Care Quality Commission

Calderdale and Huddersfield NHS Foundation Trust

RWY

Community health services for children, young people and families

Quality Report

Calderdale and Huddersfield NHS Foundation Trust
Acre Street
Lindley
Huddersfield
West Yorkshire
HD3 3EA
Tel: 01484 342000
Website: www.cht.nhs.uk

Date of inspection visit: 8-11 March 2016
Date of publication: 15/08/2016

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWY95	St John's Health Centre, Lightowler Road, Gibbet Street, Halifax.	Community health services for children, young people and families	HX1 5NB

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

Contents

Summary of findings

Overall summary

- The trust had established risk reporting structures in place. Incidents were investigated and reported in line with policy. We saw evidence of the service sharing learning with staff. Staff were knowledgable and experienced in safeguarding children and recognising risk. There were safeguarding systems in place to protect children and young people from harm.
- Staffing levels were appropriate for services provided and were in line with commissioned levels. There had been problems of recruitment in childrens therapy services. The risks had been mitigated by temporary actions.
- Staff had received mandatory training at trust level of expectation. There was a broad understanding of the duty of candour and some staff had received training.
- Staff practiced evidence based care and treatment. There was good evidence of multi- disciplinary working within the trust and with external agencies. Staff were aware of the principles of consent and we observed them practising it in their work. There were clear and accessible routes into other services. Some staff reported that the transition between health visiting services and school nursing was not as smooth now that this service was under the umbrella of a social enterprise company.
- The trust was meeting recognised targets set by NHS England for this year and it's Commissioning for Quality and Innovation (CQUIN) target for breastfeeding post delivery. However this figure decreased significantly on discharge from maternity care. The service had identified this issue and mitigating actions were being taken to address them.
- There were good appraisal rates throughout the service and systems in place to identify dates of reappraisal.
- We spoke with children and their families, and observed care taking place. We found evidence that staff practiced compassionate care and provided emotional support. People who used the service told us that they felt involved with their care. They had understood the care and advice offered to them.
- The trust planned and delivered services that met peoples needs and were responsive to the changing needs of the population. We saw evidence of innovation in care to meet the needs of the local population and hard to reach groups. This included one health visitor who services for parents who misused substances. This service took into account equality and diversity needs and that of vulnerable groups.
- There was access to translation and interpreting services and staff said that they had knowledge of the trust's interpreting policy. Staff were aware of local links into services for new migrants and lesbian, gay, bisexual and transgender (LGBT) community.
- Services were easily accessible for children and their families. There was flexibility in how these were provided to suit individual need. There were minimal complaints about the service and these had been dealt with in a timely manner.
- There was a clear vision for the service that was child and family focussed and demonstrated innovation. There were systems in place linking governance, risk management and quality measurement at service and board level. Staff said that they were aware of these and that all levels of management, including the chief executive were visible and accessible.
- Although the community management level was currently interim pending re-configuration, this had not affected staff morale. Staff told us that they worked in an open culture and were given the opportunity to develop individually and as teams. There was evidence of engagement with both the public and staff members. We saw evidence of staff and public feedback. This was used to drive and improve services.

Summary of findings

- There were many examples of innovative practice aimed at increased access to services for children and their families. These were evaluated to ensure that staff understood and could learn from both successes and failures.

Summary of findings

Background to the service

Information about the service

Community services for children, young people and their families included universal health services and health promotion (health visiting), Family Nurse Partnership (FNP), childrens therapy services for the 0-19 age group in addition, the service included the school age children's immunisation team including looked after children.

The trust provided services for a large geographical area of approximately 450,000. Children and young people made up 24.3% of the population of Calderdale. 23.1% were from a minority ethnic group. The health and wellbeing of children in Calderdale was mixed compared to the England average. Infant and child mortality were similar to the England average.

The level of child poverty was worse than the England average with 20.1% aged under 16 living in poverty. The rate of family homelessness was better than the England average. The level of five year old children who had dental caries was 39.2% which was worse than the England average. 8.4% of 4-5 year olds and 18.2% of school age children were classed as obese (CHIMAT 2016).

