BMBC Services Limited

BMBC 0 to 19 Childrens Service

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Good ●

Summary of findings

Overall summary

- The service had enough staff to care for children and young people and keep them safe. Service users were at the centre of safeguarding and staff had a proactive approach to anticipating and managing risk. Staff had training in key skills, and, understood how to protect children, young people and their families from abuse and neglect. The service controlled infection risks well. The provider had a sustained track record of safety supported by accurate performance information. All staff were encouraged to participate in learning from internal and external incidents to improve safety.
- Staff provided good care and treatment to families, children and young people. Outcomes were consistently better when compared with other similar services, and there was a truly holistic approach to assessing, planning and delivering care. Managers monitored the effectiveness of the service and made sure staff competence was recognised as being integral to ensuring high quality care. Staff teams worked collaboratively and found innovative ways to deliver seamless care. Staff were consistent in supporting people to live healthier lives. They had a proactive approach to health promotion and the prevention of ill health. Staff made sure people had access to high quality health information and advice.
- Staff treated children, young people and their families with compassion and kindness. Feedback from service users was consistently positive and people thought the support they received exceeded their expectations. Staff were highly motivated to offer care that promoted peoples' rights and upheld their dignity. Staff recognised that the social and emotional needs of families, children and young people were just as important as their physical needs.
- The service planned care thoroughly to meet the needs of local people. There were innovative approaches to providing person-centred, integrated care, particularly for people with multiple and complex needs. People could access services flexibly and there was a proactive approach to understanding the needs and preferences of different groups of people. Technology was used innovatively to ensure people had access to timely treatment and care.
- Leaders at all levels of the service were compassionate, inclusive and effective. They demonstrated the high levels of experience and capability required to deliver excellent and sustainable care. Strategies and plans were fully aligned with plans in the wider health economy and leaders demonstrated commitment to system-wide collaboration. Staff felt inspired and motivated in their role. There were high levels of satisfaction across all staff teams and they felt truly valued and supported. Staff had a demonstrated commitment to best practice performance. Any problems were addressed quickly and openly.

However:

- The governance arrangements did not take into account the potential risks of prescriptions being diverted.
- The service could not demonstrate that service users were involved in the design and delivery of their services and not all service users had been provided with information about how to complain.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for children, young people and families	Outstanding ☆	

Summary of findings

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Summary of this inspection

Background to BMBC 0 to 19 Childrens Service

Barnsley Public Health Nursing Service is a universal service provided to children and young people aged 0-19 years, (or up to age 25 if people have a disability). The service delivers elements of the healthy child programme, and, prioritises children, young people and their families' health and wellbeing. This includes promoting the Best Start in Life for Children, improving access to health services, ensuring children are safeguarded and supporting children, young people and their families to live healthier and achieve their potential.

The framework that underpins the Public Health Nursing Service provision is the Healthy Child Programme 0-5 years and 5-19 years which focuses on collaborative working in partnership with parents, carers and other agencies to improve health and wellbeing, support parenting in early life stages, undertake health and development reviews at key mandated stages of a child's development, promoting the uptake of health screening and immunisations and provide evidence based education and advise to help parents and young people make informed choices. This includes early identification of children and families in need of additional support to ensure they receive early help and intervention before problems develop further.

Services operate from the following hubs/locations:

- Business address and Office base for members of the BMBC 0-19 Children's Services team Gateway Plaza, Level 8, PO Box 679,
- Central team - Worsborough Lift, Powell Street, Worsborough, Barnsley.
- North East Team - Cudworth Lift, Carlton Street, Cudworth.
- North Team. Roundhouse Centre Athersley and Darton Lift, Huddersfield Road, Barnsley.
- Penistone Team - Penistone Town Hall, Shrewsbury Road, Penistone, Barnsley.
- South Team Hoyland Lift, High Croft, Hoyland, Barnsley
- Dearne Team. Goldthorpe Centre, Goldthorpe Green, Goldthorpe, Rotherham.

The service has been registered since 22 February 2017 for one regulated activity; treatment of disease, disorder and injury. The service has two registered managers in place, both qualified specialist public health nurses. The service has not been inspected since it was registered in 2017.

How we carried out this inspection

During the inspection visit, the inspection team:

- visited three locations and carried out two home visits with service users
- spoke with both the registered managers for the service
- spoke with twenty-one other members of staff including, service managers, nurses, staff, support workers and administrative staff
- spoke with thirteen service users including one young person
- obtained feedback from four service users using comment cards
- observed three multidisciplinary team meetings
- observed the running of one baby clinic
- looked at eight care and treatment records of service users
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- The service had imaginative approaches to person-centred care. There was a dedicated member of staff to work with travellers, asylum seekers and refugees. The worker had specialist knowledge and understood the needs of those communities.
- The service had innovative solutions to providing joined up care, especially during the pandemic. They worked jointly with the local authority safeguarding team to provide targeted intervention for families identified as needing additional support around domestic abuse.
- Despite the challenges of the pandemic, the provider continued to meet all but one of their service targets mandated by Public Health England. In this respect, they were much better than the England average for this type of service.
- Services were tailored to meet the needs of individuals. Staff had access to interpretation and sign language services within minutes of meeting a new service user. Following statutory safeguarding meetings, the provider automatically translated meeting minutes into the service user's first language.
- Every child had a personal health record that had been specially adapted to meet the specific needs of families living in the Barnsley area.
- The service continually demonstrated best practice and had introduced a health education review aimed at children aged 3-4 years, to ensure that any needs that may not have been identified at the 2-2.5-year review were not missed.
- Service users could use an accessible instant messaging to contact the service, even out of hours. Staff ensured these were responded to the next working day.

