Plymouth Community Healthcare CIC

1-271962340

Community health services for children, young people and families

Quality Report

Local Care Centre
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Date of inspection visit: 21 - 24 June 2016
Date of publication: 19/10/2016

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-297622270	Plymouth Community Healthcare CIC Head Office	Community health services for children, young people and families	PL4 7PY
1-297634914	Cumberland Centre	Community health services for children, young people and families	PL1 4JZ

This report describes our judgement of the quality of care provided within this core service by Plymouth Community Healthcare CIC. 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 Plymouth Community Healthcare CIC and these are brought together to inform our overall judgement of Plymouth Community Healthcare CIC

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

We rated this service as good because:

- Plymouth Community Healthcare CIC provided support for children, young people and their families to promote healthy choices. They provided information in a way people could understand and supported families to access health care when they needed to. They identified vulnerable families and offered specialist support for them.
- Safeguarding processes were in place and followed by staff with children and young people's health, wellbeing and safety at the heart of the workforce.
- There was a positive attitude among the staff who learned from incidents and comments to improve their service where they could.
- Risks were identified and reviewed by senior managers for their action.
- Staff were appropriately trained to ensure they were competent to provide care for children, young people and their families and displayed skill and compassion to engage them in their care.
- Staff were open and honest with their clients and ensured they were informed of options for their care and helped to make their own choices.
- Staff worked with other agencies to support families and ensured appropriate advice was available. Care pathways supported families to access the right support at the right time.
- Nationally approved guidance was used to ensure services were safe and effective.
- Technology was provided for staff to maintain their safety and share information securely in a timely way.
- Professional supervision was available for staff to ensure they were supported in their practice.
- Staff engaged with opportunities to contribute to planning how their services were delivered

However

- Health visiting staffing levels were decreased in 2016 to meet financial constraints that had been imposed by commissioners. Some health visiting teams with high caseloads were unable to offer vulnerable families additional support using the Maternal and Early Childhood Support Home visiting programme.
- School nursing and children's speech and language therapy services did not assess the acuity of their caseload to determine how many staff were needed to meet the needs of the children they provided care for.

Summary of findings

Background to the service

Plymouth Community Healthcare is a community interest company which provides community health services for children, young people and families in the city of Plymouth. Infants, children and young people aged between 0 and 19 years and their families can access support and services from:

- health visitors
- school nurses
- family nurse partnership
- speech and language therapy

The services are divided into four localities with health visiting and speech and language therapists having bases in each of the north, south, east and west geographical areas within the city. Each locality has a multi agency team working together in a hub. Limited space in buildings means that the agencies are not always based in the same building. They provide care and support from a range of premises within these localities by running clinics and through home visits or other locations families and other professionals are able to attend. School nursing staff work from one central base and travel to where they need to provide support such as in schools, clinics, social care premises and homes. Family nurse partnership staff provide an intensive programme of support for vulnerable young women who are pregnant with their first child and under the age of 18 years. They are based in one locality and travel citywide to support their clients.

During the inspection we visited all the main therapy and nursing hubs, children's centres and community settings such as youth centres and children's homes. We spoke with 55 members of staff including therapists, health visitors, school nurses, family workers, administrators, service leads and specialist nurses.

We observed nurse clinics, multi-professional meetings, school and home visits and held focus groups for staff to attend. We spoke with seven relatives, seven children and young people and looked at care and treatment records.

Our inspection team

Our inspection team was led by:

Chair: Andy Brogan, Director of Nursing, South Essex Partnership Trust

Head of Hospital Inspections: Pauline Carpenter, Care Quality Commission

Inspection Manager: Nigel Timmins, Care Quality Commission

The team included CQC inspectors and a variety of specialists: health visitors and community nurses.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

During our inspection we reviewed services provided by Plymouth Community Healthcare Community Interest Company. We visited clinics, homes and therapy bases across the city.

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 21 and 24 July 2016. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with children, young people, parents and carers. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services.

What people who use the provider say

Surveys undertaken between June 2015 and May 2016 had mostly positive responses.

The results for the Family Nurse Partnership showed responses from service users that had helped them to move on with their lives. Comments included "So helpful, encouraged me that I could achieve and so I applied for University, even though I didn't think I could do it" and "FNP really helped us as a family".

The health visiting team friends and family responses for the same period showed out of 241 responses only two would be unlikely to recommend their service.

People who used the school nursing service felt it was a friendly service held in convenient locations and they had felt supported.

The children's speech and language service received 343 responses from the friends and family test survey. Out of these seven would be unlikely to recommend their services. The majority of people who left comments felt their child had made progress where it was possible and that the service had been supportive. Some felt they did not know the targets for their child.

Good practice

- The Family Nurse Partnership provided support to vulnerable families in difficult and highly emotional situations. Staff within this part of the service demonstrated great skill in the way they listened to all members of the family with respect and compassion. This helped those who were reluctant to engage with the service access support to improve health outcomes for themselves and their children.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure staffing is assessed as appropriate for the needs of the community using national guidance tools.

Summary of findings

- The provider should ensure all areas used by children and families are assessed to maintain standards of infection prevention and control.

Plymouth Community Healthcare CIC

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- Systems were in place and used by staff to report incidents and concerns and action was taken with learning shared.
- All staff we spoke with were aware of actions they needed to take to safeguard children and young people from harmful situations and processes ensured staff training met national standards.
- Processes were in place to ensure equipment was ready for use and cleaned, to prevent the spread of infection.
- Staff training was monitored and action taken when staff were overdue in completing it.
- We saw actions were taken when risks were anticipated and perceived risks were reported to senior managers.

However

- Some soft toys were used in service but there was no system within the service for ensuring their cleaning was adequate.
- Prior to 2016 the provider had increased Health Visitor staffing numbers to meet national guidelines. However, they then had to decrease numbers due to financial constraints that had been imposed by commissioners.
- School nursing and children's speech and language therapy services did not assess the acuity of their caseload to determine how many staff were needed to meet the needs of the children they provided care for.

Detailed Findings:

Safety performance

- There were no serious incidents involving children and young people reported within the last 12 months leading up to the inspection.

Good

Are services safe?

