evidence as to how practice and service delivery had changed as a result of this feedback. Consideration should be given to ensuring that learning opportunities are identified locally by the Community Paediatrics team, in line with the Trust policy, and communicated to the wider team.

9. Reviewers saw a telephone audit which demonstrated very fast response times from Community Paediatricians to patient calls. However, reviewers felt that consideration could be given as to whether other members of the multi-disciplinary team could respond to some of these calls in order to ensure that the Community Paediatricians time could be used more appropriately.

10. The review team heard that the child and family health team was undergoing a restructure. The senior team did confirm that the intention of this restructure is to provide clearer and more integrated pathways for patients. However, consideration should be given as to how this was being communicated and implemented as staff who

the review team met with did express concerns about the impact of the restructure and the potential to destabilise some of the good working relationships that had been established to date.

11. Reviewers saw that the use of the Health Care Assistant, in a child friendly environment, to undertake pre-clinic checks was good practice. (see earlier section on Good Practice). However, they also heard from parents & carers that although this worked well in terms of settling the child before their appointment with the paediatrician, they were then asked to go back into the general waiting area, (where there were not as many play resources available) to wait for the appointment. This then caused disruption to their children, in some cases, as they were taken out of the play environment. The team should consider and liaise with appropriate support services as to whether more can be done to ensure that the timing of the pre-clinic checks are streamlined to minimise disruption to children.

In addition, whilst recognising that this review was a review of the Community Paediatric service at Coventry & Warwickshire Partnership NHS Trust, reviewers noted that there appeared to be a lack of integration between the wider Multi-disciplinary Team (MDT) and a lack of harmonisation across all professions within the MDT. This conclusion was based on the following observations:

1. Although reviewers were able to meet with other members of the wider MDT as part of this review, they did not hear of sufficient examples of extended roles for other professional staff (for example Advanced Nurse Practitioner equivalent roles) which they felt would indicate that a truly integrated pathway model was in place. Some examples given included: the epilepsy specialist nurse who took part in joint clinics, joint school review, joint review at UHCW, and individual working with patients with later supervision from Consultant Paediatric staff; The ASD pathway which demonstrated joint working with Speech and Language Therapists for assessment and MDT discussion of cases and allocation on a weekly basis; the spasticity clinic/CPIP MDT clinic which included clinics with Physiotherapists and Orthopaedic surgeons to assess patients with spasticity that is also followed by an MDT discussion and joint MDT clinic letter.

2. Reviewers also heard from staff in the Trust and some external partners, that although more clinical work was being devolved to nurses and AHPs and that direct contact with patients and their families was increasing, there was still 'more that could be done' to ensure that a more integrated model of care was embedded. Specifically, reviewers heard from the Safeguarding and Looked After Children teams of some excellent work that they were undertaking in terms of service development, however this appeared to be being developed in isolation from the Community Paediatricians, and reviewers therefore did not feel that it was being jointly developed and owned.

3. Reviewers also heard from some staff that they had limited access to the Community Paediatricians – apart from when they were working in joint clinics with them. Community Paediatricians recognised that other staff may not have as much access as they would wish due to capacity and demand issues, but that Paediatricians gave as much time as they could to addressing ad-hoc queries either face to face or via telephone or email.

4. Reviewers heard from parents & carers and from some external stakeholders of examples of good 1:1 relationships with named consultants on the team. Whilst this was seen to be valued by those individuals concerned, reviewers felt that in a more integrated multi-disciplinary model, relationships could also be with the wider professional team. This would in turn relieve some of the demand pressures currently being experienced by the Community Paediatricians and ensure that every member of the team can play a full role.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team		
Shawinder Basra-Dhillon	Sandwell Operational Manager / Clinical Lead - School Nursing	Birmingham Community Healthcare NHS Foundation Trust
Stephanie Courts	Children's Nurse Consultant and Complex Care Manager	Worcestershire Health & Care NHS Trust
Dr Rajesh Pandey	Consultant in Paediatrics (Neurodisability) Clinical Director, Department of Paediatrics	Sandwell & West Birmingham Hospitals NHS Trust

WMQRS Team		
Rachael Blackburn	Assistant Director	West Midlands Quality Review Service
Tim Cooper	Director	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No, but', where there is real commitment to achieving a particular standard, than a 'Yes, but' where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Details of compliance with individual Quality Standards can be found in a separate document.

