

South West Yorkshire Partnership NHS Foundation Trust

RXG

Community health services for children, young people and families

Quality Report

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Date of inspection visit: 07 - 11 March 2016
Date of publication: 24/06/2016

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RXG82	Kendray Hospital		
RXGX5	Mount Vernon Hospital		

This report describes our judgement of the quality of care provided within this core service by South West Yorkshire Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by South West Yorkshire Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of South West Yorkshire Partnership NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated community health services for children, young people and families as good because:

- Services were safe and people were protected from harm. Staff knew how to manage and report incidents. We saw there had been learning following serious case reviews. Risks were actively monitored and acted upon. We found that there were good safeguarding processes in place.
- We found that there was enough staff with the right qualifications to meet families' needs.
- The clinics and health centres we visited were clean.
- Services were effective. We found good evidence that the service reviewed and implemented national good practice guidelines. The trust had also successfully implemented evidence based programmes, such as the family nurse partnership programme.
- We also saw that patient outcomes and performance were monitored regularly, and that all staff received regular training, supervision and an annual appraisal. There was good evidence of multidisciplinary and multi-agency working across the services.
- Services were caring. Children, young people and parents told us that they received compassionate care with excellent emotional support.
- Services were responsive. We found the service planned and delivered services to meet the need of local families. Parents, children and young people were able to quickly access care at home or in a location that was appropriate to them.
- Services were well led. Staff we spoke with told us the patient was at the centre of what they do, they were positive and proud about working for the organisation. There was an open culture in the service, and staff were engaged in the process of service improvement. Staff reported being supported by their line managers and teams within the organisation.
- Staff worked with national and regional partners to share good practice. The service had been recognised by the Department of Health for their information sharing procedures and also received recognition from the Institute of Health Visiting and NHS England following the development of the health visitor caseload weighting tool. All managers were very proud of their teams.

Summary of findings

Background to the service

The South West Yorkshire Partnership Foundation Trust provided community health services for children and young people up to the age of 19 in Barnsley.

The organisation provided services such as health visiting, school nursing, physiotherapy, occupational therapy, paediatric epilepsy, audiology, speech and language therapy and looked after children services.

Prior to our inspection the family nurse partnership were in the process of being decommissioned, with the final hand over of clients to universal health visiting services expected to be by the beginning of September 2016. In addition the 0-19 service was waiting for information regarding the future of the service in terms of SWYPFT continuing to be lead provider and future funding and staffing structure for a future model.

Public health services were commissioned Barnsley Metropolitan Borough Council, and was accountable to the local safeguarding children's board in the same locality and also the Trust Executive Group (TEG) Children. Children and young people between the ages of 0-19 made up 23% of the population in 2013 this was just below the England average of 24%. Additionally 7% of school children were from a minority ethnic group this was below the England average of 28%. Also 24% of children under the age of 16 were living in poverty this was greater than the England average of 19%.

The health and wellbeing of children was worse in Barnsley than the England average. Infant and child mortality rates were similar to the England average.

The rate of family homelessness was worse than the England average. Children in Barnsley had worse than average levels of obesity. 9% of children aged 4-5 years and 20% of children aged 10-11 years were classified as obese.

Vaccination rates were better than the England average.

During our inspection we reviewed the health visiting service (including specialist health visitors), school nursing service, looked after children service, family nurse partnership, children's therapy services (including physiotherapy and occupation therapy) and speech and language therapy. We talked with 84 members of staff across the whole service including health visitors, support staff, school nurses, staff nurses and health care assistants and therapists. We spoke with 30 parents/carers observed the care of 18 children and 23 babies and reviewed ten patient records.

We visited 10 locations in Barnsley Locations we visited included The Goldthorpe Centre, Cudworth Centre, New Street Health Centre, Kendray Hospital, Hoyland Medical Centre, Lundwood Health Centre, Darton College, Mount Vernon Hospital, Mapplewell Health Centre and the Victoria Medical Centre. We spoke with 14 parents who were either accessing services during our inspection. We accompanied school nurses to an immunisation clinic, an audio screening clinic. We also accompanied health visitors on three home visits and one therapy group. We observed 3 child health clinics and an epilepsy clinic.

Our inspection team

Our inspection team was led by:

Chair: Peter Jarrett, Retired Medical Director

Head of Hospital Inspection: Jenny Wilkes, CQC

Team Leaders: Chris Watson, Inspection Manager, mental health services, CQC. Berry Rose, Inspection Manager, community health services, CQC

The team included CQC inspectors, a pharmacist inspector and a health visitor.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

The inspection team visited 10 locations in Barnsley. Locations we visited included The Goldthorpe Centre, Cudworth Centre, New Street Health Centre, Kendray Hospital, Hoyland Medical Centre, Lundwood Health Centre, Darton College, Mount Vernon Hospital, Mapplewell Health Centre and the Victoria Medical Centre.

Prior to the inspection we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning group, Health Education England, the General Medical Council, Local Authorities and local Healthwatch organisations.

During our inspection of community services we spoke with 84 members of staff. We observed care and treatment and reviewed the records of 10 patients. We spoke with 30. We also interviewed key members of staff and held focus groups with various staff groups.

We undertook the announced inspection visit between 7 and 11 March 2016.

What people who use the provider say

During our inspection we spoke with 16 families and service users.

The people we spoke with said:

- “The staff supported me through my postnatal depression and I believe they went over and above to support me and my child”
- “The activities provided in this group are brilliant. The therapists are really knowledgeable you can see the development in these children”
- A number of parents we spoke with described the 0-19 service using the following words:
 - “Fantastic”
 - “Amazing”
 - “Brilliant”
 - “Approachable”
 - “Helpful.”

Summary of findings

Good practice

- We reviewed evidence within the 0-19 service which showed outstanding support processes for women and children at risk of female genital mutilation. We also observed exceptional support and recognition for a young carer.
- We observed the school nursing service provide exceptional support for young girls during a vaccination clinic by providing alternative clothing to protect their privacy and dignity if they were unable to roll up their sleeves so that staff could administer the vaccination.
- The work the paediatric epilepsy team were undertaking to develop the epilepsy passport and sudden unexpected death in epilepsy work. We observed excellent support for children and young people during our inspection and this was corroborated by other teams we spoke with.
- The Theratots programme which was developed by the children's therapy team. This programme included links with portage services and supported parents with children with complex learning needs.
- We received consistent positive feedback from parents regarding the care they have received during our inspection; this was further corroborated when reviewing the friends and family data.
- We observed exceptional resilience of staff in the 0-19 service and FNP during our inspection. All staff were positive about the service they provided, which was commendable in light of the uncertainty about the future of the 0-19 service.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

- The trust should ensure that all staff adhere to infection protection and control guidelines, in particular bare below elbows, in community clinics.
- The trust should risk assess school nurse staffing vacancies to ensure that there is sufficient capacity to safely manage safeguarding concerns.
- The trust should work to reduce the referral to treatment times for children's therapy services.
- The trust should work to provide assurance to staff that services for children and young people are part of the wider trust and have strong representation from floor to board level.

