

Bradford District Care Trust

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Community health services for children, young people and families

Quality Report

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This report describes our judgement of the quality of care provided within this core service by Bradford District NHS Care 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 Bradford District NHS Care Trust and these are brought together to inform our overall judgement of Bradford District NHS Care Trust

Summary of findings

Ratings

Overall rating for Community health services for children, young people and families

Good



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

Good



Are Community health services for children, young people and families effective?

Good



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

Good



Are Community health services for children, young people and families responsive?

Requires Improvement



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

Good



Summary of findings

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Summary of findings

Overall summary

Community health services for children, young people and families included a range of services. During our inspection we reviewed the health visiting service, the school nursing service (including aspects of sexual health and immunisation), the looked after children service, the family nurse partnership service and the 'families first' health team. We talked with 58 health visitors and support staff such as nursery nurses, 23 school nurses including 2 nurses from the special school nursing service, 9 family nurse partnership nurses and the lead for the looked after children's team. We also spoke with the 'families first' lead along with 1 mental health worker and one school nurse from the same team. We talked with one of two heads of care from the service, the deputy director responsible for the services and one of the safeguarding children leads.

We visited 11 locations throughout the city of Bradford and Airedale where service teams were based and delivered services. Locations we visited included, Shipley health centre, Westcliffe medical centre, Woodroyd health centre, Flockton house, Daisy Chain children's centre, Canalside health centre, Meridian house, Westbourne Green, Undercliffe health centre, Holmewood health centre and Highfield health centre.

We spoke with 15 parents who were either accessing services during our inspection along with 2 parents by telephone. We accompanied one health visitor and one family nurse partnership nurse on home visits. We received 19 CQC comment cards which had been completed by parents prior to or during the inspection.

Services were safe. The staff we spoke with knew how to manage and report incidents, and we saw that there had been learning and development from incident investigations. Risks were actively monitored and acted on, and we found that there were good safeguarding processes in place. However, the health visitors we spoke to were concerned about number of new referrals the local authority accepted, which they felt placed them at risk. The trust said it will review these concerns and talk with the local authority. We found that there were enough staff, with the right qualifications, to meet families' needs. In addition, we saw that the clinics and health centres we visited were clean.

Services were effective. We found good evidence that the service reviewed and implemented national good practice guidelines. The trust had also successfully implemented evidenced-based programmes, such as the family nurse partnership programme. We also saw that patient outcomes and performance information was monitored regularly, and that staff received regular training, supervision and an annual appraisal. There was good evidence of multidisciplinary and multi-agency working across the services.

Services were caring. Children, young people and parents told us that they received compassionate care with good emotional support.

In general, services were responsive but they needed to be improved in one area. We found that the service planned and delivered services to meet the needs of local families. In addition, parents, children and young people were able to quickly access care at home or close to home. However, we were concerned that a lot of health visitors said the new administration hubs delayed referrals to other teams and specialities, such as speech and language therapy. Some health visitors said they now had to do their own administrative work, which meant they could not visit as many families. Health visitors and some parents also told us that families found it more difficult to speak with their local health visiting team. This meant the service may not be able to respond to a child's or families' needs quickly enough, or provide appropriate support at a time when the family need it.

Services were well-led. There were good arrangements in place for local governance and risk management, which fed into the wider trust governance systems. Staff understood leadership structures, particularly at a local level, and felt well supported by their line managers. However, we found that there was not a specific vision and strategy for the children's community health services, and that the trust did not have a formally nominated non-executive director for these services. This meant there was not a non-executive board member to champion the rights of children, and there may not always be appropriate challenge to the executive team on matters relating to children.

Summary of findings

Background to the service

There are 123,100 under 16 year old children and young people in the Bradford district, which accounted for 23.5% of the local population. This is the third highest percentage in England. Bradford has the youngest population in England outside of London. Between 2001/2 and 2012 the number of under 16 year olds increased by a further 13,500 (12.3%) and is expected to increase by a further 13,200 (10.7%) by 2021. There were more children in some wards than others. For example, over 30% of the population in Little Horton (31.3%) and Bradford Moor (31%) were aged 0-14 years of age, compared with 15.3% in Craven and 15.5% in Baildon.

Community health services for children, young people and families included a range of services delivered to the people of Bradford and Airedale area. Core services included health visiting, school nursing and the looked after children team. These services were complimented by specialist teams. There was a special school nursing team for children with complex needs. The Family Nurse Partnership programme provided intensive support for young mothers and their child up to the age of two years in certain geographical areas of Bradford. The 'families first' health team complimented the local authority led initiative based on the 'troubled families' programme.

Our inspection team

Our inspection team was led by:

Chair: Angela Greatley, Chair, The Tavistock and Portman NHS Foundation Trust

Team Leader: Jenny Wilkes, Head of Inspection – Hospitals Directorate (Mental Health), Care Quality Commission

The team included inspectors, inspection managers, Mental Health Act commissioners, a pharmacist inspector and an analyst.

We also had a variety of specialist advisors, which included health visitors, school nurses and Experts by Experience.

Why we carried out this inspection

Bradford District Care NHS Trust was inspected as part of the second pilot phase of the new inspection process we

are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

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

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

The inspection team always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services.
4. Community services for people receiving end-of-life care.

Summary of findings

We carried out an announced inspection of community health services for children, young people and families between 16 and 20 June 2014. Before visiting, we reviewed a range of information we hold about Bradford District Care NHS Trust and asked other organisations to share what they knew about the provider. During our visit, we held focus groups with a range of staff, including district nurses, health visitors and allied health professionals. We observed how people were being cared for and talked with carers and/or family members. We also reviewed the personal care or treatment records of patients.