During inspection we visited 8 locations. We spoke with 5 managers, 18 health visitors, 1 student health visitor, 3 family nurse partnership nurses, 3 child development workers, 13 mothers, 4 fathers, 4 immunisation team nurses and interacted with 10 infants and young children. We reviewed 20 child health records. We observed with consent practice in clinics and families' homes.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Care Quality Commission

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: including consultants, specialist nurses, community nurses, therapists and a nurse director.

Why we carried out this inspection

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

How we carried out this inspection

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

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

The inspection team inspected the following eight core services at Huddersfield Royal Infirmary and Calderdale Royal hospital:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning

Summary of findings

- Services for children and young people
- End of life care
- Outpatients and diagnostics

The community health services were also inspected for the following core services:

- Community adult services
- Community end of life
- Community children's services

Before the announced inspection, we reviewed a range of information that we held and asked other

organisations to share what they knew about the hospitals. These included the clinical commissioning

group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

We held stalls at Calderdale Royal Hospital and Huddersfield Royal Infirmary on 29 February and 1 March 2016 and provided comment cards and boxes at a number of locations across the organisation. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection.

Focus groups were held with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients, families and staff from all the ward areas, outpatient services, community clinics, and in patients' homes when visiting with District nursing teams. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

What people who use the provider say

- Between November 2015 and January 2016 children's community service patients responses to the friends and family test were too low to consider whether results were of stastical importance. These were recorded in November and December 2015 where both months recorded scores of 100% families recommending care.
- We saw compliments about services. An example of this was a letter to the children's physiotherapy service. "Without your detailed explanation with patience I would not have been so relaxed like I am right now. Your guidance helped my baby to crawl, stand and walk".
- During our inspection ten CQC forms 'tell us about your care' were received. All of these told us that they had received good support and respectful advice from health visiting and child development staff. They told us that clinic areas were hygienic.
- We spoke with children and their families. We found evidence that staff practiced compassionate care and provided emotional support to children, families and other professionals.

People who used services told us that they felt involved and understand the care and advice offered to them.

Good practice

- We observed outstanding care in response to the recent severe floods. Staff continued to provide good and effective compassionate care in alternative venues. Families who had been forced to move were supported to link into emergency projects.
- We saw outstanding practice in multi agency work. The health visitor who had protected time in a substance misuse project and the health visitor with a special interest in domestic abuse linked in seamlessly changed sentenceas suggested. original sentencedeleted by error

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should continue to escalate, take an action plan forward and meet with stakeholders about therapy service provision.
- The trust should audit the effectiveness of the pathway between midwifery and the health visiting service.
- The trust should ensure that staff are informed about new tendering arrangements as they develop.

Calderdale and Huddersfield NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the service as being good for safe because;

- The trust had appropriate incident reporting structures in place.The trust investigated and reported incidents in line with an appropriate policy. We saw evidence of the service sharing incidents with staff. Staff also attended learning lessons with other agencies.
- There were clear safeguarding systems to ensure children and families were protected from harm. Staff demonstrated knowledgable and experienced safeguarding practice. Staff levels were appropriate to the service and were in line with commissioned levels.There were no problems in recruitment and retention identified in the health visiting, immunisation team and family nurse partnership. Deficits in therapy service were mitigated.
- Staff received mandatory training and annual appraisals. They were mainly up to date with these. All staff had an awareness of the principles of the duty of candour although not all had formal training. They knew there was a policy about this on the intranet.

Detailed findings

Incident reporting, learning and improvement

- The service reported 37 incidents between January 2015 and October 2015. The most common incident reported concerned confidentiality and communication issues. There had been a slight increase from the previous year which staff told us was due to an increased awareness in reporting incidents. We saw evidence that refresher incident reporting training was planned for staff in the 2016 community division strategy report. 7 of the incidents related to health visitors not being informed of new ante natal cases relying on paper forms as midwifery services did not use System 1.

Good

Are services safe?

