Derbyshire Community Health Services NHS Foundation Trust

RY8

Community health services for children, young people and families

Quality Report

Derbyshire Community Health Services NHS
Foundation Trust
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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)
RY8Z2	Babbington Hospital	Child Health Clinic	DE56 1WH
RY8Y8	Cavendish Hospital	Community Health Visiting Service	SK17 6TE
RY8Y4	Ripley Hospital	Community Health Visiting Service	DE5 3HE
RY8Y1	Whitworth Hospital	Community Health Visiting Service	DE4 2JD

This report describes our judgement of the quality of care provided within this core service by Derbyshire Community Health Services 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 Derbyshire Community Health Services NHS Foundation Trust and these are brought together to inform our overall judgement of Derbyshire Community Health Services NHS Foundation Trust.

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Overall, we rated community and young people's services as good.

There were arrangements in place to minimise and mitigate the risks to children and young people receiving care and to staff working alone in the community. Staffing levels were safe although there was currently pressure on some teams due to high demands and the current staffing capacity. The service had a ten percent staff vacancy rate that they were in the process of recruiting to.

Incident reporting was consistent and there was a good awareness amongst staff of how to manage incidents. There were effective systems in place to learn from incidents both within individual teams and across the organisation.

Services were effective, evidence based and focussed on the needs of children and young people. We saw examples of good multidisciplinary work. Care and treatment was evidence based, staff were competent and people using the service were protected from inappropriate care or treatment for which they had not given proper consent. There were policies and procedures in place to support staff and ensure that services were delivered effectively and efficiently. Parents and caregivers felt well supported and involved with their children's treatment and told us that staff displayed compassion, kindness and respect.

Services delivered by the trust were caring. Staff were dedicated to their patients and worked hard to ensure that patients received the best treatment and support possible. Patients were involved in decisions and understood the services being delivered to them. Emotional support was available to patients who were dealing with difficult circumstances. Staff undertaking home visits were dedicated, flexible, hardworking, caring and committed.

We found the service was responsive to needs of children and families. Effective multidisciplinary team working, including external partners, ensured children and young people were provided with care that met their needs, at the right time and without avoidable delay. The service was in general well led with effective decision-making and strategic planning. The board and senior managers had oversight of the reported risks and had measures in place to manage these risks.

Summary of findings

Background to the service

Information about the service

Derbyshire Community Health NHS Trust delivers community based services to children and young people. It provides a range of health services including health visiting, school nursing, community, breastfeeding support, speech and language therapy (SALT), school aged immunisation, Starting Point and services for children in need and children on child protection plans.

The demographics of the population are as follows

Area

Total Population

Under 5

0-19 years

Derby City

250,568

18,071 (7.2%)

64,727 (25.8%)

Derbyshire County

773,522

42,145 (5.4%)

173,283 (22.4%)

Southern Derbyshire CCG

512,283

32,348 (6.3%)

125,114 (24.3%)

Erewash CCG

94,644

5,893 (6.2%)

21,923 (23.2%)

North Derbyshire CCG

272,075

13,918 (5.1%)

58,798 (21.6%)

Hardwick CCG

108,933

6,098 (5.6%)

24,259 (22.3%)

Services are provided to people in their own homes, in schools and in clinics across all of the geographical areas.

During our inspection, we spoke with 51 parents, three children and 75 staff, including health visitors, school nurses, managers, and heads of service, health care assistants and allied health professionals.

We looked at 17 individual plans for children, risk assessments and a variety of service based documents, for example risk assessments and referral forms.

We inspected the north and the south of the geographical area covered by the trust. We inspected speech and language services, child development clinics, child health clinics, child baby clinics, a school enhanced drop-in. We also observed home visits undertaken by health visitors and breast feeding support workers.

Our inspection team

Our inspection team was led by: Carolyn Jenkinson, Head of Hospital Inspection

Chair: Elaine Jeffers

Team Leader: Carolyn Jenkinson, Care Quality Commission

The team included CQC inspectors, inspection managers, pharmacy inspectors, an inspection planner and a variety of specialists including:

Clinical Project Manager, Non-Executive Director, Community Children's Nurses, Community Health Visitors, Dentist, Dietitian, Occupational Therapists,

Summary of findings

Physiotherapists, Paramedic, Nurse Consultants, District Nurses, Palliative Care Director, GP, Learning Disability Nurses, Specialist Nurses and a Mental Health Act Reviewer.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

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

We inspected this service in May 2016 as part of the comprehensive inspection programme.

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 provider and asked other organisations to share what they knew. We carried out an announced visit from 23 to 25 May 2016.

What people who use the provider say

Feedback from young people and parents during inspection was very positive about the way staff treated them and the care they received.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should consider supplying staff with emergency devices to alert the police in an emergency.
- The trust should ensure clear consent is obtained from parents and not just implied consent where patient information is shared with other professional services.

Derbyshire Community Health Services 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

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

- We found there were arrangements in place to minimise and mitigate the risks to children and young people receiving care and to staff working alone in the community.
- Staffing levels were generally safe in the services although there was currently pressure on some teams due to high demand and the current staffing capacity.
- There was consistency in incident reporting practices. There was awareness amongst staff to identify and consider different types of incidents and record these. There were effective systems in place to learn from incidents and share learning within individual teams and across the organisation.
- For the period March 2015 to March 2016, the trust participated in, and considered the findings of three serious case reviews, two of which have been completed. Serious case reviews are undertaken when a child or young person dies or is seriously injured, and abuse or neglect are known or suspected to be characteristics in the death. The findings of the serious case reviews and their recommendations had already been shared with the trust and the required actions implemented. During our inspection, we found most staff were very knowledgeable about the serious case reviews and the necessary actions and recommendations from them.
- Staff said the newly introduced computerised health record system was effective and internet connectivity was generally good.

However we also found

Good

Are services safe?

- Staff did not have access to emergency devices to alert the police of an emergency by GPS tracking or two-way conversations.

Safety performance

- The trust did not contribute to the paediatric patient safety thermometer as the current metrics are not relevant to the client group they care for
- During our inspection, we found that services were safe. There were arrangements in place to minimise and mitigate the risks to children and young people receiving care.
- Systems were in place to ensure incidents were reported, investigated and learnt from. Complaints and significant events were discussed at team meetings, training sessions and clinical governance meetings.
- The trust reported one serious incident in June 2015 to the NHS strategic executive information system (STEIS) for the health visiting and school nursing services.
- For the period March 2015 to March 2016, the trust reported three serious case reviews. Two of which hae had been completed. These were investigated, lessons learnt and action plans produced
- The findings of the serious case reviews and their recommendations had already been shared with the trust and the required actions implemented. During our inspection, we found staff were knowledgeable about the serious case reviews and the necessary actions and recommendations from them. For example, staff told us about the most serious case reviews and what actions and learning had taken place