Incident reporting, learning and improvement

- All staff we spoke with were aware of the incident reporting processes and could describe what they would report. Staff appreciated that they could report concerns to protect their own safety which might include aggressive responses from clients. Staff were clear that all incidents were investigated by their manager and feedback was received appropriately.
- We saw investigation reports where breaches of confidentiality had been reported. This had identified a weakness in the record keeping system and led to support and training being offered to staff to ensure they were aware of correct processes for sharing and storing sensitive information.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. Staff described how they would discuss issues with their clients in an open and honest way which was in line with duty of candour principles.

Safeguarding

- Systems and procedures were in place to protect children and young people from abuse. The organisation had professionals with responsibilities for safeguarding children and young people which included a member of the executive team, a named doctor and a named nurse. A safeguarding report was presented to the organisation's board meeting on a quarterly basis and included reports about looked after children. An integrated safeguarding committee met monthly and was chaired by a non-executive director with membership of staff from other organisation such as social care, mental health services, the executive team, locality managers and children's services' team leaders.Discussions at these meetings included learning from serious case reviews, national guidance, gaps in service and actions to improve safeguarding processes. An example of learning was workshops were provided to increase staff awareness of female genital mutilation and prompts were embedded in patient records for staff to assess whether children and young women were at risk of female genital mutilation. Learning from a local serious case review was being implemented by a task and finish group who were developing guidance for professionals about harmful sexual behaviours. The safeguarding children leadership team attended the health advisory group for the local safeguarding board. This group aimed to develop policies to improve practice across the local authority and health agencies. One policy identified for development was the 'Bruised Baby' policy. The Named Doctor for safeguarding children and young people had developed and delivered training on bruised babies for trainee GPs in a nearby locality.
- Policies contained information and guidance to support staff in recognising any person who may be at risk of abuse. These were part of the electronic record keeping system and staff showed us how they recorded the information. Staff were alerted that children may be at risk of harm by a 'flag' on the electronic record. This helped staff to assess which children need to be prioritised for care.
- Safeguarding children and young people training for all staff in the organisation met the standards set out in 'Safeguarding Children and Young People: Roles and competencies for healthcare professionals 2014'. Level three safeguarding children and young people training had been attended by 95% of staff which met the organisation's target of 90% compliance.
- The organisation's protocol was followed to ensure staff received appropriate supervision which was provided by trained supervisors on a regular basis and adhoc when needed. Staff told us of occasions they had reported concerns about a child's safety and supervision had been immediately available. The electronic record keeping system identified vulnerable children and young people who needed their care plans reviewed and staff told us these were completed at supervision sessions.
- The safeguarding team had developed a new 'safeguarding passport' which was about to be provided for staff to document supervision and learning opportunities.

Good

Are services safe?

- A system was in place that informed Health Visitors and School Nurses when a child or young person attended a Plymouth minor injuries unit. This allowed a follow up visit or call to ensure appropriate support was offered to the patient after discharge.
- Staff at the Cumberland Centre had put a system in place to protect children and young people when they were waiting for an appointment. If staff were aware that an adult patient may present a risk to children's safety an appointment would be made at a time when children were not in the department.

Medicines

- Processes were in place for the safe management of medicines storage, transportation and administration.
- School nurses attended training for immunisation processes at the beginning of each school year.. This included administration of immunisations, safe storage of medication, methods of transporting medication to a school or clinic and emergency procedures in case of a severe allergic reaction. A patient group directive (PGD) was completed by staff. This was a group prescription which gave nurses the authority to administer immunisations without the need of individual prescriptions for each child.
- Medicines were ordered by staff and stored at appropriate temperatures in secure fridges. They were transported to community settings using insulated bags to maintain the temperature and prevent degradation of the medicine. Fridge temperatures were documented as checked daily and staff described the process if the temperatures were outside of the stated temperatures.
- Equipment for immunisations was transported by nurses and included facilities for safe administration and disposal of medicines.

Environment and equipment

- Areas we visited that children and young people attended were suitable for their purpose. Waiting areas were equipped with seats and equipment to keep children of all ages occupied. Any vandalism to buildings was reported to the estates department and acted on in a timely way. Broken windows were repaired immediately.
- We were told that a building used for clinics and as a base for therapists had been subject to vandalism. Actions to improve the building to protect the staff and clients had been taken. Windows had additional panels to prevent breakages and lone user devices were available for use in the building. We were told more suitable accommodation was being looked for but nothing had been decided at the time of our visit.
- Equipment was maintained and available for use by professionals. We saw weighing scales used by health visitors that had been documented as calibrated.
- Fridges for keeping medicines were individually locked and in a secure room.
- School nurses stored equipment for immunisation sessions in locked cupboards and transported them using wheeled trolleys when they were needed. This included containers for safe disposal of needles and clinical waste and hygienic wipes to sanitise hard surfaces.
- Some premises were managed by organisations other than Plymouth Community Health. For example schools and local authority premises. Staff told us they risk assessed these areas to ensure they were safe to use.
- Electronic equipment with access to children's records was available for staff to use when they were away from their base. This allowed staff to have access to relevant clinical and social history for their client. Some staff found that lack of connectivity in some areas prevented them from using the equipment effectively. As an example, staff would need access to client's personal Wi-Fi when visiting them at their home. Staff told us how they found this time consuming and at times difficult to ask for.

Quality of records

- An electronic system of record keeping was used by all of the services for children and young people. The school nursing service maintained some paper records but there was a plan in place to convert these to the electronic system without losing any data. The electronic records were accessible using mobile devices when staff were out in the community if Wi Fi systems were available to use. If connectivity was a problem staff told us they kept handwritten notes and updated the record as soon as they returned to their base. Staff were

able to view records that other professionals had written which ensured relevant information was shared amongst professionals involved with the child or young person.

- Staff used standard templates to record any client activity. This incorporated the holistic assessment tool Framework for Assessment (DoH 2009) and encouraged staff to be consistent with assessment and record keeping.
- We looked at four sets of electronic records which clearly documented the child's history, treatment and care provided with plans for any ongoing care. We saw staff acting on the plans they had discussed with the parent and their child and updating the record for the next appointment.