During our inspection, we reviewed the health visiting service, the school nursing service (including aspects of sexual health and immunisation), the looked after children's service, the family nurse partnership programme and the 'families first' health team. We talked with 58 health visitors and support staff, for example nursery nurses, 23 school nurses (including two nurses from the special school nursing service), nine family nurse partnership nurses, and the lead for the looked after

children's team. We also spoke with the 'families first' lead, along with a mental health worker and one school nurse from the same team. We talked with one of two heads of care from the service, the deputy director responsible for the services and one of the safeguarding children leads.

We visited 11 locations throughout Bradford and Airedale, where service teams were based and delivered services. These included: Shipley Health Centre, Westcliffe Medical Centre, Woodroyd Health Centre, Flockton House, Daisy Chain Children's Centre, Canalside Health Centre, Meridian House, Westbourne Green Community Health Care Centre, Undercliffe Health Centre, Holmewood Health Centre and Highfield Health Centre.

We spoke with 15 parents who were accessing services during our inspection, two of whom we spoke to by telephone. We accompanied one health visitor and one family nurse partnership nurse on home visits. We received 19 CQC comment cards, which had been completed by parents before or during the inspection.

What people who use the provider say

During our inspection, we talked with 15 parents and received 19 CQC comment cards, mainly from parents who accessed health visiting services. We received very positive comments about the quality of service and care received, and did not receive any negative comments.

Some parents gave positive examples of the compassionate care they had received. For example, one parent explained how they had received excellent advice and support during difficult times. Another parent explained how they were supported when they had lost a baby. Parents told us they had been well supported and gave us examples of emotional support, often through difficult times. For example, one parent told us how supportive the health visiting team had been when the parent had had difficulties breastfeeding.

Parents often referred to the amount of involvement, support and information they had received from members of staff. For example, one parent explained that they always felt listened to and felt they could ask any questions they wanted. The parent went on to say they had always received all the information they needed. Another parent explained how they felt fully involved in all decisions about their baby. Parents also said they were always given options and explanations about what was happening and why. Other parents confirmed they had received information leaflets.

Good practice

Health visitors and school nurses received regular safeguarding supervision, which was formally documented on the child's SystmOne electronic care record. Any lessons from the supervision session were

Summary of findings

shared within the multidisciplinary team who were caring for the child, and learning was shared with other local teams. Staff felt well supported by the trust's safeguarding team when they were handling complex safeguarding cases.

The SystmOne safeguarding template included a multidisciplinary summary document. This ensured there was a clear and accurate record of events, as well as other safeguarding information.

SystmOne records highlighted known risks relating to children and families, for example an abusive parent, so that staff were made aware and could take appropriate precautions before visiting the family's home.

Local health visiting teams had their own governance meetings and staff we spoke with felt engaged in local governance and risk management processes.

The family nurse partnership (FNP) team included several areas of good practice, some of which could be

considered for development in other services provided by the trust. For example, the FNP pro-actively engaged people in the FNP board, held celebration events and regularly shared complex and detailed case studies with people's involvement. This helped to develop learning and understanding for the rest of the team.

The looked after children's team continued to support children in full time education until 21 years old, rather than discharge them from the service at the usual age.

The trust had positive examples of inter-agency working and developing services beyond national guidelines. For example, the Bradford families first (troubled families) pilot initiative, which is largely a social care and police-led initiative, included a dedicated health team who were based in the same location (Flockton House) as other families first teams. This meant troubled families received health support that they may not have received if the initiative had not included a directly-funded health component.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust should ensure that staff report all delays in referrals from the administration hubs to community teams working with children, young people and families, monitor performance in regards to referral delays and take expedient action to address poor performance.

The trust should improve systems to ensure any risks associated with safeguarding referrals are identified, reported and monitored, both internally and externally through engagement with the local authority safeguarding teams.

The trust should identify a non-executive board member with specific responsibility to champion the rights of children at board level discussions.

The trust should ensure that NHS complaints leaflets are available in all of the schools visited by school nurses employed by the trust.

Bradford District Care Trust

Community health services for children, young people and families

Detailed findings from this inspection

The five questions we ask about core services and what we found

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

Good 

By safe, we mean that people are protected from abuse

Incidents, reporting and learning

During the period 31 May 2013 and 31 May 2014, health visitors reported 131 incidents, school nurses 48 incidents and the looked after children service one incident. None of the incidents reported had been classified as a serious untoward incident. We talked with a number of staff from the health visiting, school nursing, family nurse partnership (FNP) team and the lead for looked after children's team, who demonstrated a clear awareness of how to report incidents when they arose. These staff groups told us they always received feedback from the trust about incident reports they had submitted. For example, health visitors, the FNP team and school nurses all provided examples of incidents they had reported and the feedback they had received.

The head of service responsible for children's community health services provided examples of how previous serious untoward incidents had led to service improvements following investigation. For example, a trend of 'shaken baby' incident reports had, in part, led to the introduction of a pilot educational programme developed by the charity NSPCC (National Society for the Prevention of Cruelty to Children). The programme 'coping with crying' was based around a film that educated parents about how to cope when their baby cries and about the risks of head injuries in babies.

Another example was provided relating to information governance within the school nursing service, which led to changes to practice across the trust. An incident had occurred that involved shredded confidential information being mistakenly placed with domestic waste. This led to

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

the incident being placed on the risk register. An action plan was developed and had led to new systems and processes to safely manage shredded paper containing confidential personal information.