Service	Number of Applicable QS	Number of QS Met	% met
Community Child Health Service	37	25	68
Commissioning	4	1	25
Total	**41**	**26**	**63**

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COMMUNITY CHILD HEALTH SERVICE

Ref	Standard	Met?	Comments
PK-101	**Service Information** Each service should offer children and their families written information covering: a. Organisation of the service, such as opening hours and clinic times b. Staff and facilities available c. How to contact the service for help and advice, including out of hours	Y	
PK-102	**Condition-Specific Information** Information for children and their families should be available covering, at least: a. Brief description of their condition and its impact b. Possible complications and how to prevent these c. Pharmacological and non-pharmacological therapeutic and rehabilitation interventions offered by the service d. Possible side-effects of therapeutic and rehabilitation interventions e. Symptoms and action to take if unwell f. DVLA regulations and driving advice (if applicable) g. Health promotion, including smoking cessation, health eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being h. Sources of further advice and information Information should cover common: i. Behavioural difficulties ii. Neurodisabilities	Y	However, some of the parents who the review team met didn't seem to be aware of this information, so the Trust may wish to consider how this information can be made more accessible by reminding staff that the information is there and that it should be proactively provided to patients and their families.
PK-103	**Care Plan** Each child and, where appropriate, their family should discuss and agree their Care Plan, and should be offered a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Planned therapeutic and/or rehabilitation interventions (if any) d. Early warning signs of problems, including acute exacerbations, and what to do if these occur e. Planned review date (if required) and how to access a review more quickly, if necessary f. Who to contact with queries or for advice	Y	However, the review of clinical letters suggested that there was a delay in typing and issuing clinic letters after the clinic (in some cases 3 or 4 months). This was also supported by what the reviewers heard from parents.

Ref	Standard	Met?	Comments
PK-104	**Review of Care Plan** A formal review of the child's Care Plan should take place as planned and, at least, six monthly. This review should involve the child, their family, and appr+C10opriate members of the multi-disciplinary team. The outcome of the review should be communicated in writing to the family and their GP.	Y	Reviewers also noted that there had been an audit of clinical letters which showed a good level of compliance along with an action plan on how the team intended to further improve compliance.
PK-105	**Contact for Queries and Advice** Each child and family should have a contact point within the service for queries and advice. If advice and support is not immediately available, then the timescales for a response should be clear. Response times should be no longer than the end of the next working day. All contacts for advice and a sample of actual response time should be documented.	Y	Good website information and clear contact details for patients and families.
PK-106	**School Health Care Plan** A School Care Plan should be agreed with each child or young person covering, at least: a. School attended b. Care required while at school including medication c. Responsibilities of carers and of school staff d. Likely problems and what to do if these occur, including what to do in an emergency e. Arrangements for liaison with the school f. Review date and review arrangements	Y	
PK-107	**Communication Aids** Communication aids should be available to enable children or young people to participate as fully as possible in decisions about their care.	Y	However, at the Learning Disability, CAMHS, Nursing and therapists team meeting, the team did confirm that there are some occasions were access to interpreters is not timely.
PK-195	**Transition to Adult Services** Young people approaching the time when their care will transfer to adult services should be offered: a. The opportunity to discuss the transfer of care with paediatric and adult services b. A named coordinator for the transfer of care c. A preparation period prior to transfer d. Written information about the transfer of care including arrangements for monitoring during the time immediately afterwards	Y	Leaflets are available for young people in terms of the support that is available. The team use the 'Ready, Steady, Go' tool. There is a Transitions policy in place with a detailed pathway.

