Room 1.46, Civic Building

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

We found that services provided by the provider were safe.

- There was a positive and open culture around reporting of incidents and learning was shared throughout the various professional teams.
- There was a high standard of safeguarding supervision being completed and staff were aware of their roles and undertook regular training. Learning from serious case reviews had been widely shared and actions implemented to address any identified shortfalls.
- The service regularly reviewed and updated their policies to ensure they were in date and in line with the latest guidance. Relevant and current evidence-based guidance, standards, best practice and legislation was used to develop how services, care and treatment were delivered.
- There were various examples of outstanding multi-disciplinary working. This included co-located teams sharing practice and information and providing support to colleagues and other partners working in the community.
- Staff provided compassionate care and treated families and children with respect. Feedback from families about the various professionals was consistently positive about the caring and professional approach provided.
- In general services reflected local needs and were flexible in providing continuity of care and choice. The provider discussed the changing demand and needs of certain services with commissioners in order to review provision.
- Children and their families were generally able to access services in a timely way for assessment and treatment. Services were appropriate and were within national referral to treatment time targets for appointments.
- There was an effective governance framework to support the delivery of the strategy and good quality care. Monthly performance data for each service was reviewed and shared with staff and management and a quarterly report shared with the joint commissioning board and the performance and quality board.
- Leaders understood the challenges to good quality care and could identify the actions needed to address them. Managers said they were empowered through the leadership of the service which enabled them to use their initiative and see work through to completion.
- Staff felt valued and respected. All staff we spoke with felt they were appreciated for the role they performed. There was a strong emphasis on promoting the safety and well being of staff. Measures were taken to protect the safety of the staff when working alone within the community.

However;

Summary of findings

- The out of hours on call system for the children's complex care team relied on just two senior staff to provide this seven days a week.
- The provider had completed a number of audits of different records and identified the recording of consent needed improving.
- Paediatric therapy, specifically occupational and speech and language therapy and the TaMHS service (Swindon Targeted Mental Health Service) had long waiting times for appointments and treatment. They were unable to currently meet the demand on their services within the target time for appointments.

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		We found services to be safe because: • There was a positive and open culture around reporting incidents and learning was shared throughout the various professional teams. • There was a high standard of safeguarding supervision being completed and staff were aware of their roles and undertook regular training. Learning from serious case reviews had been widely shared and actions implemented to address any identified shortfalls. • Safe and child friendly environments were maintained in the location hubs where services were delivered from. • Records were written and managed in a way that kept people safe and protected confidentiality. Records were regularly audited and the provider had action plans in place to improve the consistency of record keeping. • Risk assessments were completed as part of the assessment process for children receiving care or treatment. There were mechanisms in place to identify patients at risk. However: • Not all managers responsible for undertaking root cause analysis had received training • Whilst there was an increased demand for many services, staffing levels were maintained with the minimal use of agency staff, however vacancy levels combined with staff sickness in certain services were having an impact on delivery. • The out of hours on call system for the children's complex care team relied on just two senior staff to provide this seven days a week. We found the services to be effective because: • The service regularly reviewed and updated their policies to ensure they were in date and line with

Summary of findings

the latest guidance. Relevant and current evidence-based guidance, standards, best practice and legislation was used to develop how services, care and treatment were delivered.

- The service monitored patient outcomes and undertook a range of audits to promote best practice.
- Staff were being regularly supervised and appraised and were fully engaged in the process. Supervision was used to improve and support staff and share good practice. There was high completion of supervision sessions and staff were very positive about this aspect of their employment.
- There were various examples of outstanding multi-disciplinary working. This included co-located teams sharing practice and information and providing support to colleagues and other partners working in the community.
- Staff worked together to assess and plan on-going care and treatment when families or children moved between teams or services. There was clarity about the referral process and how staff could advise families to access the different services available.
- Staff were aware of the need to ask for consent and for this to be appropriately recorded. We saw care plans where consent was clearly recorded.

However:

- Some staff had concerns about the new electronic care record system as we saw that data entry was time consuming and some information had to be duplicated.
- The provider had completed numerous audits of different records and identified the recording of consent needed improving.
- At the time of our inspection, the service was not using any telemedicine equipment in the delivery of care and support.

We found services to be caring because:

- Staff provided compassionate care and treated families and children with respect. Feedback from families about the various professionals was consistently positive about the caring and professional approach provided.

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- We were told and observed that people's privacy and dignity was respected at all times.
- Staff communicated with children and young people so that they understood their care, treatment and condition. We observed staff explaining to children why they were attending and what treatment was taking place.

We found services to be responsive because:

- In general services reflected local needs and were flexible in providing continuity of care and choice. The provider discussed with commissioners the changing demand and needs of certain services in order to review provision.
- Services were planned to take account of the needs of different people. The provider collected and monitored data on the involvement of services with different ethnic groups. Staff undertook training in equality and diversity and were clear about their responsibility to be culturally sensitive and responsive to different needs.
- There were arrangements to enable access to services by children, young people and families in vulnerable circumstances and data was collected in respect of this, which ensured the provision was monitored.
- The FNP (Family Nurse Partnership) was commissioned to provide universal provision to all young mothers who were under 18 years at the time of conception. Of those offered the service the take up was measured at 95% over the previous twelve months, with very low attrition rates recorded.
- Children and their families were generally able to access services in a timely way for assessment and treatment. Services were appropriate and were within national referral to treatment time targets for appointments.

However:

- Paediatric therapy, specifically occupational and speech and language therapy and the TaMHS service (Swindon Targeted Mental Health Service) had long waiting times for appointments and treatment. They were unable to currently meet the demand on their services within the target time for appointments.

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We found services to be well led because:

- The service reflected the values and objectives of the council to provide continually improving services for the local community. There was evidence from talking to staff of a strong connection with the local communities they worked with.
- There was an effective governance framework to support the delivery of the strategy and good quality care. Monthly performance data for each service was reviewed and shared with staff and management and a quarterly report shared with the joint commissioning board and the performance and quality board.
- Leaders understood the challenges to good quality care and could identify the actions needed to address them. Managers said they were empowered through the leadership of the service which enabled them to use their initiative and see work through to completion.
- Staff felt valued and respected. All staff we spoke to felt they were appreciated for the role they performed. There was a strong emphasis on promoting the safety and wellbeing of staff. Measures were taken to protect the safety of the staff when working alone and within the community.
- Patients and their families or carers views and experiences were gathered and acted on to shape and improve the services and culture. The provider had “a children in care council”, on which youth MPs were involved.

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Services we looked at
Community health services for children, young people and families.

Summary of this inspection

Background to Room 1.46, Civic Building

Room 1.46 is the registered name of the community health services for children, young people and families provided by Swindon Borough Council. They provide a range of different services throughout the Swindon area, which is a unitary authority. Services are run from four main hubs in different parts of the town and from the main council offices. At the time of the inspection there were approximately 49,026 children under the age of 18, of which 14,000 were under 4.5 year olds, living in the Swindon area. Up until the third quarter of the year, at the point of our inspection, the service had recorded approximately 17,000 contacts with children and their families. There were 176 staff employed by the service.

The main services provided are health visiting, the family nurse partnership service, school nursing, physiotherapy, occupational therapy, speech and language therapy, a children's complex health team and the Targeted Mental Health Service, known as TaMHS. The service also provided a health service to Looked After children, completing the statutory required health assessments. There was a named nurse for child protection and also a health decision maker who provided children's health representation on the the Multi-Agency Safeguarding Hub (MASH).There was also a substance misuse service.

The family nurse partnership is a national scheme designed to support first time parents under a certain age who are identified as benefiting from more intensive support from a health visiting service.

The complex health team could provide care packages and support to children, and their families, with complex needs living in the community, which could when required include end of life care and support.

The TaMHS service works with children and young people with emotional and mental health needs that cannot be met by staff within universal settings such as schools and children's centres. They work with such concerns as, anxiety, attachment difficulties, low self-esteem, loss, trauma, emotional distress, low mood, self-harm and eating difficulties. All referrals are assessed on an individual basis and they could then refer to other services or offer short term support (up to six interventions or appointments) on a one to one basis. The team could also offer consultations and advice to families, schools or other agencies.

Our inspection team

The team that inspected the service comprised of three CQC inspectors and a team of three specialist advisors made up of two qualified nurses and an occupational therapist. The team leader for the inspections was Amanda Eddington.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive independent health provider inspection programme. Under the current CQC methodology we are not able to rate this type of service.

Summary of this inspection

How we carried out this inspection

To fully understand the experience of people who use services, 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 the inspection visit we reviewed information that we held about the provider and asked a range of other organisations for information.

As part of the inspection we visited the provider's head office, a number of the locations where services were delivered and accompanied various professionals on visits in the community. We observed clinic appointments and home visits. We organised staff focus groups and drop in sessions for staff to attend and meet the inspection team.

We spoke with 65 staff, including health visitors, therapists, administration staff, managers, community nurses and nursing assistants. We spoke with the registered manager for the service and other senior managers. We met with two elected members of the council, one of whom was the lead member for children's services.

We spoke with 10 parents. The provider had distributed CQC comment cards prior to the inspection for families and children to complete and we had a total of 154 returned to us during the inspection.

We looked at 12 case files and children's care records. We looked at staff training records, minutes from meetings, data supplied by the provider in relation to performance and examples of policies and procedures.

What people who use the service say

We received feedback from people in person and through 154 comment cards. In summary, we were told:

- Staff were friendly, helpful, compassionate, kind and calm. Children were treated with respect and dignity and privacy and confidentiality was respected at all times.
- There were good outcomes for occupational, physiotherapy and speech and language therapy patients. Treatment was comprehensive, helpful and parents were given lots of ideas on exercises.
- Staff gave good and clear communication and the information given was helpful to understanding treatment. Staff listened and answered any questions. We were told there was good engagement with children and parents.
- Parents and children said appointments were fun and looked forward to their next appointment.
- The environment was suitable as it was calm, relaxed, clean and tidy. The Saltway Centre was accessible as it was easy to get to.
- Staff had the best interests of their children at the heart of their practice. Staff were flexible and attended home visits if parents and children were unable to attend the provider's facilities.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found services to be safe because:

- There was a positive and open culture around reporting incidents and learning was shared throughout the various professional teams.
- There was a high standard of safeguarding supervision being completed and staff were aware of their roles and undertook regular training. Learning from serious case reviews had been widely shared and actions implemented to address any identified shortfalls.
- Safe and child friendly environments were maintained in the location hubs where services were delivered from.
- Records were written and managed in a way that kept people safe and protected confidentiality. Records were regularly audited and the provider had action plans in place to improve the consistency of record keeping.
- Risk assessments were completed as part of the assessment process for children receiving care or treatment. There were mechanisms in place to identify patients at risk.

However:

- Whilst there was an increased demand for many services, staffing levels were maintained with the minimal use of agency staff, however vacancy levels combined with staff sickness in certain services were having an impact on delivery.
- The out of hours on call system for the children's complex care team relied on just two senior staff to provide this seven days a week.