One health visitor demonstrated how the trust's SystmOne electronic record system highlighted individual risks relating to individual families, based on previously reported incidents. For example, the systems flagged a previous visit where a parent had been verbally abusive, which informed the health visitor of that risk before performing a home visit.

Cleanliness, infection control and hygiene

We saw that the clinics and health centres we visited were clean and had appropriate access to facilities such as hand hygiene gels. A number of parents we talked with told us they thought the clinics they attended were always clean. The head of service outlined the various children's community teams adhered to the trust's infection control policies and procedures, and had received additional talks at locality level from the trust's infection control team. Health visitors and school nurses we talked with confirmed they received regular infection control mandatory training. We saw that quarterly hand hygiene audits had been completed by a nominated member of staff at locality level which were returned to a trust representative for audit. The school nursing team did not always have access to hand washing facilities within the school environment and therefore carried cleansing gels and wipes to maintain hand hygiene.

Maintenance of environment and equipment

The health visitors, FNP team and school nurses told us they had the equipment they needed to perform their roles effectively. We found equipment was serviced and checked according to schedule which was confirmed by members of staff.

Medicines

The head of service explained there were some school nurse and health visitor trained prescribers who could prescribe medicines, such as lotions and creams, along with analgesia, such as Paracetamol.

We reviewed the management and administration of immunisations by the school nursing teams and found these were managed safely. At the Canalside base location we saw that the immunisation fridge was tested twice daily for temperature and that this was recorded. The school

nurses we talked with explained they had received training and demonstrated an awareness of the 'cold chain' to ensure the correct temperature of immunisations was maintained. The school nurses used cool bags to transport immunisations and explained they opened the bag a limited number of times to maintain temperature. Documentation of immunisation stock and used levels were maintained appropriately. We reviewed 'patient group directives' (PGD's) for all immunisations administered and these were in date. Evidence showed that school nurses had received immunisation administration training. We observed an immunisation session at a secondary school and found immunisations were administered appropriately. For example, consent was checked and one child who had a history of allergy was closely monitored to ensure no reaction occurred.

Safeguarding

The trust had a safeguarding team which included two named nurses and seven specialist practitioners who acted as a duty team to give members of staff advice, training and planned supervision. The safeguarding lead explained there were currently 640 children subject to child protection plans and this had increased from 370 for the previous year. We were told it was not clear why this increase had occurred but the local safeguarding board was considering a review to identify the reasons for this increase.

Staff were able to confidently explain how safeguarding referrals were identified, referred and followed up. Health visitors and other groups of staff also told us they received safeguarding training and were able to choose which level three module they were going to complete each year. The safeguarding lead told us all health visitors and school nurses should be trained to the level three standard of training. We found members of staff had a robust system of documented safeguarding supervision with the safeguarding team, which routinely occurred every three months. We were told the safeguarding lead and team were easily accessible for additional advice and supervision when needed.

The SystmOne electronic records system included a detailed safeguarding template and record. We reviewed a sample of safeguarding records. The records captured key safeguarding events in a chronological order, including entries made directly by the child's GP. Records demonstrated multidisciplinary working with a number of

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

agencies. Health visitors told us the electronic record system worked well and would make it much harder for children to 'slip through the net' where there were concerns about a child's welfare.

We talked with a number of health visitors throughout Bradford who raised concerns about the "high threshold" in relation to the acceptance of safeguarding children referrals. We found staff were less confident of formal escalation mechanisms where cases of concern were not deemed to meet the thresholds of the local authority. The safeguarding lead explained the specialist practitioners would support staff where a referral had not been accepted by the local authority. We were also told there was a local authority threshold document to assist with supporting staff on the different levels of intervention. We talked with the deputy director responsible for children's community services who was not aware that a number of health visitors held concerns over the threshold levels. The deputy director explained they would seek the views of the team prior to escalating and discussing with representatives from the local authority as this had not been brought to their attention.

Records

We reviewed a sample of SystmOne electronic records for health visiting staff and found detailed, accurate and contemporary records maintained for children and families. The records system was accessible to other community healthcare professionals such as GPs, and these records were integrated so that a clear chronological set of information was maintained. The trust expected members of staff who used the system to adhere to a set of record keeping standards. For example, entries had to be made into the system within 24 hours of visiting a family at home. The standards were included in the Well child quality service standards and guidance for practice.

The family nurse partnership (FNP) team, based at the Woodroyd Centre currently used paper-based records. We reviewed a sample of these records and found well-structured documentation, which was easy to navigate. The documentation was maintained to a detailed, contemporary level, with good evidence of inter-agency working. The lead for the service along with members of the team explained there were plan to move to the SystmOne electronic system. They explained individualised templates were being designed to suit the specialist nature of the service.

The head of service explained the records systems were audited and the trust submitted a previously completed health visitor audit of records as evidence that the audit was completed. Most of the health visitors we talked with were positive about the use of an electronic records system although they felt that it took longer to complete record keeping. This was because they had to make hand written notes during the visit and then record electronically within 24 hours. Some health visitors felt it took them away from completing their visits. The head of service explained the management team were aware of these issues with the electronic system and were reviewing templates to make them easier to complete.

Lone and remote working

We talked with a number of health visitors, school nurses, the FNP team and the lead for the looked after children's team who all demonstrated a clear awareness of the trust's lone working policy and procedure. Team members from health visiting and the FNP team were able to provide examples of how the lone worker escalation process worked in practice. Team members felt the escalation processes had safely tracked and protected them should there have been any concerns for their welfare and safety.