Cleanliness, infection control and hygiene

- Processes were in place for the prevention and control of infection.
- Each team had an infection control link person who carried out hand hygiene audits six monthly and at intervals between without prior notice to staff. Results we saw showed 100% staff compliance with effective hand hygiene. Audits of decontamination and cleaning of equipment and correct use of personal protective equipment were also carried out. Results ranged from 67% to 85% of equipment used meeting the required standard of cleanliness. The results were fed back to the infection prevention and control committee and displayed on the staff notice board for that area. Where compliance was below 100% actions were identified with a date for review. As an example,in one area it was identified that some equipment was left visibly dirty. This was fed back to staff for their action and a repeat audit of the cleaning of equipment was planned for a later date.
- Areas we visited were visibly clean. Staff told us there had been a problem with cleaning in one of their consultation areas and they had been vacuuming the floor before children visited the area. Housekeeping managers had been informed and a plan was in place for staff to monitor and report standards of cleaning to the housekeeping managers.
- In clinic areas where there was a range of toys available. Wipeable toys were cleaned between each use and for toys used less frequently a cleaning rota documented when toys had been cleaned. We saw cleaning was logged as completed in all areas we visited. Some soft toys were not able to be wiped clean. These were washed by a staff member in their domestic washing machine. The organisation's policy was for absorbent toys to be washed in a washing machine using a hot cycle. There was no specific temperature stated in the policy and no assurance the policy was followed.

Mandatory training

- Mandatory training for staff was provided and monitored by the organisation. This included fire safety, diversity, information governance, infection control and customer care. For the period between 1 March 2015 and 29 February 2016 staff compliance in the children, young people and families service as a whole for mandatory training was 93.6%. Managers told us that the organisation's target was 100% staff attendance. All staff we spoke with told us they were up to date with their mandatory training and were able to easily check when it was next due for renewal using the electronic data base. Managers received information each month of staff training figures enabling them to monitor mandatory training compliance. This was fed back to staff by managers at one to one meetings to ensure outstanding training was highlighted.
- Some staff were required to complete training in areas relevant to their specialty such as basic life support for children and young people and treatment of anaphylaxis (life-threatening allergic reaction). This was provided and monitored by managers in the same way as for mandatory training. We were told how a member of staff was encouraged to complete training which was overdue by identifying it as a development need. Staff we spoke with were up to date witht this training.

Assessing and responding to patient risk

- Risks were assessed to ensure children and young people were protected from harm wherever possible.
- Children and young people with complex physical health needs were referred to the specialty relevant for their care. These teams such as community paediatric nurses, diabetic specialists and paediatricians were part

of an alternative organisation in the area. School nursing, health visiting and speech and language therapy services were informed by the specialist services of any child who had ongoing care needs.

- Health visiting staff supported parents to recognise when further medical advice should be sought. Web pages were being developed that would advise parents and carers on appropriate actions to take for their children who may suffer common illnesses. This was near completion and would inform parents of how to recognise a deteriorating condition and when they needed to contact a health professional for further advice
- All school nurses were trained to recognise and deal with pupils experiencing severe allergic reactions following immunisation.
- Staff had access to advice from services such as child and adolescent mental health to assist with assessment of risk a child or young person may present to themselves or others.
- School nursing staff provided health questionnaires for children in primary school and when they moved secondary school. This allowed any concerns to be raised by the parent or young person so they could access support if they wanted it. The forms could be completed at a time and place of the young person's choosing to maintain their privacy and returned in a sealed envelope. The Self Help, Independence, Nutrition and Exercise (SHINE) programme collected feedback from participants and changed venues in response to young people's wishes.

Staffing levels and caseload

- Staffing levels were reviewed using national guidelines for health visiting and children's speech and language therapy services. Staffing for school nursing services was not aligned to any national guidelines.
- Health visiting staff had 15,862 open caseloads between 79 whole time equivalent staff and over the four localities at the time of our visit. Prior to 2016 the provider had increased Health Visitor staffing numbers to meet national guidelines. However, they then had to decrease numbers due to financial constraints that had been imposed by commissioners of the service. The largest number of caseloads was held by the west locality team which amounted to 30% of the citywide caseloads. Referrals to the service between April 2015 and March 2016 were 12,302. Staff were allocated according to where the greatest need in the community was. The individual average caseload was 200 children per health visitor which was within the Royal College of Nursing (RCN) guidelines for defining staffing levels.
- School nurses did not use any form of acuity tool to identify how many staff they would need to meet the needs of their local communities. The school nursing service had 16 whole time equivalent staff made up of support staff, specialist community health nurses and community public health nurses Staff told us caseloads were allocated according to the hours staff worked. For example, a school nurse working 20 hours would have 20 clients. This did not follow the RCN guidance on defining staffing levels which recommends each secondary school should have a specialist community public health nurse to support health needs of the pupils. There were 17 schools in Plymouth and 12 registered specialist community public health nurses.
- The children's speech and language therapy (CSaLT) service was made up of 49 staff including administrators, assistant therapists and 38 band five, six and seven therapists working a variety of hours. There had been 1,900 referrals between April 2015 and March 2016 along with 1,100 children who needed to continue with the service. Caseloads were managed by taking on a new client when one had been discharged from the service. Staff told us this method allowed them to give full attention to the clients they were treating and was keeping the waiting list within an 18 week wait at that time.
- The family nurse partnership service worked under nationally agreed guidelines regarding their caseloads. This allowed them to provide the intensive service that was commissioned.
- The number of staff leaving any of the specialties within the service during the previous 12 months was low. The highest was five health visitors leaving from the west locality of. These posts were not advertised as vacancies but contributed to the target of reducing staff numbers.
- The school nursing service had been commissioned to provide an extra immunisation programme for September 2015 which impacted on their time to deliver

Good

Are services safe?

their planned services. The organisation was unable to recruit enough additional, appropriately qualified staff to meet this additional demand. Existing school nursing staff were offered extra hours to fill the shortfall of staff although staff told us this did not fill every gap and that children and young people were waiting longer for a contact. The vacancy rate for school nursing was the highest at 6% of the 24 staff members for this service.

- Information supplied by the organisation showed health visiting and school nursing used bank or agency nurses to fill a small number of shifts and that there were none left unfilled.