Are services effective?

We found the services to be effective because:

- The service regularly reviewed and updated their policies to ensure they were in date and line with the latest guidance. Relevant and current evidence-based guidance, standards, best practice and legislation was used to develop how services, care and treatment were delivered.
- The service monitored patient outcomes and undertook a range of audits to promote best practice.

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- Staff were being regularly supervised and appraised and were fully engaged in this process. Supervision was used to improve and support staff and share good practice. There was high completion of supervision sessions and staff were very positive about this aspect of their employment.
- There were various examples of outstanding multi-disciplinary working. This included co-located teams, sharing practice, information and providing support to colleagues and with other partners working in the community.
- Staff worked together to assess and plan ongoing care and treatment when families or children moved between teams or services. There was clarity about the referral process and how staff could advise families to access the different services available.
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Are services caring?

We found services to be caring because:

- Staff provided compassionate care and treated families and children with respect. Feedback from families about the various professionals was consistently positive about the caring and professional approach provided.
- We were told and observed that people's privacy and dignity was respected at all times.
- Staff communicated with children and young people so that they understood their care, treatment and condition. We observed staff explaining to children why they were attending and what treatment was taking place.

Are services responsive?

We found services to be responsive because:

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- In general services reflected local needs and were flexible in providing continuity of care and choice. The provider discussed the changing demand and needs of certain services with commissioners in order to review provision.
- Services were planned to take account of the needs of different people. The provider collected and monitored data on the involvement of services with different ethnic groups.
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Are services well-led?

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- Patients' and their families' or carers' views and experiences were gathered and acted on to shape and improve the services and culture. The provider had "a children in care council", on which youth MPs were involved.

Community health services for children, young people and families

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

We found the services provided were safe because:

- There was a positive and open culture around reporting incidents and learning was shared throughout the various professional teams.
- There was a high standard of safeguarding supervision being completed and staff were aware of their roles and undertook regular training. Learning from serious case reviews had been widely shared and actions implemented to address any identified shortfalls.
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However:

- Whilst there was an increased demand for many services, staffing levels were maintained with the minimal use of agency staff, however vacancy levels combined with staff sickness in certain services were having an impact on delivery.
- The out of hours on call system for the children's complex care team relied on just two senior staff to provide this seven days a week.

Safety performance

- Senior staff told us each service monitored their safety performance. We saw data on safety, including incidents and risks, was being monitored and fed into quality and performance meetings.
- There had been no never events reported to us during the previous 12 months leading up to our investigation. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Incident reporting, learning and improvement

- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses and to report them internally and when appropriate to external bodies. Whilst staff were aware of their responsibility for reporting both clinical and non-clinical incidents there was some inconsistency in the understanding of the reporting of non–clinical incidents. For example aggressive behaviours, accidents, concerns about staffing arrangements and issues with equipment. However staff commented upon the open culture within the organisation and we were told they felt confident about reporting concerns, issues or incidents to their managers who could clarify the correct process to follow. They told us how they would do this and how it would be investigated.
- Lessons were learned from incidents and action was taken as a result. When incidents occurred they were discussed at team and clinical governance meetings. For example within the health visiting teams there had been a number of incidents involving health visitors arriving for appointments with women who had recently suffered miscarriages which caused distress and upset.

As a result their practice was reviewed and health visitors now rang GPs to confirm if the women were still pregnant, before letters arranging new appointments were sent out.

- Not all staff within the paediatric therapy team had completed training to use the provider's electronic clinical incident reporting system. Within the paediatric therapy team, the process for inputting clinical incidents involved completing a paper form which was then given to a trained member of staff for inputting on the electronic system. Alternatively, untrained staff would sit down with trained staff and input the incident on the system together. When questioned, staff told us the provider was in the process of delivering training to all staff but this had not yet been fully delivered. This increased the risk of a delay in incident reporting, information availability, errors and the loss of hard copy information, if written on paper.
- Not all managers responsible for undertaking root cause analysis investigations had received training. One manager we spoke with said they were responsible for undertaking root cause analysis investigations but had not received any specific training to ensure this was completed appropriately and to a good standard.

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. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person'
- Patients, families or carers were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result.
- Staff were able to provide us with a detailed explanation of when the duty of candour was applied. We were told of two examples where apologies and explanations were provided to families. One example was a letter from a health visiting team being sent to a family following a mistake over their contact arrangements. The team had written and apologised and offered to meet to explain how the error had occurred.

Safeguarding

- There were arrangements in place to safeguard children from abuse that reflected the relevant legislation and local requirements. Staff understood their responsibilities and were aware of the provider's policies and procedures. The provider had a safeguarding policy which applied to all strands of their services which meant there was a consistent approach to how safeguarding concerns were dealt with. Both the health professionals and social workers working within the organisation were following the same policy.
- There was a named nurse for child protection who was available to assist staff if required. The named nurse's primary role was to provide quality assurance of safeguarding assessments and actions.
- Staff received training at the appropriate level and frequency. All clinical staff completed level three safeguarding children training. Staff we spoke with described the training as excellent and told us they felt it provided them with the necessary knowledge to enable them to identify concerns and take the appropriate action.
- Data provided by the service showed that at the time of our inspection 91% of staff were fully up to date with training, with 4% booked on to courses to complete their training. The remaining staff were either on long term sick or maternity leave.
- Staff we spoke with described how safeguarding was regularly discussed at team meetings and learning from individual cases and concerns could be discussed. For example child sexual exploitation and parental mental health difficulties were discussed.
- We saw evidence there had been learning from serious case reviews that had been disseminated through the teams. We saw minutes from a team meeting which highlighted the issues and learning that had been discussed. This included ensuring that chronologies in records were fully completed and all staff were familiar with safeguarding escalation policies. The supervision process for health visitors had been reviewed and updated. This now ensured that reflective practice was part of the process. The named nurse for safeguarding was available to all staff for additional supervision if requested and staff we spoke with were aware of this option. Staff were aware of how to access additional support from colleagues or their manager if they required this and were able to request specialist additional supervision, from a psychologist for example, if they wished.

- Staff in the health visiting, the school nursing and the family nurse partnership teams had completed training on FGM (female genital mutilation) and (CSE) child sex exploitation.
- Within the U Turn service safeguarding assessments were carried out which were then risk screened to ensure that the level of risk was determined for each young person using the service. The U Turn service provided support, help and guidance to young people (aged 11-17), and their families, who had alcohol and/or drug-related problems.

Medicines

- Arrangements for managing medicines kept people safe. For example generally immunisations were transported to schools and clinics by courier. Upon arrival, school nurses checked the delivery and the temperature of the cool bag. They also continued to record the temperature of the cool bag every 20 minutes and/or every time the cool bag was opened. Any unused vaccines were returned to the original pick up point and collected by courier. If school nurses were running a small clinic then they transported vaccines by a cool bag themselves.
- There were registered non-medical prescribers within the health visiting and Family Nurse Partnership teams. The provider had a prescribing policy and a contract to provide support to staff through the community adult health service provider and prescribing lead within the local clinical commissioning group. However, staff felt they had not been provided with the appropriate training updates to use their skills to their full potential. Information regarding the support available from the community adult health service provider and lead within the local clinical commissioning group was not known to all staff.

Environment and equipment

- The design, maintenance and use of facilities kept children, young people and families safe. At all the clinics we visited we saw that safe and child friendly environments were maintained. Waiting areas and rooms being used for meetings with parents were clean and comfortable. There were appropriate arrangements for the management of waste and sharps including clinical waste.
- Parents and children told us they felt the environment was calm, relaxed, clean and tidy.
- The working environment for staff, visitors, parents and children at the two main location centres we visited appeared well maintained, clean and hygienic. We observed that a welcoming and friendly environment was promoted by reception staff for families entering the buildings for appointments. The waiting areas were comfortable and the toilet facilities well maintained and signposted.
- All toilets within the treatment centres we visited had been adapted for children. There was also a changing places toilet at the centre. Changing places toilets are specially adapted toilets that have facilities and equipment which can be used for people with profound and multiple learning disabilities as well as people with physical disabilities. The facilities included a height adjustable changing bench and a tracking hoist system.
- The maintenance and use of equipment kept people safe. Baby weighing scales and hearing machines, used for the new-born hearing screening programme were well maintained.
- Health visitors told us the equipment they used was well maintained. We saw that electrical equipment had been tested and received with a portable appliance testing certificate. We found the baby scales in use had been calibrated within the previous twelve months and were also regularly cleaned.
- Staff we spoke with said that equipment repairs, once reported, were dealt with quickly and efficiently.

Quality of records

- Records were written and managed in a way that kept people safe and protected confidentiality. Records were regularly audited and improvements made when necessary. The service had moved from paper records to electronic records for the majority of services in 2014. The service had recently reviewed the opening up of the case management system to allow for better joined up working across the service. This had resulted in some duplication of records for some staff during the transition. Managers and staff explained how they were managing the challenge in an ongoing process with the aim of ensuring record keeping was of a high standard.

Managers were open with staff about any shortfalls and the improvements that were required. Staff were expected to complete records on the electronic care record system no later than 48 hours after completion of a visit.

- We looked at a sample of records across the full range of services. We found records were up to date, detailed and provided healthcare professionals with a wide range of information. A mixture of electronic and paper records were in use depending on the service. Paper records were stored securely. We looked at a sample of 12 records and found they had been completed in full with clear dated entries.
- The service had conducted numerous record audits throughout the various teams and we reviewed a sample of these. These were detailed audits that considered all aspects of the records being kept. This included, for example; the recording of consent, capturing the voice of the child, the correct amount of medical details as well as the sign and dating of all entries. Learning from these audits was provided to the various staff teams. This included action around the recording of consent, the chronology of events and ensuring all entries were dated and signed. Further advice and guidance was also provided around how improved recording of the voice of the child could be achieved. The service planned to provide record keeping training for all staff during 2017.
- An audit of Speech and Language Therapy (SALT) records was completed regularly with twenty being done every quarter. Improvements required were identified and a plan developed which included additional training for staff.
- An audit of a sample of health visiting records was completed on March 2017. Positive results were recorded with the majority of categories scoring 100% compliance. Feedback was provided to the relevant teams.
- A sample of records for paediatric therapy had been audited regularly throughout the previous year. Feedback had been provided to the staff about the need to ensure that all entries were dated and signed and that there was also a need for the better recording of consent

Cleanliness, infection control and hygiene

- The standards of cleanliness and hygiene were high. In each of the settings we visited, where care was delivered, the environment was visibly clean and tidy.
- At the clinics and home visits we attended we observed staff following infection control procedures. These included using antibacterial hand gels before and after care, wearing the appropriate protective clothing and aprons when required. All staff followed the bare below the elbow policy.
- Within the centres we visited there were supplies of personal protective equipment (PPE) available to staff, including gloves and aprons. There was hand washing facilities and antibacterial gels for sanitising hands in each of the clinic rooms at the treatment centres. We observed staff using these during clinics. There was also signage in bathrooms and clinic rooms reminding staff to wash their hands.
- Examination tables in clinic rooms were covered in a disposable paper towels to increase infection prevention. We observed the towels being disposed of and replaced after each patient use.
- There was an infection prevention and control lead in each of the health visiting teams. They regularly shared learning and training with staff. Infection control training was part of the provider's mandatory training programme.
- The toys within the treatment centres were subject to cleaning protocols, with cleaning being carried out by the practitioners at the centres. We observed toys being cleaned after appointments.
- In clinics we observed scales and equipment being cleaned between patients.
- The service completed audits of hand hygiene and we saw the report from the most recent one, undertaken in February 2017. Ten different audits from various services and locations were completed. The records showed a high degree of compliance but a number of recommendations were circulated to reinforce the service policy. This included reminding teams of the need to routinely discuss hand hygiene with the users of services and the requirements around the wearing of jewellery and appropriate clothing. Areas which did not achieve 100% compliance were required to draw up an action plan, with a re-audit planned for September 2017

Mandatory training

- Training was provided for all staff to ensure they were competent to perform their roles. The provider had an

in-house workforce development team who were responsible for monitoring mandatory training for staff and developing and delivering the learning development programme. This involved sending out quarterly training reports to team coordinators and professional leads on staff training compliance rates. The report set out who had completed training within the applicable period.