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure there is a robust process in place to minimise the risks to the diversion of prescriptions.
- The service should ensure they involve service users, especially young people, in the design and delivery of their services, and consider alternative ways for people to provide anonymous feedback on the quality of services.
- The service should ensure that all service users are made aware of how to make a formal complaint.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children, young people and families	Good	☆ Outstanding	Good	☆ Outstanding	Good	☆ Outstanding
Overall	Good	☆ Outstanding	Good	☆ Outstanding	Good	☆ Outstanding

Community health services for children, young people and families

Outstanding ☆

Safe	Good
Effective	Outstanding ☆
Caring	Good
Responsive	Outstanding ☆
Well-led	Good

Are Community health services for children, young people and families safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing staff received and kept up to date with their mandatory training. At the time of our inspection, the overall, the compliance rate for mandatory training was 93%. The only course to fall below the provider's target was a health and safety qualification accredited by the Institution of Occupational Safety and Health, (IOSH), which staff did every three years. Compliance for this was at 59% because all face-to face-training had ceased due to the pandemic. However, all staff were up to date with their mandatory training in other aspects of health and safety including fire safety, lone working, display screen equipment, manual handling, infection control and conflict resolution. In addition, all managerial staff were up to date with their IOSH training and they provided advice to staff who were working remotely with limited activity on provider premises. All buildings had facilities managers in place, and these were trained to a high standard in managing health and safety.

The mandatory training was comprehensive and met the needs of children, young people and staff. Courses included child development, mental health first aid, risk assessment, domestic abuse, information governance, equality and diversity, health and safety and various modules in safeguarding.

Clinical staff completed training on recognising and responding to children and young people with mental health needs. All school nurses and public health nurses completed mental health first aid training and suicide prevention training; the latter was delivered by specialist child and adolescent mental health staff. The provider had a partnership with a local mental health charity that provided advice and support to staff working with young people with mental health difficulties. Staff could access further training as needed, including working with young people with learning disabilities and autism.

Managers worked closely with business support staff from the local authority to monitor mandatory training. They alerted staff promptly when they needed to update their training.

Community health services for children, young people and families

Outstanding ☆

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. The provider followed national guidance issued by the local authority safeguarding board about the type and frequency of training that staff should receive. Staff were trained to the appropriate level in both child and adult safeguarding. They completed additional specialist training, some of which was, delivered by in-house safeguarding leads during regular development days.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff completed mandatory training in equality and diversity and in safeguarding people from being drawn into terrorism. Staff gave us examples of how they worked to identify child trafficking and hate crime amongst the families they worked with.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave us examples of how they worked with the police and social care agencies to identify and protect children and families from harm. School nursing staff delivered training in schools to prevent cyber bullying. The provider employed a full-time member of staff specifically to work with travellers and asylum seekers in the Barnsley area.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff made direct referrals to the local safeguarding authority, but each team had a safeguarding lead where they could seek advice. All staff, including the safeguarding leads, were supported in their safeguarding role by a full-time senior safeguarding manager. The provider had employed three nurses to a local multi-agency safeguarding hub. This was to improve the quality of joint working with other agencies to identify and protect individuals at risk of harm.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff adhering to PPE protocols and wearing face masks in line with the local authority's infection control procedures. Staff and service users had access to hand gel and anti-bacterial wipes when visiting the service.

Staff cleaned equipment, such as height charts and weighing scales after each patient contact. Some equipment had disposable pieces that were only used with one service user. None of the service users we spoke with had any concerns about the provider's hygiene procedures.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. When providing care in children and young people's homes staff took precautions and actions to protect themselves and children, young people and their families.

Staff carried out appropriate checks of specialist equipment, for example, weighing scales and other portable appliances. Business support staff kept a log of equipment that needed calibrating or testing and completed this each year during the school holidays. We looked at this log and saw it was accurate, and up to date.

The service had suitable facilities to meet the needs of children and young people's families. Most of the activity carried out with service users took place in the service user's own home but clinics ran in family centres and other suitable premises managed by the local authority. Each school had suitable arrangements in place so staff could see young people in private.

The service had enough suitable equipment to help them to safely care for children and young people. Staff had access to their own equipment and did not have to share it with other staff teams. Staff disposed of waste safely in line with guidance from the local authority.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used a nationally recognised assessment tool from the 'Working Together to Safeguard Children' legislation, to identify children or young people at risk. This assessment identified how the different aspects of the child's life interacted and impacted on the child. They completed risk assessments for each child and young person on admission into the service. From health care records, we saw how staff reviewed these regularly, including after any incident.

Staff knew about and dealt with any specific risk issues. From health care records, we saw that staff used a variety of other risk assessments specific to children and families. For example, they used a tool developed by the National Society for the Prevention of Cruelty to Children, (NSPCC), to assess signs of neglect. They also completed safe sleep and domestic abuse risk assessments. All nursing staff were trained to use 'early help' assessments to identity unmet need. They used these, where appropriate to identify and escalate safety concerns.

At the height of the pandemic, the service continued to carry out face-to-face safe and well visits on the most vulnerable families. They carried out additional visits for families highlighted by safeguarding as being at risk of lower level domestic abuse.

The service had good access to mental health liaison and specialist mental health support where staff were concerned about a child or young person's mental health. During their working hours, staff could get advice from the local specialist child and adolescent mental health team. Staff could refer directly to the local community perinatal mental health team where they had concerns about maternal mental health. Out of hours, the service had an automated message with crisis support signposting information.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. There was a specific pathway in place with the local specialist child and adolescent mental health team where staff could escalate concerns about young people thought to be at risk of self-harm or suicide.