South West Yorkshire Partnership NHS Foundation
Trust

Community health services for children, young people and families

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- Staff knew how to manage and report incidents, they received feedback on incidents and we observed learning which had been undertaken from serious case reviews.
- Clinics, health centres, children's centres and school premises we visited were clean and had appropriate access to facilities such as hand hygiene. We observed at clinics that all staff cleaned equipment and prepared equipment between each use.
- Caseloads within the health visiting team were managed depending on the levels of safeguarding, and the size of individual caseloads was below the maximum recommended levels.
- Documentation was contemporaneous and appropriate.
- There were robust safeguarding policies and procedures in place. Staff received safeguarding supervision in line with their trust policies and were knowledgeable about their responsibilities regarding safeguarding vulnerable people.
- There were effective procedures in place to manage the storage of vaccines. This included the monitoring of fridge temperatures and transport of vaccines to clinics.
- The organisation managed risks to staff and to patients both at a local level and at division level. Risk assessments were carried out with patients and information about vulnerable people was communicated amongst health professionals where appropriate.

However:

- All staff did not always follow infection prevention and control protocols.

Are services safe?

- There were two band six school nursing vacancies in the school nursing team. These vacancies were not being filled because of the uncertainty about the service. However, staff in this team told us that at times the amount of safeguarding concerns was not safely manageable within current staffing levels.

Safety performance

- There had been no never events. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented correctly.
- An electronic incident reporting system was in place and all the staff that we spoke to were able to tell us about it and demonstrate how they used it.

Incident reporting, learning and improvement

- We reviewed incident report records dated between November 2014 and October 2015 the service reported 168 incidents. There were no incidents reported as red (severe), there were two incidents reported as amber (moderate), two incidents reported as yellow (low), and 164 incidents reported as green (low). Green indicated no harm.
- 86% of all incidents were reported by the 0-19 service, 13% by the family nurse partnership (FNP) and 1% by the paediatric epilepsy team
- 28% of all incidents related to safeguarding, for example making child protection referrals. The trust reported every instance of safeguarding as an incident, hence the high number of reported safeguarding incidents. 24% of incidents related to confidentiality of electronic health records, for example, printer issues and concerns about access electronic health records system for children.
- Staff told us about learning that had resulted from incidents, although there was no recognised formal system for this. An example we were given included the reporting of missing children and the subsequent development of policies for transit families.
- All staff we spoke with told us that they report missing children and follow the trust's policy in relation to this to ensure the child's safety.
- In November 2014, the duty of candour statutory requirement was introduced and applied to all NHS

Trusts. We asked staff about their knowledge of the duty of candour. Staff described this as being open and honest however; in one service six staff described this as a new initiative.

- There was evidence of learning following a serious case review, for example, the development of arrangements to review children and their families with their General Practitioner (GP). Staff reported that health visitors were invited to GP practices and discussed families as required. Staff told us this was working well.

Safeguarding

- Staff were confident about safeguarding children. Staff informed us that they received a formal supervision session every three months, in line with their local policy which states formal one to one supervision was to be a minimum of three monthly, this was in line with the Department of Health National Health Visitor Service Specification 2015.
- The trust safeguarding children team held 'lunch and learn' sessions to raise safeguarding knowledge for the teams we spoke with, staff also told us there was open access to the safeguarding team and felt empowered to call them if required. All of the clinical staff we spoke with told us they were up to date with their safeguarding vulnerable children training level three where appropriate.
- Evidence provided to us by the trust showed that safeguarding training rates across teams were mixed for all levels of staff. Level 3 training (clinical staff working with children, young people and/or their parents/carers) was 98% for the 0-19 service, 100% for the FNP, 88% for the community speech and language team, 100% for the audiology team and 100% for the paediatric epilepsy team. The trust target was 80%.
- The geographical location of the 0-19 service meant that children's services would mainly interact with Barnsley Local Safeguarding Children's Board (LSCB). However; staff might also have needed to interact with up to three additional LSCBs (Wakefield, Calderdale and Kirklees) due to children being fostered into the area.
- There was evidence of liaison between health visitors and GPs. We saw this in the electronic health care records, however, not all GP practices used the same electronic record system and information sharing

Are services safe?

protocols were not universal. This meant that health visitors were not always able to view the full health care record, senior staff we spoke with informed us they were working with GP leads to improve this.

- We saw evidence within patient records of detailed information recorded about vulnerable children and families, as well as details of how they were being supported by other agencies such as the local authority. This information included health visitor and school nurse safeguarding supervision records.
- The safeguarding team had strong links with external agencies and was represented on the multi-agency safeguarding hub (MASH) teams. This ensured that important information was shared between agencies.
- The looked after children (LAC) specialist nurse supported staff across Barnsley in the quality assurance of health checks, this included training and support when required. The specialist nurse linked with colleagues in neighbouring localities to ensure those children placed in neighbouring localities were monitored and supported appropriately.

Medicines

- There were systems in place to protect patients against the risks associated with the unsafe use and management of medicines.
- All immunisations used by the service were held centrally in one location. One member of staff managed the medication fridges. Fridge temperature check records were observed and these were complete and accurate. Staff reported that there was a standard operating procedure when fridge temperature fell outside recommended levels.
- School nurses explained the standard operating procedures and checklists to ensure that the 'cold chain' was maintained and practice was standardised across the service. We reviewed standard operating procedure documentation in the central location we visited and these were seen to be comprehensive and complete.
- All health visiting staff were nurse prescribers, and a small number were extended nurse prescribers. This meant children and young people had timely access to medicines and treatment. We were assured that processes for the issuing and storage of prescription pads was appropriate and safe.
- We observed staff checking prescribed medications for a child prior to a procedure, in line with current Nursing & Midwifery Council (NMC) (2010) guidelines.

Environment and equipment

- We found equipment used had been tested for electrical safety and serviced in line with manufacturer's guidelines.
- Scales were calibrated yearly and this was organised centrally. We looked at scales and saw stickers showing the dates that they had been calibrated.
- Health visitors each had their own set of scales which they took with them to clinics and on home visits.
- Staff informed us that they had the necessary equipment they needed to perform their roles effectively.
- The three clinics we visited were well maintained and were decorated in a suitable manner to meet the needs of children.
- We visited a number of buildings where clinics were held. We found that the environments were clean and tidy and suitable for children and their families.

