Somerset Partnership NHS Foundation Trust

RH5

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RH5AA	Mallard Court		TA6 4RN

This report describes our judgement of the quality of care provided within this core service by Somerset Partnership NHS Foundation. 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 Somerset Partnership NHS Foundation and these are brought together to inform our overall judgement of Somerset Partnership NHS Foundation

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Good l

Overall community health services for children and young people were found to be good.

Somerset Partnership NHS Foundation Trust provided community services for children, young people and families in Somerset. As part of this inspection we talked to professionals delivering these services. We also met and spoke with children, young people and their parents. We visited services across the county and also spent time on home and school visits with health visitors, school nurses and therapy staff.

Overall we judged the safety of community health services for children and young people as good. Risk was managed and incidents were reported and acted upon with feedback and learning provided to most staff. However, the area for improvement concerned the high vacancy rate in health visiting which presented a risk to capacity and continuity of care.Care was effective. Care was evidence based and followed recognised guidance. There was excellent multidisciplinary team working within the service and with other agencies.

Care and treatment of children and support for their families was delivered in a compassionate, responsive and caring manner. Parents spoke highly of the approach and commitment of the staff who provided a service to their families.

Staff understood the individual needs of children, young people and their families and designed and delivered services to meet them.

There were clear lines of local management in place and structures for managing governance and measuring quality. However, some staff felt isolated from the main trust and highlighted a lack of engagement and visibility from senior managers.

Summary of findings

Background to the service

Information about the service

The trust provided community health services for children, young people and families which supported children with chronic illness or disability, behaviour and development issues, child protection and social issues. The service worked with infants, children and young people aged 0 to19 years and their parents and carers and a range of other agencies in Somerset. Children and young people represented 22.5% of the population of Somerset.

It was a multi-disciplinary service comprising of an integrated therapy service and a public health nursing service as defined under a new contract (which included health visiting and school nursing).

Services were delivered at localities across the region with staff covering particular geographical areas. Integrated therapy services comprised of physiotherapy, occupational therapy and speech and language therapy. Therapists were based at four area offices in Bridgwater, Taunton, Wells and Yeovil and services were delivered at integrated therapy clinics and within community settings, such as schools and children's centres and other pre-school settings, or at home.

The health visiting service provided a home visiting and community based service to support children and families in promoting health and wellbeing. Teams were based in four hubs: the Mendip area, covering Central and West Mendip in Wells; the Sedgemoor area covering Bridgwater Bay in Bridgwater and North Sedgemoor in Burnham-on-Sea; and the South Somerset area covering Chard, Crewkerne and Ilminster, Wincanton and Yeovil.

The school nursing team provided care and treatment to children and young people working with parents and carers within schools, community settings and at home. The teams were based in four hubs: the Taunton and West Somerset team covering Taunton, Wellington, Williton, Minehead and Dulverton; the Sedgemoor team covering Bridgwater, Burnham-on-Sea, Highbridge and Cheddar; the Mendip team covering Wells, Glastonbury, Street, Frome and Shepton Mallet; and the South Somerset team covering Yeovil, Chard, Crewkerne, Ilminster, Langport and Wincanton.

During the inspection we visited all the therapy bases and the main nursing hubs, children's centres and community settings. We spoke with over 35 members of staff including therapists, therapy support practitioners, health visitors, school nurses, administrators, team leaders and clinical area managers. We observed therapy clinics, nurse clinics, multi-professional assessment clinics and clinics run jointly with the "Get Set" family support workers employed by Somerset County Council. We also spent time on school and home visits with the school nurses and health visitors and observed the health visitor team's duty cover. We also attended 11 focus groups where 87 staff attended.

We also spoke with eight children and young people who used the services and 18 parents or carers. We observed how children and young people were being cared for and looked at care and treatment records.

Our inspection team

Our inspection team was led by:

Chair: Kevan Taylor, Chief Executive Sheffield Health and Social Care NHS Foundation Trust

Team Leaders: Karen Bennett-Wilson, Care Quality Commission

The team included CQC inspectors and a variety of specialists including health visitors, school nurses and a designated nurse for children looked after and care leavers.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

During our inspection we reviewed services provided by Somerset Partnership NHS Foundation Trust. We visited clinics across the county.

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit we held focus groups with a range of staff who worked within the service, We talked with children, young people and their parents and carers who use services. We observed how they were being cared for and reviewed care and treatment records.

Good practice

Frontline staff and local area managers were passionate about providing a high quality service for children and young people with a continual drive to improve the delivery of care.

The equipment days held every half term enabled the occupational therapy and physiotherapy teams to assess the latest equipment and for children and young people to try a range of equipment to suit their individual needs.

The clinical area managers were strong and committed to the children, young people and families who used the service, and also to their staff and each other.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the trust SHOULD take to improve

Staffing deficits in health visiting should continue to be actively reviewed to ensure a safe and consistent service is maintained.

Somerset Partnership NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Overall, we judged the safety of community health services for children and young people as good with improvement needed in the high vacancy rate in the health visiting service which presented a risk to capacity and the continuity of care.

Staff knew how to report incidents using the electronic reporting system and were encouraged to report incidents. Most staff received feedback following incidents and learning was shared with them.

Staff adhered to infection prevention and control procedures and staff had completed the appropriate training. Equipment was correctly serviced and maintained.

The majority of staff were up to date with mandatory training and staff were receiving clinical supervision and annual appraisals.

Staff we spoke with were knowledgeable about the trust safeguarding process. They were clear about recognising possible signs of abuse or neglect of children and young people and their responsibilities.

Incident reporting, learning and improvement

- Staff were open, transparent and honest about incidents. Systems were in place to make sure that incidents were reported and investigated appropriately. All staff told us that they would have no hesitation in reporting incidents and were clear on how they would report them. However, staff felt the electronic reporting system was time consuming and not easy to complete particularly for incidents relating to non-clinical issues. Staff told us this might dissuade them from reporting incidents.
- Once reported incidents were reviewed by the appropriate area clinical manager for the service and

Good

Are services safe?

where necessary investigated. Staff told us they were able to get feedback on incidents they reported. However, feedback was variable with some staff reporting that it was not always forthcoming.