Assessing and responding to patient risk

The trust had risk registers in place which were managed via their risk and governance systems. The community children's services had held risk events with staff during 2013, which aimed to raise staff awareness. Risks were identified and escalated by locality and these were managed within the locality and heads of service as required. The head of service explained the main risks regarding the school nursing and health visiting services included capacity to meet demand, immunisation, delivery of the implementation plan and CPT's (community practice teachers – for health visitor mentorship). During our inspection of various teams and localities, we saw how these risks were being addressed, for example, the management of the health visitor expansion plan and the training of additional health visitors to fulfil CPT roles.

Staffing levels and caseload

We talked with a number of health visitors at their localities and via two well attended forums and were told their caseload levels varied across the localities. This had led to challenges within localities where there were currently shortfalls within the current health visitor establishment numbers, for example, some health visitors explained how

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

it meant visits may be more rushed than they should be and in some cases had led to routine home visits being missed. However, the health visitors we talked with were aware of the health visitor implementation plan and also felt that matters relating to individual caseloads had improved in comparison with previous years.

The head of service explained how the establishment was determined which was by utilising the locality deprivation indices. They told us the trust had recruited an additional 22 health visitors due to start in September 2014, which included nine over establishment, to ensure achievement of the implementation plan and provide additional cover for sickness and maternity leave. We reviewed documentation that set out current and projected caseloads by team locality, and this showed every team but one will have caseloads under expected caseload levels once the additional health visitors commence employment.

We talked with school nurses within their localities and via a forum. School nurses told us they were attached to secondary schools but they were experiencing heavy workloads. The trust were aware of capacity and demand issues regarding the school nursing service and had a plan in place to address this matter, including recently won investment to recruit additional members of staff.

The FNP team currently held caseloads within the expected limit of 25 per practitioner. The FNP lead explained additional funding may lead to an increase in the FNP team in the near future. The looked after children's team had recently recruited a new team member and an additional care leaver nurse. Neither of these teams told us of any concerns regarding staffing of the services.

Deprivation of Liberty safeguards

Deprivation of Liberty Safeguards (DoLS) do not apply to the children's community health services.

The head of service explained that all trust staff were made aware of the MCA (mental capacity act) via its mandatory training programme. We were told school nurses had awareness of the Gillick competency and Fraser guidelines in relation to assessing a child's ability to consent to care and treatment. However, we were not able to observe or evidence this understanding. During immunisation clinic we saw school nurses check consent to have the immunisation.

The SystmOne records management system captured consent in relation to confidentiality and the sharing of information. We saw that the health visitor clinical lead had previously conducted an audit of confidentiality consent compliance amongst teams during December 2013 which demonstrated good compliance. The audit included recommendations to further improve practice.

Managing anticipated risks

The head of service explained there were no recorded anticipated risks; the current locality level risk management processes had only recently been introduced during 2013 and all current risks were being actively managed. We talked with a number of health visitors who told us they felt listened to when they reported concerns that may become a risk.

Major incident awareness and training

There was a 'business continuity plan' for the health visiting service, which set out actions to be taken for major incidents, loss of facilities, loss of IT systems and loss of staff member. The head of service told us the health visiting team had taken part in 'business continuity exercises' at locality level. We reviewed a report from an exercise which was undertaken on the 12 April 2013. The report noted good responses from the participating teams and made some recommendations.

Are Community health services for children, young people and families effective?

Good 

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.

Evidence based care and treatment

The trust had a NICE guidance strategic group which conducted an initial review of all new national guidance. We were told any new relevant guidance for the children's community services would be discussed and reviewed in more detail via the health visitor forum and disseminated via locality team meetings. The head of service explained and our review of documentation confirmed that all current national guidance was incorporated into the 'well child pathway'. Documentation showed effectiveness of the pathway is checked regularly. Initiatives, such as UNICEF's 'baby friendly' initiative, were in operation. The service was currently accredited to the level two standard and the head of service explained the trust would soon be formally assessed against level three standards. The school nursing service followed a similar process to the health visiting service. School nurses told us there was a nominated lead for NICE guidance and new evidence was discussed via their forum and local teams.

The trust was successful in gaining a licence to provide the evidenced-based family nurse partnership (FNP) programme within certain localities of the Bradford and Airedale geographical area. The programme provided intensive support to certain families who meet set criteria with the aim of improving pregnancy outcomes, child health/development and parents' economic self-sufficiency. We reviewed the service during our inspection and found the team was providing excellent care to the families currently on the programme. FNP nurses were able to provide multiple examples of positive outcomes during interview and we observed very positive care and support during a home visit with a FNP nurse. There was client involvement throughout the care processes and via the FNP board meetings. The effectiveness of the programme was carefully monitored, audited and reported via a range of methods including an annual report for the commissioner NHS England.

Pain relief

The head of service explained there were some school nurse prescribers and health visitor trained prescribers who

could prescribe medicines, such as lotions and creams, along with analgesia, such as Paracetamol. However, we did not observe any pain relief being administered during out inspection visit.

Patient outcomes and performance information

We reviewed evidence which demonstrated that patient outcomes and performance information were closely monitored and reported by the trust. For example, an area team dashboard was submitted to the commissioner NHS England quarterly for health visitor 'system transformation and service delivery metrics'. We reviewed service delivery metrics for quarter three (October to December 2013 and quarter four (January to March 2014) which monitored performance against Department of Health indicators such as numbers of babies who received a new birth visit within 14 days. We saw evidence which showed a range of these indicators were also monitored at locality level. The HV forum meeting minutes, held on 6 June 2014, noted that Bradford was lower than other areas in West Yorkshire for antenatal contacts although were performing better than other West Yorkshire areas against other key performance indicators.