Incident reporting, learning and improvement

- Incidents were reported through an electronic reporting system. Discussions with staff demonstrated a good awareness of the incident reporting policy and how to use the reporting system.
- All staff were able to explain with confidence how they would identify and report incidents using the electronic reporting system. This meant the provider was able to identify, investigate and learn from.
- Staff were able to give examples of when incidents had been reported and what had happened as a result. Feedback from reported incidents was given via a number of routes, including face to face, team meetings, a range of cross-organisational newsletters and via email. For example, we saw one staff members' reflective account of an incident that had occurred and the learning, which had taken place, as well as the action plan.
- There was consistency in the reporting of incidents. There was a good awareness amongst staff on how to identify and consider different types of incidents and what actions to take with that information.
- Staff were given the opportunity to discuss and review unexpected deaths of children to ensure that learning took place.
- Health visitors routinely attended serious case reviews and were knowledgeable about all aspects of the cases they were responsible for.
- Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents, which affect patients directly and include incidents, which may indirectly impact patient safety or an organisation's ability to deliver on-going healthcare.
- Serious case reviews are undertaken when a child or young person dies or is seriously injured, and abuse or neglect are known or suspected to be characteristics in the death
- The trust had a Duty of Candour policy. The Duty of Candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. All staff we spoke to demonstrate an awareness of the Duty of Candour.
- Overall, staff felt that they were encouraged to report incidents and near misses, concerns from patients and identified risks to the organisation. Staff were confident that if concerns were raised in relation to patient safety, action would be taken.

Safeguarding

- There was a safeguarding policy in place and a clear pathway for reporting and dealing with child protection and safeguarding concerns. Staff were aware of them

and understood their responsibilities. The policy included a section on 'Working together 2015'; this was in-line with The Department of Health's best practice guidelines.

- We found staff were well informed about the serious case reviews and the necessary actions and recommendations from them. For example, all of the staff we interviewed were very knowledgeable about their caseloads and were able to identify any children who were on a supervision order or a child protection plan.
- All the clinical staff we spoke with said they were up to date with their safeguarding training and were level three trained in child protection. Staff said learning from serious case reviews was incorporated into the training. Level three knowledge of child protection teaches how to recognise and know what actions to take if it is believed that a child is at risk.
- The trust is part of 'Starting Point', which is the front door for referrals into children's services within Derbyshire County Council (early start and safeguarding). The trust had a team of health staff based in the referral service accessing and sharing information, this enabled swift decision making that met the needs of the children and young people.
- Staff we spoke with knew who their safeguarding lead was and how to contact them. Staff knew how to access the trust safeguarding policy and demonstrated knowledge of this. Staff said in the event of a safeguarding concern they would contact 'Starting Point' and the safeguarding lead nurse.
- Staff were confident about safeguarding children procedures and were aware of the local authority processes. Documentation showed staff were well supported with regular safeguarding supervision every three months. Staff reported they were able to access additional support when it was needed from the safeguarding leads both within the organisation and within the local authority
- Documentation indicated that 93% of staff had safeguarding level three training and 95% of staff had level three-advanced training. The trust target was 95%. This meant the trust had met their target.
- There was a safeguarding policy in place and a clear pathway for reporting and dealing with child protection and safeguarding concerns. Staff were aware of them

and understood their responsibilities. The policy included a section on 'Working together 2015'; this was in-line with The Department of Health's best practice guidelines.

- The health visiting and school nursing teams worked closely managing child protection plans. All staff told us that safeguarding was given the highest priority in their workload. Safeguarding work and commitments had increased and now represented the largest component of caseloads. Staff told us this often meant the other aspects of work, like health promotion in the community and schools, was not always being delivered to the standard that staff preferred.
- Staff we spoke with were able to describe different categories of abuse and how to identify children who were at risk.
- All staff told us they recorded safeguarding concerns on the electronic patient record system and reported the concerns as an incident. We saw patient records where safeguarding concerns had been raised or issues disclosed by parents and children. We saw actions plans to keep children safe were followed up on a regular basis as the case required.
- The trust had a policy for children on a child protection plan. Staff visited children at least every 28 days and attended a monthly core group to discuss the child's ongoing care and needs. Children with child protection plan had a named health visitor to ensure there was consistency in supporting the child and family.
- The trust told us that when children or young people had a child protection plan in place, identification markers were added to the child or young person's records, this ensured staff were alerted to safeguarding concerns and they knew there was a plan in place.
- Health visitors held monthly GP liaison meetings to discuss children and families with concerns. The trust recommended that it was best practice that school nurses attend these meetings or liaise with health visitors.
- The trust had a 'no access' policy for staff to follow when health visitors were unable to gain access to see a child. This ensured children received follow ups when they failed to keep appointments. The no access policy reported on the number of the children who did not attend appointments and where the health visitor had not been able to gain access to the family home during the past 12 months.

Good

Are services safe?

- Children that did not attend appointments were routinely followed up as identified in the trust policy.
- Support was available for staff to discuss concerns about children who frequently did not attend appointments, as this was not accepted by the service as a reason for no contact. This was not routinely audited, but missed contacts were reviewed by the teams and team leaders.
- Staff knew and followed the trust policy for missed appointments and told us they would try on three occasions to see the child before sending a letter and making an unannounced visit.
- Staff were knowledgeable concerning the child sexual exploitation (CSE) and female genital mutilation policies (FGM) and were aware of the safeguarding children policy.

Environment and equipment

- All of the venues we inspected had good security in place; this meant that staff and patients were protected.
- The children and young people's service used a number of medical centres and community venues such as Sure Start centres. The venues used were suitable for the clinics or appointments held there and we found that the environments were visibly clean, tidy, and suitable for children and their families.
- Not all of the bases we visited were used for children and young people. Some were office spaces used for the clinical teams, and their managers.
- At the clinics seen, there were adequate arrangements for the management of waste, sharps and clinical specimens.
- We saw evidence that equipment such as baby scales, were appropriately checked and calibrated to ensure their accuracy.
- Health visitors each had their own set of scales, which they took with them to clinics and on home visits.
- Staff told us that they had enough equipment to deliver care and they had no problems ordering equipment.
- Speech and language therapists (SALT) used games and equipment to aid their treatment of children and make it fun. However, this equipment had to be shared due to budgetary restrictions; therefore the therapists told us they did not always have the equipment they needed. One SALT said they had to buy their own games at times.
- Staff told us they had all of the equipment required to undertake their work, and that it was in good order.
- Hazardous items were out of reach, and sharp corners covered. However, we noted the waiting area for the Heanor child health clinic was small; and there were not enough seats for parents waiting for their appointment. There were four seats for adults. We observed the clinic was busy and some parents had to stand up holding their babies. We saw litter on the floor near where babies were placed to play, which presented a potential risk to babies and small children.

Quality of records

- There was a computerised record system, which was secure and easy to navigate. However, records were being managed across the trust in different ways. Some records were paper based and others were managed using the electronic system.
- The ultimate intention of the trust was the implementation of an electronic clinical records database that could be shared with a greater number of partner organisation and clinicians.
- Health visiting staff told us they could often could not get a signal to access the computerised system when they met people in their homes. Instead, they would make notes, and then put this information on to the electronic patient record system when they returned to base.
- Paper based records were stored in lockable cabinets, in lockable rooms so were secure. We observed one staff member obtaining the key to access one of the rooms during our inspection.
- All records were stored alphabetically and were in date. Safeguarding paper records were colour coded and easily identified.
- We reviewed 17 care records, all but one was legible and entries were signed, timed and dated.
- We found records including those of vulnerable children contained appropriate information.
- Records were clear and contained care plans, patient/parent contact, developmental and immunisation information. Staff recorded clear actions, including risks and staff notes were detailed.
- However, one record had no contact details for the child's family and three personal child health records in Brimington Health Centre were not completed. Contact details for the Health Visitor had not been entered on one record and two records did not contain evidence of contact with the Health Visitor. We alerted staff to this, who took action to address it.