- We saw evidence of learning was discussed through governance meetings. For example, following a review of an incident where a child touched a mobile heater that had been taken into a clinic it had been decided that heaters were no longer allowed in clinic areas. Another incident involving the detachment of a needle from a syringe where the needle was left in a young person's arm resulted in the immediate withdrawal of the needles and the replacement with another type of needle with a rubber stopper.

Duty of Candour

- Staff demonstrated an understanding of Duty of Candour responsibilities. This new regulation was introduced in November 2014. It requires staff to be open, transparent and candid with patients and relatives when things went wrong. We did not however, see evidence of any instances where the Duty of Candour had been employed within the service.

Safeguarding

- There were policies, systems and processes to keep children and young people safe and safeguarded from abuse. The policies included explanations of the meaning of abuse and the responsibilities and duties of staff to report any suspicions for vulnerable children and young people.
- Staff we spoke with were knowledgeable about the trust's safeguarding process and were clear about their responsibilities. They were able to explain their role in the recognition and prevention of child abuse and what actions they would take should they have safeguarding concerns about a child or young person. Staff recognised how abuse could be physical, but also emotional or neglectful and could also include child sexual exploitation. Concerns were raised via an electronic reporting system and then escalated to managers who would investigate and report the outcome at local team meetings.
- Hospital admission rates for injury in children and young people across the area were higher than the England average. During 2013 and 2014 there were 16,397 A&E attendances by children under the age of four, and 114 hospital admissions caused by injuries in children under 14 years. There was a trust policy for the follow up by the public health nursing service for paediatric (0-18 years of age) attendance at acute emergency care services to ensure staff were aware of their responsibilities to follow up and assess children's attendance at a variety of acute and emergency settings. This promoted effective communication pathways and systems which coordinated children's care between hospital and community services with assessment and follow up activity clearly identified in the policy
- Any verbal or written information from an emergency care service, for example, A&E departments, minor injuries units, NHS walk-in centres and the NHS 111 service were reviewed and assessed by a health visitor and shared with the child's named health visitor. Clear standard actions to take were recorded on electronic records. However, staff told us it was a challenge to review and assess the volume of cases due to the high number of attendances and they were concerned that the details captured on the electronic records might not reflect the whole picture.
- Staff were trained to recognise and respond in order to safeguard children and young people. Records indicated that safeguarding training to at least level 3 was up to date for all clinical staff.
- An in-house package of training was delivered by members of the safeguarding team in a modular format. E-learning modules were also available for level 3 training. However, these modules were only used every other year with trust taught modules accessed every second year. Level 3 training was accessed at least annually. Refresher or update training was also available. There was some integration with local authority training, for example, the use of DVDs and approved trainers to support the trust. Staff also had access to multi-agency training at level 3 which was available on a three-yearly basis. Level 2 safeguarding training was included as part of the induction for staff joining the children and young people's service and included child sexual exploitation, female genital mutilation and domestic abuse and had been completed by all administrators in the teams. There was a specific package of training for child sexual exploitation and e-learning packages available for female genital mutilation.

Good

Are services safe?

- There was a safeguarding lead nurse for the trust who supported a programme for safeguarding supervision and peer review. Staff were aware of and able to access supervision and review, and felt well supported by the safeguarding programme. Supervision with an area safeguarding supervisor was available every two months with additional peer and group supervision, and one-to-one supervision on request. Staff reported the supervisors were very visible and accessible
- Supervision was recorded electronically and attendance was closely monitored. Managers met with the safeguarding lead nurse to keep an overview of concerns and how well staff were coping, and whether staff needed more support to help prioritise and manage child protection cases.
- Safeguarding concerns were monitored and reviewed at clinical governance meetings and quarterly to the trust safeguarding steering group. Minutes of the meetings showed that the board were kept informed of serious case reviews and the resulting learning.
- During our visit safeguarding concerns were raised by a health visitor about the rejection of a referral to children's social care. We were informed about the trust's safeguarding team's action plan on the same day and this was confirmed to us in writing the next day.

Medicines

- Staff had access to the trust medicines policy which defined the policies and procedures to be followed for the management of medicines and included obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines. There was also a policy to set standards for the safe administration of immunisations.
- Staff were knowledgeable about the policies and told us how medicines were ordered, recorded and stored for the immunisation team. The immunisation team would request the immunisations they needed for school clinics and these were then delivered to the area team in a timely way. Medicines were stored in fridges within secure rooms in area bases with limited staff access. The fridge temperatures were checked daily to make sure the medicines were stored at the correct temperature. Special precautions were taken when transporting the medicines to school and these included the use of cool bags and the constant monitoring of temperatures.
- Health visitors were nurse prescribers and were able to prescribe medicines from a pre-determined and approved list, which included over-the counter drugs, wound dressings and applications. Prescription pads were ordered and issued against procedures outlined in the trust's prescription form policy thereby ensuring the safe management of prescription forms.

Environment and equipment

- Access to facilities was secure and maintained the safety of children and young people using the service. There were robust systems in place for staff and visitors to sign in and out of premises and staff were wearing identity badges.
- Areas were clean, tidy and well ventilated, and were suitable for children and young people. Play areas and a range of toys and activities were available and toilet areas had appropriate facilities for children with a range of child potties, toilet seats and steps available. Some clinics had open areas with limited access to private areas for more confidential matters. Parking was not always available close by to the clinic and both staff and parents told us this could be inconvenient in poor weather conditions. Comment boards were available inviting children and parents to suggest ways of improving the environment.
- Some premises were managed by the local authority and not by the provider. A number of areas were shared and a risk assessment was in place to ensure safe access. Flexibility was required to manage the shared space efficiently.
- Staff told us they had access to the equipment they needed for the care and treatment of children and young people. Staff also told us that they were trained in its use where necessary. The equipment was well maintained in line with manufacturer's instructions.
- We saw rooms were well-equipped, for example, with a variety of physiotherapy gym equipment assessment tools. Scales were calibrated annually and two health visitors were designated to ensure this was completed. Staff told us the company who had been responsible for calibration had been declared bankrupt and currently this was being carried out at the local hospital.
- Staff had access to laptops to support mobile working. This meant they were able to access the patient records, care plans, emails and policies when away from their home base.

Good

Are services safe?

