Ripplez-Revive Healthy Living Centre

Quality Report

Ripplez CIC
Revive Healthy Living Centre
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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

Summary of findings

Letter from the Chief Inspector of Hospitals

Ripplez Community Interest Company (CIC) is a non-profit making social enterprise, providing the family nurse partnership (FNP) and related services in Derby City, Derbyshire, East Staffordshire and Worcestershire.

Ripplez CIC is registered to provide the following Regulated Activity:

- Nursing Care

Our inspection was part of our ongoing programme of comprehensive Independent Health Care inspections. We inspected the provider on 6 and 7 July 2016 on an announced visit.

We inspected the core service of community health services for children, young people and families. During this inspection we visited the Ripplez CIC business base at the Revive Healthy Living Centre and held staff focus groups and individual interviews. We also visited the staff bases at Bolsover and Burton on Trent. We accompanied staff on home visits to clients. We spoke with 24 members of staff including service leads, administrators and clinical staff. We looked at five staff records.

Are services safe at this service?

There were robust incident reporting systems and examples of shared learning. Staff at all levels of the organisation understood their responsibilities to protect clients from avoidable harm. Staff had received safeguarding training to an appropriate level. All staff had completed required mandatory training. Comprehensive client risk assessments were carried out during the course of the FNP programme. The service had a clear policy and systems in place to ensure client records were kept secure. Staffing levels and case-loads were in line with FNP national unit licensing requirements. Although staff understood the need to be open and honest to clients, they did not have a good understanding of the term duty of candour.

Are services effective at this service?

The family nurse partnership (FNP) programme was delivered in line with the licensing requirements set out by the FNP national unit. Family nurses promoted breastfeeding and the provider had secured funding in order to pilot a bespoke breastfeeding support project. There was strong evidence of multidisciplinary working with other health professionals and organisations outside of the service. Family nurses were well trained and supported to deliver the FNP programme and received regular clinical and psychological supervision. Although all staff within the organisation had received a meaningful appraisal within the past 12 months, there was no evidence that the staff members had signed off or agreed the appraisal objectives.

Are services caring at this service?

There was a strong client-centred culture. Staff were highly motivated and provided individualised and compassionate care. Clients we spoke with told us staff were kind and caring. Staff communicated with clients in a way they understood. They took time to identify what was important to the client and involved them in the planning of the programme. Clients' emotional and social needs were highly valued by staff and were embedded in their care.

Are services responsive at this service?

The provider was delivering the family nurse partnership (FNP) programme in partnership with local commissioners. In addition, they were developing innovative, cost effective models of care such as the families first model and community parenting programme. Family nurses used interpreters for non-English speaking clients and limited the number of non-English speaking clients on family nurse case-loads.

There had been no formal complaints about the service.

Summary of findings

Are services well-led at this service?

The provider had a clear vision, set of values and strategy, which was shared by all staff within the service. There was an effective clinical governance framework in place. Service leads demonstrated they understood organisational risks and were positively managing these through action plans and regular review. Staff spoke positively about managers. They told us both the chief executive and clinical director were approachable, visible, and cared about staff members as individuals. We found there were very high levels of staff satisfaction and engagement across all groups of staff.

There were areas where the provider needs to make improvements.

The provider should:

- Ensure staff know about the duty of candour and how it applies to them in their roles.
- Ensure there is evidence of staff signing off and agreeing appraisal objectives.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We did not rate the services provided by Ripplez Community Interest Company (CIC).

We found

- There were robust incident reporting systems and examples of shared learning.
- Staff at all levels of the organisation understood their responsibilities to protect clients from avoidable harm. Staff had received safeguarding training to an appropriate level.
- Comprehensive client risk assessments were carried out during the course of the family nurse partnership (FNP) programme.
- The provider had a clear policy and systems in place to ensure client records were kept secure.
- Staffing levels and case-loads were in line with FNP national unit licensing requirements.
- The FNP programme was delivered in line with the licensing requirements set out by the FNP national unit. Family nurses were well trained and supported to deliver the FNP programme and received regular clinical and psychological supervision. All staff within the organisation had received a meaningful appraisal within the past 12 months. All staff had completed the required mandatory training.
- There was strong evidence of multidisciplinary working with other health professionals and organisations outside of the service.
- There was a strong client-centred culture. Staff were highly motivated and provided individualised and compassionate care. Clients we spoke with told us staff were kind and caring. Staff communicated with clients in a way they understood. They took time to identify what was important to the client and involved them in the planning of the programme. Client's emotional and social needs were highly valued by staff and were embedded in their care.
- Ripplez CIC was delivering the FNP programme in partnership with local commissioners. In addition, they were developing innovative, cost effective models of care such as the families first model and community parenting programme.
- Family nurses used interpreters for non-English speaking clients and limited the number of non-English speaking clients for family nurse caseloads.
- There had been no formal complaints about the provider.
- The organisation had a clear vison, values and strategy, which was shared by all staff. There was an

Summary of findings

effective clinical governance framework in place. Service leads demonstrated they understood organisational risks and were positively managing these through action plans and regular review.

- Staff spoke positively about managers. They told us both the chief executive and clinical director were approachable, visible, and cared about staff members as individuals. We found there were very high levels of staff satisfaction and engagement across all groups of staff.

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Services we looked at
Nursing Care.

Summary of this inspection

Our inspection team

Our inspection team was led by:

Inspection Lead: Kathryn Palmer, Inspector, Care Quality Commission.

The team included CQC inspectors and a specialist advisor who had a health visiting background.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 6 and 7 July 2016. During the visit, we held focus groups with staff who worked within the service such as family nurses, supervisors and administration staff. We observed how clients were being cared for and reviewed care records of clients who use services. We met with clients who use services who shared their views and experiences of the service.