Other audits were undertaken that demonstrated the trust monitored the effectiveness of meeting patient outcomes for people included an annual audit of the 'well child pathway.' The report found overall results demonstrated that 85.8% of core contacts were delivered within scope (agreed timescales). The report also recorded where specific advice was provided where this had been necessary such as toileting advice for the 3 to 5 age year group.

Specialised services such as the looked after children's team, and the FNP team, also monitored indicators to ensure they were meeting their respective targets. For example, the LAC annual report April 2013 to March 2014 stated that the number of child who had received a statutory annual health assessment was 88%, which the report noted was above the national average.

Are Community health services for children, young people and families effective?

Good 

Competent staff

There were formal processes in place to ensure staff had received training, supervision and an annual appraisal. We talked with a number of health visitors, school nurses and specialist teams such as the looked after children's team and FNP team. All staff we talked with told us they undertook a variety of mandatory training and received an annual appraisal. Staff explained mandatory training was delivered via a combination of face to face and e-learning modules.

Staff received regular safeguarding supervision three monthly or as required by the safeguarding teams. Professional advice and support was available for health visitors from the trust's health visitor lead. Health visitors told us they could nominate their own clinical supervisor. The school nursing team had a similar system of supervision and told us, via the school nurse forum, that they felt well supported professionally by more senior school nurses. The FNP nursing team received regular supervision from the team's psychologist.

Use of equipment and facilities

The health visitors, FNP team and school nurses told us they had the equipment they needed to perform their roles effectively. We found equipment was serviced and checked according to scheduled servicing. Staff we talked with confirmed that servicing of equipment was undertaken when required.

Multi-disciplinary working and working with others

We were provided with, and observed, a range of evidence that showed how the various children's community health teams held positive multidisciplinary working with others. For example, the Shipley and Saltaire health visiting team met monthly with the GPs to discuss areas such as safeguarding children. We reviewed a sample of SystmOne electronic care records and these recorded evidence of working with social care services, acute health services, primary medical services and other multi-agency teams to ensure positive outcomes for families. We observed a health visiting nursery nurse who worked closely with a practice nurse from the doctor's practice whilst they administered vaccinations to three siblings.

Health visitors told us they usually had positive integrated working with midwives based at the acute hospital and in

the community, school nursing teams, other health visiting teams and mental health services. Some health visitors felt communication with some social work teams could be improved although they said this depended on which social worker and team they dealt with.

School nurses told us they generally had good relationships with local schools, for example, they said school were good at letting them know about new families moving into the area. School nurses also explained they worked closely with CAMHS (community adolescent mental health services), which also involved completing joint visits where required. The special school nursing service (for children with complex needs) told how they worked with the charity Barnardo's and the sexual health team to develop the use of Barnardo's 'your choice plus' to raise sexual awareness as to what is acceptable behaviour to avoid abuse.

We saw evidence that showed multidisciplinary working at a more strategic level across all children's community teams. For example, the looked after children's team attended various meetings and forums which involved multi-agency partners. These included meetings such as the looked after children's team strategy group, which was chaired by the local authority and attended by multi-agency partners, and the looked after children's team be healthy group, which included attendance by acute health, CAMHS and paediatricians.

Co-ordinated integrated care pathways

The health visiting service used the well child pathway, which reflected the national healthy child programme. The trust, along with other partner bodies (including City of Bradford Council, Bradford Teaching Hospitals NHS Foundation Trust, Airedale NHS Foundation Trust), formally launched a multi-agency coordinated integrated care pathway on the 16 June 2014. The new universal care pathway sets out the planned delivery of health and well-being services for children and their families from pregnancy through to five years of age. We reviewed a launch summary document for families which included all planned commitments such as midwife and health visitor contacts through to hand over of care to the school nursing team. The care pathway included the current well child pathway and reflected the Department of Health healthy child programme.

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

Good 

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

We visited health centres, shadowed a family nurse partnership (FNP) nurse and a health visitor on two home visits and went with school nurses to a secondary school. Throughout our inspection we observed staff who provided compassionate and sensitive care that met the needs of the parent and child. For example, on a home visit with the FNP nurse a member of staff who had a positive and friendly approach towards the parent and child. The parent clearly had full confidence in the FNP nurse and was able to have a full and frank discussion about any worries they held. The nurse explained what they were doing and took the time to listen and support the young mother.

On our other home visit we went with a health visitor to see a mother and family who was in need, and had little money for food. We observed a health visitor who provided caring and compassionate care. The health visitor showed affection to the children and made sure they were safe, clean and looked after. The health visitor took time to provide information about the nearest food bank and how to get there. They made phone calls to get additional information and make sure the parent would get help and support regarding personal finances.

During the school visit we saw how the nursing team supported children during their vaccinations to ensure they were okay during and after the vaccination. For example, one young person became upset prior to having a vaccination and we observed staff who were patient and provided caring support prior to them having the vaccination.

We talked with 15 parents during our inspection visits across the Bradford area and we received 19 CQC comment cards largely from parents who accessed health visiting services. We received very positive comments about the quality of service and care received from all these parents. We did not receive any negative comments during our inspection.

Some parents specifically outlined positive examples of compassionate care they had received. For example, one parent explained how they had received excellent advice and support during difficult times. Another parent explained how they were supported when they had lost a baby.

Dignity and respect

Throughout our inspection visits to various parts of Bradford we found members of staff treated families with dignity and respect. Parents told us they felt respected and well supported. Parents also made clear that staff were always polite and helpful with any concerns they may have.