Staff shared key information to keep children, young people and their families safe when handing over their care. Staff exchanged information with midwives prior to, or at referral into the 0-19's service. Where staff had specific concerns, they could ring a single point of access and speak with a practitioner directly. They carried out joint assessment visits where necessary.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep children and young people safe. Each team had a mixture of nursing staff including specialist health visitors and school nurses, child development practitioners, support workers and infant feeding peer support workers. The provider had created a safeguarding team to deal with complex child protection issues. This meant that staff in the other teams did not get overloaded with safeguarding work.

Managers regularly reviewed caseloads and staff told us these were manageable. Managers were able to adjust caseloads to account for complexity and staff had a mixture of universal and more complex cases.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed, in accordance with national guidance. Managers used local data, for example, birth rates, and previous activity levels to forecast how many staff they would need, and in which roles for the coming year.

The number of nurses and support workers matched the planned numbers. Managers calculated they would need 101 whole time equivalent staff, (wte) to run the service and they had 94 wte staff in post. Of these, 69 wte were qualified nurses, which meant that 73% of all staff were nurses.

The service had low vacancy rates. There were 7 posts vacant at the time of our inspection. Managers recruited registered nurses as support workers and skilled them up with additional public health nursing qualifications to fill vacancies in the specialist community public health nursing team. Last year, they had trained six staff and currently, they had three staff on the course.

The service had low and/or reducing turnover rates. From 1 September 2020 to 31 August 2021, their turnover rate was 14% and this consisted of 20 staff leavers. Managers monitored the reasons staff left the service and most of them had either retired or they moved on to progress their careers.

The service did not have low or reducing sickness rates. The total full-time equivalent staff sickness absence rate for the period 1 September 2020 to 31 August 2021 was 13%. Most of this was due to a small number of staff with long-term sickness or health conditions. Managers told us they did not have a problem with staff short-term sickness, and this was confirmed by the staff we spoke with.

The service had low rates of bank and agency nurses. The provider did not use agency staff. They used a small number of bank staff to cover staff absence including sickness maternity and vacant posts.

Managers limited their use of bank staff and requested staff familiar with the service. All the staff currently working on the provider's bank rota had worked for the service previously.

Managers made sure all bank staff had a full induction and understood the service. Bank staff undertook the same mandatory and other training as substantive staff.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

At inspection, we looked in detail at several care records. Patient notes were comprehensive, and all staff could access them easily. All staff including bank workers had access to care records that were all kept on an electronic system. All eight records we looked at demonstrated that the care delivered was family focussed, holistic and comprehensive. Clear actions were evident and although staff had access to standard templates, the records were detailed and highly personalised.

When children and young people transferred to a new team, there were no delays in staff accessing their records. Staff shared care records with other local teams including the child and adolescent mental health team, speech and language team, therapy services and the person's GP. The members of the multi-agency safeguarding hub had access on a 'read only' basis to care records kept by the service.

Records were stored securely. Each staff member had their own unique log-on and staff were provided with training on information security and governance before they could use the system.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, we found that governance arrangements could be strengthened.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service did not deliver immunisations but nurses who were up to date with their competence could prescribe from a limited range of medicines. Staff had appropriate continuous professional development in place which meant the provider was assured staff were working within their competence.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. The service had an up-to-date non-medical prescribing policy which we looked at following our inspection. There were no medicine errors in the 12 months before our inspection and the service carried out quarterly audits of what was prescribed and by whom. The prescribing activity was managed jointly between the provider and the local clinical commissioning group. However, the governance arrangements were not as robust as they could have been in respect of prescriptions. Although the risk was minimal because each prescriber had their own unique supply of prescriptions, we could not see governance arrangements in place to minimise the risks of diversion of prescriptions.

We spoke with service users who confirmed that, where appropriate, staff provided specific advice about their medicines.

Staff followed current national practice to check children and young people had the correct medicine. We were assured that staff were not prescribing outside their role and that the prescribing was appropriate for the service user group. Quarterly audits were overseen by the quality and governance manager in conjunction with other the senior managers in the service.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. Individual staff were signed up to receive alerts but the governance manager for the service made sure all relevant alerts were cascaded to staff. Staff gave us examples of some of the alerts they had received.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. There were different reporting arrangements for different types of incident, but all staff received training and guidance in how to identify and report them.

Staff raised concerns and reported incidents and near misses in line with local authority policy. The service had very few incidents, which they monitored on a regular basis but the most commonly occurring incidents were about information governance and verbal aggression.

Staff reported serious incidents clearly and in line with the provider's policy. However, in the 12 months prior to our inspection, the service had not reported any serious incidents but they had carried out two internal reviews concerning child deaths in the Barnsley area.

Staff understood the duty to be open and transparent when things went seriously wrong. They confirmed that they would give children, young people and their families a full explanation in these situations.

Staff received feedback from investigation of incidents, both internal and external to the service. All incidents were discussed at fortnightly managers meetings and lessons learned were disseminated to staff through regular team meetings. We confirmed with staff that they had access to the quarterly incidents dashboard, so they knew what incidents had happened in the service. We looked at a presentation delivered by the safeguarding manager at a team development day in January 2021. It contained the learning from all the safeguarding practice reviews that had taken place in Barnsley over the last five years.

Staff met to discuss the feedback and look at improvements to children and young people's care. Managers and team leaders held regular governance meetings where they discussed service improvements. They held regular development days with staff where the whole team had the opportunity to discuss feedback and identify improvements to the service.