Information about Ripplez-Revive Healthy Living Centre

Information about the service

Ripplez Community Interest Company (CIC) is a non-profit making social enterprise, providing the family nurse partnership (FNP) and related services in Derby City, Derbyshire, East Staffordshire and Worcestershire.

The national delivery of FNP is led by the FNP national unit and is commissioned by the Department of Health and Public Health England, who hold the license in England. FNP is currently delivered in over 70 areas of the UK; however, Ripplez CIC is the only company to deliver FNP as a social enterprise model.

FNP is a voluntary programme for vulnerable, young, first time mothers, 19 years and under. It offers intensive and structured home visiting, by specially trained family nurses, from early pregnancy until the child is two. Visits are weekly, fortnightly or monthly, depending on the stage of the programme and last between one and one and a half hours. Family nurses are guided in their work through detailed visit-by-visit evidenced based guidelines that reflect the challenges parents are likely to meet during pregnancy and the first two years of the child's life. FNP is an evidence-based programme, which aims to, improve pregnancy health, improve the health and development of babies and children, and give the skills required for young parents to plan for the future.

Ripplez CIC employs 48 members of staff including managers and supervisors, administration staff and 30 family nurses. Four teams cover the four locations of Derby City, Derbyshire, East Staffordshire and Worcestershire.

Summary of this inspection

The FNP programme is provided to clients in their own homes, children's centres or any location that the client prefers.

During this inspection we visited the Ripplez CIC business base at the Revive Healthy Living Centre and held staff focus groups and individual interviews. We also visited the office bases at Bolsover and Burton on Trent. We spoke with 24 members of staff including service leads, administrators and clinical staff. We looked at five staff records.

We observed a client quality group session held at the Healthy Living Centre. We accompanied family nurses on home visits and spoke with eight clients in total. We looked at seven client records.

What people who use the service say

Clients spoke positively about the FNP programme and felt it had made a difference to their lives. They valued the relationships they had developed with their family nurses, appreciating the emotional support and practical advice and guidance they had received.

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 did not rate safe for the Ripplez Community Interest Company (CIC) family nurse partnership (FNP) service.

We found:

- There were robust incident reporting systems and examples of shared learning.
- Staff at all levels of the organisation understood their responsibilities to protect clients from avoidable harm. Staff had received safeguarding training to an appropriate level.
- All staff had completed required mandatory training.
- Comprehensive client risk assessments were carried out during the course of the FNP programme
- The service had a clear policy and systems in place to ensure client records were kept secure.
- Staffing levels and case-loads were in line with FNP national unit licensing requirements.

However, we also found:

- Although staff understood the need to be open and honest to clients, they did not have a good understanding of the term duty of candour.

Safety Performance

- The provider submitted a quarterly report to the family nurse partnership advisory board (FAB) for each area and included comprehensive data on safeguarding referrals, caseloads and numbers of clients completing or leaving the programme. It also included health outcome statistics including rates of breastfeeding, immunisation, smoking, alcohol and illegal drug use.

Incident reporting, learning and improvement

- From June 2015 to June 2016 there were no never events reported. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. For the same reporting period there were no serious incidents.
- The service had an incident reporting policy. Staff understood their responsibilities to report incidents, concerns and near misses. They gave examples of the incidents they had reported; these included IT issues and threatening behaviour towards staff from clients' families. Incidents were collated by the human resources manager. In addition, clinical incidents were passed to the operations manager. This meant the service had good oversight of incident trends and themes.
- There were eight incidents reported by staff within the organisation from October to December 2015. Incidents were included on the provider's 'balanced scorecard', which were reviewed at the integrated governance sub-committee meetings. We reviewed the minutes of the meeting from December 2015 and saw that incidents and the reporting process were discussed.
- The provider had introduced an electronic system in May 2016 for staff to use to report incidents, which all staff were aware of. Prior to this, staff had used a paper-based system. Staff told us they could use computers in the offices or the 'Toughbook' laptops to report incidents electronically. Staff who had used the electronic system reported that it was an easier and quicker system to use, which automatically generated an email to their manager, who in turn would investigate the incident.
- Nursing staff told us that learning from incidents would be shared across the four locations at the quarterly team days.

- Staff told us of a change to working practices as a result of learning from an incident. Staff had previously obtained information about the client's living arrangements over the course of the first few visits. However, this was being reviewed following the incident, in order to improve the safety of staff and to ensure staff were aware of all potential risks.

Duty of Candour

- 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 clients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff had limited knowledge of the duty of candour regulation, however all staff we spoke with demonstrated they understood the need to be open and honest with clients if and when things went wrong.