Quality of records

- There was an electronic system for therapy and public health nursing teams which provided a record of care and information for caseload profiling and audit. Staff were able to update records at their area base or on laptops when out in the community. They had access to multi professional notes, for example, the school nurse was able to see what another professional had written.
- We looked at 11 electronic records and care plans. Information was clear and concise with details of what was happening now, the long term goals, how they would be achieved and clear review dates. Care plans were reviewed and updated regularly in conjunction with the child's family. This made sure they were tailored to meet the needs of each child. There were standard templates for reports and care plans although staff told us it would be useful to have a wider range of templates as this would save time. Speech and language therapists also told us about the difficulties in accessing phonetic symbols which were essential elements in their work.
- We were told there were network connectivity issues in some areas of the county and staff were unable to access the electronic records. When this occurred they made hand written notes and updated the record at the earliest opportunity. We saw evidence that this took place in a timely way.
- Records identified the engagement of the child or young person and their parents in treatment and care. We looked at how interactions and observations were recorded for non-verbal children and staff told us how recent training on the infant health programme had improved their understanding of recording observations.
- Staff were able to access a shared network drive containing information about children and young people who were being seen in the community. This ensured effective information sharing for all disciplines involved in treatment and care.

Cleanliness, infection control and hygiene

- The clinics we visited were well maintained, organised and visibly clean. We observed staff washing their hands regularly and using anti-bacterial gel. Hand sanitisers were readily available and clearly visible at most sites. Personal protective equipment was available such as aprons and gloves.
- We observed meticulous cleaning of equipment and environments in between appointments and clinics. However, we observed a baby clinic that was run jointly with the local authority, where toys were not cleaned after toddlers had been sucking them. As this raised a potential infection control risk we informed the area clinical manager who agreed to investigate further.
- Staff were aware of and could easily access the trust policy on infection control through the trust's intranet.

Mandatory training

- The trust provided a programme of mandatory training for staff which included basic life support, anaphylaxis, infection control, consent, equality and diversity, information governance, safeguarding children, moving and handling and fire training.
- Electronic staff training records were monitored to review attendance and expiry dates, thereby ensuring compliance with mandatory training. A mandatory training matrix was maintained by managers to monitor attendance and analyse training needs. Most staff told us they were up-to-date with their mandatory training or had dates booked to attend training in the near future. Data provided by the trust showed a 91.3% compliance rate. This meant that staff remained up-to-date with their skills and knowledge to enable them to care for children and young people appropriately.
- Staff told us that training was delivered to meet their needs and that they were able to access training as they needed it. Training was provided through a mixture of e-learning and face-to-face modules. The e-learning programmes had been streamlined and staff reported that it was much easier to access training and they could save time by completing multiple sessions in one sitting. There were further plans to amalgamate training and deliver it to a cluster group which would further streamline training and improve access.
- We spoke with new staff who had attended the three-day corporate induction and local induction in their area which included details of supervision, peer group supervision, and action learning sets from their team leader.
- Staff told us they were encouraged to share knowledge and experience with colleagues and funding was available for external courses as part of their continuing professional development.

Assessing and responding to patient risk

Good

Are services safe?

- Staff assessed and responded well to risk through review. Risk assessments were completed and evaluated. Staff had undertaken training in completing risk assessments and we saw that where risks were identified, staff documented these on the electronic record system. All staff had access to the shared records and staff felt they were able to co-ordinate care effectively.
- We saw staff giving advice to parents on how to recognise and respond appropriately to changes in their child's condition. Information was given to parents verbally and supported by written information on the child's care plan.
- The immunisation team had an emergency kit with them during immunisation clinics and equipment was checked before it was taken out to the school to make sure it was working and the medicines and vaccinations were in date and were at the correct temperature. All the staff had been trained in emergency procedures should any of the pupils suffer an allergic reaction.

Staffing levels and caseload

- The trust reported 3,827 substantive staff as of 31 March 2015 with 556 leavers in the preceding 12 months. Of this number there was a turnover of 15% of staff in the children and young people's service. From data showing the current funded staff establishment we saw that occupational therapy was fully established with 12.9 whole time equivalent staff in post; so too were physiotherapy with 10.1 whole time equivalent and speech and language therapy with 23.2 whole time equivalent. School nursing was also fully established with 18.5 whole time equivalent.
- The vacancy rate for health visitors showed a deficit of 9.7 whole time equivalent with 124.8 whole time equivalent staff in post. There was an ongoing use of bank staff to cover the vacancies. The trust had increased the health visiting workforce by 45 whole time equivalent as part of the Health Visiting Improvement Plan. The outstanding vacancies related to new investment to reach the set trajectory of growth and were not existing posts within the health visiting establishment.
- There were challenges in recruiting and retaining staff to the area, partly due to the rural location and geographical spread of the services across the county. This was also due to competition from other health employers in the area particularly from the main acute hospital in the area.
- Recruitment of health visitors to the area was particularly difficult despite a rolling programme of recruitment. There was a high turnover of staff due to the ageing workforce and although there were high levels of student health visitors, retention to vacancies was poor. Staff felt the current position was fragile and although there was high resilience amongst the team they felt they were "left holding the fort."
- There had been difficulties in recruiting therapy staff with paediatric experience, particularly in physiotherapy, and a number of therapy staff were travelling long distances to work from Devon and Bristol. There was an ongoing review of the skill mix where managers continued to consider the further use of and development of the therapy support practitioner's role. Work was already underway for therapists to move away from the traditional model of assessment, review and treatment to a more streamlined model of assessment and review with care plans being delivered by therapy support practitioners. Although staff acknowledged there would be continuity of care for children and young people they were concerned there might be a "dumbing down" of the service.
- Managers were aware of the risks the recruitment difficulties presented to capacity and continuity of care and the shortage of health visitors had been flagged as a risk on the risk register. Team planning and development meetings continually looked at ways to address the shortfalls and managers were working closely with the trust HR department.
- Staff told us that caseloads were high amongst all disciplines. The trust had conducted an individual caseload analysis for health visiting which had resulted in a reduction and redistribution of cases amongst the teams. However, staff in health visiting reported individual caseloads of between 250 and 300 children which was above the average level of 250 as recommended by the Royal College of Nursing.
- The trust provided data which showed the number of open caseloads for each discipline at 15 July 2015. For health visiting there were 43,982 cases; for school nursing 1,119 cases; and for integrated therapy 5,672 cases. Data was also available which showed the

Good

Are services safe?

number of referrals for the period from December 2014 to June 2015: there were 10,391 referrals for health visiting, 502 for school nursing and 2,656 for integrated therapy.