There was evidence that changes had been made as a result of feedback. For example, we saw how the service escalation policy had been reviewed as a result of an internal review into a child safeguarding incident.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. The senior safeguarding manager was a member of the local area safeguarding partnership board where multi-agency reviews concerning child deaths took place. Families were involved in these investigations, as appropriate, determined by the partnership board. In the 12 months prior to our inspection, the provider carried out two internal

reviews concerning child deaths in Barnsley. Following these reviews, managers and team leaders met to discuss the findings and implement any recommendations for the service. We looked at one recently concluded investigation concerning a child death and found that the review was comprehensive and included clear recommendations which had been acted on in a timely manner.

Managers debriefed and supported staff after any serious incident. Staff confirmed managers were supportive following incidents, especially concerning child deaths. The lead safeguarding manager had received specialist training and staff could access specific counselling if they needed to.

Safety Thermometer

The service used monitoring results well to improve safety.

The service continually monitored safety performance. Auditors from the local authority carried annual health and safety audits that measured the extent to which the service complied with a wide range of elements concerning occupational health and safety management. Managers had an action log to carry out any required improvements. The last audit, carried out in August 2021, showed an audit score of 96% which, meant the service had achieved a good standard with few improvements required.

Managers monitored numbers of referrals they made into social care and audited cases from the multi-agency safeguarding hub to identify if they had missed any safety concerns.

Are Community health services for children, young people and families effective?

Outstanding ☆

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people in their care.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The quality and governance lead ensured policies were up-to-date and in line with national guidance. We looked at their standard operating procedures and found they were based on the national good practice standards for the healthy child programme 0 - 5 years and 5 – 19 years. The service had numerous pathways in place that reflected the latest guidance from the National Institute of Care and Excellence, (NICE). Managers reported each quarter which polices had been reviewed in line with new or revised national guidance.

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families. We saw evidence in care records that, in handover meetings and communication with midwives, staff took a holistic approach.

Nutrition and hydration

Staff regularly checked if children and young people were eating and drinking enough to stay healthy.

We received feedback from service users that staff provided advice where needed on diet and nutrition for parents, carers and their children. Where appropriate, staff referred families to sources of help around nutrition including local food banks. Nurses delivered healthy eating campaigns to young people in schools, and individuals were referred to specialist services, where appropriate.

Specialist support from staff such as dietitians and speech and language therapists was available for children and young people who needed it. We saw in care records that staff referred children and young people to other appropriate professionals including dieticians, physiotherapists, and paediatric services. Several service users we spoke with told us their child had been referred by the service for speech and language therapy and that this was appropriate and timely.

Service user outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

The service participated in relevant national clinical audits. For example, staff contributed to the National Child Measurement Programme. The service had submitted breast-feeding rates to Public Health England who had validated and published the data on their website.

Outcomes for children and young people were positive, consistent and met expectations, such as national standards.

Current data published by Public Health England showed that the service was meeting all but one of their mandated targets. Compared to other providers in England, the service was performing better in completing child reviews at 6-8 weeks, 12 months, and 2 years. The service also scored 100% (above the England average), for completing the Ages and Stages Questionnaire 3 as part of the healthy child programme integrated review for 2 – 2.5-year olds.

The only mandated target the service did not meet was the proportion of new birth visits completed within 14 days and this was due to the additional pressures faced by staff, as a result of the pandemic. The head of the service agreed with the service manager to locally extend the target to 21 days. Managers showed us data to evidence that they were meeting this locally agreed target. To mitigate any increased risk, staff carried out safe and well visits on the families identified as vulnerable by social care partners.

The service had excellent collaborative working arrangements in place to improve the uptake of specific services for children and young people. For example, staff were able to monitor whether children were having their immunisations at the correct time because each GP practice had a named link nurse. Through shared records, staff could identify whether children had received their immunisations and they followed up children accordingly. Staff were trained in motivational interventions and, in care records, we saw how staff encouraged families to have children vaccinated.

Managers and staff used the results to improve children and young people's outcomes. Staff had recently implemented the use of an evidence-based outcome tool to promote and measure positive change with individual service users. They had begun benchmarking individuals at the start of their care and in time, they hoped to demonstrate the progress they had made in several key areas including mental and physical health and social functioning.

As part of reviewing care records, we looked at some case studies and story boards to illustrate the impact staff had made with families experiencing abuse, unmet need and special educational needs. The stories showed positive outcomes for children and families following intervention by staff.

The service was working towards gold standard accreditation by the United Nations Children's Fund, (Unicef UK), breastfeeding Baby Friendly Initiative.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service had a comprehensive audit schedule in place, which covered areas such as quality of care, record keeping and health and safety. Section 11 of the Children Act 2004, required the provider to carry out regular safeguarding audits which we checked as part of our inspection.

Healthy Child Programme Leads audited health assessments which demonstrated that 100% of the 127 records had had an appropriate assessment using the correct Ages and Stages Questionnaire 3, (ASQ 3) for the age of child. Of these, 41 (32%) of the 127 children required onward referrals to a range of agencies.

Managers used information from the audits to improve care and treatment. Following each audit, managers developed an action log, which meant the service was aware of what they needed to improve. As a result, managers had enhanced staff training, supervision processes and care pathways to improve the service user journey.

Managers shared and made sure staff understood information from the audits. They ensured all staff were actively engaged to monitor and improve quality and outcomes. Managers shared a dashboard with all staff showing the results of the audits that had been carried out in the previous quarter. Some teams, for example, child development workers had a regular development forum where they discussed information from audits, but the whole team had regular development days where they shared learning from audits. Improvement was checked and monitored by the leadership team which met every two weeks.