Good

Are services safe?

- The community children's services undertook a record keeping audit on a monthly basis. Each month 10 records for 0-5s and five records for 5-19's were randomly audited by the clinical team leaders across the geographical areas of Amber Valley, Erewash, Chesterfield, Bolsover, North East Derbyshire, High Peak and Dales South Derbyshire. There were a number of questions on the audit plan such as 'Is the patients number recorded on every page' for which the audit showed 100% compliance. Another question was 'Allergies have been documented within the initial contact form'. The average percentage of compliance for this question was for the 0-5's was 76% and 27% for 5-19's. Chesterfield were the team with the lowest score for this standard in the 0-5's with Bolsover 13%, High Peak and Dales 20% and North East Derbyshire 20% for the 5-19's. There was an action plan as a result of the audit.

Cleanliness, infection control and hygiene

- The service had effective infection and prevention control procedures in place. Clinic areas we visited during the inspection appeared visibly clean and there was evidence of cleaning regimes displayed.
- There was a systematic programme of clinical and internal audit, which monitored quality and identified where action should be taken.
- The Infection Prevention and Control Quarterly Report for 2015-2016 quarter three (July, August and September), demonstrated between 98% and 100% compliance. In quarter, one and two 2015 to 2016 audits demonstrated 98% to 100% compliance.
- Staff had access to personal protective equipment (PPE) and were aware of how to dispose of used equipment safely, and in line with infection and prevention control guidelines.
- During the home visits we attended with health visitors, we observed good hand washing and infection control practices throughout.
- We saw four members of staff on visits use gel and clean their hands before and after home visits. We saw one member of staff who did not use cleansing gel or wipes before or after clinic sessions. The same member of staff did not clean or wipe, toys and games used to support care and treatment in between seeing each child.
- Mats, scales and other equipment were cleaned between use, and staff washed their hands or used hand-cleansing gel before handling each baby.
- Hand cleansing gels were available and were mostly used in the areas that we visited, including between home visits.

Mandatory training

- The trust used an electronic monitoring system to manage staff mandatory training.
- Staff told us they were responsible for making sure they were up to date with all of their training. They could access their training records online and were sent reminder emails when their training was due to expire.
- Staff told us the organisation placed a high importance on training and managers made sure staff attended mandatory training. Staff felt supported to undertake mandatory training.
- Data showed for mandatory training, 97% of staff were up to date with the training, against the trust target of 95%.
- Mandatory training included a number of different units, including basic life support for both children and adults, information governance, safeguarding and manual handling.
- All the staff we spoke with told us their mandatory training was allocated at the beginning of the year and they were supported to attend.

Assessing and responding to patient risk

- Overall, systems were in place to monitor and respond to the risk to children and young people. For example we saw
assessments had been conducted to ensure staff and patient safety.
- There were mechanisms in place to identify patients at risk, such as vulnerable children. Details were recorded in electronic records, which all clinical staff had access to. We saw an example of this for a child on a supervision order, the details of which was recorded electronically.
- We saw risk assessments had been conducted to ensure staff and patient safety. For example risk assessments with regard to lone working of staff.
- Staff advised parents on risk factors and sudden infant deaths. We observed all staff have this conversation on visits to new-born babies.

Good

Are services safe?

- Staff checked whether parents had seen the 'shaking baby' DVD and explained to parents about brain development and used visual aids where necessary to explain.
- Staff assessed risk through discussion with parents, taking measurements of children such as height, weight, and head circumference, and observing the home environment for children. Staff recorded risks in patient records and recorded them as incidents. If staff identified health risks, they made referrals to GPs, support services and other health professionals. In the case of emergencies, staff used the relevant emergency services.
- All staff we observed, asked questions about children's and young people's physical, cognitive, and emotional development.
- Out of the 17 care records we reviewed,we saw one electronic record not fully completed with information about a child with a child protection plan in place. There was no record of contact with the child between 2013 and 2016 because information had not transferred over from the previous provider. We raised this with a member of staff who had not requested the information from the previous provider. This presented a risk to the child when managing and identifying any concerns, or working with other providers.

Staffing levels and caseload

- The service had 141.48 whole time equivalent (WTE) staff for health visitors. At the time of our inspection, there were five WTE vacancies and three members of staff on training for their roles.
- Prior to a management review in late 2015, the service had nursery nurses who provided one to one support for children and young people. The removal of this role after the review meant health visitors and health child assistant practitioners had to undertake these duties as part of their role, including more work in primary schools. Most of the staff we spoke with, including a senior manager, said the roles were a big loss. The staff we spoke with said the loss of these roles had put extra pressure on staff.
- We saw staffing levels were on the risk register due to the changes in the universal delivery of the Healthy Child Programme and national service specification. This requires the delivery of the service be based on resident population rather than registered population by April 1st 2016 resulting in the risk of children being missed and health outcomes not being achieved.
- At the time of our inspection the service were accessing three health visitors and one school nurse who were bank staff to fill gaps on the staffing rota.
- We saw documents that showed the six community teams had a comprehensive staff skill mix that were within nationally recognised guidelines.
- After our inspection, the trust told us that all vacancies had now been recruited to. However, there was a delay in staff moving into post due to the majority of vacant posts being filled by students currently in training. Vacancies wherever possible were being covered by bank staff and there were extra hours for part time staff to mitigate the situation. Additionally, staff from other teams had provided cover as required
- There were seven geographical areas covered by Health visitors employed by the trust. Staff caseloads did not exceed the Lord Lamming 2009 recommended case load level of 300 families per health visitor for the majority of staff. However, for two of the geographical areas, this recommendation was exceeded. For example one health visitor had 314.4 cases and another health visitor had a caseload of 343.
- Caseloads ranged from 224.00 to 343.00. The average caseload for the trust was 275.4.
- Staff we spoke with from both health visiting and school nursing teams across the trust, told us the method of calculating caseloads was based on demographic information rather than caseload or the acuity of children and young people. Acuity is the measurement of the level of care required by a patient. This meant staffing levels did not necessarily reflect the complexity and extent of care children and young people required. This was due the trust had recently changed caseloads from being GP attached to geographical locations. This had increased the caseloads of some teams. Managers were addressing this by recruiting more health visitors to accommodate the increase in some locations.
- The trust told us caseloads were allocated according to information received from Derbyshire County Council's child deprivation index. In addition, the trust used The Sara Cowley tool which is a caseload benchmark recording calculator.
- The 'National Health Visitor Plan' is a joint Department of Health, NHS England, Public Health England and

Good

Are services safe?

Health Education England document. It sets out how these partner organisations will work with the health profession, families and communities to achieve the government's health visiting commitment to increase the workforce by 4,200 transform the service by April 2015 and support its sustainability beyond 2015.