Patient understanding and involvement

The children's community health services had various information leaflets available for parents and children. In relation to sexual health services for young people, the school nursing team used 'Ur Choice' delivery handbooks for year nine and year 10 students which had been developed by a number of multi-agency partners for the delivery of sex education. We found each of these booklets contained a range of valuable, but relevant, information for young people. For example, the year nine booklet set out in an easy to understand way, the legal framework (known as the 'Fraser guidelines'), so that young people aged under 16 years would know their rights to confidentiality and consent.

Parents we talked with and the comment cards we received prior to the inspection, often included reference to the amount of involvement, support and information they had received from members of staff. For example, one parent explained that they always felt listened to and felt they could ask any questions they wanted. The parent went on to say they always received all the information they needed. Another parent explained how they felt fully involved regarding all decisions relating to their baby. Parents also said they were always given options, and given explanations about what is happening and why. Other parents confirmed they received written literature such as information leaflets. One parent explained they had just started feeding their baby solid foods and they had received relevant literature.

Emotional support

During our visits to health centres, where clinics were being held, we saw members of staff who provided good emotional support to families and children. For example, during our visit to a well-child clinic we observed a health visitor nursery nurse provide excellent emotional support to three young children who were due to have

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

Good 

immunisations with the practice nurse. The nursery nurse was able to support the attending parent by interacting and distracting two of the children, while the parent cared for the child receiving immunisations.

Parents told us they had been well supported and gave us examples of emotional support, often through difficult times. For example, one parent told us how supportive the health visiting team had been when the parent had had difficulties breastfeeding.

We visited one secondary school during our inspection visit and talked with 15 students. Some students had not met the school nursing team before although they were positive about the support they had received during their immunisations.

Promotion of self-care

The health visiting teams and school nursing teams worked closely together to identify young children from age three who may not have all the skills needed to commence their school life at age five. The school readiness programme involved a process to support parents with parenting courses to ensure they could support their children before school. For example, teaching the child skills such as tying shoe laces. We saw that the school readiness programme was incorporated into the integrated care pathway.

The FNP service provided several examples of how it had supported young mothers under the age of 19 to develop their personal confidence and skills with parenting skills and also personally. For example, the support offered by the team had enabled young mothers to develop personal skills into formal study and allowed them to gain the strength to leave domestic abuse situations. The FNP service had regularly documented success stories via case study which contributed to documents such as the FNP annual report. One parent had gained the confidence to produce an illustrative story board of her young daughter's life. This collage was presented by the mother to the FNP board.

The looked after children's team enabled the promotion of self-management and independence. Each child who entered care was assigned a nurse who remained there regardless of where the child was placed. This meant the child/young person was able to develop a relationship with the nurse who could act as their advocate. In Bradford, the care leaver nurses continued to support young adults who had legally left the care system but stayed in education up to their 21st birthday to ensure they had the support needed.

Are Community health services for children, young people and families responsive?

Requires improvement 

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

Service planning and delivery to meet the needs of different people

We found that there was a range of evidence available that demonstrated how the children's community services engaged with commissioners, the local authority and other providers to address the health needs of the population. Some examples included: the health visitor implementation board, which met monthly with the commissioners (NHS England) and departments of the local authority (public health and early years) to oversee the implementation plan to ensure it continued to meet the needs of the local population. The head of service told us the 'School Nursing and Healthy Child forum' included voluntary sector membership through we did not review additional evidence relating to this forum.

Bradford city was participating in a pilot programme of the national social service led initiative 'troubled families'. This initiative in Bradford was named 'families first'. We found the Bradford partners had adopted a modified approach to the delivery of this initiative by funding a dedicated multidisciplinary health team provided and managed by the trust. Partners of the initiative included the trust, Bradford council, West Yorkshire Police, Jobcentre plus and a range of voluntary agencies. We talked with the team and reviewed evidence that demonstrated how the service planning and delivery of this service had ensured health was a key component in the delivery of the troubled family's initiative. We were provided with several examples of how integrated working with the social care aspect of the service had improved outcomes for families.

The family nurse partnership (FNP) advisory board, which met every three months, was chaired by the commissioner (NHS England) and included membership of the trust along with other stakeholders. Membership of this board included a 'graduate client' who has previously been on the FNP programme. The FNP Annual Report 2013/14 highlighted throughout the report how the programme was continually developing to ensure it met the needs of its client group.

Access to care as close to home as possible

Health visiting and FNP services were provided in people's homes and clinics were held in local areas such as health centres and GP practices. School nursing services were provided in the child's local school and included home visits where these were necessary.

Access to the right care at the right time

Health visiting, school nursing and other specialist services were provided in normal weekday office hours with some flexibility. For example, the school nursing service provided education sessions in the school setting in an evening.

Flexible community services

Health visiting, school nursing, looked after children's team and the FNP team all operate within the limits of set structures. For example health visiting and the healthy child programme. However, there was flexibility within the system to meet people's needs. For example, health visiting team would arrange home visits with families and clinics such as breast feeding support were run as 'drop-in' with no set appointment times.

Meeting the needs of individuals

Health visitors, school nurses and other specialist teams, such as the FNP, told us they had access to a range of available interpreting services. Staff we talked with appeared to understand their family's cultural needs and how these should be met. For example, one health visitor explained how well baby clinics had been normally held in a morning. It was found that the ethnic needs of the women in the area would prefer later appointment times. A change was made to the time of the appointments for the ethnic group, which had improved attendance. The FNP team told us how they had identified they felt they lacked adequate knowledge and understanding of a particular eastern European ethnic group. They arranged with the interpreter a learning session so that they could understand their client's needs and improve communication.