Ref	Standard	Met?	Comments
PK-196	**Discharge Information** On discharge from the service, children and their families should be offered written information covering at least: a. Care after discharge b. Return to normal activities c. Ongoing self-management of their condition d. Possible complications and what to do if these occur e. Who to contact with queries or concerns	Y	Discharge policy in place but was due for review (April 2017). Examples of discharge letters were made available to review team.
PK-197	**General Support for Children and Families** Children and families should have easy access to the following services and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. HealthWatch or equivalent organisation h. Relevant voluntary organisations providing support and advice	Y	
PK-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. What to do in an emergency c. Access to a Carers' Programme (if appropirate) d. Services available to provide support	N	See also PK102. Reviewers did see leaflets at CCHC and on the Trust website regarding services for carers (including how to access respite care). Reviewers also saw evidence of referral support for respite care. However, reviewers heard from parents who attended the feedback session that they did not feel their needs were being considered or met. Parents felt that any support they were receiving was based on their own research of 'what was out there'. Parents were keen to point out the incredible support that they had had from some named paediatricians. However, this was not part of a wider 'package' of support. This may have been the perception of the small number of parents who reviewers spoke to, but they clearly felt very strongly about their perceived lack of support in this area.

Ref	Standard	Met?	Comments
PK-199	**Involving Children and Families** The service should have: a. Mechanisms for receiving regular feedback from children and families about treatment and care they receive b. Mechanisms for involving children and families in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of children and families	N	The Trust's own self-assessment confirmed that this was not in place and this was supported by feedback at the patient forum where it was confirmed that their thoughts and views had not been taken into consideration in terms of developing the services.
PK-201	**Lead Clinician** A nominated lead clinician should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	N	The Trust confirmed in its self-assessment that this post is currently vacant.
PK-202	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences should be available for the: a. Number and usual case mix of children and families usually cared for by the service b. Service's role in the pathway of care and expected timescales c. Assessments and therapeutic and/or rehabilitation interventions offered by the service d. Use of equipment required for these assessments, therapeutic and/or rehabilitation interventions e. Urgent review within agreed timescales An appropriate skill mix of staff should be available including medical, nursing, allied health professionals, social care professionals, support workers and other staff required to deliver the range of assessments and therapeutic and/or rehabilitation interventions offered by the service. Cover for absences should be available so that the pathway of care is not unreasonably delayed, and outcomes and experience are not adversely affected, when individual members of staff are away.	N	It was noted by reviewers (and identified in the Trust self-assessment) that the community paediatrician team were working extremely hard and working beyond contracted hours. However, there are a number of vacancies in key roles resulting in some individuals taking on more than one role, and an increase in demand - which is impacting on waiting lists in some areas.

Ref	Standard	Met?	Comments
PK-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified covering, at least, competences in: a. Child public health b. Assessment and management of children with behavioural difficulties including recognising, responding to and ensuring effective management of behavioural, emotional and psychosocial aspects of illness in children and young people c. Safeguarding including: i. understanding of safeguarding and vulnerability in children ii. assessment of children where safeguarding concerns have been raised iii. liaison with and advising other agencies on safeguarding cases d. Assessment and management of children with neurodisabilities e. Roles, responsibilities and local arrangements for meeting the needs of Looked After Children f. Meeting the particular needs of asylum seekers, refugees, travelling families, Forces families and young carers g. Resuscitation A training and development plan for achieving and maintaining competences should be in place.	Y	The evidence provided included evidence of completing mandatory training and appraisals. Good professional development for paediatricians.
PK-204	**Resuscitation Staffing** The service should define the level of staff with resuscitation training required whenever children are present in the service and should audit achievement of the agreed staffing regularly.	Y	Mandatory training compliance provided as evidence along with copies of certificates.
PK-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	N	Reviewers heard from clinicians that there was a lack of administration support - which meant that their time was taken completing admin tasks which was not an effective use of their time. This was also evident in the time delay in sending clinic letters following appointments.

Ref	Standard	Met?	Comments
PK-301	**Support Services** Timely access to an appropriate range of support services should be available including: a. Public health b. Education c. Social services d. General paediatric services e. Specialist learning disability services f. Child and Adolescent Mental Health Services g. Children's palliative care service	Y	However, consideration needs to be given to the impact of the loss of universal services which is now provided by a different Trust resulting in care records being stored on a different IT system.
PK-401	**Facilities** Facilities available should be appropriate for the assessments, therapeutic and/or rehabilitation interventions offered by the service for the usual number and case mix of children and families.	Y	However, parents did comment in the feedback session that more equipment to 'entertain' children whilst waiting for clinic appointments would be welcome.
PK-402	**Equipment** Timely access to equipment appropriate for the service provided should be available. Equipment should be appropriately maintained. All equipment, including resuscitation equipment, should be checked in accordance with Trust (or equivalent) policy.	Y	Clinic equipment good and parents feedback confirmed that equipment needed in the community was readily available and timely.
PK-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	Y	Care notes is implemented. Some issues were identified by staff with speed of connections etc. However, the integrated nature of the records is felt to be positive and supports staff to provide more integrated care for patients.