- The audit of workload patterns showed high levels of administration particularly amongst health visitors with some staff reporting working at home to catch up on records. There was also disparity in some areas about case numbers due to coding issues on the electronic record system which affected the number of categories available.
- Sickness rates for staff as of 31 March 2015 for the preceding 12 months showed the public health nursing team having the highest sickness rate at nearly 5% and the school nursing team having the lowest at 1.3%. Staff on long term sickness were supported by the trust Well at Work service when making a return to work. Action plans were put in place to support staff to make a gradual return including adaptations that might be required, such as the availability of software to enable voice recognition on computers and laptops. Managers told us about the impact on the wider team when covering for periods of sickness or a gradual return and how challenging it was to balance the needs of an individual and the whole team.

Managing anticipated risk

- Staff managed and recognised risks. They were provided with information and guidance in the trust risk management policies which guided staff to be proactive with the safety of children, young people and their families and to the safety of colleagues and themselves.
- The trust had a lone working policy in place and staff were aware of this. Systems and procedures were implemented at a local level to ensure the safety of staff working alone in the community. There was a buddy system in place for joint working if staff were making potentially difficult visits and staff used a code word to alert colleagues if they found themselves in dangerous situations. However, staff were concerned about the poor mobile network signal in some areas of the county and the impact this had if they were working alone and found themselves in a difficult situation requiring support.

Major incident awareness and training

- The staff we spoke to were aware of the trust major incident plan and how to access this.
- As part of the winter planning arrangements staff told us about the severe weather plan which required them to make every reasonable effort to reach their normal place of work or the nearest health premises. Staff were aware that they would be expected to take annual leave if they did not attend. However, staff knew they were not expected to put themselves or others at risk.

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

Overall we judged the effectiveness of the service as good. Treatment was delivered in accordance with best practice and recognised national guidelines. Children and young people who used the services received care, treatment and support that achieved good outcomes.

There was a multidisciplinary and collaborative approach to care and treatment and staff were appropriately trained and competent to carry out their role.

Evidence based care and treatment

- Policies and guidelines had been developed in line with national guidelines. These included the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Paediatrics and Child Health. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them.
- The children and young people's service provided all the core requirements of the Department of Health's healthy child programme to deliver personalised care planning. This included early intervention, screening, immunisation, health and development review, provision of information and guidance to support parenting and healthy choices.
- The maternal early childhood sustained home-visiting (MECSH) programme was a structured programme of sustained nurse home visiting for families at risk of poorer maternal and child health, and development outcomes. The programme drew together the best available evidence on the importance of early years, children's health and development, the type of support parents needed, parent-infant interaction and holistic, ecological approaches to supporting families to establish the foundations of a positive life trajectory for their children. Training for the health visitor teams was delivered in July 2015 with the Wincanton and Taunton teams being identified as MECSH delivery sites and Shepton Mallet and Bridgwater as the control sites. The champions were meeting on a monthly basis and had developed a tool to identify potential families, feedback on individual team's e-learning progress, develop flow chart about home visiting patterns and individualising the consent in line with trust processes. There were plans to recruit families in the antenatal period with a target of 20% during the period from birth to six weeks of age. The health visitor would continue to visit and support families until the child reached two years of age, initially visiting weekly reducing to every second month.
- Somerset was chosen as a research site to measure outcomes against the healthy child programme. Research would be undertaken to assess the effectiveness of MECSH programme. The research would look at whether or not participation in the sustained home visiting programme lead to better outcomes for children and their families. Following the measurement of outcomes the programme would be implemented county wide.
- There was wide participation in community governance meetings where governance, safeguarding, performance and audits were discussed. The team were working through NICE guidelines to check compliance.

Nutrition and hydration

- Where required we saw that guidance around a child's nutritional needs were recorded in the plan of care.
- Breastfeeding rates at the six to eight week review showed that of the total number of babies visited, an average of 49.7% were being breast fed. Rates for the period from April 2014 to March 2015 showed a monthly average of 473 mothers were visited with an average of 255 babies being breastfed.
- Staff felt there were factors contributing to the low rates. There was a shortage of acute hospital based midwives and some mothers were not being seen at home in the early postnatal (0-14 days) and were not supported or advised if they had any difficulties. A lactation consultant post had also been lost in the last 12 months at the acute hospital and might also have impacted on the breastfeeding rates.
- The service had achieved stage 3 of the UNICEF Baby Friendly Awards which championed evidenced based practice to promote and support breastfeeding. This

meant that staff were able to support young mothers to recognise the importance of breastfeeding, make informed choices and to enable them to continue breastfeeding for as long as they wished. Breast feeding trainers and champions were available in area teams and could provide support through individual sessions and at weekly support groups.

Technology

- The trust had developed software to enable an App to run on smartphones and tablets to provide information for young people and parents about sexual health.
- Staff were developing the use of social media communication such as Facebook and twitter as a way of communicating with young people and to advertise services and groups. Discussions with the wider trust were planned to address governance and communication restrictions.