Safeguarding

- A fundamental aspect of the family nurse partnership (FNP) programme is to safeguard children, young people and adults. It is a licensing requirement for FNP providers to follow the safeguarding guidance set out in the FNP management manual. The provider included safeguarding data in quarterly FNP Advisory Boards (FAB) reports, one for each of the four geographical areas. The role of the FAB was to promote a community support system for the programme and to oversee programme quality and sustainability. These reports included detailed safeguarding information such as the numbers of safeguarding referrals made, serious case reviews in progress, team around the child cases and section 47 cases. Section 47 of the Children Act 1989 places a duty on local authorities to investigate and make enquiries into the circumstances of children to be at risk of significant harm.
- The service had a safeguarding adult and children's policy and a reporting and recording system. Staff we spoke with had a good understanding of their responsibilities to protect clients from avoidable harms. Staff knew how to access the policy and gave us examples of when they had used it. The provider had a safeguarding lead who was the clinical director.
- Staff could describe and give examples of how safeguarding concerns were managed; how information was shared with others and actions that were taken so clients were kept safe. We saw evidence that safeguarding information was clearly documented in the clients' records.
- The provider had robust systems, processes and practices in place to protect adults and children from abuse including a visitor access policy, which meant that visitors were not left unaccompanied with clients.
- There are five levels of safeguarding children training. Different staff groups require different levels of competence depending on their role and degree of contact with children, young people and families. Level one is for all staff working in healthcare settings. Level two is a minimum level for staff who have some degree of contact. Level three is for clinical staff working with children and young people. Level four is for named professional for safeguarding for the organisation and level five is for designated professionals at local authority or clinical commissioning group level. Data provided by the organisation showed us that all staff had received an appropriate level of safeguarding training to their need. 100% of staff, including administration and managerial staff were trained to a minimum of level two for both adult and children safeguarding. Family nurses were trained to level three and four and the family nurse supervisors and the clinical director had received training to level four. Teams accessed multi-agency safeguarding training from the local safeguarding board. Additional in-house level four training was provided annually for clinical staff. This training was in line with the intercollegiate safeguarding document. In addition, bespoke safeguarding training was provided annually to the company chairman, chief executive and non-executive directors.
- Family nurses received individual weekly supervision, which included safeguarding, from the family nurse supervisors, and bi-monthly supervision as a group from the local authority safeguarding named nurse. We observed that this meeting was being held at one of the locations during the course of our inspection. Family nurse supervisors received safeguarding supervision from the safeguarding named nurse on an individual basis once a month and a safeguarding group was held for each team with the named nurse in attendance every two months.
- Staff attended the local safeguarding children health quality assurance meetings which included

representatives from local authorities and other agencies. We saw from the minutes of a meeting that issues discussed included learning from serious case reviews, information sharing, thematic reviews and female genital mutilation (FGM). Family nurses also attended local multi-agency safeguarding hub (MASH) meetings.
- Family nurses discussed their case load during their weekly supervision. This discussion would include any clients who had disengaged from the service, or clients who had not attended planned appointments. This system ensured concerns were appropriately escalated.
- Staff had received training in relation to FGM.
- The provider participated in the clinical commissioning groups (CCG) 'markers of good practice assurance process', a survey of the safeguarding knowledge of Ripplez CIC family nurses in March 2016. In their report, the commissioners concluded the response rate for the survey was excellent (approximately 75% of clinical staff), and the findings from the audit were positive overall. There were recommendations from the audit which included incorporating Prevent (part of the Government's counter-terrorism strategy) into the policies and training, raising awareness of the whistleblowing policy, the escalation policy and the findings from local and national case reviews. Service leads told us that these learning points were being addressed and we saw minutes from a meeting with the CCG from June 2016 which confirmed this.
- From a review of minutes we saw that safeguarding was discussed at the integrated governance sub-committee meetings and the provider regularly audited staff knowledge of safeguarding procedures to provide assurance that practice was safe. We saw reports from September 2015 and March 2016, and evidence that actions had been taken as result of these audits. Actions included the provision of training on child sexual exploitation (CSE) being provided for staff.

Medicines

- The provider did not prescribe, store or administer any medicines.

Environment and equipment

- The providers main office premises was in Derby city and was the administration centre for staff. There was no client access to the premises apart from planned client quality groups (a client feedback and participation group). Additional office and storage facilities were located in Bolsover, Droitwich and Burton upon Trent.
- Family nurses provided care to clients in their own homes. Environmental risk assessments were performed and if the home environment was unsuitable, clients would be seen in local children's centres.
- Staff told us that they had enough equipment to deliver care, and we saw that processes were in place to ensure equipment such as scales were calibrated and safety tested. Staff did not carry any emergency equipment.
- Staff used other equipment for teaching clients such as dolls for demonstration purposes. Each of the four bases had a resource room and teaching aids were readily available.
- Occasionally clients and their children would attend the local base for a client quality group; age appropriate toys were available for children to play with.

Quality of records

- There was an electronic record system, which was secure and easy to navigate.
- The East Staffordshire team had only recently started to use the electronic system, so also had paper records as well. These paper records were kept securely and stored in lockable cabinets in a lockable room.
- We reviewed seven individual client records, of these six were electronic and one was paper. Without exception, all records we reviewed demonstrated care had been individualised. All records were accurate, complete, up to date and legible.
- Staff used electronic calendars which were shared with all other employees within the organisation. This meant that family nurses were able to access their diary from their password protected mobile phone and did not have to carry paper based client identifiable records with them.
- Staff told us that details of the visits were dictated verbally using the password protected mobile phones, which could then be transcribed onto the electronic system at the earliest opportunity. This meant that accurate details of the visit could be recalled and there were no confidentiality issues with paper records.

Community health services for children, young people and families

- Family nurses completed assessments in partnership with their clients. For example, we saw a nurse involving a mother in the assessment of her child for developmental milestones.
- During November 2015, staff undertook an audit of clients' records. This identified there was inconsistency of recording some information. As a result, we saw that staff had undertaken further training and another audit was planned but not yet completed.
- The provider undertook quarterly 'clear desk' audits to check compliance with the information governance (IG) policy. This audit monitored whether sensitive and confidential materials were removed from workspaces and locked away when the employee left the workstation. The audit performed in November 2015 showed 100% compliance.

Cleanliness, infection control and hygiene

- Staff followed good infection and prevention control principles and we observed staff using wipes to decontaminate items of equipment in between client use.
- Disinfecting hand gel was provided for nursing staff use and we observed nurses using the gel before entering and after leaving clients' homes.

Mandatory training

- All staff were required to complete mandatory training, which included fire, basic life support (adults and paediatric), information governance and health and safety at work. Data supplied by the provider showed 100% compliance with mandatory training.
- Mandatory training was easily accessible, often being included on the quarterly team days. Some training such as information governance was available on line. Staff could also access some mandatory training from another NHS provider.