Ref	Standard	Met?	Comments
PK-501	**Assessment Guidelines** Guidelines on assessment should be in use covering the usual case mix referred to the service covering, at least, children with: a. Behavioural difficulties b. Safeguarding concerns c. Neurodisabilities Guidelines should be specific about family involvement in assessments and about the arrangements for multi-disciplinary and multi-agency discussion and agreement of assessments. Guidelines should also be specific about the arrangements for assessment of Looked After Children.	N	Flowcharts were available (Genetics, FGM etc). However, reviewers did not feel that they constituted a guideline which would usually include more narrative around roles & responsibilities, review, monitoring etc. In some cases, the documents provided were not dated so there was no indication of who they had been developed with and how. The only detailed guideline seen by reviewers in the evidence provided was the NAI guideline. Reviewers did see a robust Autism Spectrum Disorder (ASD) pathway and supporting documentation as well as a robust spasticity pathway supported by MDT documentation.
PK-502	**Clinical Guidelines** Guidelines on management of the usual case mix of children referred to the service should be in use covering, at least: a. Therapeutic and/or rehabilitation interventions offered by the service b. Monitoring and follow up c. Arrangements for liaison with other services Guidelines should cover, at least, children with: i. Behavioural difficulties ii. Safeguarding concerns iii. Neurodisabilities	N	The review team did not see copies of the guidelines identified in these standards. However, the team do access services provided UHCW and these working relationships were felt to be positive by the representatives from UHCW. Evidence was included regarding the Coventry neurodevelopmental team. There was a safeguarding policy in place.
PK-595	**Transition** Guidelines on transition of young people from paediatric to adult services should be in use covering, at least: a. Involvement of the young person and, where appropriate, their carer in planning the transfer of care b. Involvement of the young person's general practitioner in planning the transfer c. Joint meeting between paediatric and adult services in order to plan the transfer d. Allocation of a named coordinator for the transfer of care e. A preparation period prior to transfer f. Arrangements for monitoring during the time immediately after transfer	Y	
PK-596	**Discharge Guidelines** Guidelines on discharge from the service should be in use.	Y	

Ref	Standard	Met?	Comments
PK-599	**Care of Vulnerable People** Guidelines for the care of vulnerable children and young people should be in use, in particular: a. Restraint and sedation b. Missing patients c. Information sharing d. Palliative care e. End of life care	N	The evidence provided did not meet all the requirements of this standard - b, d or e. However, reviewers were impressed with the health assessment for unaccompanied asylum seekers. The review team have noted that (a) restraint and sedation is not applicable to the community paediatrics context.
PK-601	**Operational Procedure** The service should have an operational procedure describing the organisation of the service including, at least: a. Expected timescales, including for initial assessment, start of therapeutic and/or rehabilitation interventions and urgent review, and arrangements for achieving and monitoring these timescales b. Responsibility for giving information to children and families at each stage of the pathway c. Arrangements for responding to children and families' queries or requests for advice by the end of the next working day d. Arrangements for follow up of children and families who 'do not attend' e. Arrangements for child death reviews f. Arrangements for liaison with key support services (QS XX-301) g. Arrangements for maintenance of equipment (QS XX-402) h. Responsibilities for IT systems (QS XX-499)	N	Reviewers could not see an overarching operational procedure that covered all the requirements of this standard. Evidence provided included: - Referral triage form - Policy for use of cameras and photographic imagery in a clinical care setting - Service spec 2010/11 - does include some of the items required in this standard - but is significantly out of date. - Process for DNAs
PK-602	**Multi-Agency Working** Arrangements for multi-agency discussion of appropriate children and families should be in place covering children with: a. Behavioural difficulties b. Safeguarding concerns c. Neurodisabilities	Y	Reviewers were impressed with the Quality Assurance framework and performance tracker in the LAC Annual Report.