Patient outcomes

- Clinical pathways were in place and gave clear and consistent guidance across the service. Outcomes were measured to ensure that the needs of children and young people were being met in the service.
- Therapy outcome measures were in place such as the Canadian Occupational Performance Measure and scoring for gross motor functioning. Therapists used goal attainment scales such as the World Health Organisation International Classification of Functioning, Disability and Health classifications based on treatment goals of identifying and reducing disorder or dysfunction; improving or maintaining function and ability; assisting to achieve potential or integration; alleviating anxiety or frustration.
- The health visiting team used the evidence based questionnaire called Ages and Stages to measure the development of children at the age of two. However, not all health visitors were trained in the use of the child development tool and there were concerns that they were not on target to complete the questionnaires. Managers were monitoring the targets and reviewing training.
- The trust scored above the England average for the children receiving appropriate immunisations. For example, 97% of appropriate children had received the triple vaccination (Dtap / IPV / HiB) compared to an England average of 96.1%.
- Audits were carried out to monitor performance and maintain standards. There was an annual auditing of records across the service to ensure the standards identified in the trust's record keeping standards and data collection were adhered to.
- There were other examples of audits including postnatal care audits, infant feeding audits, an audit for constipation and an audit of antenatal communication which captured the level of communication from maternity providers to the health visiting service during the months of January to March 2015. The aim of the audit was to provide evidence to a serious case review in relation to adequate information received by the health visiting service from maternity providers at the local acute hospitals. The serious case review indicated that communication had been a concern and, in order to establish the degree of concern, and as part of the action plan an audit was undertaken. This was the fifth audit since January 2014 and although improvements had been made it remained short of the required 95% adequate information sharing for antenatal contacts from the health visiting service. The compliance rate had improved from 70% in April 2014 to 94% in July 2015. Work to continue to improve multi professional communication processes was under way with clinical area managers meeting with midwifery managers in the acute hospitals to share concerns and target areas where communication had been particularly poor and to develop action plans to address any difficulties.
- Staff told us how good practice was shared across the area teams. An example was the "Let's play group" which had been developed as a pilot in one area and following its success and presentation to the wider team at development day, had been rolled out across the county.

Pain relief

- There was guidance in care plans about pain management for children where it was appropriate and where necessary children's pain was assessed using a variety of methods suitable for children and young people.

Good

Are services effective?

Competent staff

- All staff had specialist knowledge and skills to treat children with their presenting conditions.
- There was a commitment to training and education within the service. Staff told us they were encouraged and supported with training and that there was good teamwork. Peer training was available at professional meetings and clinical days. Staff were encouraged to keep up-to-date with their continuing professional development and there were opportunities to attend external training and development. However, staff told us funding was not always available for additional training and they had approached charities to raise the funds instead. Other staff were concerned about attending further training as it would take them away from their heavy caseload.
- There was a trust wide electronic staff record where all training attended was documented. Managers were informed on a monthly basis of training completed and alerted to those staff requiring updates.
- Most staff we spoke with were positive about the quality and the frequency of clinical supervision they received. Attendance was monitored by managers with follow up for non-attendance. Managers received training on coaching and motivating staff, and managing change.
- As part of the Health Visitor Implementation Plan – A Call to Action the trust added a framework of preceptorship to increase the retention of newly qualified health visitors. A programme was in place for newly qualified staff to support them with their competency and confidence before practicing independently. Staff felt supported by their preceptor and the wider health visiting team.
- Peer and group supervision was available from colleagues and if staff felt they needed additional support this would be requested and provided. The administration teams also had regular supervision and team meetings to address concerns and share practices.
- However, some staff were concerned about the adequacy of supervision for young parent practitioners. They told us one practitioner could have a caseload of between 45 to 50 families and the depth and intensity of such a caseload required further support. Managers were aware of the situation and saw it as a priority to address once the new management structure was in place.
- All the staff we spoke with told us they had received an appraisal during the last year. The figures provided by the trust showed a compliance rate of 100% for the children and young people's services. Staff learning needs were identified through the appraisal process and through supervision meetings.

Multi-disciplinary working and coordinated care pathways.

- We saw evidence that staff worked professionally and cooperatively across different disciplines and organisations to ensure care was co-ordinated to meet the needs of children and young people. Staff reported good multidisciplinary team working with meetings to discuss children and young people's care and treatment. Staff told us they were most proud of the integrated work across all disciplines with one member of staff telling us the child centred assessments were like "a one-stop shop."
- Staff reported collaborative working with the hospital based paediatricians when children were seen by both teams at a review clinic. There was also proactive engagement with other health and social care providers and other bodies to co-ordinate care and meet the needs of children and young people. A number of services were collocated with local authority staff.
- We observed a MAISEY (Multi Agency Information and Support in the Early Years) meeting where representatives from the community children's services attended together with a senior educational needs co-ordinator to discuss and monitor children in pre-school years and their families. This ensured that the services and provision were looked at as a whole and were co-ordinated within a multi-agency context.
- Staff also told us about the joint working with the Royal Navy and Royal Marines Welfare for Families which was an early intervention service providing support for families with one or more parents working in the Navy or the Marines.

Referral, transfer, discharge and transition

Good

Are services effective?

- Information was shared with GPs, other health professionals and where appropriate other agencies such as education either via the electronic record system, reports and verbal or written communication.
- Where children or young people required specialist support, appropriate referrals were made. They were fully discussed and agreed with parents or carers and where possible the child or young person.
- Children and young people receiving therapy were discharged when they no longer required intervention. Children seen by the health visitors were transferred to the school nurses at the age of five years.
- As part of the trust Clinical Quality Improvement Plan 2015-2016 a generic approach was being developed for the transition of children and young people aged 14 to 18 years to adult services. Data was collected monthly and reported quarterly to the clinical commissioning group and there was a target of 95% of children and young people to be on the transition programme by 30 March 2016.
- The teams worked with young people to help them prepare for the transition to adult services. We observed a meeting with a child and their parents, and teachers to discuss the transition to adult services. The differences in the adult services were explained and a plan to prepare and support the child through the transition was agreed.
- Staff reported good links with pre-school, early school, secondary schools and colleges, and adult services.

Access to information

- Staff reported the trust intranet was a good forum for communication and links between groups. Good intranet-based guidance information was distributed to staff by global email. Staff had access to individual children and young people's notes as well as clinical guidelines and protocols via their laptops.
- Literature for children, young people and their families was displayed in most clinic areas. Information about more personal information such as chlamydia testing was available in the toilet areas.

Consent

- Staff told us they obtained consent from children, young people and families prior to commencing care or treatment and always gave children and young people choices when they accessed their service. Staff were aware of and knowledgeable about the Fraser guidelines and Gillick competence. Fraser guidelines refer to the provision of contraceptive advice and treatment for children and young people without their parents' consent and Gillick competence identify children and young people under the age of 16 with the capacity to consent to their own treatment.
- Throughout the inspection we saw staff explaining the assessment and consent process and the need to share information with other professionals such as GP, nursery, school before obtaining written consent.
- We observed staff discussing the treatment and care options available to children, young people and their parents, and during a school visit a child was asked if they were happy for their condition and levels of motor functioning to be explained to the teaching staff to enable them to plan PE sessions.
- Staff in the immunisation teams told us they collected and checked consent forms were signed as well as available for the session.