Competent stafff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The clinical educators supported the learning and development needs of staff. All service managers, including team leaders were qualified public health nursing staff. The team had quarterly development days and completed practice development sessions, for example, in safeguarding. Qualified staff had nationally validated competence frameworks in place and some nurses had been supported to complete additional training to enable them to support external vaccine clinics. The service had three practice educators trained to support student staff.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. The service had a good skills mix of staff including qualified nurses and midwives with additional specialist public health qualifications, child development practitioners trained to deliver evidenced based parenting programmes, public health support workers trained to carry out specific public health duties and infant feeding peer support workers that also received specialist training for their role. The staff we spoke with were experienced and highly knowledgeable about their role in the delivery of the healthy child programme.

Managers gave all new staff a full induction tailored to their role before they started work. As part of our inspection, we spoke with a group of newly recruited staff. They all confirmed they were in receipt of a full structured induction in the role. This included an induction into the relevant local authority procedures and systems.

Managers supported staff to develop through yearly, constructive appraisals of their work. The compliance rate at the end of the quarter April to June 2021 was 91%. All the staff we spoke with confirmed they had an up-to-date appraisal and some newer staff we spoke with told us they were encouraged to have a mini appraisal even though they had been in post less than 12 months.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Managers and team leaders were trained to carry out effective supervision. The compliance rate at the end of the quarter April to June 2021 was 100% for qualified nurses and 96% for other staff. Staff also received regular group and individual safeguarding supervision. At inspection we spoke with a wide range of staff including managers, nurses and support workers. They all confirmed they had received supervision in line with the provider's policy.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We spoke with staff who confirmed they had access to regular team meetings and full minutes were circulated to all staff, following the meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Regular training needs analysis was carried out by the quality and governance lead for the service and managers used the results from serious case reviews to identify learning for staff.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers discussed training needs with staff as part of their supervision and appraisal. Staff spoke in an effusive way about the training and development on offer in the service.

Managers made sure staff received any specialist training for their role. In addition to mandatory training, all staff had a training matrix which outlined the required training for their role. For example, infant feeding peer support workers received specialist training in feeding choices and child development workers received training in identifying child development issues. Some nurses had been offered the opportunity to undertake additional public health qualifications.

Managers identified poor staff performance promptly and supported staff to improve. Staff were supported by business development teams in the local authority and they had access to robust capability and disciplinary procedures. Managers gave us examples of how they supported staff with improvement plans, additional training and increased supervision to support them to improve.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit children, young people and their families. They supported each other to provide good care and communicated effectively with other agencies.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. At inspection, we observed staff engaged in several meetings including a 'child in need' meeting and a 'team around the child' meeting. We saw how staff from the service worked with other staff from within and external to the service to plan effective interventions for service users. Many service users we spoke with commented how skilled and supportive staff were in these meetings.

Community health services for children, young people and families

Outstanding ☆

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. We saw many examples of how they worked in partnership with safeguarding teams, the police, health, education and voluntary sector organisations to provide appropriate and timely interventions for service users.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression. The service had a specific pathway in place with the local child and adolescent mental health service which allowed staff to escalate concerns about a child's or young person's mental health so they could receive specialist assessment.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support. Service users confirmed that they had access to a range of healthy lifestyle information through an information portal hosted by the local authority. Service users told us staff provided them with healthy lifestyle advice and practical support such as help with housing and benefits.

We saw examples of health promotion campaigns carried out by staff including substance misuse and sexual health, aimed at young people. Staff told us they had more time for preventative work since the creation of a safeguarding team that dealt with complex safeguarding cases.

Staff had implemented support for parents with crying babies aimed at reducing stress & abuse. Between three and four weeks following the birth, staff sent a text message to parents to notify them of help around how to cope with a crying baby.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. When we spoke with staff, they demonstrated a good understanding of mental capacity including unwise decision-making. They gave us an example of this with a young person they had worked with.

Staff made sure children, young people and their families consented to treatment based on all the information available. Feedback from service users was that staff explained that visits from staff were not mandatory and they could refuse if they wished.

Consent was clearly recorded on the person's electronic healthcare record. We saw this when looked at a sample of care records.

When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions. Staff described how they might go about this process to us, but they had not encountered any situations where they needed to make best interest decisions.

Community health services for children, young people and families

Outstanding ☆

All staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We looked at the current mandatory training data, which showed 97% compliance with this course. Staff undertook refresher training every three years.

Appropriate staff received guidance in Gillick Competence and Fraser guidelines. The service had a pathway with a local specialist sexual health service and staff could seek further guidance as appropriate to the needs of young people.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff had access to social workers and other specialists within the local authority who provided advice as needed.

Records

Staff always had access to up-to-date, accurate and comprehensive information on children and young people's care and treatment.

Staff had access to an electronic records system that they could access and update remotely. This could be shared with other professionals in the wider health system including the service user's GP. All service users were made aware of that their record would be shared with other relevant professionals on a need to know basis.

Staff had on 'read only' access to records held by the safeguarding multi-agency hub to facilitate joint working to protect children.

Are Community health services for children, young people and families caring?

Good

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. At inspection, we received feedback on comment cards from four service users. Following the inspection, we spoke with a further 13 service users including one young person. We also attended two home visits where we observed interactions between staff and service users.

Children, young people and their families said staff treated them well and with kindness.

The response from all but two of the service users was highly positive They said staff were very caring, compassionate and listened to their needs. Most people praised the service and said staff had gone out of their way to provide excellent care. The two service users that gave negative feedback said that some staff did not always have a non-judgemental approach. However, even those service users had experienced positive care from other members of the team.

From our observations of staff, we found they demonstrated a caring and responsive approach with service users. When we spoke with them, we found they were very passionate and highly motivated to provide excellent quality care.