Quality of records

- We looked at six electronic records for children and one for an adult which related to two of the children's records. We found that all records were fully completed. We saw that correspondence, for example referral letters were also scanned into or attached within the record.
- The paediatric therapies service used paper records. We reviewed two sets of records during our inspection, we found these to be clearly set out, legible, dated and signed, relevant pathways were also in place where required. Staff informed us that they were soon to transfer to the electronic record system which would enable them to share information with other teams and services.
- All records had appropriate individualised risk assessments and care plans in place.
- The paediatric epilepsy team devised a care plan for each child. This was shared with all relevant partners including the child's school. This was regularly updated to ensure accuracy.
- We observed contemporaneous record keeping that reflected national guidance. This meant that records were in line with staffs' registering bodies such as the Nursing and Midwifery Council (NMC) record keeping guidance for nurses and midwives.

Are services safe?

Cleanliness, infection control and hygiene

- We saw staff bare below the elbow (BBE) and washing their hands between patients in baby clinics. However, we observed that not all health visitors observed bare below the elbow. We were informed this was due to the service having a non-touch policy. We observed variable BBE compliance in clinics. Staff had long hair was tied back and jewellery was kept to a plain wedding band, however we observed staff wearing watches and nail varnish.
- In baby clinics, equipment was cleaned between patient use using cleaning wipes. It was also covered with paper roll which was changed after every patient.
- We observed an immunisation clinic. Staff at this clinic used alcohol gel between each immunisation; however they did not use gloves during the administration of the medications. Staff were also not adhering to BBE guidelines.
- Training compliance for infection control was 92% across all services.

Mandatory training

- All staff told us that they were up to date with mandatory training. They told us that most of this is completed on line and they are able to complete this during work time.
- Two groups of staff we spoke with told us that they received an automated e-mail alert when any of their mandatory training was due.
- We reviewed the trust's records for training which were broken down by service and location. We found that 92% of staff had completed mandatory training; however, we reviewed evidence that compliance on the trust electronic record was variable across community services for children and families. The trust target for mandatory training rates was 80%. Training included:
 - Equality, Diversity and Human Rights. We found that 94% of staff had completed this training.
 - Fire safety awareness training was 84%. However, we found that only 69% of staff in the community speech and language therapy team had completed this training.
 - Information governance training compliance was reported as 99% across all teams delivering services to children and families.

Assessing and responding to patient risk

- Staff accessed and referred directly to specialist services for children when needed. We were told of incidences across these services when specialist advice was sought and delivered in a timely manner. For example, health visitors referred directly for paediatric speech and language and therapy reviews. We were also informed due to the good relationships the 0-19 service had with general practitioner they were able to refer for advice. Staff we spoke with also told us they to contact paediatric staff in the Barnsley Hospital for advice and referral.
- In all health records we reviewed, all risk assessments were completed and updated as required.
- Teams used ages and stages questionnaires, which are an evidence based tool to inform discussions. Areas of need are identified and referrals to support services and additional support is provided by the health visiting team. We saw evidence of this documented in patient records, along with individualised care plans.
- Health visitors routinely created genograms to explore and record the family structure and household composition. This allowed practitioners to understand and assess risk with parents regarding their child's development.
- The school nurses told us that as part of the above process they routinely checked the child's immunisation status and that they were registered with a dentist, however, we were unable to corroborate this when reviewing health care records.
- Health visitors and midwives completed safe sleeping risk assessments and gave advice in relation to risks identified in homes. Additional information was available for parents in the personal child health record "Red Book".
- We saw evidence that the paediatric epilepsy team reiterated risks during each consultation, for example we saw the team discussing swimming and bathing arrangements and also when applicable, alcohol consumption with their clients.

Staffing levels and caseload

- The health visiting service had been an early implementer for the 2011 health visitor implementation

Are services safe?

plan. Early implementer sites benefitted from learning from the national family nurse partnership programmes in conjunction with the Department of Health health visitor expansion programme.

- Health visiting caseloads were reported by the trust, service leads and corroborated by staff as being 1 to between 165 and 351 children, this averaged out to one health visitor to 215 children. The Laming enquiry recommends a maximum caseload of 1 to 400 children. This is dependent upon the levels of safeguarding and if staff are newly qualified. Health visitor caseloads were well within the maximum recommended levels.
- The service used the Benson Wintere online tools to inform the school nursing caseloads. Senior leads informed us this tool showed a shortfall of two band six school nurses. However, due to the uncertainty surrounding the 0-19 service at the time of inspection the service was not recruiting to the posts. School nurses reported individual caseloads of one comprehensive school and up to eight feeder primary schools. Staff reported at times the amount of safeguarding concerns was not safely manageable within current staffing levels. We raised this with service leads; however, due to the uncertainty surrounding the service, recruitment was on hold.
- The health visiting and school nursing teams implemented the enhanced healthy child programme (HCP) model. All mandated HCP visits were undertaken in the parental home, alongside child health drop-ins. During our inspection staff were in the process of implementing a local healthy child programme, which included appointment slots at child health clinics. The aim of this was to reduce waiting times and allow more privacy in child health drop in clinics.
- We reviewed data which showed the overall sickness rate for all children's and young people's services was 2.6%, and the overall level of staff vacancies was 8%.

Managing anticipated risks

- Services had plans in place to manage and mitigate risk including changes in demand due to disruption to facilities or adverse weather. For example, staff told us that in adverse weather they would report to their nearest base and triage the most urgent visits.
- Staff we spoke with told us and we saw that risks, for example, domestic violence situations or aggressive dogs in homes were logged on the electronic care records. Staff told us that if necessary two staff would visit a home where risks were identified, for example when it was known that there was a risk of violence or aggression.
- Staff were able to access colleague's electronic diaries so they could triage and rearrange or re-appoint colleague's visits and clinics in the event of short notice sickness.
- A lone working policy was in place and staff told us of the trust's protocols for arranging and carrying out home visits, including maintaining staff safety. Staff followed the lone working policy. The trust were in the process of upgrading the electronic lone worker devices and staff were being given training.
- There were systems in place to promote the safety of staff when working alone. Staff told us they operated a joint working system for high-risk activities. We saw that there were reporting systems to ensure that the whereabouts of staff were known. Staff were also provided with mobile phones.

Major incident awareness and training

- Staff reported awareness of major incident and business continuity plans and knew where to access them. However, during discussions staff were unable to recount details within the plans.

Are services effective?

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

Summary

We rated effective as good because:

- The Healthy Child Programme (HCP) was delivered through children and young people's services including, the Family Nurse Partnership (FNP), health visitors, staff nurses, nursery nurses, and school nurses.
- Staff assessed and delivered treatment in line with current legislation, standards and recognised evidence based guidelines
- Patients received care from clinicians who were competent. Staff received an induction to the organisation and to services, as well as regular safeguarding supervision and annual appraisals.
- Support for breastfeeding mothers had been re-accredited to United Nations Children's Fund Baby Friendly Initiative (UNICEF BFI) Level 3, just prior to our inspection. However, there was no specialist support provided by a lead health visitor for women with complex breastfeeding problems.
- The organisation had policies and standard operating procedures to ensure that multidisciplinary and multiagency work took place. Additionally, there were good arrangements in place to support young people who were transitioning to adult services.
- The service was implementing an agile working policy; this enabled staff to connect to the intranet to review policies whilst in clinics and also support parents to complete online forms as required.
- Staff had a good understanding of how to obtain consent. 'Fraser' and 'Gillick' guidelines were followed to ensure that people who used the services were appropriately assessed in terms of their competence.