Assessing and responding to client risk

- Staff told us that they would liaise closely with the midwife or health professional that had made the initial referral (known as notifications) into the service in order to share information about known risks or concerns. Information or concerns about environment risks were also shared by the wider multi-discplinary team such as health visitors and social workers. Clients who were pregnant would also be seen by a midwife or obstetrician. The family nurse visits were in addition to universal antenatal care.
- Family nurses told us comprehensive risk assessments were carried out using an assessment framework based on child development needs, parenting and family and environmental factors. Any concerns or issues that were identified would be openly discussed with clients and referrals made to other agencies including safeguarding, local authorities and charities.
- Environmental risk assessments of clients homes included assessing potential risks to staff and fire safety factors. In the event of concerns, relating to fire safety, staff would contact the local authority fire safety team, who would advise on smoke and carbon monoxide alarms and would devise escape plans for clients if required.
- Environment assessments also included suitability of housing and the service was working closely with a housing support worker from a national charity to address inadequate housing for their clients.
- Safe sleep assessments were undertaken as part of the FNP programme in an attempt to reduce the risk of cot death.
- Staff assessed antenatal and postnatal maternal health and habits which included smoking and the use of alcohol and illegal drugs. Relationships were included to assess the risk of domestic violence.
- Nursing staff used the hospital anxiety and depression scale (HADS) as a tool to assess maternal mental health.
- Infant health was assessed at every visit, formally or informally.

Staffing levels and caseload

- The maximum caseload for a family nurse was 25 families in line with the licencing agreement for the FNP programme. The average caseload across the service as of January 2016 was 22 clients per one whole time equivalent (WTE) nurse.
- Family nurses who worked part time had their caseloads adjusted accordingly and new family nurses had a reduced caseload until their training was fully completed.
- The provider did not use bank or agency staff. Clients tended to see the same family nurse for the whole programme and this supported the development of a

positive relationship between the nurse and the client. This meant that clients were telephoned to rearrange appointments in the event of staff sickness, rather than asking another family nurse to cover the workload.
- In order to provide resilience, the provider had recruited over establishment to ensure sufficient numbers of trained family nurses to cover maternity leave.

Managing anticipated risks

- The provider had a lone working policy, which we reviewed. It included a risk assessment of clients' homes and whether it was safe to attend alone, a system to record that staff were safe and a procedure for raising the alarm if staff had concerns about themselves or colleagues.
- Staff we spoke with knew of the policy and could explain how they would use it. They also told us they all knew their own clients very well, but would follow the lone working policy if they had any concerns. Family nurses would organise to meet clients in a children's centre or similar place if the home environment of a client was not considered to be safe. We observed the logging of staff in and out of work to make sure they were safe.
- All staff used an electronic calendar which could be accessed by phone or laptop and which was shared across the organisation. This meant that other staff could access their diary and find out where all staff were at any time and rearrange appointments in the event of sickness or unplanned absence.
- The provider had a business interruption plan, which staff were aware of and IT systems provided to nursing staff allowed them to work from home and maintain the home visiting service. In the event of adverse weather clients would be telephoned and appointments rearranged.

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

We did not rate effective for the Ripplez Community Interest Company (CIC) family nurse partnership service.

We found:

- The family nurse partnership (FNP) programme was delivered in line with the licensing requirements set out by the FNP national unit.
- Family nurses promoted breastfeeding and the provider had secured funding in order to support a bespoke breastfeeding support project.
- There was strong evidence of multidisciplinary working with other health professionals and organisations outside of the service.
- Family nurses were well trained and supported to deliver the FNP programme and received regular clinical and psychological supervision. All staff within the organisation had received a meaningful appraisal within the past 12 months.

However:

- There was no evidence that the staff members had signed off or agreed the appraisal objectives.

Evidence based care and treatment

- The family nurse partnership (FNP) programme was delivered under license from the family nurse national unit. In order to meet the licensing requirements, family nurses must follow closely the FNP learning programme and visit guidelines. We observed family nurses delivering the FNP programme during our visits to clients' homes.
- The family nurse programme incorporated the Department of Health 'healthy child programme'. The healthy child programme is a public health programme for children, young people and families, which focuses on early intervention and prevention.
- Clients were asked about domestic violence, which is in line with National Institute of Clinical Excellence (NICE) quality standard 116.

Nutrition and hydration

- Family nurses discussed the importance of good nutrition during pregnancy with clients and gave practical information as to how this could be achieved.
- Family nurses made assessments of infant's nutritional needs as part of the general well-being assessment. We reviewed a client's records and saw that nurses were documenting the discussions had with mothers about feeding.
- Breastfeeding rates were included in the quarterly reports to the FNP Advisory Boards (FAB) in each area. From December 2014 to December 2015, rates of

breastfeeding initiation at six weeks and at six months were generally above or the same as the national FNP figures, apart from Derbyshire, which were slightly lower. Service leads told us that reasons for this had been explored but no specific cause identified. To further support clients, nursing staff were working closely with midwives and a local breastfeeding support team.

- The provider was working towards "Baby Friendly" accreditation. The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast feeding.
- The provider secured funding from NHS England to pilot a bespoke breastfeeding project for clients. The funding enabled the provider to employ two health and wellbeing project workers to support up to 200 young clients to improve breastfeeding and other wellbeing outcomes.

Technology and telemedicine

- All staff were provided with smart phones. This enabled staff to be able to access their diaries and phone apps, which provided easy access to resources such as guidance to the mental capacity act.
- Staff were also able to use smart phones to show clients approved applications such as the Baby Check app from a charity and video clips on the internet.
- Family nurses frequently communicated with clients via text message, as this was often the clients' preferred method of communication. These electronic conversations were captured and stored as part of the client record.