Staff followed policy to keep care and treatment confidential. Staff followed robust confidentiality procedures that were evident from looking at healthcare records and speaking with service users directly.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. The young person we spoke with confirmed that staff provided individualised care and displayed a non-judgemental approach.

Emotional support

Staff provided emotional support to children, young people, families and carers to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. Service users told us staff were highly responsive in providing support and offered valuable advice and help. Many service users named individual staff to praise them for the support they offered. Some service users told us they did not know what they would have done without the support from staff.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. Staff made sure there were suitable private areas in schools and shared buildings where they could meet service users. All the service users we spoke with told us staff were mindful of their privacy and dignity.

Staff did not undertake specific training on breaking bad news, but nursing staff undertook communication skills training as part of their qualification. We observed that staff demonstrated empathy when having difficult conversations, for example, in safeguarding meetings.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. For example, we saw in care records how staff supported parents with feeding choices that were appropriate for their personal, social and cultural needs.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families, well-being. The interactions we observed and the feedback we obtained from service users told us that staff were highly skilled and experienced in understanding impact on families of living with a family member with a health condition. Service users told us how compassionate and empathic staff were in these situations.

Understanding and involvement of service users and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. We saw evidence in healthcare records that staff spoke with service users about their treatment in ways that were appropriate for them. Feedback from service users including the young person we spoke with confirmed that staff used clear language with no jargon.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this.

Community health services for children, young people and families

Outstanding ☆

Service users could give feedback via the provider's social media page. Managers monitored the number of 'followers', 'likes' and recommendations the service received. Individuals could also post compliments, though many of the service users we spoke with would have preferred a less public way of being able to provide feedback. Some also said that they would have liked the opportunity to provide confidential, even anonymous feedback following visits from staff. Managers told us they were working on improving their service user feedback processes.

Service users gave positive feedback about the service. All but two of the 13 service users we spoke with gave highly positive feedback about the service, and, all four service uses that filled out comment cards gave very positive feedback.

The service did not involve service users in the design or development of the service, but they were working on ideas for progressing this with their colleagues in the local authority.

Are Community health services for children, young people and families responsive?

Outstanding ☆

Service delivery to meet the needs of local people

The service proactively planned and provided care in a way that met the needs of local people and the communities served. Staff also worked with others in the wider system and local organisations to plan and deliver care.

Managers engaged in detailed planning activities so they met the changing needs of the local population. They were constantly looking for ways to improve and ensure services met existing and emerging needs. Managers looked at public health and demographic data from the local authority to plan staffing, skills mix and services. They had access to an up to date needs assessment of the local authority area and knew, for example, they had a large traveller and migrant population. As a result, they had appointed a full-time worker to work exclusively with travellers, refugees and asylum seekers.

In response to the need identified in the local area, the service had a dedicated staff team to work exclusively with looked after children. Staff monitored the numbers of health assessments undertaken with children in care and whether they took place in a timely way.

Managers identified gaps in services for teenage parents and, as a result, were developing an intensive home support programme aimed at new and expectant teenage and young parents aged 20 years and under.

The service had a dedicated safeguarding team to work with complex safeguarding cases. This meant staff in the other teams were more available to focus on prevention and early intervention with children, young people and families.

During the pandemic when children were not attending school, the service introduced walk and talk sessions for school aged children. On request, a staff member met the young person outside to walk with them. This was intended to help reduce social isolation and anxiety during the pandemic.

Facilities and premises were appropriate for the services being delivered. Most activity took place within service users' own homes or in school, but the provider used health centres and multi-occupancy buildings to deliver some clinics. These spaces had been specially adapted for use by the provider's service user group.

Community health services for children, young people and families

Outstanding ☆

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. The placement of the service in the local authority's wider public health department meant that staff had access to specialist interventions for families who needed them.

Staff had undertaken a joint piece of work with 'children in care' services to introduce a health passport for all young people leaving care and transitioning to adult services. The passport was a highly personalised record containing information about the person's mental and physical health as well as other important public health information. The service was planning to work with the special educational needs and disabilities (SEND) service to extend this to other young people using the service service.

Service users told us that staff had an excellent knowledge of specialist services and often went the extra mile to identify services that could benefit individuals and families. The service had a specialist infant feeding team that worked in partnership with the health visitors to provide additional support to parents.

Managers monitored and took action to minimise missed appointments. Appointments were flexible and service users were sent text reminders when their next appointment was due.

Managers ensured that children, young people and their families who did not attend appointments were contacted. We saw examples in healthcare records where staff re-visited service users that were not at home when they called. We saw how staff made appropriate safeguarding enquiries where they were concerned and could not contact families directly. Managers could monitor failed contacts because staff recorded it on a specific template in the appropriate healthcare record.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. Every child had a personal child health record which contained details about their growth and development. The service had adapted this to meet the needs of the population in Barnsley and it contained other information useful to parents with babies, children and young people.

In addition to their partnership work for 2-2.5-year olds and integrated reviews, the service had introduced a health education review aimed at children aged 3-4 years. This was to ensure that any needs that may not have been identified at the 2-2.5-year review were not missed. Managers thought this was especially important in the light of the pandemic and the fact that a child may not have accessed any setting during the restrictions.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss.

In healthcare records, we saw evidence that service users with a disability or sensory loss could access communication support and were provided with information in a format they could understand. However, the service planned to improve this by developing a specific communication template on the healthcare record. This would ensure managers could demonstrate that all staff routinely asked about communication needs at assessment.

The service had information leaflets available in languages spoken by the children, young people, their families and local community. Leaflets could be translated into any community language as needed by staff in the local authority. Service users had access to a family information service through the local authority. Content on both this website and the provider's website could easily be translated by the user into any community language. Users could adjust the font size and contrast.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. All staff had access to an interpretation service which was highly responsive. Staff could set up three-way conversations with service users and interpreters within minutes of arriving at their home. The service included access to signers.