However:

- The arrangements for clinical supervision was not formalised and there was limited evidence of regular one to one meetings between operational staff and their line managers.

Evidence based care and treatment

- All health visitors, specialist health visitors, school nurses and staff nurses we spoke with were aware of the

guidelines relevant to their practice and said they were well supported. The Healthy Child Programme (HCP) is an early intervention and prevention public health programme. We were informed that health visitors undertake an enhanced model of the HCP and all planned points of contact and visits take place within the home. Parents are also encouraged to attend child health clinics through timed appointments. Compliance with the HCP was monitored through key performance indicators which included, when visits were undertaken, for example that the health visitor new birth visit occurred between 10-14 days,.

- The HCP was delivered across the 0-19 age range by the Family Nurse Partnership (FNP), health visitors, specialist health visitors, school nursing, community children's staff nurses, nursery nurses and community support workers.
- Children and young people's needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence based guidance. The trust FNP teams worked across Barnsley. The FNP was a voluntary health visiting programme for first-time young mothers, underpinned by internationally recognised evidence-based guidelines. The FNP used a psycho-educational approach and provided on-going intensive support to young, first-time mothers and their babies (and fathers and other family members, if the mothers consented to take part). Structured home visits were delivered by specialist nurses, starting in early pregnancy and continuing until the child's second birthday.
- Health visiting staff reported they have used ages and stages questionnaires as part of their assessment of children. This is an evidence based tool to identify a child's developmental progress, and provide support to parents in areas of need.
- There was evidence of discussions about National Institute for Health and Care Excellence (NICE) guidance and local procedures and policies being discussed at team meetings. There were clinical care pathways in place across the organisation, using NICE and other national guidance.

Are services effective?

- Staff we spoke with in the FNP, therapy, health visiting, school nursing and therapy teams were aware of the national guidelines relevant to their area of practice. They were supported by the service leads to follow this practice.
- There were policies and standard operating procedures in place to ensure that looked after children and children with long term and complex needs had their needs met in appropriate ways.
- During one home visit, we saw that the use of evidence-based practice was embedded within the care provided. This included weaning, sleep and the use of the Whooley depression screen, which is a recognised post-natal depression-screening tool and also the generalised anxiety disorder tool.
- The paediatric epilepsy nurse explained that sudden unexpected death in epilepsy patients is rare but research had shown when this does happen parents are often not aware of this risk. This member of staff felt that it was important to promote truth-telling relationships with their clients and families and therefore as part of his masters he had completed research based on this subject and was implementing this initiative within the team.

Nutrition and hydration

- Staff demonstrated a good understanding of individual children's needs and care plans were in place to minimise risks from poor dietary intake as required. The health visiting teams demonstrated robust monitoring of outcomes for children.
- The week prior to our announced inspection the services had received confirmation they had been reaccredited as UNCEF Baby Friendly Initiative accreditation level three (this is an evidence based programme of best practice standards to support breastfeeding). There was no specialist support provided by a lead health visitor for women with complex breastfeeding problems, however, there was a training lead to train staff in the best practice standards and lead on the implementation of the UNCEF BFI best practice standards.
- Health visitors promoted and audited the number of breastfed babies in the area. Information provided by the trust showed that between January 2105 and December 2015, 30% of babies were still receiving breastmilk at eight weeks of age which was worse than the England average of 45%.

Technology and telemedicine

- The service was implementing an agile working policy across the 0-19 service. All staff we spoke with had access to laptops and were able to take them into people's homes and completed health records contemporaneously.
- Staff were also able to show parents information on line and we were told of instances where staff had completed nursery registration forms with parents online.

Patient outcomes

- Patients' needs were assessed before care and treatment started and we saw comprehensive needs assessment and care planning. This meant that children and young adults received care and treatment appropriate to their needs. The service monitored the outcomes of interventions.
- Between April and December 2015, 1385 pregnant women received an antenatal health visiting contact; however data provided by the trust did not provide percentages. Staff informed us there were robust pregnancy referral protocols between Barnsley Hospital and the 0-19 service, however, information from neighbouring trusts was not always reliable. Leads informed us that they were working with leads in neighbouring areas to improve pregnancy notifications.
- 92% of new birth visits from health visitors occurred within 14 days after birth. This is worse than the England average of 98%, this was due to visits timescales and day 14 falling over a weekend, however, the implementation of the local HCP would improve. However, 100% of all families received new birth visits by 21 days and this is better than the England average.
- 96% of children received a 12 month review in the month of their first birthday which is below the England average of 100%. 95% of children had a review by the time they were two and a half years old compared to the England average of 98%, the implementation of the local HCP which included timed clinic appointments was aimed to improve the timeliness of these health reviews.
- Between April and December 2015, 94% of women had a six to eight week review by health visitor and breastfeeding prevalence rates were 30%, which was worse than the England average of 45%.

Are services effective?

- The FNP breastfeeding initiation rates were 45%. The six to eight week breastfeeding prevalence rates in the FNP were 11%, however, there is no data collected nationally to allow a comparison.
- Immunisation rates for the measles, mumps and rubella (German measles) (MMR) vaccine were 96% which was above the England average of 92%.
- Between April 2014 and March 2015 we reviewed data which showed the FNP immunisation was 100% of children were fully immunised by the age of two.
- We reviewed evidence related to the data collection for the National Child Measurement Programme (NCMP) which was 89% for reception age children. No data was recorded for 11% of children. For year six children the data collection was 94% with 6% where not data was recorded.
- We reviewed data which showed the cycle skills group had been attended by 116 children in the past eight years, with 76% being able to ride independently following the programme. 100% of the parental feedback for the group between April and December 2015 was positive.
- Staff told us that in addition to mandatory training, they also completed role specific training. For example, one team of health visitors told us that they had all completed maternal mood training that had been provided by an external company.
- Eight staff from school nursing and health visiting teams at one base told us that they had regular one to one meetings with their managers. Health visiting staff in this team also told us that they held group clinical supervision sessions approximately every six months but this was not recorded, and were not formalised across all teams within the 0-19 service.
- Staff had mandatory safeguarding supervision every three months in line with local policy, a summary of the cases discussed was scanned into the electronic record system, to accompany the patient record as evidence it had been through supervision. We reviewed data which showed 92% of staff had achieved their supervision requirements between April and December 2015, plans were in place and in progress to ensure that 100% of supervision needs were met by the end of March 2016.
- The Local Safeguarding Children's Board in Barnsley offered a wide range of training for staff to access. Staff we spoke with told us this was some of the most comprehensive training they had attended.
- A newly qualified health visitor told us that she was completing a year long, values based induction, which incorporated quarterly reviews with her line manager. The induction programme was delivered in line with national guidance where newly qualified health visitors are not required hold a safeguarding caseload until they had been in post for six months.