- There was a designated list of mandatory training which covered safety systems, processes and practices. Staff we spoke with were positive about the services' commitment to their training, quality of training and the support they were provided with to complete it. Reminders were provided by managers to ensure staff were completing the required courses. However, some staff felt it was difficult to keep track of what training had been completed as the records were kept on two different electronic systems. Some staff thought a number of the training courses, described as mandatory, were onerous and irrelevant for their role. There were mixed feelings on the efficiency and effectiveness, between supervisors, regarding the ease of monitoring training compliance among their staff. Some said the process was adequate while others found it difficult and convoluted.
- Data provided by the service showed that at the time of our inspection 75% of staff were fully up to date, 11% were booked onto their required training and 7% were new staff who were working through the mandatory training programmes, which ran over an 18 month period. The remaining 5% of staff were on maternity leave or long term sick.

Assessing and responding to patient risk

- Risk assessments were completed as part of the assessment process for children receiving care and treatment. This would include the home environment and any associated risks depending on the service being delivered. There were mechanisms in place to identify patients at risk. Details were recorded in the patient records which all staff had access to.
- The healthy child programme identified the children, young people and families according to their level of need. The level of service used depended on need and the risk of harm. Alerts were recorded to indicate specific risks, such as domestic abuse. There were pathways for staff to use when risks were identified. When risk assessments were carried out in respect of a child's or families' vulnerabilities, alerts could be flagged on the electronic care recording system which put staff on notice before they attended appointments.
- There were arrangements for staff handovers and shift changes which kept patients safe. Within two of the health visiting teams, a handover template had been developed which was used to pass on information about the care of a patient to a colleague when staff went on leave. The handover template recorded information about patients' history, care or treatment and any associated risks. The template was completed by the staff member going on leave and then passed to their colleague. In addition to this template the team coordinator had a template which recorded all of the patients who had been handed over and who now held responsibility. This was used to ensure the coordinator knew what visits needed to be completed during the staff member's absence.
- If children were placed outside the borough, but still under the providers' care, they were monitored carefully and regular reviews were carried out. This took into account how long the child had been placed there, what care and treatment they were receiving and if there were any risks associated with the placement.

Staffing levels and caseload

- Staffing levels and caseloads were planned and reviewed so that children, young people and families received safe care and treatment at all times, in line with relevant tools and guidance.
- Whilst there was an increased demand for many services, staffing levels were maintained with the minimal use of agency staff, although agency staff had been used more occasionally in the occupational therapy team.
- Staff told us their workloads were generally manageable, although they were demanding and often at capacity. The Community Practitioners and Health Visitors Association (CPHVA) recommend caseloads for health visitors should be a maximum of 400 in the least deprived 30% of the population. The health visiting staff's caseloads ranged between 300 and 400. New starters had lighter caseloads of 250 until they were fully integrated into the team and organisation.
- If health visitors were struggling with their caseloads, discussions during monthly supervision meetings would take place. The staff member was able to discuss what

the challenges were and given guidance on how to address them. If necessary, caseloads were reduced and reallocated if it was likely to lead to safety and quality issues.

- If staff were under pressure, caseloads could be looked at and patients could be reallocated on a daily basis depending upon demand. Each staff member completed their own matrix on the types of families on their caseload, which could be accessed by their supervisor. Information in the matrix included what their safeguarding demands were, how many children were on the universal, universal plus and universal partnership plus health visiting services. These are the different levels of health visiting provision that can be provided.
- Health visiting coordinators had either small caseloads or did not have a caseload at all which allowed them to focus on managing and supervising their teams. This gave them the opportunity to dedicate time to regular supervision and administration. It also created capacity to cover staff sickness if required which, in turn, ensured children and families were seen without delay.
- Within the family nurse partnership team caseloads were regularly reviewed by the team lead. The service had capacity for 143 clients and at the time of our inspection there were 133 on the caseload. When new referrals were received they were allocated on the basis of numbers of how many new-borns a staff member had and safeguarding demands. The caseloads for the staff in the team did not exceed 25 per whole time equivalent. Caseload reviews were carried out once a week for full time staff and every ten days for part time staff to identify any issues and/or increased demands. A full caseload review took place bi-monthly when each staff member's entire caseload was looked at to determine capacity.
- Some health visitor staff told us they were concerned about the low numbers of nursery nurses within the health visiting teams. There were a number of positions that were not being recruited to after nursery nurses had left the organisation. Staff said the role was vital in assisting them with their work and for providing the appropriate skill mix. Staff felt children and families would benefit from having more nursery nurses in the team as it would have an impact on alleviating capacity as they would be able to delegate. Staff told us this had been raised with senior management but were unsure as to whether more nursery nurses would be recruited. However, they told us there had been discussions regarding the recruitment of staff nurses to assist with capacity. There were some staff in the health visiting teams who had been told discussions were taking place on pooling the remaining nursery nurses in all teams centrally so their services could be shared.
- Within TaMHS (Swindon Targeted Mental Health Service**)** staff we spoke with told us there were currently three vacancies in the team, along with two staff on long term sick leave. We met with the team manager who confirmed this was the case and showed us evidence of the current team structure. They confirmed that the vacancies were being recruited to in line with the provider's policy.
- Health visitor caseloads were managed by the senior practitioners, through the supervision process. Staff we spoke with told us this system worked well and there was flexibility across the health visiting teams which helped to balance caseloads and increasing demand.
- Within the complex care team the out-of-hours on call system for staff to contact for advice was being covered by just two staff. These staff were providing this cover for seven days a week. Action had been previously taken to address this, including providing on call advice from an acute service, but so far none had proved successful. This was due to the complexities of the service being provided and the need for specialist advice. The current arrangement placed a lot of responsibility on two staff and left little flexibility in the case of annual leave or sickness.

Managing anticipated risks

- There was a Lone Working policy in place which had been reviewed in December 2016. There were processes in place to promote safety. For example in the health visiting service there was always one person on duty and in the office for the last hour of any day. Staff operated a buddy system that required them to keep colleagues informed of their whereabouts. Staff who undertook visits in the community were informed on how to promote their safety and that of their colleagues. Staff we spoke with were aware of the procedures they were required to follow when working out of hours. Staff we spoke with said their safety was taken seriously by the service and risk management of community visits was well organised and monitored satisfactorily.

Major incident awareness and training

Community health services for children, young people and families

- The service had a comprehensive business continuity plan which had been reviewed in February 2017. The plan was designed to prepare the service to cope with the effects of an emergency or crisis. Individual continuity plans were also in place for the individual specialist teams. These had also been reviewed. Plans provided guidance about practicalities and safety, for example in the event of the loss of the use of building or power, as well as instructions on the prioritising of services in the event of this becoming a necessity.

Are community health services for children, young people and families effective?
(for example, treatment is effective)

We found the services provided to be effective because:

- The service regularly reviewed and updated their policies to ensure they were in date and line with the latest guidance. Relevant and current evidence-based guidance, standards, best practice and legislation was used to develop how services, care and treatment were delivered.
- The service monitored patient outcomes and undertook a range of audits to promote best practice.
- Staff were being regularly supervised and appraised and were fully engaged in this process. Supervision was used to improve and support staff and share good practice. There was high completion of supervision sessions and staff were very positive about this aspect of their employment.
- There were various examples of outstanding multi-disciplinary working. This included co-located teams who shared practice, information and provided support to colleagues and other partners working in the community.
- Staff worked together to assess and plan ongoing care and treatment when families or children moved between teams or services. There was clarity about the referral process and how staff could advise families to access the different services available.
- Staff were aware of the need to ask for consent and for this to be appropriately recorded. We saw care plans where consent was clearly recorded.

However:

- Some staff had concerns about the new electronic care record system as data entry was time consuming and some information had to be duplicated.
- The provider had completed a number of audits of different records and identified the recording of consent needed improving.
- At the time of our inspection the service was not using any telemedicine equipment in the delivery of care and support.

Evidence based care and treatment

- We saw the service regularly reviewed and updated their policies to ensure they were in date and in line with the latest guidance. Relevant and current evidence-based guidance, best practice and legislation was used to develop how the services, care and treatment were delivered.
- For example in the previous twelve months the following service specific policies had been reviewed and updated to reflect best practice and guidance: Immunisation, infant feeding, and practice guidance and pathways for Faltering Growth in Breastfed Babies. There had also been reviews of general policies including record keeping, child protection and the hand hygiene policy. The provider was discussing with staff the “Allied Health Professions into Action” strategy document recently produced by NHS England in January 2017. This has the objective of outlining the strategic role of allied health professionals in the drive to transform health, care and wellbeing for citizens over the next five years
- The provider had achieved the full stage of the Unicef Baby Friendly Initiative accreditation in 2016. The initiative is to protect, promote and support breastfeeding and loving parent-infant relationships. The accreditation lasts for three years and was due for reassessment in 2019. As a result of their accreditation, a new feeding pathway and guidance had been introduced.
- Within the health visiting teams there were six annual professional development days which all four teams attended. During the development day one team led on delivering updates on best practice, professional guidance and new processes to the rest of the teams. Staff said attendance at the development days was vital for learning as it was shared across all teams to ensure practice was consistent and in line with professional guidance.