Managing anticipated risks

- Staff were aware of risks and how to report them to senior management.
- The organisation had a lone working policy and provided easily worn devices for most of the staff who visited their clients without a colleague. These devices used a GPS tracking system and were activated by staff if there was a risk to their safety. School nursing staff did not have these devices as a routine but we were told further devices had been ordered for their use. Other parts of the policy were followed by staff working with a colleague wherever possible and risk assessing the situation they were to encounter if this were not possible.
- School nursing staff worked variable hours at different times throughout the year to meet the planned fluctuations in demand for their service. For example, there were fewer staff working when schools were closed for the holidays. During additional Department of Health programmes of immunisation staff recruitment was increased to meet the demand. This caused difficulties if there were not enough appropriately qualified staff applying for the roles. The response from the service was to offer extra hours to existing part time staff and reallocate work that did not require the skills of school nursing staff.
- Health visiting staff had anticipated a risk in being unable to deliver their service within nationally agreed timescales due to a reduction in their numbers. They had been asked by managers to think of more efficient ways of working for the future. A suggestion was put forward to replace a routine visit when the baby was between six and 8weeks old, with a targeted visit for vulnerable families. This was yet to be approved by the executive team.

Major incident awareness and training

- Staff we spoke with were aware of the organisation's business continuity and major incident plan which was accessible on the intranet. Training had been attended regarding fire safety and staff were aware of ensuring the buildings they visited had safe exits for staff and other visitors.

Good

Are services effective?

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

Summary

We rated effective as good because:

- Policies and protocols were based on national guidelines and standards and were accessible to guide staff in their practice.
- The service contributed to national and local audits and identified where improvement could be made.
- Staff attended update and specialist training to ensure they were competent to support the families with which they were in contact.
- All staff worked with multiple agencies and offered advice and support to improve the health of families and children.
- Technology was used to provide up to date information for professionals working away from their bases.
- Where possible information about health needs and how to access services was made accessible for the public.

However

- Some staff had difficulties with connecting through their electronic devices in clients' homes.

Detailed Findings:

Evidence based care and treatment

- Policies had been developed in line with national guidelines. These included the National Institute for Health and Care Excellence (NICE) guidelines, Royal College of Speech and Language Therapists and the Royal College of Paediatrics and Child Health.
- A system was in place for NICE guidelines to be assessed for appropriate use within the service.

  A professional within each specialty assessed NICE guidelines for their service. Changes to practice were incorporated in any new protocols and cascaded to staff at team meetings. The children's speech and language therapy (CSaLT) service had made recent changes to ensure they could provide a service which followed their professional body's recommendations for seeing children with dysphagia (difficulty in swallowing). This had involved supporting staff to enhance their skills in assessing and treating children with dysphagia.
- Health visiting and school nursing services provided requirements of the Department of Health's healthy child programme. This included early assessment and intervention, immunisation, health and development review and provided information and guidance to support positive parenting and making healthy choices. The health visiting service had been accredited with level three UNICEF Baby Friendly Initiative which encouraged and supported new mothers to breast feed. This allowed new mothers to make informed choices about how to feed their baby.
- School nurses followed nationally approved guidelines on supporting children with a variety of issues such as continence problems, mental health and making healthy choices. We saw records for children with additional needs completed with clear plans for the future. School nursing staff supported a programme that used the principles of NICE guidelines for overweight children and young people.
- Vulnerable children and young people had their health needs assessed using the Department of Health's framework for assessment of need.
- Looked after children and young people had health assessments completed by health visiting and school nursing staff when requested by social care. The health information was shared with the social worker and we saw recommendations of actions that would support healthy choices.
- Other programmes were in place to support vulnerable families and those recognised health issues. The family nurse partnership provided intensive support to new mothers who were under 19 years of age. Mothers were offered support if they met the criteria for referral. If the mother refused family nurse partnership support they were offered support from the maternal early childhood

sustained home-visiting (MECSH) programme. This was a structured programme of sustained nurse home visiting provided by the health visiting service. Children between the years of 13 and17 could access a programme for self help, independence, nutrition and exercise (SHINE). This was a 12 week programme to support children, young people and their families to make healthy lifestyle choices to reduce the prevalence of obesity.

Technology and telemedicine

- Electronic systems were available to support staff in providing care for children and families. Remote electronic devices allowed access to child health records from remote locations although these were not always used as internet access was required.
- Lone working devices were supplied to most staff who visited families in the community. These were devices worn by the professional in an easily accessible way that would raise an alarm that they needed help. The exception to this was school nursing but we were told by staff that further devices had been ordered for them.
- The organisation was developing an updated website and each service was tasked with supplying information about their service. Children and young people's services and families services were providing extra information about managing common childhood illnesses.
- We saw staff telephoning other professionals for specialist advice and arranging further appointments with parents to share the information.

Patient outcomes

- Outcome measures were based on activities that were recommended by the Department of Health to improve long term health for children, young people and their families.
- For the period January to March 2016 reported figures showed that of 778 babies visited, 240 were being totally breast fed. This was similar to the England average of 30% for the same period of time.
- School nurses provided immunisations sessions for children and young people of school age. These were held in schools and uptake was monitored. Uptake of the Human Papilloma Virus vaccination (HPV) up to August 2015 was reported to be 87% which was a little below the England average of 89%.
- Audits were undertaken to monitor effectiveness of the service and to identify where improvement could be made. Results were reported to the appropriate governance committee and the organisation's board meetings. Each locality team took responsibility for their part of the audit and developed an action plan where compliance had not been met. A child protection record keeping audit was undertaken in July 2015 with 87% compliance. This was reported at the organisation's board meeting of November 2015. The health visiting service had audited the quality and timeliness of visits to new parents with 86% having received a visit from a health visitor within 10-14 days of the new birth. Where compliance with protocol for this visit was below 100% action plans had been developed with review dates. This included teams liaising with midwifery colleagues to share information more effectively and ensuring that activities were documented accurately.
- Clients referred in to services were placed on the electronic record keeping system which produced waiting lists. Anyone waiting close to 18 weeks was highlighted automatically for staff to be aware. These were monitored daily by individual staff and at team allocation meetings.
- Audit of the SHINE (Self Help, Independence, Nutrition and Exercise) programme showed the referral and attendance as being low in number for the programme between September and December 2015. Of the participants, 40% reduced their BMI, 60% reduced their waist circumference and 60% had improvement in their general health including lung capacity. Recommendations were made based on the audit findings for future programmes which included reducing time from referral to commencing the programme. These recommendations had not been agreed with executive team members at the time of our visit.