Competent staff

- There were formal processes in place to ensure staff had received training, supervision and annual appraisal. We talked with a number of health visitors, school nurses, speech and language therapists, children's therapy teams and the FNP. All staff we spoke with told us they undertook a variety of mandatory training and received an annual appraisal.
- Health visiting staff had yearly appraisals based on trust values. However, there were no formal arrangements in place to monitor their objectives throughout the year. Some staff told us their objectives were monitored through triennial reviews. Staff informed us this was done through safeguarding supervision and informal discussions with leads.
- Data provided by the trust showed that 92% of staff delivering children and young people's community services had an annual appraisal.
- Staff felt confident to voice their own concerns about their development and also areas of improvement for their colleagues.

Multi-disciplinary working and coordinated care pathways

- We were provided with, and observed, a range of evidence that showed how the various children's health teams demonstrated positive multidisciplinary working with others. For example the children's therapy team had developed a programme called "Therabuds". This was a multiagency group to support children and families with complex needs including physiotherapy, occupational therapy and work was underway to involve speech and language therapy.
- The specialist health visitor for asylum seeking families, migrant health and roadside gypsy and traveller families told us that she provided joint reviews for gypsy and traveller families in conjunction with the specialist

Are services effective?

education welfare team and lead children's centre for gypsy travellers. In addition to the health visitor also attended gypsy traveller case conferences that included representatives from the police, enforcement, legal and education services as well as colleagues from other health services.

- We saw evidence of multidisciplinary working within the care records we reviewed, these included details of other health services as well as evidence of integrated working across health and social care.
- We also saw that health visitors liaised with other agencies such as charities to support the children in their care.
- All staff we spoke with in community young people's teams including the FNP, health visitors, school nurses, and the paediatric epilepsy service told us that they liaise with and refer children across a wide multidisciplinary team.
- The paediatric epilepsy team told us that they had good links with the 0-19 services.
- Health visitors told us that they each acted as a link health visitor for a GP practice. These staff attended practice meetings and shared new initiatives with GP colleagues.
- Staff also told us that they had links to local authority children's centres and we saw evidence of this when we visited a drop in clinic where staff from the local children's centre were providing a 'weaning party' for the parents attending the clinic.
- School nurses told us they had good relationships with local schools. Many staff told us they had worked with their school for a number of years, therefore their face was known by teachers and the senior management teams in the school.

Referral, transfer, discharge and transition

- A new single point of access had recently being rolled out for community health teams, this was a freephone telephone number manned by an administration team. This service was available Monday to Friday.
- The paediatric epilepsy team had a central administrator who took calls for them. The team aimed to respond within two working days to all calls but told us that usually they managed to respond on the same or next working day. This team also discussed their transition processes with us. These were seen to be robust and individualised for each child dependant on the needs of the child.
- We saw a system in place for the transition from health visiting services to school nursing services whereby details of school age children were collated and sent to a central administrator who then referred the children to the appropriate school nursing team. A health assessment questionnaire was sent out to the parents and once returned this was reviewed by a staff nurse from the school nursing team and any actions taken as appropriate. Staff also told us that they provided a verbal handover if a higher level of need was identified.
- The specialist health visitor for asylum seeking families, migrant health and roadside gypsy and traveller families told us that she received referrals for her client groups from local authority, housing contractors and the local council.
- Staff said that there was written pathway for 'transfers in' from another area. Once staff received notification, via a task allocated to them on the electronic records system, of a transfer in they were able to triage and arrange visits based on priority. For example, if a child had safeguarding alerts logged these would take priority. Staff told us that they sometimes received a verbal handover from the transferring trust.
- All staff informed us that they referred directly for specialist support, for example, speech and language therapy and paediatric reviews such as speech delays and concerns with child growth and development.
- We reviewed handover documentation between health visiting and school nursing, which were comprehensive and complete.
- When children moved between services their needs were assessed early, with the involvement of all necessary staff, teams and services including LAC, school nursing and adult services. For example, for children with complex needs or epilepsy, planning started when the child was 14 years old for transition to adult services at 18 years old.
- In the case of looked after young people transitioning to adulthood and adult services, a care plan remained in place for the person up to the age of 18.
- There was a health visitor who worked within the Barnsley Hospital Accident and Emergency department. Their role was to triage all of the 0-19 attendances, prioritise the cases and 'task' the named health visitors directly to follow up.

Are services effective?

Access to information

- Staff were able to access all policies on the intranet page, and all staff we spoke with knew where and how to access a policies
- Information about named health visitor, school nurse was stored on the electronic record keeping system.
- All staff we spoke to had agile working devices. We were told that connectivity was good in the area and the trust intranet was accessible. Staff also told us that they shared records with other partners such as general practitioners.
- Health visitors told us that midwives completed a cause for concern form if they needed to share information of concern between the teams.
- Staff we spoke with also told us that they received national alerts for children who were subject to a child protection plan transferring into the borough.
- Staff used electronic diaries that were accessible to colleagues. This meant in the event of short notice absence staff could reschedule colleague's workload.
- All health visiting staff we spoke with told us that they attended weekly team meetings and that these were minuted and saved on the shared drive for all staff to be able to access.

Consent

- We saw health visiting and school nursing staff asking for parental consent for vaccinations. We also observed

and heard staff seeking consent before providing any care or treatment, for example staff in a school nurse immunisation clinic sought consent verbally before administering the immunisation. In addition to this all children attending the clinic had brought signed parental consent forms.

- Services told us they took in to consideration the voice of children and young people when obtaining consent.
- School nursing services followed “Gillick” and “Fraser” guidelines to assess the maturity and competency of children to make decisions and consent to treatment. We asked staff how they would deal with a situation where the child was deemed to be “Gillick competent” but the parent refused to consent, for example, for immunisations. Staff told us that they would always try and arrange a home visit in these circumstances to try and help to understand the issues but that ultimately if the young person was competent they would heed their wishes.
- Staff told us that they used implied consent in some situations. They took in to account not only verbal communication, but also non-verbal communication when deciding whether a parent or young person was giving consent.
- We saw consent to share information documented in all the care records we reviewed.
- Within the FNP, consent was obtained formally as patients signed an agreement to join the programme.



Are services caring?