- Patients had their needs and care goals assessed and identified and their care planned and delivered in line with evidence-based guidance, standards and best practice. Children and families, under the care of the health visiting teams, had their own named health visitor which was in line with best practice. Aside from promoting continuity of care it meant each health visitor had detailed knowledge of the families on their caseload and allowed them to accurately assess the risks associated with each family they visited.
- The health visiting teams had implemented the Healthy Child Programme. This is a programme introduced by the Department of Health which covers a child's development from pregnancy to the age of five. It is the early intervention and prevention public health programme that lies at the heart of all universal service for children and families. As part of the programme the health visiting teams had five points of contact with children and families; the neonatal examination; the new baby review (around 14 days old); the baby's six to eight week examination; by the time the child is one year old; and between two and three years old. The provider had also introduced a sixth point of contact at 12 weeks.
- There were champions for breast feeding and blood spot testing within health visiting teams. The champions attended additional training in their various topics and could be approached by staff in their teams to provide advice and assistance on the latest guidance.
  Any training attended by the champions was shared by them at team meetings and professional development days.
- The family nurse partnership lead attended supervisory days twice a year which were held by the Family Nurse Partnership Unit. During the supervisory days case reviews were discussed which outlined best practice. After attendance the lead shared learning with staff and ensured practice was implemented. The staff within the team also followed the management manual for the family nurse partnership programme which set out the criteria for what was expected to be delivered.
- The paediatric therapy teams were using National Institute for Health and Care Excellence (NICE) guidance on the management and support of children and young people on the autism spectrum; spasticity in children and young people with non-progressive brain disorders and cerebral palsy in under 25s.
- The Speech and Language therapy (SALT) were one of the few locations in the country to offer a residential course for children with stammering difficulties. The service worked closely with Fluency Trust, a local charity that raised funds to pay for the residential costs of children and staff who attended the courses for children who stammer. They ran the course once a year with input from professionals from other areas. The SALT team had regular meetings that focused solely on stammering, with a lead therapist and line manager taking a lead role for this work. We saw very positive feedback from children, and their families, about this aspect of the SALT teams work.

Technology and telemedicine

- At the time of our inspection the service was not using any telemedicine equipment in the delivery of care and support. Technology was used to enhance the delivery of effective care and treatment. The provider had provided most staff with mobile telephones and laptops, in order to aid them in delivering effective care and treatment. Work laptops were used to record patient notes and access policies, protocols, procedures and best practice guidance. However, not all staff had laptops with 4G connectivity.
- Staff in one of the health visiting teams commented that there was no mobile network coverage in some of the localities they provided treatment. They felt this was a risk as they would not be able to telephone anyone or be contacted. The signal coverage had been raised and the network provider was changed but coverage was described as worse. The matter had been raised again and the issue was being addressed.
- Staff used text messaging, email and mobile apps to communicate with children, young people and families to promote cooperative relationships and deliver information in the most accessible way.

Patient outcomes

- The service monitored patient outcomes and undertook a range of audits to promote best practice. Information was collected and disseminated to the teams. There was a clear approach to auditing and benchmarking the quality of the services provided and the outcomes for patients receiving care and treatment.
- The provider used an electronic performance case management system which was used to pull data from

each service line on their quality and performance. The system could also produce reports on individual performance which was used in supervision and team meetings.

- Each service line had quarterly board meetings which were used to monitor the performance of the service, looking in detail at audit results, cancellations, delivery of the service and feedback.
- Information about the outcome of patient care and treatment was routinely collected and monitored.
- The speech and language therapy team collected data on the therapy outcome measures, specifically information on a child's impairment, their level of activity, their social participation and both the child and their care giver's wellbeing.
- The FNP (Family Nurse Partnership) achieved 100% of the nationally prescribed Healthy Child Programme key contacts They had recorded breastfeeding rates above the national average and had offered a service to all under 18 year olds during the previous 12 months. Data was also being collected on the work they did with young fathers. The information related to their mental health and employment and was being submitted to the FNP National Unit. The team had only recently started collecting and submitting this data and therefore outcomes were not yet available.
- The national Healthy Child Programme stipulates various targets for services to meet. For example a new baby review should take place within 14 days with the mother and father in order to assess maternal mental health and discuss issues such as infant feeding. Evidence provided by the service showed they were meeting the majority of the set targets for this programme. For example data provided by the service showed that 74% of women received an antenatal face to face contact with a health visitor at 28 weeks or above, against the national average of 68%. New birth visits receiving a visit at 14 days was measured at 79% against the national average of 88%, however this represented an improvement on the previous year's performance by 5%. Children receiving their six to eight week review was measured at 84% against a national average of 82%.
- An audit of new birth visits was undertaken in April 2016. This showed that whilst all the visits were being carried out within the required timescale some of the visits were actually being carried out too early which could potentially blur professional guidelines between health visitors and midwives. Health visitors were provided with a reminder about the guideline of visiting between 11 and 14 days.
- The records for breastfeeding showed that the various teams was providing advice at six to eight weeks to 95% of women, with the national average being 87%, and the number of women recorded as breastfeeding was at 47%, against the national average of 43%.
- The service was above the national average for new-born blood spot screening, being at 97% against a target of 95% and for new-born hearing screening the percentage was measured as 99% being completed.
- An audit of SALT records completed by the provider showed that 19 out of 20 records checked had an outcome recorded. The service was implementing the use of Therapy Outcome Measures (TOMS) going forward, this is the process recommended by the Royal College of Speech and Language Therapy. The TOM is an outcome measure that allows professionals working in health, social care and education to describe the relative abilities and difficulties of a patient in the four domains of 'impairment', 'activity', 'participation' and 'wellbeing' in order to monitor changes over time.
- We saw two examples of audits of the multi-agency involvement with families identified as at risk of domestic abuse. Outcomes were recorded and learning identified and disseminated to the appropriate teams. For example one audit recommended clearer recording of unstructured discussions between the health professional and their supervisor. We spoke with staff who described how they welcomed feedback from their managers and any audits that were carried out.
- The required health assessments for looked after children were being completed. The most recent figures showed that 90% had been completed within the national target of 20 days. Assessments not completed were for children placed out of county. These assessments are usually completed by the authority in which the child is located, but the specialist nurse for looked after children had taken action to complete a number of these which were within a certain radius of Swindon.
- The team who worked in U-Turn service conducted a clinical audit to review the quality of the service and that safeguarding and risk was screened appropriately.

Record keeping and data collection was audited at the same time. This produced positive outcomes. An example of an action was to ensure the identified risk was recorded in full.

Competent staff

- Staff had the right qualifications, experience and knowledge to undertake their roles and were supported to undertake further training.
- Staff were regularly supervised and appraised by their managers. Supervision was given a high profile throughout the service, which was recognised by staff and managers. Staff told us they were encouraged to develop their skills and share their learning with colleagues. A standard supervision framework was in place which included a written agreement, appraisals and the recording of meetings. Managers we spoke with explained how they monitored and prioritised the supervision of staff and how this information was fed up through the organisation. An audit had been carried out in March 2016 which showed that all staff were receiving supervision and at the correct frequency. Staff also had the option of additional meetings if they requested this. We were told about group supervision, live supervision or the observing of practice, clinical supervision and when requested additional safeguarding supervision. Staff we spoke with were positive about the service's commitment to regular supervision and described how the support was essential to them undertaking their professional roles. Managers had undertaken training in the delivering of supervision.
- During supervision meetings outcomes from previous supervision meetings were recorded on templates and discussed. Discussions also took place regarding staff wellbeing, caseloads, training needs and safeguarding and each one ended in a celebration of good practice. Actions plans were created after each meeting to set out what needed to be done over the next four to six weeks.
- Group supervision took place bi-monthly within the health visiting teams. During this process each member of the team would present a difficult or challenging case to the rest of the team and they would discuss what was done well and what aspect of the care could have been improved. Staff said this process was invaluable as it had given them the opportunity to discuss concerns and they were also able to learn from others and implement best practice. The meetings were minuted and shared with all staff.
- Data provided by the service showed that at the time of our inspection 80% of staff had received supervision within the previous month.
- Nurses working in the FNP regularly received weekly supervision and an observation of a home visit was undertaken an average of three times per year. It was also planned for the staff to have an annual supervision meeting with the named nurse for safeguarding. Restorative and reflective supervision was also available from a practitioner outside of the immediate team if this was requested.
- The senior management team observed practice of staff within each service line on a regular basis and provided feedback to supervisors on positive and negative findings. If negative, actions were taken to ensure practice was improved. When observing practice, the senior management team followed a template. Following observation the staff member's practice was discussed with them and their supervisor. One example involved an observation which identified that an out of date policy was being accessed on a laptop by a member of staff. This was addressed straight away with the staff member and they were directed to where they could access the most up to date information. This was then discussed with the staff member's supervisor and then shared across the service so checks could be carried out on whether the most recent policy was being followed by all staff.
- All staff received an annual appraisal. Staff told us the process allowed them and their supervisors to identify areas for development and any areas where performance could be improved.
- The service monitored the renewal and re-validation of nursing qualifications and we saw evidence that this record was up to date. Appropriate reminders were given to staff of upcoming dates. Staff said they had no problems accessing and obtaining training to develop their practice. They said they were supported by their supervisors when applying for training. Supervisors said they balanced training requests against the needs of the staff, team, overall service and budget constraints.
- All applications for training were sent to the workforce development team where they would be considered based on the information provided by the staff member and supervisors. They were then assessed in accordance with the needs of the staff member's continual professional development, the service and provider.

- The workforce development team were proactive in terms of delivering an up to date training programme. They researched available training for staff on an ongoing basis to identify opportunities for further practice development and did this in partnership with professional leads. If a training course was identified by the team they approached the professional lead of a service to see if it was applicable and if staff were interested. This was then balanced against service needs and budget constraints.
- All training courses were displayed on the provider's intranet and staff were able to see what was available for their role. Displayed alongside the courses were descriptions of the courses and an application form which staff could complete and submit.
- Staff within the family nurse partnership team had their practice observed three times a year by the service lead. If poor practice was identified the lead would highlight this following the observation and address it with additional training or extra supervision as required. For example, the lead had observed practice regarding the delivery of information which was not very engaging or supportive to the parent to be. The lead gave advice to the staff member on how the information could be provided in a more effective way.
- Staff within the paediatric therapy teams had access to the Oxford Postural Management Course. The course taught practitioners how to support and provide treatment to children with cerebral palsy. Access to the course allowed staff to develop their practice and provide a safer and better quality service to children receiving care.
- Staff working within the complex care team attended end of life training run by the Child Bereavement UK.
- Newly qualified staff went through a preceptorship. The Nursing and Midwifery Council define a preceptorship as a period to guide and support newly qualified practitioners to make the transition from student to develop their practice further. Staff told us they had mentors within the organisation who provided support, guidance and advice whenever needed but regularly met every six weeks. Staff said the form of the preceptorship was dictated by the new member of staff and was informal which meant it was flexible and gave them the opportunity to ask questions as and when they arose.
- We were told by staff within one of the health visiting teams that they had received an award for placement of the year from a local university in 2016 in respect of their student nursing placements.