- Data showed the trust had achieved the required number of health visitors to meet the National Health Visitor Plan.
- The National Health Visitor Plan is a joint Department of Health, NHS England, Public Health England and Health Education England document. It sets out how organisations will work with the health profession, families and communities to achieve the government's health visiting commitment to increase nationally the workforce by 4,200, and transform the service by April 2015 and beyond.

Managing anticipated risk

- There was a lone working policy, which was in date, however, interpretation amongst the health visitors varied. Some staff knew the code which identified they needed assistance and other staff had independent codes. The use of multiple systems did not ensure staff would identify the code word being used.
- Staff did not have access to any emergency devices to alert the police in an emergency by GPS tracking or two-way conversations. Two members of staff visited children and young people if there was an identified risk. The on-call midwives received notification when the health visitors finished their visits. If they were late, they would contact the police, however this could be some hours after the member of staff was last seen. Staff did not report any concerns with this system to us
- Risk assessments were carried out before staff visited potentially risky areas and kept on the electronic recording system. For example, where there was known drug misuse or previous evidence of firearms use. This was particularly important if staff were taking on additional hours with unfamiliar caseloads.
- An electronic system was used in the offices to indicate when staff were in or out, and where they intended to visit so staff movements could be traced if needed
- On the trust website, there was the Royal Society big book of accidents, which provided information on accident prevention; this included a section on 'Strategies and policies relating to children, young people.

Major incident awareness and training

- The trust had protocols and plans in place to respond to major incidents, and staff were of aware of escalation procedures for areas of risk.

Good

Are services effective?

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

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

Overall we found services were effective;

- National Institute for Health and Care Excellence (NICE) guidance was followed.
- There was a systematic programme of clinical and internal audits, which monitored quality and identified where action should be taken, such as the breast-feeding audit, audits of records and infection control audits.
- Staff were supported with training, supervision and appraisals.
- There was a well-developed system for multi-disciplinary and multi-agency working.
- Staff understood and were able to explain both Gillick competency and Fraser guidelines. Gillick competency is a term used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.
- There was a robust induction schedule for new staff joining the trust. Staff transferred over from another trust with their existing caseload which they were familiar with and provided continuity of care for young people. However they had not completed their induction for the present employer which meant that the service could not be assured of their competency whilst completing the induction and having a working caseload.

Evidence based care and treatment

- Overall, we found that care provided was evidence based and followed recognised and approved national guidance. Staff were clear of their roles in care pathways.
- Health visiting and school nursing teams aimed to work in accordance with the Healthy Child Programme. The Healthy Child Programme is an early intervention and prevention public health programme that offers every family a programme of screening tests, immunisations, developmental reviews, information and guidance to support parenting and healthy choices. The programme also identifies key opportunities for undertaking developmental reviews that services should aim to perform.
- Speech and language therapists used evidenced based communication cards and tools from the Nuffield Dyspraxia Programme. We also saw therapists using evidenced based assessment and progress tools to inform examinations for example, staff used the Clinical Evaluation of Language Fundamental 2nd Edition to monitor and measure progress.
- Health visitors used 'Whooley questions' to identify signs of post-natal depression in parents. The Whooley questions were developed by NICE in 2007.
- Staff we spoke with were aware of the national guidelines relevant to their scope of practice. They told us they were supported by the trust to follow this practice.
- We saw evidence based information produced in line with UNICEF guidance by the infant feeding co-ordinator, which included detailed information concerning breastfeeding and set out the benefits to both baby and mother.
- The trust achieved full Unicef Baby Friendly Initiative Accreditation (stage three) in 2011 and it was evident this was fully embedded in practice.
- The Baby Friendly Initiative is a worldwide programme of the World Health Organization and UNICEF. It was established in 1992 to encourage maternity hospitals to implement the Ten Steps to Successful Breastfeeding and to practise in accordance with the International Code of Marketing of Breastmilk Substitutes.
- We observed staff giving evidence based advice to a mother about introducing solid food to her baby at the correct age. This was supported by the staff member giving the mother a leaflet.
- New policies and procedures were communicated to staff through staff meetings, emails and the weekly updates. All the staff we spoke with were able to demonstrate to us that they received regular communication from the board, head of service and team leaders. This meant that staff were able to keep up to date with current practice and national guidance.

Good

Are services effective?

- We saw evidence that patient needs were thoroughly assessed before care and treatment started and there was evidence of care planning. This meant that children and young people received the care and treatment they needed.
- Adherence to NICE guidance and local procedures and policies were discussed at team meetings. There were clinical care pathways in place across the organisation, using NICE and other national guidance.
- The trust undertook a "Children's Community Services Priority Audit School Readiness," for the period April 2015 to March 2016. The purpose of the audit was to gain a baseline of school readiness across Derbyshire based on the feedback provided by parents as part of the health questionnaire completed in the first term of school reception (September 2015). The term school readiness is widely used and relates to an individual child's physical and emotional development on school entry. It is a key public health outcome measure. The findings of the audit were used to map unmet health needs on a population level.

Nutrition and hydration

- Staff gave parents up to date and relevant advice about breastfeeding, weaning and nutrition and hydration in children and monitored breastfeeding and weaning rates. Staff provided extra visits or put on additional clinics when they could to provide extra nutritional support to parents. The extra support given was determined by the baby's weight gain and confidence of the mother following the clinic assessment.
- The service had two band six Infant feeding specialists which equated to 0.8% WTE and one band five band 5 infant feeding advisor which equated to 0.6% WTE.
- Parents told us they acted on health visitor advice and one parent told us how their baby's weight had improved after taking feeding advice from a health visitor. Staff also provided advice and information on night feeding.
- The trust monitored breastfeeding rates on a quarterly basis and the results were presented through the governance committees. In Quarter one 2015/16, the percentage of mother's breastfeeding at 10 days was 53%. The percentage of mothers who had continued breast-feeding at six weeks was 77%. Breast feeding data was monitored quarterly.
- We saw staff give dietary advice to young people. One young person told us they had found the advice from school nurses helpful.
- There was a systematic programme of clinical and internal audits, which monitored quality and identified where action should be taken, such as the breast-feeding audit, audits of records and infection control audits.
- The service did not have a dietetic children's service, instead, dependent on the location would refer to two local acute hospital paediatric dieticians.

Patient outcomes

- We saw documentation that showed the service was delivering the Healthy Child Programme (HCP) 2009 across the County. The HCP is a public health programme for children, young people and families, which focuses on early intervention and prevention. It offers a programme of screening tests, immunisations, developmental reviews, information and guidance on parenting and healthy choices. It sets out the good practice framework for prevention and early intervention services for children and young people aged five to 19 and recommends how health, education and other partners working together across a range of settings can significantly enhance a child's or young person's life chances, from the age of two up to the child's 20th birthday.The foundations of the HCP lie in the five Every Child Matters (HM Government, 2004) outcomes, that children and young people identified as fundamental to their lives should be healthy, stay safe, enjoy and achieve, make a positive contribution; and achieve economic wellbeing.
- The Healthy Child Programme stipulates that a new baby review should take place with 14 days. From April 2015 to April 2016 the trust had achieved 98% of new baby reviews within 14 days. The healthy child programme includes discussions around maternal mental health, infant feeding and how to reduce the risks of sudden infant death syndrome.
- Documentation showed the 12 month review by age one completion rates were 96.9% for January 2015. 98% for February 2015 99% for March. The average total for this quarter was 99.24%. The previous quarters for 2015, showed similar figures.