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

Summary

We rated caring as outstanding because:

- Service managers and staff created a strong, visible, person-centred culture and were highly motivated and inspired to offer the best possible care to children and young people, including meeting their emotional needs.
- Every member of staff we spoke with, across every service, was very passionate about their role and, in some cases, went beyond the call of duty to provide care and support to families.
- There was respect for the different personal, cultural, social and religious needs of the children and young people they cared for, and care and treatment was focussed on the individual person rather than the condition or service.
- Feedback from families we spoke with was unanimously positive about all aspects of the care they and their children received. They described staff as being very caring, compassionate, understanding and supportive.
- Staff worked in partnership with children and young people and promoted empowerment, enabling them to have a voice and realise their own potential. Service managers and staff valued the emotional and social needs to children and young people and this was reflected in their care and treatment.

Compassionate care

- All staff we spoke with were very passionate about their roles and were clearly dedicated to making sure children and young people received the best patient-centred care possible.
- As part of our inspection we observed care in patient's homes, clinic settings and observed staff speaking to clients on the telephone. We observed staff tailoring advice to the needs of children and their parents and they ensured that their privacy was maintained.
- In order to gain an understanding of people's experiences of care we talked to 16 people who used the services. Without exception all parents we spoke with were happy with the care they received. They felt supported by staff and could not give any suggestions about how the service could be improved.
- During our inspection, we saw that all staff were compassionate and caring towards the service users

they were looking after or involved with. We saw staff behaving professionally at all times, providing reassurance when required. We observed staff talking to children in a kind and considerate manner, for example we saw a member of a health visiting team calming a toddler who was on the weighing scales.

- We were told of an instance where staff had gone a long way to support a family in extremely vulnerable circumstances and supported them to seek asylum, financial support, food and housing.
- We witnessed two consultations by the paediatric epilepsy team. We found this service to be outstanding. The staff were extremely responsive to the children in their service; they were very knowledgeable, caring and compassionate. We observed staff supporting children awaiting further review, by providing key messages and interim support measures. One team member told us that they are passionate that they provide the best service they can.
- We visited a school during our inspection and saw an immunisation clinic in progress. We saw positive interactions between the staff at the clinic, including school nurses, a student school nurse and school nurse support workers and the young people attending the clinic. Many of the young girls were anxious and some were visibly upset. We saw staff reassuring the girls and allowing time for them to ask questions.
- Staff were proud of their scores on the Friends and Family Test. Between August 2015 and January 2016 the service scored between 96% -100% positive feedback which gave an average of 99% over the six months. During this timescale there were no negative responses.

Understanding and involvement of patients and those close to them

- Parents and carers of children told us staff focused on their needs and those of their children.
- A health visitor we spoke with gave an example of how she had referred the mother of child to the Webster Stratton programme in order to help her to develop strategies to cope with some difficulties she was



Are services caring?

experiencing. The Webster Stratton programme is an evidenced based programme which provides parents with the tools to be able to develop strategies and overcome challenging behaviour in their child.

- Services were developing and using social media to provide information for service users and families.
- We saw up to date patient information leaflets and witnessed staff giving these to service users or their carers during consultations. Health promotion information was available in all clinics we visited in child-friendly language.
- Staff told us that having agile working devices enabled them to share their records in real time with parents and older service users and we saw evidence of this in the clinics we visited. For example we saw health visitors showing parents electronic versions of babies' centile charts. We were provided with an example of how a nursery nurse was able to use her agile working to support a family to complete an online nursery registration form.
- The paediatric epilepsy team had introduced an e-mail account to allow more ways for children in their care to communicate with them. One member of the team told us that they often see children who do not communicate very well face to face and they hoped this would allow more open dialogue of any worries or concerns that service users. We were given an example of a young person who spoke very little in clinic but who had started to e-mail the team regularly for advice and support.
- Parents and carers reported being involved in discussions about care and treatment options and told us that they felt confident to ask questions about the care and treatment they received and make informed decisions. Parents described staff as 'fantastic', 'trustworthy', 'responsive' and 'accessible'.
- Staff told us that whenever possible they supported children and their parents and carers to manage their own treatment needs. Staff told us they would discuss goals with families and give them advice about how they could make progress to achieve these goals.
- We observed staff supporting the privacy of young girls during an immunisation clinic. There was a selection of t-shirts available to maintain the modesty of girls who were wearing long sleeved shirts which they were unable to roll up.

- Staff we spoke with told us how they had assisted a family in accessing family funds which enabled them to buy sensory equipment for a child with impaired sight.

Emotional support

- Staff in health visiting teams managed their own caseload. This meant that mothers met the same health visitor at each appointment in their home. Consistency meant that health visitors built up relationships with mothers and children, and we saw evidence of this during home visits.
- Health visitors undertook ages and stages questionnaires with families. If areas of need were identified they were referred to community nursery nurses to provide support in breastfeeding, fussy eating, children with allergies and enuresis (bed wetting).
- We saw the paediatric epilepsy service providing exceptional emotional support during a consultation with a vulnerable child. We also observed the team providing emotional support to both the parents and the children in their care.
- During home visits, we saw that staff used emotional wellbeing assessment tools.
- We attended a drop in baby clinic at one location and were told by a parent that she would not have been able to continue to breastfeed her baby if she hadn't received the emotional support that she had from her health visitor.
- During our inspection we witnessed school nurses emotionally supporting a young person who had told them they were being bullied. Staff were caring and compassionate and allowed the young person time and space whilst being supportive and ensuring a plan of care was implemented to help them.
- Staff also told us about another incident where they had recognised that a young person was 'not quite right'. After speaking to the young person they admitted that they were struggling because they were a young carer. Neither the school nor the school nursing service had been aware of this previously, and both immediately put actions in place to ensure that the young person was fully supported.

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- Care was provided to people in their home and also in local clinics, treatment centres, drop in sessions and also timed appointments as and when required.
- The service provided clinics in the local community for children who were home schooled or who were not in school.
- The trust followed the NHS complaints policy and staff were aware of how to deal with complaints or escalate them as required. Learning from complaints was shared locally and more than half of staff felt that feedback from patients influenced how services developed.
- There was sufficient equipment to ensure that people with disabilities were able to access services and buildings complied with the Disability Discrimination Act 1995.
- There were specialist staff who worked across the 0-19 to support vulnerable groups for example, asylum seekers, migrants and gypsies.

However:

- Waiting times for assessment the children's therapies team (physiotherapy and occupational therapy) were between 18-20 weeks.

Planning and delivering services which meet people's needs

- Health visitors provided a range of clinics across the locality to meet the needs of the local population. Clinics included some drop in clinics and some that were appointment only. Appointment only clinics had recently been introduced as part of the new HCP. Staff we spoke with told us that service users had been consulted with and had responded favourably to the introduction of appointment only clinics. Staff told us that they felt that this system was beneficial as it assisted in maintaining client's privacy and dignity and also allowed for greater confidentiality for parents and their children.
- School nurses visited schools and also held drop in sessions at each secondary school once a week. School nurses also told us that they offered all of the services

provided by them to any children who were not in school, including those being educated at home or children excluded from school. These were held in local clinics close to their client's homes.