Multi-disciplinary working and coordinated care pathways

- We observed and saw evidence of various examples of exceptional multi-disciplinary working. All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering patient care and treatment. Staff spoke positively about the co-location of services and the joined up working with their colleagues from different professional disciplines.
- Within the provider locations we visited, we observed services working side by side. Staff told us this allowed them to work in a cohesive manner and have prompt access to each other's expertise. Referrals to the service were handled effectively with clear criteria in place and a multi-agency approach which helped ensure children and young people received the right care from the appropriate service. Team members were aware of who had overall responsibility for each individual's care.
- Care was delivered in a coordinated way when different services were involved. As locations were shared by a range of different services, staff were able to communicate quickly and effectively to ensure patients received a combined treatment plan. Being in the same building allowed staff to have frequent and face to face conversations without delay. The environment also promoted team working as each service understood each other's role, meaning effective and prompt referrals could be made when required.
- Training was provided in mixed teams to promote relationships between staff in different teams. Staff told us they found this useful as it aided communication between different teams as they were able to identify colleagues and create new avenues to seek advice.
- The multi-disciplinary working included all necessary professionals and extended to include other aspects of children's lives including education and social care.
- One example of the positive integration of services was the role of occupational therapists in training teaching assistants in the support of children with motor skills needs. An education pack was available for the assistants and a rolling programme of training was

delivered by the therapists. Speech therapists could also attend other professionals meetings and appointments with children to provide expert input and assistance with communication.

- The director of children's services had oversight of the children, families and community health services and education services. This meant working relationships between the two service streams could be coordinated and encouraged to provide a joined up service for those children using all services.
- Staff within the organisation shared offices with both education professionals and social workers. Staff told us this enabled them to discuss children on their caseload with other professionals easily and promptly. They said this benefitted the children as there was less delay in contacting the appropriate case worker. Having regular face to face contact promoted the planning and delivery of care, treatment and other support to children and young people in a holistic and joined up way.
- Within the Saltway Centre the premises were shared by the children, families and community health services and a local charity. Both worked alongside each other and shared resources in order to benefit the children they provided care and support to. For example, the charity had raised money for the redevelopment of their outside space. As a result the children being cared for by the portage service also had access and benefitted from it. The portage service offered education to children aged zero to four years and 11 months, who have special needs and disabilities.
- There were seven clinic rooms at the Saltway Centre which were regularly used by consultant community paediatricians employed by the local NHS acute hospital. As a result the paediatric therapy team had close working relationships with the paediatricians and could discuss mutual patients if and when appropriate. It also allowed close liaison between the different professionals to coordinate care and arrange joint consultations and assessments when required.
- The U turn service worked with the police, social services, probation service and schools to support, advise and educate young people on drugs and alcohol. We were told they received referrals from a wide range of organisations and from parents, youth engagement officers and young offender institutes. Staff also worked well internally as they attended meetings with social services if they were involved with a looked after child or young people under a child protection plan.
- The health visiting teams had close links to GP practices and those working within them, with each health visitor having assigned practices. In order to maintain their relationships with midwives at GP practices they held relationship meetings every four to six weeks. Staff felt that having regular contact assisted with communication and cooperation.
- There were both positive and negative aspects to the working relationships between GPs and health visitors. Some health visiting teams attended quarterly meetings with practices where as in other teams there were no formal arrangements for information sharing.
- There were formal arrangements for information sharing and liaison between the provider and the local NHS acute trust maternity department. There was information flow between the health visitor and Family Nurse Partnership services as representatives met with the local NHS acute trust safeguarding midwife regularly. The safeguarding midwife shared information regarding children, within their service, with the health visiting, Family Nurse Partnership and Baby Steps teams using formal information sharing forms. The named nurse for child protection within the service, linked with the named midwife and the named nurse at the local NHS acute trust. However, staff within the health visiting teams felt the arrangements were not as effective as they could be and were not fully aware of all the contact taking place between the two organisations.
- Within TaMHS (Swindon Targeted Mental Health Service) staff we spoke with told us that due to the established nature of the team (in excess of six years) they had built up good relationships with a wide variety of other providers of services. They showed us the pathways they used for making onward referrals and ensuring children's needs were being met. They did express concern about the capacity of some of the charities they referred to and the negative impact when they had to close their caseloads. Staff spoke very highly of the close working relationships with the Consultant Paediatricians whose input they valued with complex cases and also with educational work for staff.

Referral, transfer, discharge and transition

- We saw that staff worked together to assess and plan ongoing care and treatment when families or children

moved between teams or services. There were clear protocols for referrals and for the discharge of children and young people. Staff were clear about the referral process and how they could advise families to access the different services that were available.

- There were clear protocols when children or young people needed more specialist advice. Staff were aware of the specialist services available to children, young people and families within the locality and made referrals to them whenever appropriate, whether internally or externally. For example the health visiting team would regularly refer children and families to family centres if they required additional support but did not meet the threshold for early help. The co–location of the different services helped with the referral process between services
- The complex care team used a structured formal process for preparing children to transfer into adult services. The format used was called Ready Steady Go and was based on the Nation Service Framework for children transition guidance produced by the Department of Health. The documents were completed in three stages usually from the age of 14, though this could be started earlier if required.
- There was an effective process in place for making referrals to the TaMHS (Targeted Mental Health Service). This was accessed via a request for service form usually via a GP or another health professional, such as a school nurse, health visitor, or the child/young person's school, social care or any other statutory or voluntary agency. We attended the daily joint triage meeting with members of the local CAMHS (Children and Adolescent Mental Health Service) team. In this meeting new referrals were assessed for initial suitability, and a decision made as to whether an assessment was required and which pathway would be most suitable.

Access to information

- Staff had access to information needed to deliver effective care and treatment. All staff had access to the electronic patient care record system which held the records for all children and young people using their services. However, the health visiting and paediatric therapy teams held both electronic and paper records. Access to paper records was restricted to those who had permission.
- As well as health records staff had access to the multi-agency safeguarding hub records. Staff said this was really helpful as it meant they could see any changes or actions put into place for children who were on their caseload.
- However, staff told us of concerns regarding the electronic care record system that was in use. Staff within the health visiting and school nursing teams felt the electronic care record system was not fit for purpose as data entry was time consuming and some information had to be duplicated. Staff also told us it was not easy to access data quickly and it took a long time to locate specific data. The issues had been escalated through to senior management. Some staff had been told that the system was in the process of being improved while others had not heard anything.
- The health visiting teams had a combined records system of computerised and paper records. Staff told us they felt there was a risk something could be missed as there were two places to look for and record information. For example there was an incident when a child had not had their development checks because information had not been checked on both sets of records. This issue was raised and as a result a template was created which was worked through during supervision to ensure all development checks had been completed.
- Staff within the health visiting teams subscribed to emails from the Institute of Health Visiting which provided them with information on the most up to date best practice and professional guidance.
- There was only one staff member who had access to the electronic care record system in operation at the local NHS acute trust. This meant staff had to go through that member of staff to access the system, which led to delays as each request had to be dealt with on an individual basis. This was important to staff as they could not automatically check what treatment a child had recently received at the hospital. Staff had escalated these issues but as a temporary measure staff were phoning a consultant's secretary directly for updates, which was time consuming.
- The TaMHS (Targeted Mental Health Service) team used a different electronic record system to their colleagues in the CAMHS (Children and Adolescent Mental Health Service) team. Staff told us this proved cumbersome and required staff to enter information twice onto the different systems. At the triage clinic we saw this

duplication for staff. We were told the TaMHS team were in the process of recruiting to a new administrative post and they were planning for the new post holder to have access to both systems. They would be delegated responsibility for inputting relevant referral information onto the respective systems.

Consent

- Consent to care and treatment was sought in line with legislation and guidance. Staff were aware of the need to ask for consent and for this to be appropriately recorded. We saw care plans were consent was clearly recorded. However, the provider had completed numerous audits of different records and identified that the recording of consent needed improving. Information and learning from these audits was disseminated through the teams.
- We spoke with speech therapists who explained how they used types of communication to engage with children with complex needs who had limited capacity to consent. This included signing, talking mats and the use of symbols.
- We observed staff asking for consent before starting any care or procedure or treatment. Parents and children we spoke with told us that staff always asked for consent and explained what they were doing and why.
- We observed one instance were a referral was received by the TaMHS team without the required consent having been recorded. The referral was accepted although it should have been sent back to the referrer, with an instruction for them to obtain consent or record that this had been obtained. We were told later that this was the normal practice the team followed and there was policy and procedure in place that required this and normally would have been followed.
- School nurses we spoke with explained how on their first meetings with children they would explain the records they kept and the need for consent to be provided for this. Staff were knowledgeable about the Fraser Guidelines and Gillick competence. Fraser guidelines refer to a legal case which found that doctors and nurses are able to give contraceptive advice or treatment to under 16 year olds without parental consent. The Gillick competence is used in medical law to establish whether a child (16 years or younger) is able to consent to his or her own medical treatment without the need for parental permission or knowledge.

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

We found services to be caring because:

- Staff provided compassionate care and treated families and children with respect. Feedback from families about the various professionals was consistently positive, specifically about their caring and professional approach.
- We were told and observed people's privacy and dignity being respected at all times.
- Staff communicated with children and young people so that they understood their care, treatment and condition. We observed staff explaining to children why they were attending and what treatment was taking place.

Compassionate care

- Staff took the time to interact with children and young people who used their services and spoke to those close to them in a respectful and considerate manner. We saw multiple interactions where staff spoke to children in a clear, calm but engaging way which put the child at ease. They addressed the child directly and showed interest in what they were saying. For example, we observed a physiotherapy clinic involving a child with a visual impairment. The therapist introduced herself to both the child and their mother and told them clearly what they were going to do. The therapist was very patient with the child and consistently engaged her in conversation by asking her about school and what she enjoyed doing. She also asked the child if she was comfortable, experiencing any pain and whether they were happy to continue with the treatment, at every opportunity.
- A child told us they were really happy with their appointment and thought the therapist they had seen was kind, nice and friendly.
- Privacy and dignity was respected at all times, including during physical and intimate care. For example, we observed therapists drawing curtains around children and young people when they were getting changed

during all clinics. During one specific interaction a therapist had found and provided a pair of shorts for a child to wear while being examined which made it more comfortable and private for them.

- Staff respected confidentiality at all times. Within the U Turn service staff explained to young people that their information would be kept confidential but encouraged them to discuss their issues with their parents, when appropriate. Staff and young people also signed confidentiality agreements which were explained to the young person, i.e. what they were and what responsibilities the agreement placed upon them. They explained to young people that certain information would be logged and what that data would be used for. They also signed shared information agreements, which were signed by both and authorised staff to share the young person's information with other professionals, if appropriate to do so.
- We received a large number of comment cards from parents, children and young people, of which the vast majority had described staff as friendly, helpful, compassionate and calm.
- The complex care team could provide support to families for up to a year following bereavement. Sessions for siblings and parents could be organised. In the event of a bereavement we were told how equipment could be removed as soon as the family requested, as this was known to be an important consideration for families in these circumstances
- In the TaMHS (Targeted Mental Health Service) we witnessed staff dealing with clients and parents in a supportive and caring manner. They used an empathic approach and spoke to children in a supportive manner.