Good

Are services effective?

- Documentation showed the age two to two and a half review completion rates were 96.49% for January 2015, 96% for February 99% for March. The average total for this quarter was 97%
- We saw in patient records evidence of staff working with mother and child to develop action plans.
- **Competent staff**
- There was a robust induction schedule for new staff joining the trust. Staff told us their induction and training was positive and thorough. We saw staff had induction plans and formalised timetables, which were role specific. We viewed a new member of staff's induction pack, which included the staff handbook and training record signed and completed. Staff had transferred over from another trust with their existing caseload which they were familiar with and provided continuity of care for young people. However they had not completed their induction for the present employer which meant that the service could not be assured of their competency whilst completing the induction and having a working caseload.
- This meant there was inconstant practice as to how the trust assessed the clinician's readiness and competence to receive a working caseload.
- All staff were supported to attend training covering areas such as safeguarding children child protection, information governance, medicines management, infection and prevention control and record keeping.
- All staff we spoke with said they had regular appraisals and supervisions. Staff had clinical supervision three times a year and we saw evidence these had been scheduled in three staff calendars.
- Documentation showed staff appraisal rates were at 93% against the trust target of 95%.
- We saw that staff reviewed journal articles and case studies to keep up to date with the latest evidence based guidance and practice.
- Speech and language therapists attended clinical excellence networks and had internal study days to improve and update their skills and knowledge.
- Staff in each locality team had champion roles. The champion roles were topic specific and enabled staff to develop specialist knowledge and provide advice and support to other staff and providers. For example, breastfeeding champions attended specific training sessions and provided advice and support to staff regarding breastfeeding. We spoke to staff who were team champions and focussed on elements of leadership.

Multi-disciplinary working and coordinated care pathways

- There was good multi-disciplinary and multi-agency working within the organisation.
- We saw examples of positive multi-disciplinary working. For example, the speech and language therapy service (SALT) worked closely with parents, hearing impairment specialists (HIS) and schools. Therapists invited parents to their child's appointments and worked closely with HIS when children had dual needs. The SALT team communicated treatment plans and strategies to teaching assistants in schools so they could continue supporting the child in class.
- We saw evidence of working with teaching assistants, schools and other services in patient records.
- Staff had a good awareness of the services that were available to children in the area they worked and were able to contact other teams for advice and make referrals when necessary.
- Staff gave a number of examples of how they had worked with other clinicians and other organisations to be able to meet the needs of children and their families, such as the school nurses could liaise with staff at the children and adolescent mental health teams CAMHS for advice regarding a child or young person.
- One school nurse we spoke with said they received counselling supervision from CAMHS for people who use counselling skills during their work, but they were not counsellors.
- The trust participated in 'Think Better', which is a three-week programme delivered in partnership with CAMHS. Young people who have been identified by the school nurse or school as experiencing low-level anxiety worked with school nurses who had training in cognitive behavioural therapy and mindfulness.

Referral, transfer, discharge and transition

- There were procedures in place to ensure that young people made the transition to adult services smoothly, this was done sensitively when the patient was ready to start the transfer process.
- There were suitable pathways which included discharge from service for children who moved out of the area or

were transitioning to adult services. This included sharing appropriate information with the GP and other relevant professionals to ensure the child and family fully understand what was happening.
- The process of transition to adult services usually began as the young person approached the age of 14 however this was dependent on each individual, their maturity and their wishes.
- Transition plans were commenced as soon as possible and included the patient's choices and decisions. This ensured that the child's health needs continued to be met.
- There were clear referral protocols when children or young person needed to be referred to specialist services.
- There were policies and procedures in place to make sure that as children transferred from health visiting to school nursing, information was provided accordingly to the school nurses. Health visitors and school nurses told us they worked closely with each other to make sure vulnerable children and their family's needs were discussed and important information was communicated.
- An example of this was where the local Child and Adolescent Mental Health Service (CAMHS) was provided by a different provider. Staff reported referring children to this service and working closely as part of multidisciplinary team to ensure the best outcomes possible for the young people.
- We observed evidence of effective documentation when families moved out of area. This was one of the actions from a recent serious case review, as it provides information concerning the family and child to the service at the new geographical destination.
- We saw the Adoption Pathway for Children's Community Health Services; this was in-depth involving a number of different professionals including social workers.
- All health visitors said they followed the trust's agreed joint antenatal pathway and met midwives on a monthly basis with the midwives in their locality to discuss caseloads and share information.

Access to information

- The trust used an electronic patient record system, which meant staff could access patient records flexibly. However, this was not fully integrated or embedded within the service. This meant that both electronic and paper records were being maintained.
- Some staff could access information in the office or remotely using an electronic tablet within the family's homes, whilst other members of staff experienced internet problems and could only use the electronic system at their office base.
- We reviewed the personal child health record or 'red book' being used; this was given to parents before being discharged from the midwife. The red book holds medical information about a child from birth to four years of age and recorded child, family and birth details, immunisation records, screening, routine reviews and growth charts.
- Speech and language therapists wrote a summary at the end of each session to leave for the school and parents. Summaries were clear and identified progress. This enabled parents and the school to have access to information to help continue the treatment for the child. The summary also included contact details in case further discussions were required.
- Some staff said they did not always receive full details of referrals from Starting Point. Staff gave examples of when they had not information or guidance about the child and the referral. This meant staff had to chase information or were unable to act as quickly as they would like. This meant there could be delays in the provision of suitable care to children and young people.

Consent, Mental Capacity Act 2005

- Staff understood and were able to explain both Gillick competency and Fraser guidelines. Gillick competency and Fraser guidelines refer to a legal case, which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16 year olds without parental consent.
- School nursing staff worked within Fraser and Gillick guidelines to make decisions about whether young people had the maturity, capacity and competence to give consent themselves.
- We saw records showed parents had signed consent forms for speech and language therapy services. Records of consent were kept on the trust electronic record system.

Good

Are services effective?

- We reviewed four patient records. We saw consent was recorded with regards to involvement of children in action plans around their health needs. We saw staff did not always record consent to share information with other organisations however we saw staff recording implied consent. This meant that information was shared with external agencies without the written consent of the parent.
- During home visits, we saw staff asking parents and gaining consent before they examined children.

Good

Are services caring?

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

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

- People we spoke with who used the service were positive about the way they were treated by staff. Children and young people told us they were treated with compassion, dignity and respect. Families were involved in discussions about treatment and care options and able to make decisions.
- During our inspection, we observed children, young people and their families being treated with kindness and compassion. We observed staff ensuring that confidentiality was maintained.
- We observed some staff undertaking home visits and we found staff to be dedicated, flexible, hardworking, caring and committed. They showed a good understanding of the policies and procedures relating to their practice and were respectful of the cultural diversity of the communities served.
- We spoke with eight families who felt the care provided was caring, responsive and considerate.