Client outcomes

- The provider measured a wide range of client outcomes, which were reported quarterly to the FNP Advisory Boards (FAB) for each area. Some outcome data was unavailable for Worcestershire area as, being a newer service no clients had yet completed the programme.
- Between January and March 2016, 60.7% of clients in Derbyshire and 57.2% of clients in Derby city were using long acting reversible contraceptives (LARC) at the end of the FNP programme. This was better than the FNP national average of 57%. For East Staffordshire in the reporting period October to December 2015, 73% of clients were using LARC, again better than the FNP national average.
- Clients were asked at 36 weeks of pregnancy whether they had consumed any alcohol during pregnancy. The national FNP average was 1.8%. Between January and March 2016, the average for Derby City was 0.7%. The average for Derbyshire in the same period was 3.8%, this had reduced from 9.5% for the previous quarter. The figure for East Staffordshire for the period October to December 2015 was 0%. Data for the Worcestershire area showed levels of alcohol use decreasing from around 7% in December 2015 to 4.5% in February 2016. As a result the nursing team told us they had shared learning with their clients from some training attended by one of the nurses on the impact of alcohol on babies.
- The percentage of clients smoking at 36 weeks of pregnancy had reduced compared to the start of the programme for all areas. The percentage of clients smoking at intake for the Derbyshire area was 62.5% compared to 33.1% at 36 weeks. In Derby City, the percentage was 53.6% at intake compared to 40% at 36 weeks. For Worcestershire, the percentage had dropped from 60.5% to 50% at 36 weeks. In the East Staffordshire area, 61.5% of clients reported they were smoking fewer cigarettes that at intake.
- For the period, January to March 2016 100% of babies in the Derbyshire area and 96% of babies within the Derby City area had up to date immunisations at the end of the programme. This is better or about the same as the national FNP target of around 97%. For East Staffordshire for the reporting period October to December 2015 the number of immunisations was 100%.
- The service was working with a local university to undertake a review of FNP services and compare this to the national research and an evaluation of the accreditation of the FNP programme.

Competent staff

- Recruitment criteria for family nurses required they should have a background as a midwife, health visitor and paediatric or school nurse and in addition, they should have extensive practical safeguarding knowledge.
- We saw an induction checklist for new employees to the organisation. Items included were: a welcome to the organisation, health, safety and security, communication, list of equipment provided, staff support and governance and initial training booked if applicable.
- When appointed to the post of family nurse, staff were required to undertake a comprehensive training

programme provided by the FNP national unit. This included online training material and residential course attendance. The total length of this training was 14 months, during which time staff were supported in the work place to develop their skills and gradually increase their caseload.

- We saw there was a comprehensive schedule of clinical supervision. Clinical supervision is an activity that brings skilled supervisors and practitioners together in order to reflect upon their practice. Family nurses received weekly individual clinical supervision and monthly managerial supervision from the family nurse supervisor. The family nurse supervisors received monthly clinical and managerial supervision from the operations manager, monthly psychological supervision from a clinical psychologist and monthly safeguarding supervision from a safeguarding named nurse. The family nurses and supervisors also received group psychological support from the clinical psychologist.
- All staff we spoke with told us how they were actively encouraged to develop their skills and knowledge. One staff member told us how they were supported to undertake a business degree and another had been supported to undertake a leadership course.
- Data provided by the provider showed that all staff within the organisation had received an appraisal within the previous 12 months. All the staff we spoke with said they had appraisals with their line manager that were meaningful and useful. Staff who were responsible for completing appraisals received appraisal training. The appraisal records were retained as electronic documents; however, this meant that there was no evidence that the staff members had signed or agreed their appraisal objectives.
- From April 2016, all registered nurses are required to revalidate with the Nursing and Midwifery Council (NMC) in order to continue practising. The provider had a system of annual review of professional registrations and therefore were aware of the revalidation dates for all clinical staff.
- Service leads told us they were in the process of developing a training needs analysis, which would be in place for September 2016.

Multi-disciplinary working and coordinated care pathways

- The provider worked effectively with other health care providers to ensure clients received coordinated care. We saw evidence in clients records that family nurses communicated with midwives, GPs, school nurses, health visitors, and social workers when appropriate.
- Family nurses worked closely with sexual health teams and specialist midwives for substance misuse.
- Family nurses told us they would attend meetings with schools nurses and midwives to explain the role and purpose of the FNP programme, in order to raise awareness and promote partnership working.
- The provider worked in partnership with the FNP national unit and commissioners of the services, who were the local councils. In addition, we saw from minutes of meetings that the provider worked closely with other local NHS providers.
- The provider had worked with a local charity to secure grant funding for a housing support worker.

Referral, transfer, discharge and transition

- In accordance with the licensing requirements of the programme, there were strict eligibility criteria for referrals into this service. Clients were required to be high-risk, first –time mothers aged 19 and under. The license agreement also required that 60% of clients be enrolled by the 16th week of pregnancy and 100% of clients no later than the 28th week of pregnancy.
- Referrals to the service were called notifications and were handled effectively. Notifications were usually made by midwives, however any professional or the client themselves could also refer into or notify the service. Notifications were made either through the electronic record system or by telephone. Information from a telephone call was documented and attached to the client's electronic record.
- Clients who wished to leave the service before the programme was concluded were not instantly discharged. Family nurses kept in touch with occasional calls and texts to ensure their well-being and in case they wished to re-engage. All clients who left the programme were discussed in clinical supervision and a plan recorded in the electronic record. As their place was kept open and due to limited caseload capacity, family nurses were unable to recruit further clients to the programme until inactive clients were finally discharged.
- Clients were discharged from the service, once their child was two years old. At this point care was handed

over to a universal services health visitor (HV). Family nurses told us ideally this handover would take place at a joint visit with themselves and the HV at the client's home, however due to various reasons this was not always possible however joint visits were prioritised for the most vulnerable families.