Good

Are services caring?

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

Summary

We have judged the care given to children, young people and their families as good. Parents, carers, children and young people were treated with compassion and respect. Feedback from children, young people and parents had been positive and they were happy with the care provided by the staff.

We witnessed positive interactions between staff and children, particularly when explaining what was happening to them and the treatment plans. Parents were encouraged to be involved in the care of their children as much as they wanted to be, whilst young people were encouraged to be as independent as possible.

All parents we spoke with felt they had enough information about their child's condition and treatment plan. They praised the way the staff really understood the needs of their children, and involved the whole family in their care.

Compassionate care

- During our inspection we observed children, young people and their parents being treated with dignity and respect at all times.
- We observed staff taking time to talk to children in an age appropriate manner and involved and encouraged both children and parents as partners in their own care.
- The trust used the NHS Friends and Family Test to find out if children, young people and their parents would recommend their services to friends and family if they needed similar treatment or care. Data from January to June 2015 showed that 94.5% said they would be either likely or extremely likely to recommend the service to them. Comment cards were also available for children and young people or their parents to complete. Feedback showed that parents found the staff to be efficient and friendly and would recommend the service.
- The feedback we received from parents we spoke to was consistently positive about the care their children received. One parent told us "It's been a life-saver for us." Another explained that "the staff are very kind and supportive." A young person told us "my walking is better and I can join in things with my friends at school."

Understanding and involvement of patients and those close to them

- Staff we spoke with explained how they worked with children, young people and parents. They said they tried to ensure parents and children were fully involved and as informed as possible about their care and treatment. Parents we spoke with were positive about this aspect of the service. One parent we spoke with explained how they felt a pivotal part of the care plan with an emphasis on the priorities for their child and the family. They were always kept informed of options about treatments. Another parent told us how staff had mediated between them and their teenage child when they had differing views about the treatment and had successfully negotiated a compromise solution.
- We observed parents being listened to, supported and asking questions about treatment. We also observed staff explaining to a child as much as possible about the treatment they were receiving and checking with them throughout the consultation.
- We also observed staff explaining the main characteristics of a child's condition to teaching staff during a school visit and how they impacted on the child's movement and discussed ways of incorporating movement during PE lessons.

Emotional support

- We observed staff providing emotional support to children, young people and their parents during their visit. Parents told us they felt supported emotionally by staff. A parent who had received support from the nursing staff said they were "always there for me ... I know I can talk to them if I need to".

Good

Are services responsive to people's needs?

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

Summary

The service was responsive to the needs of children, young people and their families.

Services were designed and delivered to meet the specialist needs of children and young people.

Staff understood the different needs of the children and young people and attempted to ensure that services were as flexible and accessible as possible to the widespread community.

Planning and delivering services which meet people's needs

- Staff were committed to delivering care as close to home as possible, minimising disruption for children and their families. Staff visited children and young people in their own homes or in local children's centres, GP surgeries, schools and nurseries. Staff were creative in making the best use of their time and were mindful to plan and organise as many visits and appointments as possible in one local area.
- Staff told us about a number of programmes: firstly the Family Partnership, which was a basic communication model promoting listening skills for health professionals to empower families to set their own goals and develop strategies to resolve problems themselves; and secondly Mellow Parenting, a pilot six-week programme based within a group setting to help young parents relax and to help young mothers to identify their own needs, inform them of how to access support both in pregnancy and after the birth of their baby. It had been agreed to take the programme forward and a plan was being developed to obtain funding from charitable sources locally and countrywide. Health visitors also told us about a pilot group they were facilitating for parents living with postnatal depression with plans for it to be rolled out across the county.
- In response to the Health Visitor Implementation Plan: A Call to Action (2011) the trust looked at ways to work with families to improve the lives of children in Somerset. The health visiting service developed an updated Family Health Needs Assessment tool to ensure a full assessment of the child and family's health needs, and an understanding of the parenting capacity.
- This tool was based on a strengths and deficit model. A RAG (red, amber, green) assessment process had been developed to identify appropriate levels of intervention by the health visiting team. Green, illustrating no unmet health needs identified or no needs identified; Amber, needs identified requiring intervention by a health visiting team or another internal health or children's centre service and would require a personalised care plan or a brief intervention required and; Red, a complex situation needing high levels of multi-agency intervention.
- A young parent's programme was in place which was an integrated model of enhanced support and sustainable care pathway to support vulnerable young expectant parents during both antenatal and postnatal periods. A programme was available through an antenatal workbook which offered eight structured sessions to provide specific advice and support to young parents on an individual basis. Staff explained the programmes had improved outcomes, for example, in terms of improved emotional and physical health for parents and their baby, improved sexual health and improved parenting capacity.
- Emergency contraception advice was available during weekdays for pupils at school. A request was made to the school receptionist to ask to see a school nurse who would see the pupil to offer advice and medication if required. If it was not a planned clinic day a school nurse would visit as soon as possible. Health and dietary education was also available such as the sugar content in drinks and learning was promoted on an individual or group basis, and through a variety of mediums such as posters and quizzes.
- We observed the health visitor team's duty cover where all contacts were recorded on the electronic records system with an email being sent to the appropriate health visitor to read the record and action as appropriate. Details were recorded in the child's and mother's record to ensure linkage of information and

any significant alerts were flagged with a red triangle. There was a clear handover between health visitors and school nurses either electronically or face-to-face if there were additional concerns.

- Clinics had been running for paediatric incontinence. Discussions with commissioners had taken place about activity units, integrated pathways and outcomes to enable a county-wide service, and a service specification had been drawn up.
- The integrated therapy service had designed a "fact file for early years" to support professionals who worked with all babies and young children (0-5 years) in order that they would have a greater understanding of young children's development and the ways they could help them and their families. Advice sheets were available for parents, carers and pre-school settings ranging from basic communication strategies, dressing skills and rough and tumble play.
- A "fact file for school age" had also been designed to support children and young people (4-19 years) during their development milestones. Advice sheets were available for schools, parents and carers about a range of topics ranging from confidence and esteem, developing fine motor skills to verbal comprehension and vocabulary. Both fact files informed and skilled the wider children's workforce to enable them to provide good practice guidelines and give advice to parents.
- During a multidisciplinary assessment at school a dark den was constructed to provide a safe, calm place for a child to retreat to during the session. The child was encouraged to engage with another child in the den and the therapist provided help and support for the teaching assistant to work with the child at school.
- There were concerns about the signing in processes that were required by Somerset County Council at clinics at jointly run clinics. Parents were asked to complete a communal attendance form which could be seen by all parents attending. This posed a risk to confidentiality and might deter some parents from attending. We discussed this with the area clinical manager who planned to address the concerns with the council with a view to finding an alternative solution.