A number of health visitors and school nurses raised concerns about the trust's administration hub, which may mean there were delays in meeting the needs of families in a responsive way. The trust had reorganised administrative support for community health teams at locality level and

Are Community health services for children, young people and families responsive?

Requires improvement 

placed these within area hubs. Throughout our visits to health centres and staff forums, we found that staff views about the admin hub were mixed. Some health visitors thought the hub worked reasonably well though others gave several examples of how it had become very difficult to contact other staff members. Some health visitors explained they were having to do their own administrative work which took them away from doing visits and other interaction with families.

Health visitors gave several examples how it had become difficult to contact other health visitors when transferring families to another locality team within Bradford. One health visitor gave an example where it took four days to try and get hold of a speech and language therapist (because they now have to contact via a single point of contact number rather than ringing the clinic directly). Other health visitors explained that they did not always get a message from the administration hub informing them a family was awaiting contact. We were told the new contact system meant families could no longer phone the local health visiting team directly on an informal basis to seek advice. One health visitor said, "We used to get a lot of calls from families seeking advice and support... These have significantly reduced since the hub has commenced... What has happened to these calls?"

We received information from the trust in relation to the measures they had taken and planned to take to reduce the risks identified with the administration hubs. We saw on the information the trust provided staff had now been given direct telephone numbers extensions for other members of the team. In addition, a fault had been identified on the workflow management system and this system was checked daily to ensure patients weren't missed. However staff we spoke with were not aware of the changes made by the trust and therefore these changes had not been embedded in practice.

Parents we talked with or who had completed our comment cards often told us their health visitor usually

returned their telephone calls promptly. However, some parents directly referred to the hub phone line negatively because they had to wait for the health visitor to ring them back.

The FNP service currently had its own administrative support though the nursing team expressed concerns about the possibility of losing their support to the hub. They felt this would adversely affect the quality of the service should this occur.

Moving between services

Systems were in place to move people between services, including within the Bradford area between locality teams and to other towns and cities. During our visit, we reviewed SystemOne electronic records. We reviewed one record which showed how a family had moved to another town. The process for moving between services was captured with the well child pathway. There was a transition approach for moving between services such as health visiting and the school nursing service at five years of age. Transfer arrangements were in place for transfer from the FNP team at two years of age to the locality health visiting team.

Complaints handling (for this service) and learning from feedback

The services followed the trust's NHS complaints processes. We saw there were complaints leaflets available within the health centres we visited. We visited one school that did not have complaints leaflets available. We were told that the number of formal complaints were low within the service. Staff told us they knew how to manage complaints locally to ensure local resolution. People's views were sought via questionnaire surveys and other methods. Staff we talked with provided examples of how learning had taken place from via feedback from members of the public, for example, adjusting clinic times and how they were organised. Staff we talked with demonstrated awareness of the trust's whistleblowing policy should they wish to raise concerns themselves about an aspect of the service.

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

Good 

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.

Vision and strategy for this service

The head of service (city area) and deputy director (responsible for children's services) told us there was not a specific strategy for children's community services. The head of service explained the most relevant strategy relating to the service was the nursing strategy and the safeguarding strategy. However, there were on-going plans in place to develop services to ensure the local population's needs were met such as the health visitor implementation plan.

When we asked members of staff they did not refer to the nursing or safeguarding strategies, but they did demonstrate awareness of the health visitor implementation plan regarding the expansion and development of the service. Some health visitors also demonstrated awareness of the national specifications for health visiting.

Guidance, risk management and quality measurement

We found that the community health services (adult and children) had locality-based governance arrangements in place. These arrangements included monthly meetings which were held locally. The meetings included representation from the various staff groups involved in the delivery of community care, such as community nurses, health visitors and other staff groups. We reviewed a sample of meeting minutes from different localities and found they included various embedded attachments to disseminate further information, guidance and detail. Other areas discussed included areas such as risk management, public involvement and learning arising out of incident investigation. Health visiting and school nursing teams we talked with demonstrated a clear awareness of the governance structures in place. The local governance processes fed into the wider trust governance processes.

We saw that health visitors and school nurses held regular team meetings where guidance, risks and quality measurement targets may be discussed. Other meetings attended by these groups included 'standards groups' to review the implementation of standards and guidance along with the health visitor forum.

The specialist teams such as the family nurse partnership (FNP) service and the looked after children's teams had their own local governance arrangements. The FNP team held quarterly governance meetings. In addition, the team held a range of other meetings where governance matters may be discussed, such as their weekly team meeting that discussed matters such as general business, quality data targets such as breastfeeding and a case study to share learning. Other meetings held included quarterly safeguarding meetings and the quarterly FNP board meeting.

There were locally-managed risk processes, which fed into the trust risk management systems. Staff showed awareness of the risk management processes and said they felt listened to when risks were identified and reported. Quality measurement of the delivery of services was actively monitored and data fed back to locality teams. For example, breastfeeding had recently fallen slightly below the expected target. We heard a range of examples of how the health visiting and FNP teams worked hard to promote breastfeeding with mothers and provide support to enable mothers to continue breastfeeding. Mothers we talked with told us they had been supported with breast feeding. We were told of the initiatives in place to promote breastfeeding and saw that it was a regular topic of discussion at team meetings. This demonstrated that the various teams were proactively working toward increasing and sustaining breastfeeding among the mothers of Bradford and surrounding districts.

Leadership of this service

There was a leadership structure for the various children's community health teams and staff understood their structures, who their line manager was and who they reported to on the structure. The leadership structure varied between the different staff groups. At locality level, we found the health visiting teams had a flat structure and self-managed their respective teams by participating in a shared duty rota. The health visitor on duty would actively manage and allocate new parents to the rest of the team and coordinate other matters such as safeguarding concerns.