Competent staff

- Job roles specified qualifications needed to ensure staff were able to deliver effective care and treatment for children, young people and families. For example, a school nurse had to have completed a Specialist

Community Public Health Nursing training programme as well as a course for supporting learning in practice. Across the children, young people and families service other grades of staff were supervised in their support of families. All staff we spoke with were clear about their responsibilities and viewed supervision as a positive support.

- Staff had link roles which supported sharing good practice. Children's speech and language therapy (CSaLT) had staff with additional skills in swallowing problems and stammering treatments. Link roles in the health visiting service included child protection supervision, champions in perinatal mental health, domestic abuse and nutrition and breastfeeding.School nursing link roles included immunisation lead, emotional wellbeing, national child measurement programme and personal and social health education in schools. Training was provided for each of these roles with updates to maintain skills. At the time of our visit an update session for managing behaviour in children was being held.
- All nursing staff working with children and young people received child protection supervision by trained supervisors.
- Appraisal rates were monitored by the organisation and 93% of staff had received an appraisal between 1 February 2015 and 31 January 2016. Staff told us their development needs were discussed with their managers at appraisals and they were able to access training.
- Staff performance was monitored by managers and protocols were used to manage staff who were not following procedures correctly. We were told how a member of staff had been supported through difficulties and dismissed from the service when this was ineffective and there was risk to clients. Another member of staff had been supported to improve following an incident report.

Multi-disciplinary working and coordinated care pathways

- All of the services we met with worked with other agencies and used care pathways to co-ordinate the care of the child or young person. Staff we spoke with were clear of their responsibilities, who co-ordinated the care of the child or young person and how to access further support. Children and young people with long term conditions were supported by specialist nursing services who liaised with health visitors and school nurses to support them in the community.
- Children and young people who were subject to a child protection plan had their health needs supported by school nurses or Health visitors. Staff attended core group meetings to feed back on health needs to the multi-agency group.
- Children's speech and language therapy (CSaLT) received referrals from GPs, parents and schools. Forms were completed by the referrer which provided information about the concern and social situation. This allowed the therapist to assess the urgency of the concern. The child would be placed on an urgent two week waiting list or the routine 17 week waiting list. Staff provided support in a variety of locations across the city and organised group work where a number of children would benefit from similar interventions. Advice was provided for parents, teaching and nursery staff so that support could continue between therapy sessions. Feedback was provided to the parent, referrer and GP on outcomes of care. Regular work with a charitable organisation was provided to support a vulnerable group of children with speech and language development.
- There were strong links with social care organisations, schools and voluntary organisations. School nursing staff liaised with schools to assess health needs of families within that community. Health visiting staff worked closely with children's centres across the city. A multi-agency meeting had recently been formed by leads of the children, young people and families service. This was to have an overview of services and ensure children's needs were recognised in all areas of the organisation, including adult services. We saw meeting notes of the Children and Young People's Strategic Operational Group which met quarterly and included membership of locality leads, service leads, Child and Adolescent Mental Health Services (CAMHS), safeguarding professionals. Information from this group was fed back to staff at team meetings.
- Midwives who worked for an alternative organisation liaised with health visiting teams to ensure new mothers received seamless ongoing care. There had been some difficulties with communications between these

services but action plans were in place to improve it. A joint meeting between maternity and early years professionals was formed to improve the communications.

- The was no direct referral route to a paediatrician. If a health professional recommended paediatrician advice they contacted the GP requesting they refer the child to the paediatrician service which was provided by the local NHS foundation trust.
- Professionals could access CAMHS advice line by telephone to gain support for families with emotional concerns.

Referral, transfer, discharge and transition

- Information was shared with professionals who were overseeing the care of children and young people following episodes of care and at times of transition.
- When children were about to start school and transfer from health visitor to school nursing care, a system ensured that information was shared appropriately. Health visiting staff completed electronic records for children starting school and had face to face conversations with school nursing staff about any health needs the children may have. This allowed school nursing staff to liaise with the school to ensure appropriate support was available and monitor ongoing progress.
- midwives informed health visiting staff of expected birth dates for pregnant mothers. Ante natal visits could then be offered by the health visitor.
- The child's GP was informed of any completed episode of care from CSaLT, health visiting and school nursing service that had been provided for the child. This was administered either electronically or by letter to the GP.

Access to information

- Information needed to deliver effective care and treatment available to relevant staff was available in a timely and accessible way. Information sharing protocols were in place between the organisation and other agencies it worked with and staff we spoke with told us of who and why they would share information. We saw how they gained consent from children before referring to other professionals for specialist advice. Information shared was on a 'need to know' basis. Staff described how information may be shared with other professionals if there was a safeguarding concern.
- The electronic record keeping system ensured that information was accessible to staff who were providing care for a child or young person. They were able to update their own records in a timely way and view records from other professionals who were using the same system. Agencies using alternative systems would communicate by e mail, verbally or in writing and the professional would add this to the care record.
- Clinical guidelines and policies were available to staff on the organisation's intranet by using their mobile electronic devices.
- We saw red books (Paediatric Community Health Records) filled in by health visiting staff to ensure the parent had an up to date record of their child's health development.
- Appropriate information about local services was displayed for parents and young people to view. Children's speech and language therapy (CSaLT) displayed helpful methods of supporting children's speech.
- Information was accessible to the public on the internet. Information was provided about the service and included helpful advice. CSaLT gave advice for a variety of concerns including stammering, feeding and swallowing and promoting speech in young children.

Consent

- Policies were available to guide staff on issues of consent and staff were knowledgeable about options and limitations of consent. Staff described how they would seek consent from a parent or person with parental responsibility for treatment such as immunisations where the child was under 16. If it was appropriate staff would assess a young person's ability to consent for their own treatment using Gillick competency guidelines.
- We saw how staff involved families in decision making processes by talking to vulnerable young people and their parents at the same meeting ensuring each person was listened and responded to.

Good

Are services effective?