Ref	Standard	Met?	Comments
PK-603	**Child Public Health** Arrangements should be in place for the service to: a. Advise commissioners on the development of local child health services b. Contribute to needs assessments and service planning, development and evaluation c. Advise schools and other relevant organisations on: i. Health promotion and injury prevention activities and programmes ii. Management of common infectious diseases and infestations iii. Management of children with severe allergic problems iv. Screening-related issues, including ethical dilemmas d. Respond to media interest about child health and child health services	N	Could not see evidence of (a) or (d). The only evidence provided was in relation to obesity and the foster carers newsletter.
PK-604	**Screening** The service should meet applicable Standards for any screening programmes which the service is commissioned to deliver.	N/A	The Trust is not commissioned to provide screening services.
PK-605	**Immunisations** The service should: a. Actively participate in local arrangements for monitoring and reviewing immunisation programmes b. Contribute to training and auditing for local immunisation programmes c. Provide advice for paents and relevant professionals regarding children with complex immunisation histories	Y	Training for Immunisations and Vaccinations team submitted as evidence. Also see foster carers newsletter. Co-location with Vaccination and Immunisation team supports joint working.
PK-606	**Safeguarding** Arrangements should be in place for the service to: a. Contribute actively to local Child Safeguarding overview arrangements b. Write reports, including police statements, medical reports for social services and court reports c. Attend relevant case conferences, strategy meetings and court hearings	Y	
PK-699	**Liaison with Other Services** Review meetings should be held at least annually with key support services to consider liaison arrangements and address any problems identified.	Y	

Ref	Standard	Met?	Comments
PK-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source of appropriateness of referrals b. Number or assessments, urgent reviews and therapeutic and /or rehabilitation interventions undertaken by the service c. Outcome of assessments and therapeutic and /or rehabilitation interventions d. Number of discharges from the service and type of care after discharge e. Key performance indicators Data collection should cover: i. Child public health ii. Care of children with behavioural difficulties iii. Safeguarding iv. Care of children with neurodisabilities	Y	
PK-702	**Audit** The services should have a rolling programme of audit of compliance with: a. Evidence-based clinical guidelines (QS XX-500s) b. Standards of record keeping c. Timescales for key milestones on the pathway of care	Y	Audits for NAI, Clinic letters, Obesity Management. The Trust clinical audit forward programme was also included as evidence.
PK-703	**Key Performance Indicators** Key performance indicators (QS XX-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	Y	See PK702. Evidence also included the Trusts integrated performance management framework and minutes of the Contract meeting where the KPI and Quality performance report is discussed.
PK-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency.	N	MDT review of feedback, incidents etc was in evidence - through structured Q&S meetings. However, reviewers did not see any specific examples or evidence of changes to practice that had been made as a result of learning from incidents, complaints or other feedback.

Ref	Standard	Met?	Comments
PK-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	A number of the documents that were provided lacked any version control. Policies appeared to follow the Trust format and were standardised. However, other documents were often overdue for review e.g. 'where to find support for you and your child with autism' not reviewed since 2014. ADOS guidance was due for review in March 2018. Enuresis pathway draft from 2012. Melatonin prescribing chart review date was November 2011. Some other documents e.g. Cerebral palsy integrated pathway were not dated.

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COMMISSIONING

Ref	Standard	Met?	Comments
PZ- 501	**Safeguarding Policy** The local Safeguarding Policy should include specific consideration of the needs of children and young people	**Y**	
PZ-601	**Needs Assessment and Strategy** For each patient pathway commissioners should have an agreed: a. Needs assessment b. Strategy for the development of services to meet local needs across the patient pathway The local strategy should cover, when appropriate, prevention (primary and secondary), assessments, therapeutic interventions, rehabilitation and re-ablement.	**N**	It was confirmed that the service specification has not been reviewed since 2010.
PZ-602	**Commissioning of Services** Services for each patient pathway should be commissioned including, for each service: a. Range of assessments, therapeutic and/or rehabilitation interventions offered by the service b. Criteria for referral to and discharge from the service c. Key performance indicators	**N**	See XZ601.
PZ-701	**Quality Monitoring** The commissioner should monitor key performance indicators and aggregate data on activity and outcomes from the service at least annually.	**N**	See XZ601. Reviewers did see some KPIs, however they were not based on a current service specification or specific to the community paediatric team.

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