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

Good 

The health visiting teams were line managed by a locality level manager, who was not always a health visitor. For example, at the Shipley Health Centre, the two health visiting teams were managed by a community nurse. However, the majority of health visitors we talked with did not express concerns about being managed by a healthcare professional who was not a health visitor. They often said they felt well supported and could receive support from the trust-wide health visitor lead. One health visiting team at a different health centre did feel it had not been supportive of the trust to remove a tier of line management from the health visiting service a couple of years ago. Most health visitors we talked with was aware of line management arrangements through to the two heads of service responsible for children's services. The school nursing teams had team leaders and were able to clearly set out their leadership structures.

The specialist teams, including the FNP service, looked after children's service, and family's first health team, had a lead who reported directly to a head of service. We found these three leaders displayed an outstanding level of dedication, enthusiasm and commitment to their respective services and teams, which was reflected in the quality of the service delivered.

The deputy director responsible for children's services delivered by the trust told us the director of nursing was the executive lead responsible to promoting the rights of children. The deputy director, head of care and the various members of staff we talked with were not aware of a formally nominated non – executive director who led on the trust board for children's rights.

Culture within this service

We found there was a culture of openness and flexibility amongst all the teams and staff we met. Staff spoke positively about the service they provided for children, young people and parents. Placing the child and the family at the centre of their care delivery was seen as a priority and everyone's responsibility. We saw that staff worked well together and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of community health services.

Public and staff engagement

We reviewed evidence that showed the views of people who used the service were regularly sought via survey questionnaires known as 'Improving patient experience' (IPE). We reviewed results from quarter four (January to

March 2014) which showed there was positive feedback. For example, for the health visitor IPE question "How well supported have you felt as a parent?", 100% provided a positive rating on a scale of 0-5 with 80.7% rating the question at five (very supported). The school nursing service and health visiting service both had reports detailing any learning and action point arising out of feedback comments made within these surveys.

Health visitors we talked with gave several examples of how they had responded to verbal and other feedback from parents. For example, adjusting and changing well baby and other clinics to suit the needs of the local population. Health visitors also gave examples of local level involvement groups that had been set up within a particular locality. For example, at Highfield health centre we were told about a 'travellers' focus group which was attended by a representative of the traveller community. We were told this had resulted in an agreed plan to access this community by visiting them monthly and knock on doors to offer services to a group that may be difficult to reach and access.

The FNP service actively involved its clients in the development and management of the service. There were two clients who sat on the FNP board and clients were regularly encouraged to share their experiences through the presentation of case studies. The FNP service held regular events for clients and other interested parties. Events included an annual celebration event held to celebrate the young parent's success on the FNP programme.

The head of service explained how their services actively worked with the voluntary sector (who represented groups of people in the communities). For example, the school nursing and healthy child group included membership from voluntary agencies such as the Barnardo's charity. However, the head of service recognised members of the public could be further involved in other forums and groups managed by the trust.

We saw evidence which showed the board regularly received case studies from healthcare professionals and people who used services about their experiences whilst accessing services. Previous case studies had involved the range of services provided to the parents and children of Bradford and surrounding districts.

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

Good 

Members of staff told us they received regular communication from the trust and its board. Some health visitors we talked with recalled previously being visited by members of the board. The FNP team told us they had been visited by the CEO and some other members of the board. There was limited evidence of staff involvement in the design or development of services although health visitors had felt well informed during the health visitor implementation plans.

Some staff we talked with felt the trust had introduced too many changes at the same time, which had made it much more difficult to deliver services among all the changes. Changes referred to included the administration hub, introduction of SystmOne, changes to staffing and leadership and the introduction of more 'agile' ways of working. Staff views about feeling valued by the trust varied, some staff did feel valued, while others felt valued by their line managers but not by the organisation.

Innovation, improvement and sustainability

We found that the trust had introduced specialist teams and developed other services to promote improvement and innovation with the community healthcare setting for children.

The trust gained a licence to provide the evidenced based family nurse partnership" (FNP) programme within certain localities of the Bradford and Airedale geographical area. We reviewed the service during our inspection and found the team was providing excellent care to young parents and children on the programme. FNP nurses were able to provide multiple examples of positive outcomes during interview and we observed very positive care and support during a home visit with a FNP nurse. There was client

involvement throughout the care processes and additional engagement via the FNP board meetings. Events were held to celebrate success stories for young mothers. The effectiveness of the programme was carefully monitored, audited and reported via a range of methods including an annual report for the commissioner NHS England.

Bradford city participated in a pilot programme of the national led initiative 'troubled families' named 'families first' in Bradford. Partners of the initiative included the trust, Bradford council, West Yorkshire Police, Jobcentre plus and a range of voluntary agencies. We found the Bradford partners had adopted a modified approach to the delivery of this initiative by funding a dedicated multi-disciplinary health team provided and managed by the trust. We talked with the team and reviewed evidence which demonstrated how the service planning and delivery of this service had ensured health was a key component in the delivery of the troubled family's initiative. We were provided with several examples of how integrated working with the social care aspect of the service had improved outcomes for families. For example, the service helped a mother register with a GP so that her physical health needs could be addressed. The mother was also taken to the together women project so that she would receive help with debt, low self-esteem and mental health.

At a locality level, health visitors gave examples of how they had improved services for the local population. The health visiting team at Undercliffe Health Centre how a simple audit of attendees at two small clinics equated to the volume of one large clinic. As a result the team decided to offer one morning clinic and one afternoon clinic and planned to review the improvement in six months.