Equality and diversity

- Staff received equality and diversity training as part of their mandatory training. Of staff providing services to children and young people, 98.4% had received this training at July 2015. In addition there were policies and procedures relating to equality, diversity and interpretation and translation.
- The areas we visited were accessible to disabled people and there were appropriate toilet facilities.
- The service saw a low percentage of children, young people and families whose first language was not English. However, the service had been adapting to the population needs of an increasing Polish community in Yeovil and were trying to address the specific health needs of the population for example childhood obesity, dental care and inappropriate use of A&E services. Following meetings between clinical leads and A&E services clinics were initially set up in church halls but communities reported feeling isolated and attendance at A&E increased. The clinics were moved to a children's centre in Yeovil and offered well baby clinics and clinics looking at developmental issues with an interpreter being present every week. Health visitors were working to link families with the local community and the team were establishing links with the local walk-in centre. One interpreter was available for an hour a fortnight in the health visitor base to help the health visitor telephone families about appointments. A Polish police community support officer also worked with the team. The attendance and effectiveness of the service was being audited and adapted to meet the needs of the families.

Access to the right care at the right time

- Staff were committed to delivering care as close to home as possible, minimising disruption for children and their families. Staff visited children and young people in their own homes or in local centres, schools and nurseries.
- We looked at monthly key performance indicators reports for integrated therapy services. Reports were generated by each area team with monthly referrals ranging from between 82 to 129 each month with no children waiting longer than 13 weeks for an initial assessment.
- Equipment days were held every half term by the occupational therapy and physiotherapy teams where representatives from equipment manufacturers demonstrated the most appropriate equipment available for individual children and young people. This enabled the teams to assess the most suitable

equipment for individual children and young people, for example standing frames, walker systems and sleep systems, and to develop good working relationships with manufacturers and to be up-to-date with the latest developments.

- The integrated therapy service had introduced a telephone advice line, available four mornings every week to support parents or carers and professionals to meet the needs of children and young people whose development might be causing concern. The line was staffed by therapists from the three disciplines. Callers could discuss their concerns and therapists could advise them on how to support the child or young person and consider whether a referral to the service might be needed.
- Referrals to the integrated therapy service could be made from anyone who had professional or parental responsibility for a child or young person and had concerns about their development. Referrers included GPs, teachers, educational or clinical psychologists, health visitors, school nurses, children's centre staff, social care teams, parents / carers and young people themselves. Forms were available on the trust website and submitted electronically. A team of therapists considered all referrals and decided whether the referral was appropriate and if so the most appropriate professional(s) to assess the needs of the child or young person.
- There were plans to streamline the triage and advice line service to reduce clinical time and utilise administration time more effectively by introducing stricter referral criteria and rejecting poor or limited referrals back to the original referrer.
- Assessment clinics were generally held at the area team bases with any subsequent appointments taking place in the child's school or in their home. A period of intervention with episodes of care followed with a review of the child's progress towards their goal and their continuing needs and discussions with the parents / carers to determine whether further involvement was required. Discharge was agreed if no further intervention was required with a proviso that a referral could be made at any time should the child or young person's needs or circumstances change.
- We looked at key performance indicators for the nursing team. Reports were generated for the new birth visits (at the six – eight week review) and we saw, during the 12 month period from July 2014 to June 2015, an average of 455 visits each month. School nurses delivered an immunisation programme across the county. Out of a total of 265 schools, ranging from infant to secondary schools, immunisation for human papilloma virus was delivered in 52 schools; meningitis C was delivered in 48 schools; and flu vaccinations were delivered in 205 schools.
- We observed a parent group that had been set up to strengthen children's social skills, emotional regulation and school readiness skills. The session we attended was the second in a series of 14 and focussed on child directed play through group discussion and role play. Parents who attended were very positive about the group and wished that more groups were available in other areas of the county as they felt that many other parents could benefit from the sessions.
- To address the high volume of missed appointments the administration teams sent letters to parents advising them to phone to make an appointment for review as part of the healthy child programme. Similar letters were sent asking parents to opt into the integrated therapy services. Both changes had resulted in an increase in attendance and less time wasted by missed appointments, thereby freeing up time to see more children and young people

Learning from complaints and concerns

- Parents knew how to make a complaint if they needed to and also felt they could raise concerns with the clinical staff they met. Information about making complaints was available in most of the clinics we visited. However, in some clinics jointly run with the local authority and held in local authority premises leaflets were not available. This meant that parents might not have been aware of the process to raise a complaint or any concerns.
- Prior to the inspection the trust confirmed there had been six complaints in the preceding 12 months. Of these, three had been upheld following investigation. We saw details of the outcome of the complaints; one related to the integrated therapy service and two concerned the health visiting team.

Good

Are services responsive to people's needs?

- Staff encouraged children, young people and their parents or carers to provide feedback about their care and comment cards were available in clinics asking parents to indicate how likely they were to recommend services to friends and family.
- Staff were aware of complaints that had been made and any learning that had resulted. The staff we spoke to were all aware of the complaints system within the trust and the service provided by the Patient Advice and Liaison Service (PALS). They were able to explain what they would do when concerns were raised by parents. Staff told us that they would always try to resolve any concerns as soon as they were raised, but should the family remain unhappy, they would be directed to the area clinical manager or the trust's complaints process.
- Administration staff were praised by managers and colleagues for their skill in dealing with initial complaints and for de-escalating concerns. Complaints were rare and those that were made related to parents concerns about the availability of services. Teams were effective in setting clear expectations for parents and felt this contributed to low numbers of complaints as parents had realistic expectations of the service and outcomes for their child.

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 have judged the leadership of the children and young people's service as good.

Good local leadership was provided throughout the various teams and staff were particularly complimentary about the support they received from their area clinical managers.