Compassionate care

- Staff treated parents, children and young people with kindness, dignity, respect and compassion.
- We observed good relationships between the staff and the parents/young people. Care was family centred.
- We observed good, warm and positive interactions between staff and children. Staff maintained eye contact with children, sat on the floor with them, smiled and nodded in response to each child. We saw staff praise children and young people, providing support and encouragement. Staff asked open questions, allowing children, and young people to talk freely without interruption.
- Children appeared happy, without distress during time with the nurses and were smiling. One child said, "I like the nurses" and another said they were very happy because they were "friends with the nurses".
- All staff asked parents about their welfare and we saw positive interactions between staff and parents. Staff asked questions in a sensitive manner, and built a positive relationship with parents. Parents appeared to be open and honest with staff as a result of positive relationships.
- A breastfeeding support worker told us that she attended home visits to ensure mothers were confident breastfeeding throughout the night. One mum told us 'it was really helpful to have the support worker sit with me'. Another mother said 'there was no way I could have done this on my own'.
- All staff we spoke with were passionate about delivering high quality client centred care. An example of this, is we observed health visitors using positive body language, using good eye contact and when asked questions, explaining answers in depth and in plain English.
- We observed this care being delivered one to one at child development checks, in groups and at child health clinics.
- Staff took the time to interact with children and young people who used services and those close to them in a respectful and considerate manner.
- During our observation of home visits by health visitors, we saw warm and compassionate behaviour towards patients and their families.
- Throughout our inspection, we observed staff giving non-judgemental care to families.

Understanding and involvement of patients and those close to them

- Parents told us 'health visitors are really good' they are 'always happy to give advice'.
- Parent interests were asked and responded to. Parents told us 'health visitors are really good' they are 'always happy to give advice'.
- We observed good staff interactions between parents, babies and children. Staff listened to parents concerns and gave them evidenced based advice, and backed this up with leaflets. Staff ensured that the parent had understood the information given by using reflective conversations.
- Staff used different approaches to ensure children and young people were involved in their care and treatment. Staff recognised when they had to change how they

communicated in order to be understood, or enable a young person to be involved. We saw an example where a speech and language therapist switched from verbal to visual cues.

- Staff asked questions, repeated and clarified information to ensure children, young people, and parents understood information and what was happening. Staff explained to children what was going to happen and even practiced elements of testing, for example asking children to provide a cue when they heard a noise.
- We observed staff interact with children and young people in order to engage and involve them in their own care and treatment. Staff asked about their social life and personal interests. By speaking with children and young people on their level, it allowed staff to better involve them in conversations and decision-making. One young person said, “I am always taken seriously”.
- All the parents we spoke with said they felt listened to. Parents said health visitors acknowledged they were the parents and knew their children better than the health visitors and as a result, parents felt comfortable to listen and take advice from them.
- The trust used a translation service which all community teams could access.

Emotional support

- We found the trust staff delivered good emotional support. The parents we spoke with told us there was effective communication from staff and any concerns were addressed quickly and appropriately.
- We joined two child health clinics which were both very busy one clinic had two health visitors who between them saw 34 under five year olds. The support given to parents was consistently compassionate throughout the session.
- We also joined an enhanced drop in at a local school and observed the emotional support given to the young people was consistently compassionate. One young person told us they thought the school nurses were “fantastic” and that their support had really helped in dealing with their emotional problems.
- We observed staff giving holistic care often having an awareness of all family members and any additional support that the family may require.
- Holistic care means consideration of the complete person, physically, psychologically, socially, and spiritually, it is underpinned by the concept that there is a link between our physical health and our more general 'well-being'.
- Staff discussed sensitive issues such as post-natal depression with parents. Staff provided emotional support, asked if parents were alright, as well as providing information on support services. Staff monitored post-natal depression by asking questions and enquiring about the welfare of the parent. One parent said, “If I’m feeling down, I can speak to health visitors”.
- Staff had procedures in place if children were distressed when attending clinics in schools. Staff worked with the school to provide emotional support and children would often be accompanied by a teacher or adult they knew so they could feel calmer and more relaxed.

Good

Are services responsive to people's needs?

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

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

- Child health clinics were held in community venues which allowed parents to have easy access to have their children weighed and speak with the health visitors.
- Parents were overwhelmingly positive about the community service offered by the health visitors.
- There was an equality and diversity inclusion policy, which included information on the trust's commitment to building a workforce, which reflected the wider community. It also covered aspects of the Equality Act 2010 as well as organisational and individual responsibilities.
- There were very good networks of support in place for looked after children.

Planning and delivering services which meet people's needs

- Child health clinics were held in community venues, which meant there was easy access for parents. Children could be weighed and a health visitor was available for parents to talk with.
- The service offered breast-feeding support groups. These were facilitated by breast feeding coordinators, breast-feeding peer supporters and health visitors also attended.
- Women had 24 hour, seven day a week access to support from the breast-feeding support service.
- The health visiting service had developed a peer support group for parents of children with additional needs. This enabled families to have a support network other than with the health professionals.
- School nurses completed health needs assessments for their local area. They worked with schools and the local authority to devise a plan for each school to determine what services and support for children was required.
- The trust's staff worked with other providers, including children's centres and voluntary organisation, to provide support and services to parents and families. Clinics and support groups were set up and based out in local communities to meet the needs of local people.
- The School Nursing teams worked with 12 allocated communities to carry out a healthy schools community award. This process aligned school nurses, schools and Derbyshire County Council health data to inform action planning.
- Guidance was available for parents about a range of support services if required.
- Parents were complimentary about the provision of clinics and commented they were so good "I brought my second child back".

Equality and diversity

- The trust had an equality and diversity inclusion policy, which included information on the trust's commitment to building a workforce, which reflected the wider community. It also covered the Equality Act 2010 as well as organisational and individual responsibilities.
- All the staff we spoke to was knowledgeable of the policy and understood the concept of equality and diversity.
- Staff demonstrated a good understanding of the cultural diversity of the local community and provided sensitive and respectful care in line with equality and diversity outcomes.
- Services were designed with the needs of vulnerable people in mind. For example, staff were able to access interpreters for people whose first language was not English, or for those who had a sensory disability.
- There were leaflets available in a range of different languages in the areas we inspected.
- Buildings we inspected were easily accessible and adhered to the requirements Disability Discrimination Act 1995 and the Equality Act 2010.
- We spoke with two families, they told us they were treated as individuals.
- There was an audible hearing loop available in all of the clinics we inspected, this system improved communication to people who used hearing aids.
- Staff from black and minority ethnic groups working for the trust overall told us they felt supported by their managers and by other staff.

Meeting the needs of people in vulnerable circumstances

Good

Are services responsive to people's needs?