Understanding and involvement of patients and those close to them

- Staff communicated with children and young people so that they understood their care, treatment and condition. We observed staff explaining to children why they were attending and what treatment was taking place. For example, we observed a therapist explaining to a child why they were having an examination and asked if the child understood what had been said. When treatment was discussed the therapist removed insoles from their packaging and let the child feel them before putting them in their shoes. The therapist then asked the child if they would like to try walking in the insoles before taking them home, to which the child agreed. Following this the child was asked if they were comfortable and the therapist clearly explained how the insoles would help them.
- Parents and children described communication as good and told us they understood their treatment. They said staff explained treatment to them clearly and in simple language. They felt staff had listened to them and answered all of their questions. They also felt staff were engaging.
- We observed a number of clinic appointments for physiotherapy and occupational therapy. We saw therapists explaining and agreeing with parents and children the next steps they would take and when the next appointment would be best. We saw various examples of excellent practice. For example one therapist encouraged the parent to engage more with their partner to encourage consistency over the exercises they were completing with the child and offered to meet with the family to support this. We saw a therapist provide very positive and encouraging feedback to a parent and their child as they had made significant progress since their previous appointment. The parent explained how the therapist had given them the confidence to persevere through being supportive, positive and ensuring they understood what was required of them.
- Information and support was provided in a format that was suitable for children and young people. Within the baby steps programme staff set up a private group on a social network which facilitated communication and networking between new parents. The private group was closed after the programme had finished and was monitored by the baby steps group leader. It provided new parents with a forum to discuss topics away from the group.
- Children, young people and families were routinely involved in planning and making decisions about their care and treatment. We saw staff working with patients and families to ensure treatment was provided at times and in a way that was suitable. For example, staff told us there was a child who had been in the care of the paediatric therapy team for some time and had recently transitioned from primary to secondary school. The staff involved in their care worked with him to develop a

treatment plan which was suitable for him by decreasing the amount of visits and time spent on treatment. This meant they could attend more classes and socialise with friends during meal times.

- Within the speech and language therapy teams, children and families were involved in decision making regarding their treatment. During the application for an education and health care plan (EHCP) children were involved in the process and asked what their objectives, hopes and goals were. Both children and parents were invited to attend "team around the child" (TAC) meetings and encouraged to contribute.
- The family nurse partnership ran a Christmas party for the families every year which was also as an opportunity to gain feedback about the service. Feedback was also sought when families moved out of the programme, called graduation. Staff explained how they would always try if possible to engage with fathers
- We observed in a group run by the TaMHS that staff had a good knowledge of the patient group both on an individual basis and their wider family issues. At the triage clinic we saw how they checked previous involvement with services and were able to talk with confidence about past interventions they had been involved with.

Emotional support

- Staff recognised and supported the broader emotional well being of children, young people and families. For example there was a family who were going through the deportation process and were being supported by the health visiting service. It was known the family were in financial difficulties and were struggling to buy toys for their new-born child. A member of the health visiting team arranged for some of the toys and books within the service to be donated to the family. This was done to relieve some of the pressure on the family.
- Staff supported the emotional well being of children, young people and their families. For example, the health visiting team worked with families who suffer domestic abuse. In one such case a mother, with a new born child, needed to seek shelter at a women's refuge outside of the locality. Her health visitor helped her to find a refuge and then made the arrangements for her to move there. Following her move to the new locality, the health visitor maintained contact to ensure she was safe and also helped with the transfer of care by liaising closely with the new health visitor.

Are community health services for children, young people and families responsive to people's needs?

(for example, to feedback?)

We services to be responsive because:

- In general services reflected local needs and were flexible in providing continuity of care and choice. The provider discussed with commissioners the changing demand and needs of certain services in order to review provision.
- Services were planned to take account of the needs of different people. The provider collected and monitored data on the involvement of services with different ethnic groups. Staff had training in equality and diversity and were clear about their responsibility to be culturally sensitive and responsive to different needs.
- There were arrangements to enable access to services by children, young people and families in vulnerable circumstances and data was collected in respect of this which ensured the provision was monitored.
- The FNP (Family Nurse Partnership) was commissioned to provide universal provision to all young mothers who were under 18 years at the time of conception. Of those offered the service the take up was measured at 95% over the previous twelve months months, with very low attrition rates recorded.
- Children and their families were generally able to access services in a timely way for assessment and treatment. Services were appropriate and were within national referral to treatment time targets for appointments.

However:

- Paediatric therapy, specifically occupational and speech and language therapy and the TaMHS service (Swindon Targeted Mental Health Service) had long waiting times for appointments and treatment. They were unable to currently meet the demand on their services within the target time for appointments.

Planning and delivering services which meet people's needs

- Commissioned services were planned to meet the needs of the local population. We saw that the provider

discussed with commissioners the changing demand and needs of certain services in order to review provision. In general services reflected local needs and were flexible in providing continuity of care and choice

- The paediatric therapy team engaged and involved patients and their families in designing and running the service. Senior staff told us there was a parent advisory group, members of which were invited to participate in the recruitment process for new speech and language therapy positions. We were told the team enjoyed a good working relationship with the advisory group, however, we did not speak to the group during our inspection.
- The services provided reflected the needs of the local population's and ensured flexibility, choice and continuity of care. The U Turn service worked with young people to arrange meetings at the best location and time for them. Although the service operated from 9am to 5pm they worked late on Tuesdays to accommodate and ensure young people in employment could access the service. The staff regularly met young people at school, collage, at home or a neutral location. They also were able to offer drop in clinics for those not in education or employment and who may be homeless.
- Where children's, young people's and families' needs were not being met, they were identified and used to inform how services were planned and developed. For example, within the health visiting teams it was identified that because of low staffing levels they were unable to deliver the healthy child programme for each of the mandated parent and child contacts in a way which was safe and of high quality. As a result the service was risk assessed and it was identified the current staffing levels could not accommodate all five contacts in a safe way. Following this the service delivery model was amended. At the time of our inspection, health visitors were completing all new birth (around 14 days) and six to eight week reviews but were targeting 12-16 week, nine to 12 month and two year reviews. As part of the targeting process, instead of face to face visits staff were writing to and telephoning parents to see if a visit was needed. Staff felt that the service was now safer and they could devote the appropriate amount of time to each visit.
- The paediatric therapy team worked with the local NHS acute trust in seeing urgent referrals from the special care baby unit and arranged clinics at the trust one day a week. The team also prioritised children with talipes (club foot) and liaised with specialist services to ensure patients with brain and burn injuries were seen at the earliest opportunity.
- Staff within the paediatric therapy teams arranged to meet children, young people and families at the local NHS acute trust before appointments were arranged to determine how their services could be delivered in a way that was most suitable for the child, after which appointments would be arranged as appropriate.

Equality and diversity

- Services were planned to take account of the needs of different people. The provider collected and monitored data on the involvement of services with different ethnic groups. The latest figures showed for example that 60% of services were provided to "White British" families, 10% "White Not British" families, and 9% to Asian families, 2% of services were provided to "Black" families and less than 1% to "Chinese" families. Staff we spoke with were aware of the cultural diversity of the areas they worked in and were able to describe how this influenced their practice to ensure they were sensitive to people's needs. Staff explained how they prepared to meet and interact with families by being aware of cultural differences and ensuring that communication could be facilitated.
- For example, the U Turn service ensured opportunities were given for group meetings to take place in single sex environments, with females and males attending at different times or dates. This was done to ensure that both had equal opportunity to discuss topics in a forum where they felt comfortable.
- The school nursing team also arranged for immunisation and vaccination clinics to take place in single sex environments to avoid female children and young people having to reveal their bare shoulders in the company of males.
- There were arrangements to help address inequalities and to meet the diverse needs of local people. The health visiting teams saw children and families in deprived areas and so understood the need for appointments to take place close to their homes. In order to assist with this health visitors arranged clinics at centres close to the family homes in order to save bus and taxi costs.
- The provider planned services to take account of the needs of different people on the grounds of age,

disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation. For example, the health visiting teams who covered the central areas of the locality had a higher proportion of families from ethnic minorities and therefore had to adapt the way they planned and delivered their service. Specifically, they avoided arranging visits to Muslim families on a Friday as that was a day of prayer and staff wanted to respect their culture and beliefs by visiting at more convenient times.

- Another example included delivering a more focussed approach to breast feeding education to families whose culture was to prolong the practice. We were told this was especially common in families from Asian cultures. The health visitors were aware that this could have adverse effects on the child if their diets were not supplemented with solid foods so targeted families who were prolonging breast feeding to ensure they were educated on incorporating solid food into their child's diet at the appropriate time.
- The provider had made arrangements for staff to access translation services which could be delivered in person and by telephone. All information and leaflets could be translated into different languages for families from ethnic backgrounds. Information could also be printed in braille for visually impaired children, young people and families. One therapist described how they had booked an interpreter to attend a meeting they were having with a family who did not speak English.
- At the time of our inspection there were staff, within the speech and language therapy team, who were completing a sign language course to aid communication with children with hearing impairments.
- We were told the guidance for therapists was to encourage parents to use their first language at home with their children as well as English. This was good practice as it provided support to parents when reinforcing cultural identity.

Meeting the needs of people in vulnerable circumstances

- There were arrangements to enable access to the service of children, young people and families in vulnerable circumstances.
- The provider collected data in respect of vulnerable groups it provided a service to and to ensure it was monitoring this provision. For example they recorded for each quarter the open involvement of health visiting in various groups categorised for example as referred to social care, open child protection plan or having an Education Health Care Plan (EHCP) in place. The figures showed that in the most recent quarter 91% of children under the age of 4.5 years with an open child protection plan had an involvement with the health visiting service. The provider further broke the figure down to analyse which groups were receiving which level of health visiting service, for example universal partnership or universal partnership plus.
- Within each service there was a named mental health champion, which meant staff could access additional guidance and advice when providing care to young people and families who suffered from mental health issues. The majority of staff we asked knew who their champion was.
- The health visiting team were part of the Care of the Next Infant Programme. The programme supported parents who have suffered a sudden and unexpected death of a child. The health visitors provided an enhanced health visitor package which included additional training for parents to reduce anxiety, spot the warning signs and reduce the risk of an unexpected death happening again. Health visitors worked with the Care of the Next Infant coordinators within their teams to ensure packages of care were delivered to those who needed it.
- The FNP (Family Nurse Partnership) was commissioned to provide universal provision to all young mothers who were under 18 years old at the time of conception. Of those offered the service the take up was measured at 95% over the previous twelve months, with very low attrition rates recorded. The service was also offered to 18 and 19 year olds where extra vulnerabilities such as social care involvement or mental health had been identified. In 2016 a service was also offered to care leavers up to the age of 21.
- Parents not offered the family nurse partnership were offered the Swindon Baby Steps programme as an alternative. The Baby Steps programme was based on the course devised by the NSPCC. It was a perinatal educational programme for parents in the run up to the birth of their baby and afterwards. It was designed to help prepare people for becoming parents, showing them how to care for the baby, reduce the stress that can occur with a new born child, not just for the birth itself. The course started with a home visit in the 7th month of pregnancy and then included group sessions

each week before the baby was born. After birth the family was visited again at home, followed by more group sessions, which could include discussions and creative activities. There was a focus on building relationships between the parents and their child. We received very positive feedback from parents who had been or were part of the course. Comments included: "the staff are excellent, it's really helped us", and "I would not have coped without the course, the staff were brilliant, I feel confident about being mum now".