- School nursing staff demonstrated their skill in ensuring the young person attending the clinic understood their options for care and agreed the actions together with their parents. Young people being seen without a parent or carer present were informed that information would not be shared without their consent unless there was a safeguarding concern.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Staff showed empathy and understanding in highly emotional situations and acted skilfully in engaging their clients. The aim was to ensure clients understood their options and were able to make choices in their care.
- We saw staff speaking to all ages of children and adults in appropriate ways.
- Clients stated they felt listened to and involved in making their own choices.
- Staff had attended additional training to ensure they could provide emotional support for young people and adults.
- Staff were clear that improving outcomes for children and young people was at the heart of their work.

Detailed Findings:

Compassionate care

- We saw how staff treated parents, carers and their children with respect at all times during our inspection. Staff were presented with highly emotional situations and were able to respond in a calm way that reduced anxieties. This allowed the parents and children to discuss their health needs with the professional.
- Staff took the time to speak with young children in a way they could understand and at the same visit expressed understanding of the parent's and grandparent's situation.
- School nurses held 'drop ins' at local secondary schools to allow young people to attend without having to ask school staff.'Drop in' sessions were held in private spaces without school staff or parents present.
- Paper work for immunisation sessions held in schools was checked prior to the session to identify any problems that might arise for individual young people. This could be investigated prior to the session and protect the young person's privacy. As an example, school nursing staff could check the form was signed by a person who held parental responsibility for a fostered child before the session was held. This meant the fostered child would not be singled out from their peers as any concerns about consent for the immunisation had been dealt with.
- During immunisation sessions some young people needed to remove their shirt to expose their upper arm. This had been raised by young people as an issue. The service responded by providing clean theatre gowns to cover the young person and maintain their dignity.

Understanding and involvement of patients and those close to them

- Staff communicated with children, young people and their families to help them to understand their options for care. We saw clinic appointments where parents and children made decisions for their care based on information given by school nurses and health visitors.
- Survey results between June 2015 and May 2016 showed that 100% of those who were seen understood information that was provided by the school nurse.
- The family nurse partnership used skills in communicating with all ages to help to engage young people in health care. A few occasions we saw involved non-communicative new mothers, grandparents and babies in the same home. Empathy was shown and information was provided in ways that could be understood. Each adult was listened to and good care was demonstrated by the professional to the baby. Survey results showed 100% of young people felt the family nurse partnership involved them in decisions and respected their privacy.
- Interpreters were available for people with English as their second language. Information about language was requested on referral forms and any appointments that were made were arranged with an interpreter present if it was indicated.
- Health questionnaires were provided for young people when they attended secondary school. These were confidential and gave information to support the child to identify when and how they could seek support if they needed it.

Good

Are services caring?

- Feedback from surveys demonstrated that parents felt involved in the decision making of their child. One comment about Children's speech and language therapy (CSaLT) was "I did feel listened to & that I did have a valued point."

Emotional support

- Emotional support was available for children, young people and families.
- Young people could access the school 'drop in' to talk privately to school nursing staff which provided a degree of emotional support. If further input was identified as needed Child and Adolescent Mental Health Service (CAMHS) could be accessed either by telephone advice or a meeting with CAMHS and other professionals involved in their care.
- Some staff had attended training around emotional and mental health needs of children and young people and were able to provide initial emotional support for children and young people.
- Other staff had attended adult mental health training so they could have a better understanding of how to support parents with mental health concerns to support their children.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- Support was provided for children, young people and families in areas they could access. All staff showed their commitment to providing services that children, young people and their families could access. Professionals travelled and set up clinics in all areas of the city and worked flexibly around school and work times where they could.
- People were treated as individuals and support was offered to access services.
- Where more intensive support was needed programmes were put into place such as Family Nurse Partnership and Maternal and Early Childhood Support Home (MECSH) visiting programmes.
- Staff used the complaints and comments system as a learning opportunity and put improvements in place where they could.
- Length of time clients waited for a contact was monitored by staff and their managers at weekly allocation meetings to ensure waiting was within 18 weeks.

However

- Area teams with high caseloads were unable to offer the MECSH.
- Feedback opportunities for children and young people were variable across the service although there were plans in place to work with the local authority to gather this information.

Detailed Findings:

Planning and delivering services which meet people's needs

- Senior managers were liaising with the local authority regarding the provision of services for children, young people and families in Plymouth. An integrated action plan for 2016 -2017 was in the process of being negotiated between the commissioning body and the organisation delivering community services for children, young people and their families.
- The organisation had responded to the Health Visitor Implementation Plan: A Call to Action (2011) and increased the numbers of health visiting staff to meet the demands of the area. In April 2016 funding was reduced for public health nursing. There was a directive to maintain numbers of school nursing staff. The plan was to reduce the numbers of health visiting staff by 10 whole time equivalent substantive posts in 2016. The service responded by analysing health needs of the community using a nationally approved acuity tool to determine how many health visiting staff would be required to provide their service and meet national guidelines. This information had been fed up to senior managers for their review. Health visiting staff were also asked to think of ways they could deliver their service more efficiently. One proposal was for the routine six – eight week post-natal contact to be face to face for targeted families. This would offer telephone contact for routine families and retain support for vulnerable families.
- Teams were arranged in localities around the city to provide multi-agency working. However, accommodation was not always available for agencies such as social care, Children's Speech and Language Therapy (CSaLT), school nursing and health visiting to be co-located. Staff valued contact with other agencies and responded in alternative ways to maintain communication by telephone, e mail and multi-agency meetings.
- Health visiting teams shared caseloads within their team according to individual capacity. Each GP surgery had a named health visitor allocated for joint working and liaison.
- The school nursing service liaised with schools annually to determine the needs of the community and plan immunisation sessions, health education contributions, drop-ins and any specific needs of the school pupils. They had responded to the additional immunisation

programme delivered to teenagers by advertising for additional staff. They were unable to recruit to the posts advertised and filled many of the gaps with offering additional hours to existing staff. Staff told us this was a challenging time as the immunisation programme was made a priority. This impacted on other people who were waiting longer for contact with school nursing staff.