- Most staff had a good knowledge of the people they had on their caseload, or who attended the schools they looked after. They were aware of the needs of the population and the type of support they needed.
- The children's therapy teams supported children following discharge from acute paediatric care usually at one year old. They developed groups to support children with complex learning needs through the five week Therabuds and Theratots groups. Also a cycle skills group to support children with complex needs to learn to ride a bike over whilst working through eight stages.
- The Family Nurse Partnership (FNP) team was one of the first waves of teams commissioned in the national pilot. The FNP supported vulnerable young parents in Barnsley through intensive evidence based antenatal and postnatal programme. At the time of our inspection this service was in the process of implementing an exit strategy following the decommissioning of this service by the local authority.
- The service were involved in the 'having a baby' programmes. Some of these sessions were held outside normal working hours, which allowed for working families to be able to attend.

Equality and diversity

- Services were designed with the needs of vulnerable people in mind.
- Buildings were easily accessible and adhered to the disability discrimination act 1995 and equality act 2010. There was equipment available to support people with disabilities.
- There were two specialist health visitor roles. The disability health visitor was in the process of extending their remit from 0-5 years to support children with disabilities across the 0-19 service. The specialist health visitor for asylum seeking families, migrant health and roadside gypsy and traveller families supported people in hard to reach groups.

Are services responsive to people's needs?

- We were told that staff were able to access sign language services for parents and children who had hearing impairments.
- Staff told us that they had effective systems for accessing translation services. All teams we spoke with told us that the translation services met the needs of the local population.
- Teams used texts to remind service users about appointments and these could then be electronically translated using electronic applications on their mobile telephones.
- Staff were able to support children with sensory disabilities. We observed a Therabuds group and saw appropriate, responsive and effective communication skills between staff, the children and the family members participating in the group. Parents we spoke with informed us that staff were 'excellent' and very supportive of their children.
- Staff told us they made sure that people understood information before they left the service when written information was not available for them to take away.
- School nurses worked closely with pupils to help them to understand cultural differences, such as forced marriage, sexual exploitation and female genital mutilation.
- Most staff were aware of the ethnic and religious makeup of the people who used their services and were able to describe how they could make modifications to ensure they were culturally sensitive.
- People who used the services told us that they were treated as individuals.
- There was no service specific information; however, trust wide results for the national NHS Staff Survey (2015), the trust had scored 11% for staff experiencing discrimination at work. This was just above the national average for mental health and learning disability trusts at 10%.
- One health visitor we spoke with told us how she had assisted a mother in seeking asylum, this also involved helping the mother to access housing and food parcels. We saw evidence of this in the care records we reviewed.
- A health visitor we spoke with told us that she had assisted a family in seeking family funds which enabled them to buy sensory equipment for a child with impaired sight.
- Staff we spoke with told us that they did experience delays when referring children to child and adolescent mental health services (CAMHS) and we also were told this by a service user's parent at a clinic we visited.
- We spoke with health visitors and school nurses who told us that they worked closely together to manage the needs of children with complex health needs. This included performing early help assessments.
- The paediatric epilepsy team were in the process of introducing new epilepsy passports for all children. During the consultations we observed, we saw staff explaining this to the children and their parents and asking for their views on this. The team also routinely visited the children's schools to ensure that the school were aware of the current care plan for each child.
- In addition to this, we witnessed a child with some mental health concerns. This child was isolated and was self-harming. They were awaiting a CAMHS appointment. The paediatric epilepsy nurse was caring and thoughtful and suggested coping strategies, which may help the child in the interim.
- The looked after children's nurse supported staff in undertaking health reviews on children in care. This took the form of training and quality assuring the checks as required. We were told that continuity was important for these children therefore; to see the same health visitor or school nurse was beneficial in building that relationship and trust.

Meeting the needs of people in vulnerable circumstances

- The trust employed a specialist health visitor for asylum seeking families, migrant health and roadside gypsy and traveller families. The aim of the service was to try to offer the healthy child programme to these groups.
- Staff received training from the trust safeguarding lead to raise awareness about female genital mutilation and had links to a sexual exploitation support group in Sheffield.

Access to the right care at the right time

- We found that all children's services delivered responsive, good, coordinated, safe care. This was supported in all areas we inspected where we found that care arrangements met the needs of children and their parents. We found effective communication between community multidisciplinary teams and partner organisations to focus care and treatment on the needs of children who used the service.
- The CYP teams had recently introduced a single point of access. This meant that service users could use a

Are services responsive to people's needs?

freephone number to access services. Calls were assessed and referred to the appropriate team by an administrator who created a task on the electronic records system for the member of staff covering the duty rota.

- The SALT team implemented a triage system to reduce waiting times and to support the prioritisation of treatment. Staff we spoke with informed us that there was no waiting time for assessment and this was corroborated by data we received from the trust.
- Staff told us and this was corroborated by data provided by the trust showed referral to treatment times (RTT) for children's physiotherapy was between April 2015 and January 2016 was an average of 18 weeks and 12 weeks for outpatient treatment. For occupational therapy services there was an average wait of 20 weeks for treatment following triage, with the shortest wait being 17 weeks and the longest wait being 24 weeks (however there is no national data available to benchmark this against). We were not provided with assurance that plans were in place to reduce the RTT, staff told us the service was trying to recruit to posts, however, this would not have an immediate impact on the waiting

times. Information provided by the Trust following our inspection showed that waiting times had decreased since the levels in 2012, however referrals into the service had increased disproportionately.

Learning from complaints and concerns

- Staff told us and we saw customer services leaflets that explained how service users could raise concerns or make a formal complaint. Health visitors told us that they gave leaflets to all parents at the time they joined their caseload and we saw that this information was included within the red book.
- Staff at one health visiting base told us of the changes to practice that had happened because of complaints by service users, for example having appointment only clinics to maintain confidentiality.
- Services for children, young people and families received eight formal complaints between February 2015 and January 2016, however, one complaint was withdrawn. Outcomes were clearly documented and were appropriate to the complaint. Evidence we reviewed showed that three of the remaining complaints were upheld and apologies offered appropriately.

Are services well-led?

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

Summary

We rated well led as good because:

- Staff we spoke with told us the patient was at the centre of what they do, they were positive and proud about working for the organisation. Despite there being growing uncertainty about the future of the service, staff showed exceptional resilience.
- There was an open culture in the service. Staff were engaged in the process of service improvement, however, at the time of inspection the service was waiting for the final commissioning intentions from the local authority the launch of the new HCP had been delayed.
- Staff reported being supported by their line managers and teams within the organisation. However, there was a disconnect between the board and operational staff, who believed there was no board representation for services for children and young people.
- We observed and found a number of innovations within children's therapies services and evidence of national recognition and joint working, for example information sharing protocols developed among local authority, acute hospitals, social care and community services.