- At the time of our inspection, the trust had 200 children subject to care supervision orders and 702 children subject to a child protection plan.
- Staff were knowledgeable about their caseloads and especially if they had any vulnerable children on them.
- Staff worked closely with young people and built up close working relationships with them. Staff were very dedicated to supporting looked after children, and children with child protection care plans.
- We saw that when children moved out of the area, staff still worked hard to maintain contact with them and continue to deliver support. This was part of a time limited transition plan.
- The speech and language therapy (SALT) service had a mobile phone and text service because parents could not always respond to 'landline' calls. This meant parents and families could access the service by text message.
- Staff asked parents if there was anything they would like them to do. Staff responded to parent's needs and performed examinations or provided information based on the requests of parents. Staff signposted or contacted additional services for parents such support groups or other services based on the needs of the family.
- Staff advised women on breastfeeding. We saw staff sat with mothers observing feeding and providing tips or further advice to ensure the child was feeding correctly. The service had specialist breastfeeding support workers who could provide enhanced support to mothers.
- Some clinics had areas for parents to make drinks or warm up milk for babies and children. Clinics also had a wide range of toys for babies and children to play with while waiting to be seen.
- Children's special needs schools had a named school nurse. School nurses work across education and health, providing a link between school, home and the community. Their aim is to improve the health and wellbeing of children and young people. They work with families and young people from five to nineteen and are usually linked to a school or group of schools.
- We observed staff supporting young people with anger management issues. Staff used a range of strategies and tools to help young people to cope with their anger. For example, we observed staff identify coping mechanisms with young people and suggesting ways to deal positively with anger.
- The service had health visitors who specifically worked with women's refuges to support vulnerable women and their children. There were three health visitor roles across the county who worked with refugees however; one member of staff in Amber Valley was solely dedicated to this role. We saw staff had good relationships with the staff and residents of the refuge. Staff responded to and supported vulnerable women to access services, including registering families at a GP practice.
- Since 2010, there were 15 deaths of young people and adults due to suicide. In response to this, a number of agencies including the trust were in the process of devising the Derbyshire suicide prevention strategic framework. The framework was based on a number of principles: supporting people in distress, providing support, allowing people to talk openly and responding to people before they reached crisis level, and working towards suicide prevention. The areas of action in the framework were identified as part of the strategy on Preventing Suicide in England.
- The trust was in the process of devising a Teen Health questionnaire, which asked questions concerning the mental and emotional health of the young person.

Access to the right care at the right time

- Children and young people could access speech and language therapy services (SALT). Referrals to the service came from health visitors, school nurses, and parents could refer their own children. Parents could access information on referring their children to SALT through the trust website.
- At each office, the service had a health visitor available on-call to take calls from parents and allocate tasks generated by phone calls. This meant when parents called they could speak to a member of staff and book an appointment
- Parents told us they could access services when they needed it. Staff were responsive and when the situation was urgent, staff could see parents the same day or following day. Staff said if parents called, they would always respond and see them at the earliest opportunity. One parent said, "Staff are lovely and I always get appointments". However, some clinics were busy and therefore at times some parents had to wait longer to be seen by a health visitor.

Good

Are services responsive to people's needs?

- Patient records showed there were regular contact with parents and children in accordance with the specified Healthy Child Programme contact points.
- The service had guidance for staff on what to do when children or parents did not attend appointments, had withdrawn from service, or when staff could not get access on a visit. Staff knew about the guidance and used it to recognise early signs of disengagement, and the subsequent risks this posed to a child or family.

Learning from complaints and concerns

- Staff were informed about the outcome of complaints and incidents within their area of Practice. Staff told us if a patient, parent, or caregiver had a concern, they would at first try and deal with the issue to resolve it. This demonstrated a pro-active attitude towards concerns and complaints. Staff could tell us what they would do if a patient, parent or caregiver wanted to make a complaint. They would advise the complainant to write a letter to their line manager, a band eight manager, or the chief executive. Health visitors gave out complaints information at every new birth visit. Families we spoke with said they were aware of how to make complaint should they want to. Information was displayed in the clinics about how patients and their representatives could complain.
- Nursing, midwifery and health visiting services received 69 complaints for the period 2013/14, with 45 of these being upheld. For the period 2014/15, the service received 59 complaints with 36 being upheld. This is a decrease of 10 complaints received, and a 4% reduction in complaints upheld.
- For the period January 2015 to January 2016, the service received 33 complaints, 25 of these were upheld which equates to 76%, seven of these complaints were fully upheld with 18 of the complaints partially upheld. None of the complaints were referred to the Local Health Ombudsman.
- Community health services for children and adults combined for the period January 2015 to December 2015 received 3,719 compliments.
- Complaints were covered as part of the staff 'essential learning day', which was part of annual mandatory training.
- With the exception of one member of staff that we spoke with, staff knew how to sign post patients and carers to make a complaint and how to follow the process.
- Managers would support staff to answer the questions required to enable the trust to respond to a complainant.
- Staff told us they welcomed feedback from complaints to allow them to develop and improve the service. We saw evidence of this being done in practice.
- Any lessons learned from complaints were highlighted in the report produced by the investigating manager handling the complaint. This information is shared with the clinical team leaders at the governance meetings. The minutes of governance meetings were shared with all staff at their operational meeting. Actions were minuted on the trust actions log to ensure they were completed within a timely manner.
- A trust-wide policy included information on how people could raise concerns, complaints, comments and compliments with contact details for the Patient Advice and Liaison Service (PALS).
- Information was displayed in the clinics about how patients and their representatives could complain.

Good

Are services well-led?

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

We rated community health services for children, young people and families as 'good' for well-led because;

- We found that the trust vision and strategy was visible at all locations we visited. Staff knew about the trust vision and values and all staff we spoke with could tell us about the 'DCHS way'.
- There were clear lines of accountability within children and young people's services. Staff knew who was responsible for managing communications both up to senior managers and down to the front line staff.
- There were clear line management and governance structure at a local level with staff aware of their roles and responsibilities.
- Staff we spoke with were positive about the Chief Executive and all staff said they received her weekly emails. Staff said the Chief Executive was approachable and visible.
- There was a culture of openness, flexibility and willingness among all the teams and staff we met.
- Staff were adapting to changes within the service.

However ;

- Morale was varied from being good to having concerns with regard to the recent change in working conditions.

Service vision and strategy

- The trust vision and strategy was visible at all locations we visited. Staff knew the trust vision and values and all staff we spoke with could tell us about the "DCHS way." Staff gave examples of how the DCHS way impacted on their role; for example putting patients first and improving communication to provide a quality service. Staff and managers said they were committed to the DCHS way.
- We saw that staff had the DCHS way as a screensaver and we saw posters and information on staff notice boards.
- The service had a non-executive director representative for children and young people's services. This person was responsible for making sure the interests of the service as well as children and young people were considered by the board when making decisions.

Governance, risk management and quality measurement

- We saw the annual safeguarding report to the executive board, which set out the priorities for the coming year. The main priorities were working with partners in the prevention of and protection from child sexual exploitation and online exploitation and the emotional health and wellbeing, of vulnerable families and children
- We spoke with the management team of the service; they acknowledged to us that new governance and risk management procedures had been recently introduced. The management team felt that the procedures were robust but were still to be fully embedded.
- There was a strategic risk register in place, which included details of the risks, its rating, controls and actions with review dates. This contained detailed information about the risks faced by the service as well as action being taken to mitigate and minimise risks. A band eight nurse manager had the lead role within the service for risk management
- For example on the risk register we saw an entry which stated there was a risk to children and young people following the transfer of school nursing records from the north of the county due to the differences in service delivery resulting in the potential for children and young people who are home educated not being identified as the records had been archived by the previous providers. This identified risk had an action which stated the trust were liaising with other professional bodies to identify children who were not in education. Health Visitors would also be asking GPs at the link meetings to inform the service of any school aged children they were aware of who were not in education.
- There were robust and joined up escalation, oversight and governance systems in place in localities which the reported up to trust board level.
- There were clear lines of accountability within children and young people's services. Staff knew who was responsible for managing communications both up to senior managers and downwards to the front line staff.