- We saw examples of managers following up incidents and appropriate action taken to alert staff to incidents and the outcomes. This included e-mailing staff via the electronic reporting system. The service reported no 'never' events involving the care that they provided and recorded no incidents that the service considered to have caused anything in excess of moderate/permanent harm between January 2015 and October 2015.
- All staff we spoke with knew how to report incidents using the trust's electronic reporting system. An appropriate policy was in place. Once incidents were reported, the system flagged incidents with managers. Staff told us that incidents were acted upon promptly and fed back to the teams. We observed that there was now a link on the trust website which staff told us made it easier to access and complete.
- The service shared feedback from incidents at team meetings and one to one meetings with staff members. Managers told us that they also e-mailed staff separately and in addition to the electronic record system. This was because there was some uncertainty as to how effective the electronic system was. Staff told us that managers contacted them about incidents using the electronic record system or by e-mail.
- The service discussed learning from incidents and this was cascaded to staff by team meetings and the health visitor's forum. This forum had also completed a piece of work in December 2015 which had highlighted the importance of incident reporting and examples of how these were dealt with. We observed the training materials with information on. It was factual and clear, giving examples of where learning had changed practice.
- Staff told us that sometimes there were communication difficulties with midwifery staff. This had been mitigated by monthly meetings being arranged between health visiting and midwifery staff to share information.
- Staff told us that they were invited to external 'lessons learned' sessions. We heard of an example where important information about a father from another agency had not been shared. Interagency training had followed this episode.

Duty of Candour

- The duty of candour was introduced in 2014 to ensure that providers are open and transparent with people who use services and other 'relevant people' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- Staff we spoke with understood the principles behind the duty of candour. There had been a recent incident where the duty of candour had been carried out. This was about a child's development check which was carried out late. This had been dealt with appropriately and the lessons shared at the health visitors forum.
- Not all staff had received specific duty of candour training but were aware of the need to be open and transparent following incidents. The trust had a policy concerning the duty of candour. The trust's incident reporting policy also referenced the duty of candour and directed staff to the policy.

Safeguarding

- The trust had a comprehensive and up to date policy in place for safeguarding children. This included how to recognise concerns in and out of hours. Policies and procedures were in line with HM Government guidance 'Working Together to Safeguard Children' (March 2015) and local children's safeguarding board procedures. All information was available on the trust safeguarding site on the trust intranet. The trust had guidelines about female genital mutilation. There had been no known notifications.
- Safeguarding was strategically led by the head of safeguarding who managed the integrated team. The team contributed to section 11 audits and challenge events on behalf of the trust. The trust's annual safeguarding report was accessible on the intranet and set out clear information about progress and future planning. Named and designated professionals were represented on both local safeguarding boards and sub groups. We saw the last 3 sets of safeguarding board minutes from the local authorities which verified this.
- The trust provided training in line with the (Royal College of Paediatrics and Child Health 2014)). Some staff required a higher level due to direct working with children and their families. Level 1 was provided by

separate child and adult e-learning, level 2 by joint adults and children's e-learning, and level 3 separated adults and children face to face. All staff and managers we spoke with reported being up to date with level 3.

- Most staff we spoke with had received PREVENT training with an average of 90.9% against a trust target of 100%.
- Staff we spoke with were knowledgeable about safeguarding procedures and were able to give examples from their own practice. There was safeguarding supervision which was planned and additional support was available for staff when required. This allowed staff to share practice and understand the families on their caseload. We saw this recorded on System 1 and observed clear planning.
- Health visitors told us that they usually received safeguarding supervision every 3 months from the community named nurse in line with the NHS Health Service Specification (March 2014) and the Intercollegiate Document (2014).
- However, due to sicknessNamed Nurse in the safeguarding team_this was a potential risk Staff told us that this was mitigated by being able to access the hospital named nurse. Managers had initiated group supervision regularly and managers had the knowledge to provide advice on many cases for newly qualified staff. The trust was recruiting for a temporary secondment at the time of our inspection.
- Clinical supervision which could include safeguarding issues took place every 6 weeks for the health visiting teams. This included staff presenting cases to their peers including those outside their immediate teams, for discussion, challenge and learning.
- We saw an example of how a safeguarding concern was dealt with in clinic. The response to the incident was well managed and accurately recorded. The health visitor was not clear about whether an escalation process existed if other agencies did not share the same concerns about a child. However we saw that this did exist.
- All staff we spoke with demonstrated knowledge about safeguarding processes and knew how to raise concerns with senior staff and other agencies. They had specific knowledge about sexual exploitation and some had received external training. We saw that health staff were represented on a 3 tier multi-agency sexual exploitation strategy to share information to protect young people.
- However, when we observed one safeguarding issue in clinic, one member of staff was unclear about the escalation policies regarding multi agency work. We found within the trust there was an escalation policy and an associated multi agency escalation policy if staff did not agree with social care decisions.
- The trust provided a response to the Jimmy Saville enquiry (May 2015) although it had not been involved. This included checks for celebrities visiting the trust. There was ongoing work around employment checks in line with the NHS employment check standards. The trust had been audited internally and was compliant against these standards. We saw that the trust provided an update paper March 2016.
- We spoke with a specialist health visitor with a special interest in domestic abuse. She was in close communication with the multi-agency domestic abuse 'hub' which was a new initiative She was a resource for other health visitors and attended the Multi Agency Risk Assessment Committee (MARAC). Information was then given to the families' health visitor and records flagged.