Access to information

- Staff had access to electronic records via the use of 'Toughbook' laptops. Staff spoke positively about the electronic client record, as it created a single client record that was accessible by all staff.
- In some of the locations, the same electronic record was used by professionals from other health care providers, for example the school nurses or the midwives. This meant that information could be accessed and shared easily with the clients consent.

Consent

- The provider obtained written consent from clients in order to share information with other professionals and to take photography.
- We saw written consent being obtained in a client's home; the family nurse supported the client by reading through the consent form and explaining in simple terms what it meant.

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

We did not rate caring for the Ripplez Community Interest Company (CIC) family nurse partnership service.

We found:

- There was a strong client-centred culture. Staff were highly motivated and provided individualised and compassionate care. Clients we spoke with told us staff were kind and caring.
- Staff communicated with clients in a way they understood. They took time to identify what was important to the client and involved them in the planning of the programme.
- Clients' emotional and social needs were highly valued by staff and were embedded in their care.

Compassionate care

- The family nurse partnership (FNP) programme was individualised to the client's needs, with the client at the centre. Clients tended to see the same family nurse for the whole programme and this supported the development of a positive relationship between the nurse and the client.
- Clients we spoke with told us how the family nurses had provided a compassionate service. They told us they were treated with respect and their individual needs were valued.
- We observed family nurses taking time to interact with both clients and their children and demonstrating an encouraging and non-judgemental manner to the clients.
- Clients told us they felt confident that their confidentially was maintained.

Understanding and involvement of clients and those close to them

- Whilst the FNP was a structured programme, clients were involved in their care, could decide what aspects of the programme they wanted to do and in what order. For example, for one client it was important to stop smoking, so support was given early on to do this.
- Family nurses communicated in a way the clients understood. Staff often used different approaches, such as using games, to explain key messages. Clients told us they felt happy to ask questions if they were unsure.
- Family nurses took time to identify who was important to their clients, what support others provided and what involvement the client wanted others to have.
- One client told us how the family nurse had supported them to develop a positive relationship with a family member.
- We saw examples of clients' partners being included in the programme if appropriate.
- During the delivery of the FNP programme, clients completed a survey about their relationship with the family nurse. The survey asked if clients felt cared for, respected, whether the family nurses believed in them and whether they talked about things that were important to them. In Worcestershire, between December 2015 and February 2016, 100% of the clients responded positively to all the questions.

Emotional support

Community health services for children, young people and families

- Without exception clients we spoke with told us of the emotional support they had received from their family nurses. Many told us that at times they had had no one else and did not know what they would have done with the support of the family nurses.
- As well as providing emotional support, clients told us that the family nurses encouraged them to seek support from other networks such as developing positive relationships with others or by joining local support groups. Clients reported that family nurses gave them the confidence to do this.
- The process of moving to different services began up to a year before the transfer in order to prepare clients for the change to universal health visiting services. During a home visit to a client with a ten month old infant, we observed a family nurse talking about universal health visitors, offering support and reassurance to the client and starting the preparation for transfer.

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

We did not rate responsive for the Ripplez Community Interest Company (CIC) family nurse partnership (FNP) service.

We found:

- The provider was delivering the family nurse partnership (FNP) programme in partnership with local commissioners. In addition, they were developing innovative, cost effective models of care such as the families first model and community parenting programme.
- Family nurses used interpreters for non-English speaking clients and limited the number of non-English speaking clients on family nurse case-loads.
- There had been no formal complaints about the service.

Planning and delivering services which meet people's needs

- The family nurse partnership (FNP) service was commissioned by local councils and followed the rigid model set out by the FNP national unit.
- The provider was designing, piloting and testing a new programme called the families first model, for families who were not eligible for the FNP service. Families first would be more integrated and share learning with the universal health visiting teams. Whilst retaining some of the learning and models of the FNP programme, service leads told us the family first programme would be more flexible and therefore more cost effective, allowing commissioners to provide services to more families.
- The provider was also developing the Derby community parenting programme, which would use a community parenting model in alignment with the delivery principles of FNP and in partnership with statutory services. This was a community development model with community parent volunteers supporting other parents.
- Staff told us they organised graduation ceremonies for clients being discharged from the programme. For example clients were given a certificate at a children's party organised by the family nurses for the graduating clients.
- To be as inclusive as possible, the service provided transport for the clients that were coming to the office base for the client quality group if travel was a barrier to attendance.

Equality and diversity

- Staff told us that the majority of the clients tended to be white and British, although there was a more mixed ethnicity within the Derby city caseload, with some clients being of Eastern European origin.
- Staff had access to translation services if required which would be used on every visit. Staff told us that they would try to use the same interpreter at each visit and would never use family members as interpreters because of the vulnerable circumstance of their clients. Staff told us there was a limit of four non-English speaking clients in any one case-load as the use of an interpreter was time consuming. There was no evidence base for the programme for non-English speaking clients and staff told us that it was difficult to establish the close positive relationship with a client that was the basis of the FNP programme through an interpreter.
- Staff were almost exclusively female. There was one non-clinical male employee. Service leads told us the narrow employment criteria for family nurses resulted in an almost exclusively female workforce.

Meeting the needs of people in vulnerable circumstances

Community health services for children, young people and families

- All clients referred into this service were considered high risk and may be in vulnerable circumstances by nature of their age.
- Staff told us family nurses had provided parcels for new-born babies containing nappies and clothes for clients in difficult circumstances when required.
- In Derby City, the dedicated housing advisor was able to support those vulnerable clients living in unsuitable accommodation.