- CSaLT services were not commissioned to provide preventative activities such as training other professionals in basic skills. Staff felt if other professionals and parents had some basic knowledge of speech and language therapy techniques it would support children more widely and allow CSaLT professionals to provide the expert aspects of the service. CSaLT professionals had provided information to the executive team that supported the effectiveness of preventative work and were waiting for a response.
- All staff we spoke with were committed to providing services as close to people's homes as possible to enable them to access services. They did this by visiting people's homes and holding clinics in children's centres, youth clubs and schools at varying times of the day. This helped people to organise appointments outside of school and work hours and provided appropriate settings for consultations.
- The Self Help, Independence, Nutrition and Exercise programme (SHINE) was delivered in collaboration with the school nursing service. Groups were organised for young people to attend but it relied on parents providing the transport for their child to attend. Staff told us this caused difficulties for some families.

Equality and diversity

- Children, young people and their families had their needs assessed on an individual basis and care was tailored to these needs.
- Staff arranged and travelled to clinics in areas across their locality. This allowed people to access the service in areas that were suitable for people with disabilities. Home visits were also arranged if clinic visits were not suitable.
- There was a low percentage of families whose first language was not English. Staff told us of the arrangements they had made on a few occasions that an interpreter was required. A Family Nurse Partnership was offered to young people who met the criteria for the programme of intensive two year support. This was a voluntary programme and if the young woman refused the offer they were offered support from the Maternal Early Childhood Support Home visiting programme (MECSH). This was a programme of concentrated support for vulnerable families delivered by the health visiting service. However, staff told us that one locality were instructed by managers not to offer this as there were not enough staff to deliver it effectively.

Meeting the needs of people in vulnerable circumstances

- Staff worked with other organisations to identify and support vulnerable children, young people and their families.
- Programmes offering additional support were offered such as the Family Nurse Partnership (FNP), MECSH, SHINE and clinics were held in deprived areas of the city. Staff attended multi-agency meetings for children in need and supported families and social workers to meet the health needs of the child.
- A system was in place for looked after children to receive health assessments by a health visitor or a school nurse which identified any health needs. Foster carers were supported to ensure these health needs were met.
- A process had recently been put into place to ensure vulnerable pregnant women received the support they needed. All ante natal forms were sent by the midwife to the FNP team for assessment of need.
- School nursing staff operated a rota for child protection activity. A small team relinquished their routine case load activity and took on all the child protection cases for that period. This allowed them to identify unmet health needs of the children and young people and put pathways of care into place.

Access to the right care at the right time

- The service used an electronic record keeping system that allowed them to monitor how long families and children were waiting for an appointment or contact.
- Children's speech and language therapy (CSALT) assessed those children who needed more immediate treatment using information provided on the referral form. They would see them within two weeks and

remaining children would be seen within 18 weeks. We were told that reasons for people waiting more than 18 weeks had been investigated and was a result of parents being unable to attend the allocated appointment. The first appointment would take the form of a triage to identify what the best course of treatment would be.

- School nursing staff accepted referrals from school staff, self-referral, GPs, social workers and health visitors. They assessed the urgency using the information provided and discussed their waiting list with their managers and assessed whether young people needed to be seen more urgently. Anyone waiting over 18 weeks for a contact was highlighted on the system. We were told of times when it was more difficult to maintain the waiting list within 18 weeks of referral. These were during times of immunisation programmes being delivered and during the summer holidays. The summer holidays had fewer school nursing staff working. Contact would be made by the school nurse with the parent or young person requesting the appointment.
- Care and treatment was only cancelled when absolutely necessary. We were told of a planned group therapy session that should have two staff present. On one occasion a member of staff was unexpectedly absent and no other staff could be found at short notice. No child or young person was turned away at this time but the lone working policy was not followed.
- Health visiting staff had an operational policy which detailed timescales and types of contact with parents and carers. Expectant mothers were assessed for the level of service they should be offered depending upon their social situation. For example, expectant mothers should have been offered an antenatal visit at 28 weeks of pregnancy. If the health visitor assessed there were additional needs, further visits should be offered. Once the baby had been born a health visitor should visit between 10-14 days. Timeliness of these visits was audited in October 2015. Out of 254 new births 151 had not been offered ante-natal visits. Visits had occurred within 14 days of the birth in 223 out of 260 new births. Reasons for visits not having been carried out were analysed and included mother and baby in hospital, incorrect address, non-attendance by parent and unable to contact parent. Each team had developed an action plan to improve the timeliness of visits.

Learning from complaints and concerns

- The organisation had a process for acknowledging and learning from complaints. There were 14 complaints reported about the children, young people and families service for the period between 1 February 2015 and 31 January 2016. Seven of these complaints were assessed by the organisation as being valid complaints.
- We saw details of three complaints which described the investigation outcomes and action plans following the complaint. Part of the process involved the investigating manager offering contact with the complainant to discuss actions and outcomes. A manager we spoke with expressed how they found this useful in maintaining positive relationships with complainants.
- Staff were aware of any complaints made and learning was shared. As an example, we were told how changes of appointments for children needing speech and language therapy were sent to the referrer without copying parents in to the letter. Following a complaint the process was changed and parents were routinely informed of any appointment changes. Staff told us how a 'glitch' was identified when saving information to the electronic record keeping system meaning that some information was not shared with other health professionals viewing the child record. All staff were advised of a method of ensuring information was available for professionals to view as appropriate.
- Leaflets were available in clinics for parents to make comment about the service they received. Feedback was encouraged using a variety of methods. The service documented how the feedback was received and collated any survey results.

Good

Are services well-led?

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

Summary

We rated well-led as good because:

- The organisation's vision was shared with staff and embedded in practice. Helping people to be independent in their health care and to stay safe was the aim of all parts of the service.
- Risks were reported and managed where possible and staff were consulted about how to reduce risks within their service.
- Meetings were held to monitor effectiveness of the service and share information with adult and children's services.
- Managers were approachable and supportive to staff.