At the end of statutory safeguarding meetings, staff made sure the notes were automatically translated into the first language of the service user before being sent to them.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers and staff worked to make sure children and young people did not stay longer than they needed to. The service worked with people from birth up to the age of 19 or longer if they had a disability. Staff worked closely with other specialist providers where they could ensure transitional arrangements were in place for young people to transfer to adult services.

Service users could use the instant messaging function on the provider's social media page to leave a message for any of the staff in the service, day or night. Messages would be responded to the next working day. Some service users told us they found this particularly helpful especially if they were too busy to use the phone or the service was closed.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. Managers made sure they allocated resources to meet their mandated contacts, so they did not have a waiting list. During the pandemic and at times of staff shortage, they prioritised work with the most vulnerable families to ensure people received the right intervention at the right time. According to current data from Public Health England, the service performed better than the England average for meeting all but one of their mandated contacts.

The service had a single point of access staffed by duty workers during the service opening times of Monday-Thursday 08.45am to 4.45pm and Fridays 08.45am to 4.15pm. The phone line was staffed by administrators, but service users could be put through to members of the healthy child programme team that operated a duty rota. Managers monitored how long service users had to wait. In the quarter ending June 2021, 82% of service users received a call back within 2 hours where they requested to speak with a duty worker. This was just short of the service target of 90%. None of the service users we spoke with told us they had any difficulties in speaking with staff via the duty system and in fact, most said they could contact staff very easily.

Managers worked to keep the number of cancelled appointments to a minimum. They monitored the number of appointments that were cancelled by the service. From 1 October 2020 to 30 September 2021, the service had to cancel 2% of scheduled appointments. When families, children and young people had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible. Managers monitored the numbers of appointments that were cancelled with at least four hours' notice. In the quarter ending June 2021, 75% of appointments cancelled met this target.

Community health services for children, young people and families

Outstanding ☆

Staff supported children, young people and their families when they were referred or transferred between services. Service users told us that staff went out of their way to support them to access appropriate specialist services. Staff attended case conferences and strategy meetings to support families to access the right care. We attended several of these meetings as part of our inspection. We observed how staff contributed to professional discussions and assisted service users to express their own views and concerns.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Children, young people and their families knew how to complain or raise concerns. Many of the service users we spoke with could not remember whether they had received information about how to make a complaint but most people told us they had no reason to make a complaint and that if they did, they would feel confident to ring the single point of access to find out.

The service did not clearly display information about how to raise a concern in patient areas because they used shared buildings. Information about how to complain was on the council's website. Many of the service users we spoke with could not remember whether they had been given information about how to make a complaint.

Staff understood the policy on complaints and knew how to handle them. Staff dealt with and resolved as many complaints as they could quickly and without the need for highly formal procedures. In the period 1 April 2020 to 31 March 2021, the service received one formal complaint and 15 informal complaints where staff facilitated an early resolution. In the same period, the service received 69 compliments.

Managers investigated complaints but there were no recurring themes.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. We looked at a sample of staff meeting minutes from across the various teams. We saw that at team staff received copies of the complaint monitoring dashboard with details of how complaints had been resolved. Where learning was identified, this was also shared with staff.

Staff could give examples of how they used patient feedback to improve daily practice. Following a formal complaint, staff told us how they had revised the procedures to make it clearer where families had opted out of contact with the service. Since the introduction of a more robust process, they had not had any further complaints.

Community health services for children, young people and families

Outstanding ☆

Are Community health services for children, young people and families well-led?

Good

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for children, young people, their families and staff. They supported staff to develop their skills and take on more senior roles.

The head of public health for children and young people in Barnsley was a qualified public health nurse and acted as the senior manager for the service. There were two registered managers both of whom were experienced public health nursing staff and they directly managed a team of qualified team leaders. Together, these leaders had an in-depth understanding of the needs of service users and the issues staff faced in delivering universal and targeted services to the population of Barnsley. Managers thought being in public health was of significant benefit to the service because of the synergy between the priorities of the service and the public health agenda. Being part of the local authority also meant that staff were well integrated into statutory procedures like child and adult safeguarding and sudden infant death review processes.

Staff said leaders were visible, approachable and led by example. Senior leaders in the council visited the service and spoke with staff. Staff were on first name terms with the director of public health. Service managers were in touch with the day-to-day issues facing staff and some undertook shifts on the duty rota to answer calls from service users. When the service was transferred to the local authority, some staff left the service or chose not to transfer, but staff told us that many had returned to the service because of the strong leadership in place. There was a coherent management structure in place with each team member being clear about their role and what they were supposed to achieve.

Managers and team leaders supported staff to develop their skills and staff spoke highly of the training and development opportunities on offer. Although not formalised, managers had strong recruitment strategies and succession planning in place. They offered nursing staff the opportunity of further training to become qualified as specialist public health nurses. Non managerial qualified staff undertook leadership training, and staff at all levels were encouraged to develop their skills to their full potential.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had the same vision as the local authority, which was to improve health outcomes for children, young people and families in Barnsley. The vision and the values of the local authority were integrated into the work of the team and formed part of the staff induction process. The registered managers met with all new staff to speak with them about the vision for the service and how the work of the teams connected with the wider public health agenda.

The service had strong partnerships and multi-agency working arrangements in place, which meant staff could deliver high quality care within the budget available. The head of service was a member of both the council's public health directorate management team and the children's directorate management team and was accountable to the director of public health for Barnsley. Staff knew what the health priorities were for the locality within the wider public health system. They ensured their local plans reflected these priorities.