Good

Are services well-led?

- There was a process in place to feedback information to staff via newsletters, emails and staff meetings.
- All staff had access to the business intelligence system (BIS). The BIS was online system that staff used to look at key performance indicators, including breastfeeding rates, development checks and any areas where the service had not met targets. Managers used the BIS to inform discussions with staff at team meetings on performance.
- Staff had regular monthly team meetings. We saw from minutes of various team meetings across the service, that staff discussed performance, feedback from serious case/safeguarding reviews, complaints and best practice against national guidance.
- There were 11 clinical team leaders across the county who managed health visitors and school nurses. The clinical team leaders reported to four band eight managers. This demonstrated a clear line management structure at a local level. Staff were aware of their roles and responsibilities.

Leadership of this service

- The majority of staff we spoke to were positive about the Chief Executive and all staff said they received weekly emails. Staff said the Chief Executive was approachable and visible. A band eight nurse said they found the trust leadership team accessible and felt they really listened to their concerns.
- In the north of Derbyshire, school nurses had recently been transferred over from another provider. While staff acknowledged this had been a difficult experience they praised the trust for the way it had been organised. They were positive about the information and support they had been given through the process. Managers communicated and involved staff. Team leaders were visible and staff reported they were available for discussion. Three members of staff said they had been involved in transfers before and the way the trust had handled this one had been the best one experienced.
- All staff told us clinical team leaders were visible and available if staff needed them. Staff said they did not see the band eight nurses often; however they did attend team meetings.
- All staff we spoke with said that they were able to share concerns with their manager.
- Staff told us that they were aware of who the executive team in the organisation were, and how to contact them.

Culture within this service

- Most staff spoke with passion about their work and were proud of what they did. Staff knew about the organisation's commitment to people and their representatives and the values of the organisation they worked for. There was a culture of openness flexibility and willingness among all the teams and staff we met.
- Morale was mixed with some staff positive about working for the trust. Other staff said the impact of the changes at the trust adversely affected them. For example, a few members of staff said they had experienced low morale and increased stress due to changes made by the trust. Roles had expanded, creating higher caseloads. This was mainly centred on the restructure in the health visiting service and the reduction of nursery nurse staff.
- However, the managers informed us they were recruiting more health visitors to improve the size of caseloads. We saw evidence of recruitment taking place.
- Teams had arranged away days to address low morale support each other and look at the impact of changes to the service.
- The children and young people's teams had lost their local administrative support; this was now provided by a central hub of administrative staff based at the hospital.
- Staff said they felt supported and lucky to work at the trust because of the supportive culture and environment. One member of staff described how they had been supported by a team leader regarding workload.
- There was a patient centred culture throughout the service. All staff we spoke with said they enjoyed watching children progress and meet their developmental milestones. Patient stories were used in team meetings so staff could reflect on practice or share good practice. Staff said using patient stories helped them to focus on why they do job and ensure the patient was at the heart of everything they did.
- The service had a culture of openness and candour. Staff and managers described how they were open and honest when they got things wrong. Staff said the trust leadership team were also honest and acknowledged when they had not got things right.

Public engagement

- The service took part in national children's take over day. One day a year the service let children make

decisions about the service. For example, children and young people designed and were involved in a new texting service, a new logo and a questionnaire as well as the 5pm – 10pm evening clinic services in youth clubs.
- The service ran a 'school nurse champions' programme which involved children and young people working to educational badges as well as involved in giving out health messages to their peers. The school nurse champions provided a link between school nurses, the school council and pupils.

Staff engagement

- The trust took part in the annual staff survey 2015. This survey is required by NHS England for all NHS trusts. The survey demonstrated that 93% of staff from community and young people's services were enthusiastic about their job.
- The trust also carried out annual internal staff surveys. The trust staff survey for community and young people's services demonstrated in May 2015 that 100% of staff felt they looked forward to going to work. The survey also showed 100% of staff felt involved in improvements within the service and that their views and suggestions were listened to. However the response rate for this survey was 36%.
- Staff could email directly to management or the executive team. Managers told us staff comments and emails were welcomed by senior management. An example of this was during the recent organisational changes, where staff had emailed the senior management team with suggestions, with regard to the changes.
- Staff who contributed told us they were listened to and changes made within the service.
- The majority of staff we spoke with said they had been involved in recent structural changes at the trust. The trust had engaged staff through a series of events, meetings, and electronic communication.
- All nursery nurses we spoke with said they had been fully engaged in their recent transfer from another provider. Health Visitors gave us an example of where they had influenced job roles through staff engagement.
- The SALT service introduced a mobile phone service for parents and families due to families not responding to landline calls. Despite trust policy, stating that work mobile numbers should not be given out therapists requested special permission from the senior management team to introduce the service for families living in deprived areas. The request was listened to and SALT services were allowed introduce this service development.
- Staff had regular monthly team meetings. We saw from meeting minutes and staff told us they were involved in meetings and staff were given the opportunity to feedback regarding their champion roles and any training undertaken.
- Staff received a regular children's services newsletter. The newsletter contained health information and updates including feedback on working groups and ongoing projects.
- Staff could email the senior management or the executive team directly. Managers told us staff comments and senior management welcomed emails.
- The majority of staff we spoke with said they had been involved in recent structural changes at the trust. The trust had engaged staff through a series of events, meetings, and electronic communications.
- All nursery nurses we spoke with said they had been fully engaged in their recent transfer from another provider. Health visitors gave us an example of where they had influenced job roles through staff engagement.
- Staff had regular monthly team meetings. We could see from the minutes that staff were involved with the agenda and the discussions. Staff were given opportunities to feedback on their roles that they championed.
- Staff received a regular children's services newsletter. The newsletter contained health information and updates including feedback on working groups and ongoing projects.

Innovation, improvement and sustainability

- Staff we spoke with were focussed on sustaining their services despite a recent 1.4 million budget reduction.
- Reduced budgets at the trust meant some services had to cut or reduced. For example, the 'Baby Peeps' programme. This programme was a service for new mothers to meet with other mothers and their babies, to discuss issues and child development. Two parents told us it was a good service and they missed it.
- On the trust's website, there was access to the Derbyshire Children and Young People's Health

Good

Are services well-led?

Promotion Programme. This programme aimed to provide information and support for those working with children and young people aged 0-19 in Derbyshire to help improve health and wellbeing outcomes.

- Three members of staff were nominated for the Cavell nurses trust award. The staff had been nominated for their work regarding child takeover day, a street project educating young people, and a 'think better' project raising awareness of mental health.
- The service had two Facebook pages. One (Derbyshire Health Visiting Service) that was used by patients as a two way process for the health visiting teams to post local information and any information and or advice to support parents and care givers. The Derbyshire School Nursing was for young people. Both services had a twitter page.
- The trust had an infant mental health lead who had undertaken work on attachment theory and had used this to support parents and staff to understand how attachment theory is relevant.
- Attachment theory is a psychological model that attempts to describe the dynamics of long-term and short-term interpersonal relationships between adults and children.