Detailed Findings:

Service vision and strategy

- The organisation had a vision to provide services for local communities in a sustainable way. They aimed to achieve this by using the views of the public and empowering employees to lead.
- The organisational statement "Helping people to be safe, well and at home" to support the vision was displayed on corporate communication tools including paperwork, posters, website and information leaflets. All staff we spoke with were aware of the aims of the organisation and worked towards these aims within their service. Health visiting staff had developed a personalised statement "supporting you, supporting your child" which they incorporated within their service to promote independence in the clients they supported.
- All parts of the service had information on the organisation's internet site which supported the aims for independent living and how to access services.
- All staff we spoke with expressed how the quality of their service affected children and young people.
- Service leads were involved with commissioners in plans for providing integrated health and social care. Negotiations were ongoing to assess how health care could be provided without compromising client safety and stayed within the financial budget allocated by commissioners.

Governance, risk management and quality measurement

- Processes were in place to monitor performance, quality and risks within the service with clear lines of accountability for safeguarding children and supporting children who were looked after.
- A variety of management meetings were held at regular intervals and minutes we viewed showed discussions around audit results, incident reports, complaints, and improvement actions. We also attended meetings where these were discussed. We saw that progress was monitored at each meeting until actions were completed. The Quality and Performance meeting of 19 November 2015 had provided an update on actions for increasing numbers of staff who had completed level 2 and 3 safeguarding children training.
- A Children and Young People's Strategic Operational Group meeting (CYPSOG) had been formed since April 2016. It met alternate months and included representation from each locality team, children's services, safeguarding and was overseen by the Director of Operations. The plan was for the professional service lead to present feedback to the executive team on a three monthly basis although this had not occurred at the time of our visit. Locality managers and professional leads could use the CYPSOG to present staff views and cascaded information to staff at team meetings. Staff we spoke with expressed concerns that children's services had previously not been represented to the same degree as adult services within the organisation, but that since the CYPSOG had started they felt representation had improved.
- Staff had link roles within their services. Some of these involved partner agencies. The link person attended the relevant meetings and fed back to their teams.

Good

Are services well-led?

- All staff we spoke with were aware of how to access the risk register. Managers showed us how they could check the progress of the risk they had added. There was an escalation process where the risk was assessed and escalated to corporate level if needed. A risk management team supported staff in completing a risk workbook for their team which included assessing fire risk, lone working and included actions taken to reduce the risk. One risk added in April 2016 was regarding reduced numbers of health visiting staff being unable to meet all the actions in the service level agreement. Actions ongoing were to identify how they could create efficiencies within the service.
- Health visiting staff were concerned about the reduction in their numbers from 89 to 79 whole time equivalent staff having an impact on their capacity to deliver a service according to national guidelines. This had been put on the risk register and was being fed up to senior managers and executive team members for review.

Leadership of this service

- Senior managers were visible to the locality teams. All staff we spoke with would recognise the chief executive and talked about how he would "roll up his sleeves and work the weekend" at times of pressure. Other members of the executive team had attended presentations from staff who had completed a leadership course at the local university. These staff had been asked to present their findings on the benefits of providing speech and language training to other professionals at a Plymouth Community Health Board meeting.
- We were told there had been a lot of change at locality level and staff had many changes of manager. Staff also said that locality managers and deputy locality managers were available to them, provided support and represented their views when needed. Where performance improvement was needed support was provided and further action was taken if this proved to be ineffective.
- Each of the service groups had a professional lead who could advise locality leads on best practice for their profession.
- All staff we spoke with told us they could approach their manager if they had a concern.

Culture within this service

- Staff we spoke with expressed pride in their work and displayed a passion about their focussing on the needs of their clients. Staff told us how managers had supported them.
- Managers told us how hard their staff worked to maintain a reasonable waiting list and provide a high quality service. All staff we spoke with told us they felt pressurised in their jobs but were supported by managers to keep their work activities within manageable limits.
- Staff were encouraged to follow the lone working policy to ensure their safety was maintained. Devices that were worn by the professional were provided for most staff. Additional devices had been ordered for the school nursing team to use.
- Staff we spoke with felt part of their own team and supported one another when it was needed. Staff were aware of the difficulties of finding suitable accommodation but expressed the advantages of working in the same location as other professionals.
- Most staff we spoke with said they felt valued and were aware of the awards process for good practice. Some staff told us how poor working accommodation made them feel less valued.
- Most staff we spoke with felt the organisation was open and supportive. However, a small number of professionals expressed how they felt there was a 'blame culture' in parts of the organisation if something went wrong. Some staff said there was some heavy handed management systems where minor omissions had resulted in formal written warnings followed by robust performance management processes. Managers told us they had managed these situations by following advice provided by their managers.

Public engagement

- Systems were in place to engage with the public and seek feedback from children and young people in the form of comment cards, surveys and electronic feedback. This was collated and fed back to locality teams for their information.
- Friends and family test feedback was collated and fed back to staff. Some teams had additional methods of

gaining feedback from clients. The Family Nurse Partnership advisory board held quarterly meetings and involved clients in the meetings. Health visiting staff attend children's centres board meetings and took feedback from parents

- We were told of existing work between Plymouth Community Healthcare and local authority engagement teams in gaining children and young people's views about the health service. This was in discussion at the time or our visit.
- The majority of the responses to feedback between June 2015 and May 2016 were positive. The Family Nurse Partnership received feedback from the young people they supported with comments such as "FNP really helped us as a family, out of everyone; you've always been there someone to talk to."

Staff engagement

- Staff told us they felt they could inform the executive team of their ideas for improvement. The staff forum Our Voice provided a method for staff to contribute their ideas and for leadership teams to seek staff opinion.
- Most staff valued the opportunity for consultation and feedback. Some staff felt that engagement was encouraged in a limited way on superficial aspects rather than on any real issues. Staff had been consulted about a recent organisational name change and uniform policy.
- Staff we spoke with told us they could approach any of their managers if they had a concern about poor practice or ideas about improvements to their service.

Innovation, improvement and sustainability

- Staff were clear that their focus was to improve the quality of care for children, young people and their families.
- Health visiting and school nursing staff had developed information to be put on the organisation's internet to promote independence for parents. This information would help parents to decide a best course of action and when they needed to contact a health professional.
- Staff told us the pressures of a waiting list did not compromise the care they delivered to their clients as no one was discharged from the service until they were ready.
- Staff were encouraged to attend a leadership programme with the local university. Those that did developed ideas based on evidence about how to improve services. These ideas were viewed by executive team members and presented to management meetings.