Frontline staff and local managers were passionate about providing a high quality service for children and young people with a continual drive to improve the delivery of care.

Most staff were positive about working for the trust. Staff took pride in their work and being at the centre of the community. They wanted to come to work. Staff felt informed about the project for integrated services across the community but uncertain and unsettled about the impact of the proposed changes.

Children and young people were able to give their feedback on the services they received; this was recorded and acted upon where necessary.

Service vision and strategy

- The trust mission was "Caring for you in the heart of the community" with a mission "to be the leading provider of community based health and social care." To help achieve the vision the trust had six strategic themes: "Respect and dignity"; "Commitment to quality of care"; "Compassion"; "Improving lives"; "Everyone counts"; "Working together for patients." Staff we spoke to had a good understanding of the trust core values and were proud of the service they provided.
- The children and young people's service vision was to deliver an equitable and integrated package of care and treatment tailored to the child or young person's individual needs.
- A transformational change project was in place across the trust and had reached the Integration Phase 2 (IP2) phase. The project was designed to integrate services across community services. The trust board approved initial outline proposals in January 2015 and proposals for new models of care had been shared with staff in July 2015 through 21 consultation events around the county. The implementation phase was due to occur between September and November 2015. The management structure of the children and young people's service was changing with a reduction in the area clinical managers for the public health nursing teams and the therapy teams.
- Staff told us area clinical managers had kept them updated about developments but senior managers had not visited the area teams. Most staff had provided feedback to the consultation and had received an acknowledgement in May 2015 from the chief executive and had seen the consultation feedback document issued on 1 September 2015. Staff were full of admiration for the professionalism of the managers who themselves were affected by the changes and felt they had shielded their teams from some of the stress and uncertainty.
- Staff felt decisions had been made and rushed through with little notice and were anxious about the effectiveness of the new structure and the accessibility of managers given the reduction in numbers. There was also concern about the professional leadership of the therapy teams as there would be no lead in physiotherapy within the new structure.
- The integrated therapy service had re-written their service specification to introduce new ways of working and staffing levels to ensure services were safe, effective and equal to all families in the county and were awaiting approval / sign off from commissioners.

Governance, risk management and quality measurement

- There was a clear structure for clinical governance with regular bi-monthly reporting to the clinical governance group which looked at areas such as incidents requiring investigation, safeguarding, clinical effectiveness, patient safety, infection control and medicines management. We saw minutes from these meetings which showed that issues affecting the service were discussed and actions taken.

Good

Are services well-led?

- There was a range of service and team meetings held at regular intervals. All meetings were minuted. A senior managers' operational group met monthly and comprised of all directors and associate directors, all heads of division and other senior management staff, and was chaired by the chief executive. The group reviewed performance at divisional level against key performance and quality standards, and monitored staffing and workforce issues, and key strategic themes, as well as acting as a ratification group for trust policies.
- Risks were clearly understood and defined. A risk register was in place and we noted that this had been kept up to date. Reference was made to known risks, for example, the risks posed by the high vacancy rate in the health visiting service.
- We saw that regular auditing took place with evidence of improvement or trends. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results. Waiting lists and clinics were monitored and the action plan devised to improve performance was regularly reviewed by managers.
- Clinical policies and guidelines were available for all staff via the trust intranet system.

Leadership of this service

- The senior management team communicated with staff by a monthly newsletter which was sent out by email. Staff told us the chief executive had visited the community sites and had attended the health visitor away day. However, there was limited visibility from senior managers. Teams felt segregated from the rest of the trust although immediate area managers provided support and links with the wider trust.
- The local area leadership of the services had the skills, knowledge and integrity to lead the nursing and therapy teams. The clinical area managers were an experienced and strong team with a commitment to the children, young people and families who used the service, and also to their staff and each other. They were visible and available to staff and we saw and heard about good support for all members of the team. We received positive feedback from staff who had a high regard and respect for their managers.

Culture within this service

- The staff we spoke to during the inspection told us they were proud to work in the community team and were passionate about the care they provided. Managers we spoke with told us they were proud of the staff they supervised and that there was a high level of commitment to providing quality services to the community. One member of staff told us "I feel supported by my colleagues and a valued member of the team" "I really value the comradeship and support … we are all like-minded and do the best we can … we give time for each other."
- Staff were positive about working for the trust, although at times they told us they felt stretched and under pressure because of the volume of their caseload.
- The culture in area teams encouraged candour, openness and honesty. It also centred on the child, young person and their parents. Most staff we met said they felt supported within their teams to raise concerns and anxieties. However, staff did not feel there was a trust wide culture of inclusion and engagement and wanted the senior executive to demonstrate to them that they had an important part to play in the future of the trust.

Public engagement

- We saw there were systems in place to engage with the public to ensure regular feedback on service provision for analysis, action and learning. In addition to the Friends and Family Test and comment cards, young people were encouraged to make comments via comments boxes.
- Parents and carers and partner professionals were encouraged to contribute to service development. We saw an example of a user group contributing to service delivery. In response to evaluation forms provided by all mothers attending post-natal groups, the group programme and the topics to be covered were changed to suit the express needs of the group.

Staff engagement

- Systems were also in place to engage with staff. "What's on" emails and monthly area meetings provided opportunities to have feedback from governance meetings covering issues such as incidents, complaints risk assessments, recruitment, project feedback and an update from each workload coordinator.

Good

Are services well-led?

- A Voicebox group provided a forum for staff to feedback ideas and for the senior management team to test out staff opinion on projects. Ideas were reported to the workforce governance group who met on a bi-monthly basis. Members brought topics for discussion on behalf of colleagues and cascaded feedback on discussions to colleagues within their teams.
- Staff were positive about the staff welfare available to them. A number of staff told us about the problems they had experienced with shoulder injuries as a result of carrying heavy scales and computer equipment. The trust had responded swiftly by providing physiotherapy and by providing new lightweight scales and back packs for their laptop docking stations.
- Staff were aware of the trust whistleblowing policy and the arrangements for reporting poor practice without fear of reprisal and felt confident about using this process if required.

Innovation, improvement and sustainability

- Staff were clear that their focus was on improving the quality of care for children, young people and their families. They felt there was scope and a willingness amongst the team to develop services.
- Despite the uncertainties about the new management structure of the service most staff were prepared for change and would continue to drive for high-quality care.