- The team of specialist nurses for looked after children had taken steps to improve the health assessments. They had included a more holistic "well-being" approach to part of the health assessment to make it more meaningful for the children. Also children over the age of 16 were contacted three times to arrange their health assessment. If they still declined or did not respond they were sent a hand written card, respecting their decision but providing contact details if they should change their mind in the future.
- Staff told us the clinic rooms within the Saltway Centre were suitable for the treatment they provided and were utilised efficiently. Within each clinic room we saw there were toys, books and colourful artwork for children to play with. However, some parents commented there were no toys for older children and too many toys in the treatment rooms, which could distracted their children.
  - Within the Saltway Centre there were was a soft play and light sensory rooms for children with complex health needs.
  - The Saltway Centre also had facilities for parents and carers to use while children attended the portage services, which included a kitchen and lounge.

Access to the right care at the right time

- Children and their families were generally able to access services in a timely way for assessment and treatment. Services were appropriate and were within national referral to treatment time targets for appointments. The exceptions to this was paediatric therapy, specifically occupational and speech and language therapy and the TaMHS service (Swindon Targeted Mental Health Service), all of which had long waiting times for appointments and treatment.
- Although the TaMHS service did not have specific targets formally agreed with Commissioners of the service they were operating to target times of a referral to assessment of 4-8 weeks and a referral to treatment of 18 weeks. Staff and managers we spoke with confirmed that due to the level of staff absence they were only meeting these targets for 50% of referrals. At the time of the inspection there was a 10 week delay for new routine assessments. The number of assessment slots available to the team was usually eight per week and staff told us this had been reduced from the previous year due to the staffing situation. Staff told us they were frustrated by the situation but confident that the vacant posts would be filled, and consequently they would be able to offer more assessments and treatment sessions. The service leads were discussing with commissioners about increasing the size of the TaMHS service to increase the capacity to meet the demand which had increased over the previous two years. Up until the third quarter of the year when we inspected the service there had been 1444 open involvements with children
- The occupational therapy service was able to accommodate urgent referrals when these were assessed as being required. Other services were also able to accommodate urgent appointments when these were assessed as being required.
- The paediatric therapy team had a locally commissioned 13 week referral to treatment target, which applied to physiotherapy, occupational therapy and speech and language therapy. The way in which referral to treatment times were calculated was set by the provider and there were no set rules for when the time from referral to treatment started. At the time of our inspection the provider was working with their commissioners to develop additional key performance indicator targets but at this stage the only performance indicator reported to the commissioners was the 13 week target. Specifically, the service must see 80% of children, on their caseload, within 13 weeks, however this target was not being met at the time of our inspection.
- We were told there was a child who had been waiting for their first occupational therapy appointment since June 2016. Within the social care occupational therapy team there were some children who had been waiting for nine to ten months. However, staff told us families were kept informed about long waits and kept in regular contact. This had been raised with management and a business case had been submitted for increased funding to recruit an additional occupational therapist. When

questioned, senior staff told us recruitment had been difficult and they were looking to appoint an occupational therapist with a combined role within the health and social care occupational therapy teams.

- The 13 week referral to treatment time was also not being met in the speech and language service. As a measure to address this management had taken the decision to upskill their speech and language therapists so referrals could be spread over additional therapists rather than increase the waiting lists of a few specialists. We were told this measure had decreased waiting times for the service.
- The various teams had systems in place to prioritise care and treatment for the most urgent needs. For example in the health visiting service there was a daily duty system which required the staff member to review messages for off duty or absent health visitors. Health visitors were required to check their own emails and phone messages every day and were expected to reply within one working day. When a referral was identified as being urgent, staff attempted contact within two days and offered appointments within a week. Staff we spoke with explained how they were flexible to accommodate urgent referrals and would reorganise visits and cover colleagues to ensure the urgent referral was responded to.
- In physiotherapy and occupational therapy there were systems in place to ensure that urgent referrals could be responded to and prioritised. Priority was given to certain criteria, for example when there was risk of family breakdown or following a hospital discharge, and a scoring system to help inform decision making was in place. There was a process in place for health professionals to make urgent referrals to the therapy teams. Urgent referrals were generally seen within two weeks, though there was target of seven days, and the physiotherapy clinics for example had emergency timeslots allocated.
- Referrals received by the U Turn service were reviewed as soon as possible and then contacted by telephone with face to face appointments being arranged, if appropriate, within seven days. A new feature on the U Turn service's web page had been added which allowed young people to send private messages to staff. The private messages would then be responded to which allowed young people to obtain support and information promptly and not have to wait for an appointment.
- The health visiting service and the FNP implemented the national 'Healthy Child Programme'. This stipulates various targets for services to meet. For example a new baby review should take place within 14 days with mother and father in order to assess maternal mental health and discuss issues such as infant feeding. Evidence provided by the provider showed they were delivering the majority of mandated contacts in the HCP within the mandated timescales to the local population. However due to staffing shortages as a result of maternity leave the service undertook a risk assessment of the visits required at twelve weeks. An action was in place which allowed for staff to make contact by telephone for the twelve week visit if there were no previously identified concerns. This allowed the service to carry on completing all the other visit requirements. For example the teams were delivering face to face visits within 14 days of birth at 99 % and the required reviews at 6 to 8 weeks were averaging at 91%. Children receiving a two year review was recorded as being at 94%.
- The family nurse partnership received referrals from a range of sources including their website, midwives, direct telephone calls, youth engagement officers and social services. Referrals were received and reviewed by the service lead and then allocated within a week. Once allocated, the staff member contacted the referrer to ensure the family had consented to being referred, following which they contacted the parent directly to arrange an appointment.
- Referrals into the paediatric therapy team were screened by an appropriate therapist and assessed based on the likely level of service required, whether it was a routine or urgent referral and whether specialist involvement was required. Following assessment the referral was allocated accordingly.
- The speech and language therapy team co-ordinated in partnership with specialist resourced education provision the running of a special provision service at schools within the locality. A special provision is a service which supports children with speech, language and communication needs who may struggle in a mainstream environment. The children have access to a full curriculum, opportunities to develop socially and intellectually and receive specialist support through small group teaching and therapy. The speech and language team were able to offer 15 places to children but in order to allow access to more children the service

ran an outreach service. There were two therapists providing the outreach service who could provide support, care and treatment to children who were not able to access the special provision service due to lack of space or could not attend the schools at which the special provision was run. The children on the outreach service were seen at the mainstream schools they attended. However, there were only two spaces for children on the outreach service if seen every week or four places if seen fortnightly. It had been recognised that the outreach service needed to be expanded and at the time of our inspection discussions were being held to prepare a business case to request further funding for an additional speech and language therapist.

- Care and treatment was only cancelled or delayed when absolutely necessary. Cancellations were explained to children, young people and families and supported to access care and treatment again as soon as possible. Staff told us children, young people and families were told why an appointment was cancelled and arranged a new appointment at the next available and most suitable time.
- An audit had been completed of Looked After Children health reviews that were delivered by the school nurses. A sample of 66 assessments were reviewed and of these 65 had been completed within the statutory timescales. Feedback about the audit was shared with the school nursing teams.

Learning from complaints and concerns

- At the locations we visited we saw that information was displayed about the complaints process available to families. Information was also displayed on the provider web site.
- There was openness and transparency about how complaints and concerns were dealt with. For example, we were told of an informal complaint which was made regarding a staff member within the family nurse partnership team. The complaint was regarding a breakdown in the relationship between a family and the member of staff after a referral to social services was made. The lead for the team called the complainant and requested further information and explained how the complaint would be investigated and resolved. Following the conversation the team leader discussed the complaint with the staff member and it was agreed it would be appropriate to change the staff member seeing the family. The complainant was called and the lead explained how things would proceed.

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

We found services to be well led because:

- The service reflected the values and objectives of the council to provide continually improving services for the local community. There was evidence from talking to staff of a strong connection with the local communities they worked with.
- There was an effective governance framework to support the delivery of the strategy and good quality care. Monthly performance data for each service was reviewed and shared with staff and management and a quarterly report shared with the joint commissioning board and the performance and quality board.
- Leaders understood the challenges to good quality care and could identify the actions needed to address them. Managers said they were empowered through the leadership of the service which enabled them to use their initiative and see work through to completion.
- Staff felt valued and respected. All staff we spoke with felt they were appreciated for the role they performed. There was a strong emphasis on promoting the safety and well being of staff. Measures were taken to protect the safety of the staff when working alone and within the community.
- Patients' and their families' or carers' views and experiences were gathered and acted on to shape and improve the services and culture. The provider had "a children in care council", on which youth MPs were involved. The UK Youth Parliament (UKYP) is a youth organisation in the United Kingdom, consisting of democratically elected members aged between 11 and 18. The parliament has around 600 members, who are elected to represent the views of young people in their area to government and service providers. The Children in Care Council (CICC) are a group of young people (aged between 11 and 18) who meet to talk about things that matter to children and young people in care.

Service vision and strategy

- There was not a bespoke service vision or set of values for the children and families service, though senior managers explained that the service reflected the values and objectives of the council to provide continually improving services for the local community. There was evidence from talking to staff of a strong connection with the local communities they worked with. Staff told us they believed the vision of the service was to ensure that they could meet all the increasing needs of the local area and that the strategy was the design of services that had been implemented. Managers at all levels and staff we spoke with shared the same view of the service and spoke of the shared supportive and open culture in place.
- Individual services had a variety of plans and action plans in place outlining their objectives and plans for the coming year.