Managers had effective strategies in place to ensure a focus on preventative and early help work while maintaining a strong emphasis on safeguarding. They did this by creating a specialist team to deal with complex safeguarding concerns. Being part of the local authority meant that managers could keep running costs, like overheads, to a minimum. This ensured they could make efficiency savings when they needed to, without losing front line staff.

The service had an improvement plan in place and used this to monitor progress against service objectives. Staff had made improvements in meeting mandated contacts, increasing the uptake of a virtual group for breastfeeding mums, improved provision for teenage parents and revised health education reviews for children aged between 3 and 4 years.

Culture

Staff felt respected, supported and valued. They were focused on the needs of children and young people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where children and young people, their families and staff could raise concerns without fear.

All the staff we spoke with at inspection told us they felt supported and valued. Team morale was high, and staff were proud to work for the provider. Our interviews with staff demonstrated that staff were highly motivated and passionate about their work. Most service users said staff were focussed on their needs and went above and beyond to provide excellent care.

Managers strongly encouraged staff to develop their careers and provided opportunities for them to expand their skills and experience. Many managers and team leaders were recruited from within the service. The service was training their own specialist public health nursing staff, and, during the pandemic, some staff had been trained to help in external COVID vaccination clinics. Supervisors had supervision skills training and qualified staff undertook leadership development training.

Staff described an open culture where they could raise concerns without fear. They told us managers were approachable and would listen to any issues they raised. All but two service users said they felt confident to approach their individual worker with any concerns. Staff and managers preferred to resolve any service user concerns quickly and informally to the satisfaction of the person concerned.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a clear governance structure with links to the local authority's public health and children's' directorates. Service managers were accountable to an integrated executive commissioning group, chaired by the local authority executive director of children's services and clinical commissioning group,(CCG).

The head of service was working with the chief nurse at the CCG to develop joint indicators for measuring quality across the system of children's health and social care. They were confident they were not missing contact with any child in the locality because of the systems they had in place. For example, each GP practice and school had a named nurse they would contact to inform if a child missed their immunisations. Staff shared information with other relevant health care providers who were on the same electronic system.

The service had strong governance processes in place to ensure that the service was appropriately staffed, and that staff were well trained and supervised. Since the service had transferred to the provider, managers could evidence substantial improvements. For example, there were improvements in outcomes and the service was better than other similar service in England at meeting the mandated contacts. In 2021, for the first time, the service had been able to submit breastfeeding rates that had been validated and published by Public Health England. A new governance lead had been appointed and the staff were undertaking regular audits and starting to carry out peer audits. Managers and staff re-designed services to improve their effectiveness and responsiveness. For example, a new safeguarding team had been created and they had introduced a traffic light system to prioritise safeguarding work.

All teams took part in regular development days to discuss the performance of the service. Managers had increased the frequency of development days during the pandemic so staff could share and learn as each phase developed.

The service had strong partnerships including formalised pathways with adult and child health services including mental health providers. As a result of emerging issues in the pandemic, staff were involved in a partnership with social care to provide additional support for families experiencing domestic abuse.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Managers had a performance dashboard that they shared with staff and discussed at monthly governance meetings. They collected a wide range of information including safeguarding activity, supervision and training compliance rates, service user feedback, incidents and complaints. The service had a risk register that reflected the concerns of staff. An example of one such risk was communication with the local midwifery service that managers were trying to improve. Staff had been asked to incident report any issues so managers could monitor progress with improvements. Managers regularly reviewed risks and had appropriate mitigation in place for all risks identified.

Being part of the local authority meant the service had robust plans to cope to with unexpected events. At the start of the pandemic, staff were geared up to working in an agile way and it was a relatively smooth transition to working remotely. Despite the restrictions, staff continued to meet their service targets and worked effectively with service users remotely. They prioritised vulnerable families with face to face contact and continued to offer school children walk and talk sessions to reduce social isolation.

Staff felt included in decision making about potential efficiency savings and the impact on the quality of care. They were consulted about financial decisions that directly affected the work of the teams.

Community health services for children, young people and families

Outstanding ☆

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had a system development lead employed into the team from the local authority. They worked closely with the governance lead and with front line staff to improve information systems and data collection. Managers felt better equipped to utilise data to improve services. For example, they had identified that some children were not taking up their nursery offer so they worked in partnership with education to improve uptake. Managers had a performance dashboard that they continuously improved and shared with staff. The electronic healthcare record and performance data were easy for staff to use and keep updated.

Managers submitted appropriate safeguarding and other notifications to the Care Quality Commission.

Engagement

Leaders and staff did not always engage effectively with children, young people, their families, staff, equality groups, the public and local organisations to plan and manage services. However, they collaborated with partner organisations to help improve services for children and young people.

Managers and staff acknowledged that engaging families and young people to plan and improve services was an area they needed to develop. Some of this work had been halted due to the pandemic. However, service users and the general public had access to high quality up to date information on the work of the provider via various websites and social media pages. Service users could give feedback via social media and many chose to do so but some of the service users we spoke with said they would have preferred to give feedback in a less public way. Managers were considering other feedback mechanisms and it was on their service improvement plan, along with consulting with young people to develop services.

Managers engaged staff effectively and consulted them about changes to the service through a specially designed staff forum that met regularly. Service managers engaged with local stakeholders and were well connected with NHS Integrated Care Systems and regional commissioning frameworks.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Managers encouraged staff at all levels to continually learn and improve practice. The whole staff team met together for regular development days and this led to improvements in the way services were delivered. A new governance lead had been appointed to strengthen staff involvement in quality improvement and they had just developed a research interest group that front-line staff were involved in.