However:

- Staff reported they did not feel part of the wider trust as there was a strong focus on mental health services during training and very little on universal health services.

Service vision and strategy

- There was a clear vision for the service and this was documented in the refreshed local healthy child programme (HCP) document. At the time of inspection the local HCP was in the process of being rolled out, it had been delayed due to the uncertainty surrounding the service. However, staff were fully aware of the future of the service.

- The service strategy was documented within the 'Service Line 2 Year Operational Plan 2016/17 Onwards'. Due to the uncertainty surrounding the service and the decommissioning of the Family Nurse Partnership (FNP), it did not truly reflect the service.
- There was a clear exit strategy in place for the FNP. This was due to be completed by the beginning of September 2016. However, when we spoke to health visiting staff, some were not aware of the transition procedures to transfer the FNP clients into the mainstream health visiting service.

Governance, risk management and quality measurement

- We spoke with the divisional management team. The risk register was aligned to the 0-19 business development unit. It contained detailed information about the risks faced by the service as well as actions being undertaken to mitigate and minimise risk. These included records storage and retrieval for school nursing services and recruitment to the immunisations and vaccination team.
- Leads informed us that they reported on performance on a monthly basis. We observed a locality team meeting where performance was discussed. Staff we spoke with told us that the risk register for the teams was discussed at service meetings that were held monthly. Staff could access the minutes of the meetings electronically.
- We reviewed records audits which were undertaken by service leads using a standardised online survey. We reviewed an action plan which was developed following the audit which documented clear and achievable actions and milestones to improve documentation in the 0-19 service.
- We were informed that governance and risk were standard agenda items on all meetings within the Barnsley business delivery unit (BDU) and observed minutes of meetings showing this.
- Some staff we spoke with were not confident that their concerns were fed up to board level, as there was little information fed back; however, this was not the view of all staff.

Are services well-led?

Leadership of this service

- The service was led by the district director and the deputy district director, however, staff informed us they felt connected with the trust board through the director of nursing and deputy director of nursing. Staff did not mention the role of the district and deputy district directors during interviews and conversations. Staff we spoke with said links to the board were improving. However, some said that it could be better.
- The director of nursing was the board lead for children and young people, and had a good awareness of the service including the vision for future development.
- All community services for children and families were part of the BDU.
- Staff reported good support from team leads or direct line managers. All staff we spoke with were positive and had confidence in the 0-19 service managers.
- All staff we spoke with told us that their managers were visible and approachable.
- Staff told us that managers were engaging them in the reconfigurations that were taking place across the services at the time of our inspection.

Culture within this service

- Staff in all areas visited during our inspection were, without exception, friendly, approachable, caring and helpful.
- We found that all staff were enthusiastic and proud of their services despite the uncertainty that they were facing in relation to the future of the teams they were part of.
- Staff we spoke with told us that they would recommend the trust as a place to work.
- We found there was a culture of openness and flexibility among all the teams and staff we met. Staff spoke positively about the service they provided for children, young people and parents. Placing the child and the family at the centre of their care delivery was seen as a priority and everyone's responsibility.
- Staff informed us they were empowered to raise concerns with local managers and service leads; however, they could not recall instances when this was required.

- Staff worked well together and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of children's services.
- Staff we spoke with in the FNP informed us that despite the decommissioning of the service there were no staff on sick leave as staff were committed to supporting their clients.
- One member of staff we spoke to said that her role had become more administrative due to financial restraints. They told us that this meant they provided less health promotion in their role.

Public engagement

- The organisation took part in the Friends and Family Test, a nation-wide initiative to help organisations to assess the quality of their services by asking service users whether they would recommend the service. Staff were proud of their scores on the Friends and Family Test: Services for children regularly scored 100% positive feedback in the six months prior to our inspection.
- Staff had consulted with parents with regards to the changes in the 0-19 service in particular sought their views on moving clinics from drop in to appointment only. We were told this was well received by all parents asked.
- Health visitors had introduced a two hour time slot system for home visits. This was following concerns parents had raised that they were waiting at home all day for health visitors to arrive.
- Staff in the paediatric epilepsy service told us that they were part of a trust task and complete group which was looking at developing supportive functions for their service users. For the epilepsy team this had resulted in the development of specialist epilepsy social media website including Twitter (#epilepsybarnsley) and a Facebook page for children who were accessing their service, although they had advised clients that they should not use social media to ask about their condition.
- The epilepsy team had also introduced an e-mail account to communicate with their service users, they had asked clients about this and they had viewed this

Are services well-led?

positively. In addition to this, the service was due to introduce epilepsy passports. We saw these being discussed with their clients and the client's views being sought

- We were provided with an example of engagement by the stop smoking team, who worked with college students and LAC to gather feedback on the services. Media students developed posters and a creative minds group put together a dance on stop smoking and presented it to the trust and the clinical commissioning group.

Staff engagement

- Staff told us that the teams held weekly team meetings and monthly service and area meetings were also held. In addition to these the service leads held staff forums regarding the commissioning of the services including the FNP.
- Staff from the 0-19 service and therapies services told us that they felt there was a disconnect between the community teams and the senior trust level. They used an example of face to face mandatory training being focused around mental health services with few examples being given for universal services.
- Staff told us that their main channel of information is from the trust intranet. All staff we spoke with told us that the trust sent a weekly bulletin to update staff and we saw examples of these on the intranet.
- Trust staff had taken part in the national NHS staff survey in 2015 although results were not available specifically for children and young people's services. The trust-wide results showed that on a scale of one to

five, with five being fully engaged and one being completely disengaged, the organisation scored 3.75. This was better than the 2014 survey where the trust scored three; however, this was worse than the England average of 3.81.

- Staff acknowledged that locally engagement within their teams was good. They felt listened to by their managers and well supported by their teams.

Innovation, improvement and sustainability

- The paediatric epilepsy team chaired the Trent regional epilepsy forum. This was a quarterly forum that was attended by representatives from across the region including colleagues from other trusts such as Sheffield and North Lincolnshire. The forum looked at research and case studies. This was seen as a forum to share innovation and learning.
- Following an academic piece of work the paediatric epilepsy team had begun to implement a truthful explanation of sudden unexpected death in epilepsy patients to clients and their families to raise awareness,
- The child health information team worked with national leads to improve systems, for example the team shared the locally developed information sharing protocols as an example of good practice and been nationally recognised by the Department of Health.
- The 0-19 services leads worked with other regional leads to share learning and best practice across the region.
- The 0-19 service leads had devised a weighting tool to allocate health visiting caseloads. We were informed this tool has been recognised by NHS England and the Institute of Health Visiting.