Governance, risk management and quality measurement

- There was an effective governance framework to support the delivery of the strategy and good quality care. Part of the governance structure included monthly performance meetings between the director for children's services and the councillor for children's services.
- During these meetings the director of children's services provided assurance to the councillor regarding the performance of the service and highlighted any issues along with any actions put into place. The council leader also attended these meetings. As part of this process the director escalated anything deemed serious to the councillor. In addition to the meetings the director and councillor maintained regular dialogue and included the councillor in important emails regarding service performance. The councillor also accompanied staff on visits to gain an understanding of the care and treatment being provided to children, families and young people.
- Meetings regarding performance also took place between the councillor for children's services and the head of children's, families and children's health on a regular basis.
- Staff were clear about their roles and understood what they were accountable for. The provider had a clear management structure within all service lines, with identifiable service managers. There was an overarching management structure which reported in to the head of children, families and community health.
- The provider had a principal officer for health and wellbeing who provided an advisory function to services as well as a point of contact to the senior management team. They were responsible for overseeing quality assurance across all services and reported directly to the director on quality assurance improvements, issues and achievements. Quality assurance meetings took place monthly where the performance reports for each service were discussed. During these discussions issues and incidents within each service line and the actions needed to address them were discussed.
- Monthly performance data for each service was reviewed and shared with staff and management. A quarterly report was produced and shared with the joint commissioning board and the performance and quality board. The information within the reports included information regarding clinical audits, referral to treatment times and incidents.
- Health visitor development meetings took place monthly with the principal officer for health and wellbeing, team coordinators, safeguarding lead, baby steps lead and infant feeding lead in attendance. During the meetings the attendees discussed how they could improve the services they provided and created action plans for implementation of changes to practice.
- All four of the coordinators for the health visiting teams attended monthly meetings to discuss performance and incidents. At the time of our inspection there was no professional lead in post, although the provider was recruiting for one. We had been told the lack of a professional lead was an issue as there was no one to drive best practice and innovative ideas across all teams. It was hoped this would change once a professional lead had been appointed.
- Team meetings took place bi-monthly within the health visiting teams. Meetings followed a set agenda but could be added to if appropriate. Items on the agenda included performance, complaints, incidents and capacity.
- There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. Each service maintained their own local risk register which recorded significant service risks. It was the responsibility of the service and professional leads

to review and update the risk registers weekly to ensure risks were effectively monitored and mitigating actions implemented. The actions were shared with the senior management team, service leads and staff as appropriate.

- For example, the disabled childrens team had highlighted their most significant risk as being the increased referral rate and caseloads for the occupational therapy and speech and language teams. The impact to the service and staff had been recorded and shared with the senior management team through the governance process and to the clinical commissioning group. As a result a business case for additional funding had been submitted and granted. Before the additional funding was granted, in order to address the increased referral rate, the occupational therapy and speech and language team provided additional training, advice and guidance to referrers to ensure they were making appropriate referrals. This also included a resource pack which referrers used to guide them on what actions they could take to respond to communication and physical difficulties before a referral was made. As a result senior staff told us the referral rate into the paediatric therapy team had plateaued and they were now receiving more appropriate referrals.
- There was an organisation wide risk register which recorded corporate risks and was reviewed at quarterly meetings. These meetings were attended by all professional leads for health services, operational managers, service managers, principal officer for health and well-being, risk manager, infection prevention and control lead.
- The family nurse partnership had an advisory board that met quarterly with the service supervisor. The supervisor fed back information to the board members who were from across other service. The service presented an annual thematic report to the quality and performance board chaired by the director of children services.

Leadership of this service

- Most leaders within the organisation were visible, approachable and supportive. Staff told us they saw their service leads regularly. However, a large majority of staff we spoke to said they did not see the director for children's services or the head of children, families and community health but knew their names.
- Leaders understood the challenges to good quality care and could identify the actions needed address them. Two managers we spoke with said they were empowered through the leadership of the service which enabled them to use their initiative and see work through to completion. We were told that change management was carried out thoughtfully and staff we spoke with told us they were kept informed of changes and ongoing issues and developments. Staff told us they were able to approach their supervisors with issues and they would be listened to and taken seriously. They told us supervisors were accommodating and would find ways to alleviate their concerns.
- Team coordinators within the health visiting team made themselves available to their team for informal meetings and staff said they were able to talk to their team coordinators if they had concerns.
- Staff within the U Turn service felt their ideas were embraced by their service lead and were supported in putting them into practice. For example, a member of staff wanted to help build the self-esteem of one of the young people she was working with so asked her supervisor if art work, created by the young person, could be displayed in one of the provider's buildings. Her supervisor approved her idea within a day.
- In the TaMHS team staff we spoke with were positive about the local management of the service, and told us the service was well managed. They told us they had a challenging past 12 months with the long term absence of the professional lead and a number of unexpected staff changes. Despite this they told us they felt the team was very supportive to each other with a good level of motivation and high morale.

Culture within this service

- Staff felt valued and respected. All staff we spoke with felt they were appreciated for the role they performed and the majority felt like they were part of the organisation.
- Action was taken to address behaviour and performance that was inconsistent with the vision and values of the provider. Staff told us they felt able to challenge practice that was not in line with best practice or guidance no matter a person's seniority or title. We were told that supervisors and managers encouraged challenge.
- There was a strong emphasis on promoting the safety and wellbeing of staff. Measures were taken to protect

the safety of the staff when working alone and within the community. The provider had an organisation wide lone working policy which all services had to adhere to. There was an emergency duty system in operation which required one of the senior management team to be on call seven days a week.

- Within each service there was a standard operating procedure which derived from the corporate policy, but differed from service to service. All staff told us they knew what the standard operating procedure was for lone working and could provide examples of the steps they needed to take to keep themselves safe. For example, staff within the health visiting teams held electronic diaries which all members of their team could access. There was also a buddy system which meant each member of staff had someone in their team who would check where they were supposed to be. Staff also had work mobile phones they could be contacted on at regular intervals and staff organised attendance at appointments in pairs, if the environment was deemed high risk. Staff were required to telephone their buddies before and after appointments to confirm they were safe. Staff would also arrange appointments in neutral locations, if meeting patients and families at their home was too high risk.
- The children, families and community health service had access to a security team who could be called if there were any safety issues. If a staff member was seeing a family in clinic, who posed a safety risk, the security team could be telephoned to attend the appointment to ensure there was additional security present in the event of a safety incident. The service was available during regular office hours and in evenings and Saturdays.

Public engagement

- Patients' and their families' or carers' views and experiences were gathered and acted on to shape and improve the services and culture.
- The provider had "a children in care council", on which youth MPs were involved. As part of this an annual meeting was held and was chaired by the councillor for children's services. During this meeting the youth MPs could ask the chair questions about the service and contribute ideas about the services provided to children. The UK Youth Parliament (UKYP) is a youth organisation in the United Kingdom, consisting of democratically elected members aged between 11 and 18. The parliament has around 600 members, who are elected to represent the views of young people in their area to government and service providers. The Children in Care Council (CICC) are a group of young people (aged between 11 and 18) who meet to talk about things that matter to children and young people in care.
- Service user feedback differed within services. Staff told us they contacted service users and their families directly for feedback and shared comments, good and bad, with their teams. The health visiting team had also collected feedback from service users and families at clinics.
- The health visiting team had amended their consent forms to include a question requesting participation in a telephone audit for the baby feeding initiative. This audit was being carried out and had only been in operation for six months. We did not see any evidence of the data collected but was told the audit was collecting data specifically on the quality of feeding support and the service provided as a whole.
- Within the baby steps programme staff were collecting evaluations from service users at two points; following the six antenatal sessions and then following the three postnatal sessions. Baby steps is a perinatal educational programme for parents in the run up to the birth of their baby and afterwards.
- Young people who used the U Turn service could provide feedback using the service website. There were options to complete a feedback form which could be sent directly to the service's email inbox. All feedback from service users was collated into an annual report to identify common themes after which actions plans were created to improve the service. As part of the feedback process an ex-service user volunteered her time to telephone service users and obtain additional feedback.
- The family nurse partnership held focus groups for families to attend to provide feedback regarding the service. They recently held a focus group. The attendance was low but the feedback provided was positive with comments being made regarding how they thought their relationship with their children would not have been as strong if they did not receive the support of the service.
- The school nursing service had feedback from children about their immunisation programme which resulted in action be taken to improve the privacy arrangements.

Staff engagement

- Staff we spoke with said they were engaged with the organisation and kept informed of developments and issues. Information was distributed promptly and effectively. Staff were aware of how to access the latest information or news from the council or the senior management team. Leaders encouraged the participation and involvement of staff in all aspects of the service development.
- Within one of the health visiting teams a Friday meeting was held every week which was purely a debrief session for staff. Staff told us it was used to maintain and enhance staff wellbeing. All staff attended the meeting, unless on annual leave, and it was held at 4pm each Friday. During these meetings staff shared their good and bad experiences, feelings about how their week had gone and also any research they had found on best practice. It was used as a tool to ensure staff were not taking stress and anxiety home with them. Minutes of the meetings were taken and made available to those who were unavailable to attend.

Innovation, improvement and sustainability

- Managers and staff told us they were enabled to contribute ideas and develop their practice. We were told that they were listened to and that innovative ideas for practice or service improvements were shared at team meetings. The co-location of the services supported the sharing of professional discussion and advice, both formally and informally.
- The impact on quality and sustainability was assessed and monitored when considering developments to services. Leaders within the services assessed the impact their actions had on patients when making changes to services. Thorough risk assessments were routinely carried out and actions taken to ensure changes were implemented which had the least detrimental effect on patients but maintained the safety and quality of the service provided. For example, the changes to the delivery of healthy child programme by the health visiting teams.
- Leaders and staff strived for continuous learning, improvement and innovation. Staff in some service lines told us their supervisors and operational leads drove development and improvements to practice to improve the service they provided. For example, within some of the health visiting teams staff had recognised there were gaps in how colleagues provided cover during annual leave and sickness which led to improvements in their practice. New protocols were implemented to ensure the service ran efficiently and effectively which improved awareness among staff as to their patient's needs and the time by which they needed to be addressed.
- Information was used proactively to improve care. Within services user feedback was regularly used to improve the way in which a service was delivered. For example, within the U Turn service staff had recognised, through working with service users, their services were not always addressing needs at the required time as it was only a nine to five service. As a result the U Turn service ensured their website was improved to allow private messages to be left at any time which could be answered quickly and, if appropriate, without the need to wait for a telephone call or face to face meeting.

Outstanding practice and areas for improvement

Outstanding practice

We saw examples of outstanding multi-disciplinary working between different professional teams and across the service. This was evident in communication, support and the sharing of information and best practice.

The responsiveness of the children's complex care team to the meeting of acute and urgent end of life care and support to children and their families in the community was judged as being outstanding.

The specialist speech and language therapy service "fluency", provided to children with stammering difficulties, which included the provision of a residential course was judged as being outstanding.

Areas for improvement

Action the provider SHOULD take to improve

The provider should ensure there is increased cover for the out-of-hours on-call advice and support to the children's complex care team.

The provider should continue to take action to reduce the waiting times for paediatric therapy appointments.

The provider should continue to take action to increase the capacity to the TaMHS service.

The provider should ensure that staff are consistent in their understanding of the processes to follow for the reporting of non-clinical incidents.

The provider should ensure that consent is consistently and accurately recorded.