Access to the right care at the right time

- There was a strict eligibility criteria for referral into the FNP service. The programme was voluntary with family nurses providing structured home visits which could be weekly, fortnightly or monthly depending on the stage of pregnancy or the age of the infant. Visits were scheduled to last between one and one and a half hour.
- Achievement of the number of visits each client received was recorded in line with the national FNP target. The targets required each client to receive 80% or more of expected visits during pregnancy, 65% or more expected visits during infancy and 60% or more during toddlerhood.
- Between December 2014 and December 2015 the East Staffordshire area exceeded two out of the three visiting targets but did not meet the toddlerhood target.
- Between February 2015 and February 2016 the Worcestershire area had exceeded the first two targets. No data was available for the third target as this was a relatively new service and clients had not completed the FNP programme.
- In the Derbyshire area, between March 2015 and March 2016, the targets were exceeded or met for infancy and toddlerhood. They were not met in pregnancy because clients had been referred late into the FNP service. Late referrals could be because clients were late accessing the universal maternity services, because midwives were late referring clients into the FNP service, or because clients were initially uncertain about joining the programme.
- Between March 2015 and March 2016, Derby city area did not meet any of its targets. This was because clients were not always available for visits and because there had been maternity leave and long-term sickness within the family nurse team. However, during this time priority was given to the most the most vulnerable clients and the provider had since over recruited numbers of family nurses to provide cover for maternity leave and sickness in the future.

Learning from complaints and concerns

- The provider encouraged clients to feedback to the service using the 4 C's. The 4 C's were compliments, concerns, comments or complaints.
- Staff we spoke with understood this process and told us wherever possible they would try to resolve any concerns clients had as soon as possible.
- Clients were provided with verbal and written information about the 4C's at the initial meeting with the family nurse.
- The provider had not received any formal complaints about FNP service between June 2015 and May 2016.

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

We did not rate well-led for the Ripplez Community Interest Company (CIC) family nurse partnership (FNP) service.

We found:

- The provider had a clear vison, set of values and strategy, which was shared by all staff with the service.
- There was an effective clinical governance framework in place. Service leads demonstrated they understood organisational risks and were positively managing these through action plans and regular review.
- Staff spoke positively about managers. They told us both the chief executive and clinical director were approachable, visible, and cared about staff members as individuals.
- We found there were very high levels of staff satisfaction and engagement across all groups of staff.

Service vision and strategy

- There was a clear strategy and vision, which was to make a positive difference to the lives of young parents and children. We saw a draft five-year plan and managers were due to present it to the board in May 2016. There were strategic objectives set for 2016-2019 which included; establishing Ripplez CIC as the provider

of choice to deliver the family nurse partnership (FNP) programme, improve the quality measures and outcomes for the young parents and children, reduce inequalities within the client group, encourage innovation for future sustainability and establish a charity to benefit future generations. We saw a copy of the presentation made by the chief executive to all staff at the most recent team day on 21 June 2016 where she had described the strategy to staff as 'keep, grow, new'.

- Staff had developed the values and behaviours for the service which centred on RIPPLEZ; reliable, inspirational, professional, passionate, learning, energising and zealous. These behaviours were demonstrated in relationships throughout the organisation at all levels and between family nurses and clients. Service leads told us the organisation was mindful of these values and behaviours during recruitment processes to ensure future employees also displayed these behaviours.

Governance, risk management and quality measurement

- The provider had a clear and effective governance structure and framework.
- The Ripplez CIC board included a chairperson, a chief executive, clinical director and company secretary. There were four non-executive directors and a staff director.
- The finance and performance sub-committee met at least twice a year and reported directly to the Board and monitored performance, financial processes, contracts, fundraising and pay and conditions.
- The integrated governance sub-committee met quarterly and also reported to the board and led on clinical, corporate and information governance and was responsible for risk management, safeguarding and infection control. The quoracy requirement was that one executive director, one non-executive director and one family nurse supervisor should be present. The group led on clinical quality, effectiveness, safety, experience and standards.
- The clinical governance and quality group reported to the integrated governance sub-committee and met at least six times a year. The group was chaired by the operational manager and was attended by the clinical director and a family nurse representative from each team.
- The provider had a risk register and board assurance framework. We saw risks were categorised as; reputation risks, people risks, information governance risks and financial and business delivery risks. Comprehensive risk analysis was undertaken and risks were assigned an owner to ensure that the mitigation plans were put in place. Service leads told us the risk register was a live document which meant it was constantly updated. We saw through review of the minutes that the risk register was discussed at the integrated governance committee meeting.
- The service leads demonstrated they had a clear understanding of the external risks to their organisation.
- FNP advisory boards (FAB) were held quarterly for each of the commissioning groups that the service was contracted to. We reviewed minutes from the Derbyshire FAB meeting from June 2016 and saw in addition to staff from Ripplez CIC there were senior staff from the county council, two other NHS community health providers and the designated safeguarding nurse from one of the clinical commissioning groups. This forum was used to ensure that quality was being maintained and was an opportunity for the stakeholders to feedback to the organisation.
- As part of the inspection process we spoke to local commissioners of the service and one concern was raised about the effect of maternity leave and vacancies on the provider's ability to deliver the level of service commissioned. However the commissioners believed that Ripplez CIC was responding positively to this challenge and service leads told us that they had recruited over establishment for family nurses in order to provide some staffing resilience.

Leadership of this service

- The service was led by a chief executive and clinical director.
- Staff spoke positively about the service leads. They told us both the chief executive and clinical director were approachable and visible, motivated staff and cared about staff members as individuals. Leaders had an open door policy and staff could approach them at any time. We saw many positive interactions between staff and their leaders.
- Local team leadership was effective. Staff we spoke with said they were supported by their line managers and supervisors and local leaders were visible and approachable.

Community health services for children, young people and families

- Service leads contributed positively to the inspection process by identifying clients who were willing to allow us to accompany nurses on home visits and by providing a list of clients who were happy for us to telephone them to discuss their experience of the service. This meant we could talk to more clients and relatives and get a wider range of feedback about the service.
- The Fit and Proper Person Requirement (FPPR) places a requirement on providers to ensure directors and board members are fit and proper to carry out these roles. The organisation had a recruitment and selection policy, which contained the criteria and processes for checking whether current and newly recruited board members were fit for their role. This included a list of evidence required and a self-declaration form for the recruitment of executive and non-executive directors and other board members.
- We checked the employment files for two executive staff, who had been recruited prior to the FPPR regulations coming into force. The majority of the evidence for the FPPR checks had been collected including proof of identity, DBS checks, professional registration checks and relevant qualifications, skills and experience. We saw an action plan to ensure that other missing evidence was collected and we had assurance the full checks would be in place prior to the recruitment of further non-executive directors.

Culture within this service

- There were high levels of staff satisfaction; staff were proud of the organisation and the work they did.
- Staff demonstrated effective teamwork and recognised and valued the contribution everyone made.
- Without exception, staff felt valued, listened to and supported in their roles.
- Staff spoke of an open and transparent culture and felt able to speak up if they had concerns.
- There was a lone worker policy and staff we spoke with were familiar with this. We were given examples of how staff were kept safe, for example environment risk assessments were performed and if the home environment was unsuitable, clients would be seen in local children's centres. Staff felt their safety and wellbeing were promoted.

Public engagement

- As part of the inspection process we sought feedback from the local council commissioners. The feedback was overwhelmingly positive, with responders citing good engagement from service leads and good quality data reports.
- The provider held regular client quality groups to seek feedback from clients. During our inspection we observed one of these groups and saw clients were given the opportunity to discuss the service. Service leads told us this was being developed into a client voice group, with clients past and present giving feedback on the quality of the service.
- Feedback from the users of the service was actively sought by the provider. A leaflet with contact details was given to all clients and clients could leave comments of feedback on the provider's website. We were told it was sometimes difficult to contact clients as mobile phone numbers were regularly changed therefore the service was collecting clients' email addresses as a method of contact. The provider was also developing an interactive app for the clients to use.
- Local FAB meetings were attended by clients, in order for clients to provide feedback of their experience of the programme. Family nurses told us of a recent seaside themed event in East Staffordshire that allowed FAB members to mingle with clients as part of the annual review.
- Clients were part of the recruitment process and participated in the interviewing of potential family nurses. One client, who had been involved with this, was positive about the experience and appreciated having a voice in the selection of new family nurses.
- Within Worcestershire area, clients completed a survey which asked clients about their relationship with the family nurse. The clients were asked 16 questions about their relationship with family nurses. Between December 2015 and February 2016, 100% of the clients responded positively to all the questions.

Staff engagement

- The provider was a staff led organisation. Staff were guarantors of the company with individual liability of £1 each. There was a staff council, which met quarterly and a staff council member was on the executive board. We reviewed two sets of minutes for the Ripplez CIC board meetings and saw staff were represented on the board and there was a standing agenda item for the staff council.

- Staff confirmed that they felt involved and listened to. They gave an example of having their recent concerns listened to about the proposal to introduce the peer support group.
- The provider sent a survey to all staff members for 2015/2016. The response rate was 72%. Staff were asked to rate answers to nine different questions as always, frequently, sometimes or never. For example, staff were asked if their opinions were listened to at work and the responses were, always 39%, frequently 51% and sometimes 9%. Staff were also asked if their work related directly to the vision and mission of Ripplez CIC and the responses were, always 64% and frequently 36%.
- We found there was a structured approach to team meetings. Staff from the different locations would meet as a group once a week and would cover different aspects during a four week cycle. Team meeting topics were; learning, operational and safeguarding/learning. On the fourth week, the whole clinical team would come together for psychological supervision.
- Quarterly team days provided an opportunity for all staff to meet, to receive updates and share learning. The scheduled day of the team days was alternated to allow for part time workers to attend and the dates were set 12 months in advance to allow staff to arrange their diaries accordingly. Staff confirmed they always felt they were kept up to date. The chief executive sent a monthly email to all staff to ensure everyone in the organisation was kept informed about developments, finance and planning.
- As a social enterprise company reliant on grants and local health commissioner's contracts, there had been a degree of concern and uncertainty amongst staff in the months prior to our inspection regarding tendering processes for new contracts. However staff told us service leads had been honest about the processes and they had been kept fully informed.

Innovation, improvement and sustainability

- When the company was formed, it was envisaged that the FNP programme would be developed in the East Midlands area and Ripplez CIC would be able to bid for new contracts. However a recent research programme into FNP nationally suggested that it might not be cost effective for the outcomes achieved. As a result, the provider recognised that there was a need to develop and diversify the services they offered, in order to provide a more innovative, cost effective service that still met the needs of clients. The strategy of 'keep, grow, new' recognised the need to continue with the FNP model, and develop the families first model and the community parenting programme, and search out new areas of funding and growth.
- The service was piloting a scheme that allowed clients who completed the programme modules to receive a qualification comparable with a GCSE. The provider was working with an external verifier to achieve accreditation. This would mean that clients would obtain recognition that would support access into education or employment.
- The service worked in partnership with a local clinical commissioning group (CCG) and a children's centre to secure funding to support local young people. The support included confidence building workshops and allowed the young people to talk to senior staff at the CCG about improving local services.
- The provider was developing an interactive app for mobile devices for the clients to use to allow easier feedback.

Outstanding practice and areas for improvement

Outstanding practice

Ripplez Community Interest Company (CIC) is the only company to deliver the family nurse partnership model as a social enterprise model.

The service was piloting a scheme that allowed clients who completed the programme modules to receive a qualification comparable with a GCSE. The provider was working with an external verifier to achieve accreditation. This would mean that clients would obtain recognition that would support access into education or employment.

Clients were part of the recruitment process and participated in the interviewing of potential family nurses

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure staff know about the duty of candour and how it applies to them in their roles.
- The provider should ensure there is evidence of staff signing off and agreeing appraisal objectives.