Medicines

- All health visitors were nurse prescribers. 100% had received the appropriate training. There had been updates provided by the local university which most staff had attended. This was a rolling programme. There had been one prescribing error in the past year which was reported as a no harm event and dealt with appropriately.
- Prescription forms FP10 were kept in a locked cupboard in-between visits. They were observed not to be kept in cars.
- Vaccines used for infants were kept in the GP surgeries and therefore not considered in this inspection.
- The immunisation team based at St Johns used a cold chain with appropriate fridge storage. We saw that this was checked daily. Temporary storage boxes were used to transport vaccines in line with guidance.

Environment and equipment

- The trust did not own or manage all the locations used by staff. The family nurse partnership was based in a children's centre owned by the local authority. All rooms which had facilities for parents and babies were appropriately maintained. Equipment had been safety tested. Baby weighing scales had been calibrated recently and we observed stickers indicating the date tested. Scales were calibrated every 6 months.

Good

Are services safe?

- Most staff we spoke with told us that they had access to the equipment they needed. Staff had access to mobile phones and laptop computers for offsite working. There were occasional problems with signals in the area.
- A health visitor who delivered the Care of the Next Infant Programme (CONI) stated that occasionally equipment was a problem if families who had finished with equipment had not brought it back in a timely manner.
- The trust used medical device link to log new devices and to upload service dates for equipment. Staff were alerted to any items due for reservicing.
- Services which provided a women's group for vulnerable mothers who had substance misuse problems had safety locks on the door to the centre. This was a request from the women, some of whom had fled domestic abuse.

Quality of records

- We reviewed twenty records on the electronic 'System 1' database used by the health visiting, family nurse partnership nurses and therapy services. Staff had appropriately completed records with client details and demographics, clinical information, and communication with other professionals were fully documented. All were of good quality in line with professional guidance. They contained factual and comprehensive client information plans for care, which clearly documented and showed evidence of family involvement. There was evidence of evaluation and chronologies of significant events.
- Staff could show us the flags and icons on System 1 used to identify vulnerable families.
- We saw clear documentation of liaison with other agencies in a case where the mother was subject to domestic abuse and a plan of action logged.
- We saw that records were audited in a number of ways. The service was involved in the trust's annual record keeping audit. There was a peer review audit of record keeping underway. Clinical and administrative audits were carried out such as audits of scanned records to ensure the scan accurately reflected the paper record received.
- The immunisation team kept their own records which were scanned on the system and sent to the central child health department by the administration team. There was no backlog of these.
- We saw that the health visiting staff had oversight of the child development worker's documentation on System 1. The process which was in the health visiting guidelines and included that a task was put on the system to alert the health visitor that a visit had taken place and the entry was then checked.

Cleanliness, infection control and hygiene

- We observed health visitors using appropriate hand hygiene precautions including washing their hands when they provided care.
- The premises we visited were clean with infection and infection control and hygiene advice and instructions were displayed for staff and families. Health visitors and child development workers cleaned equipment in clinics and family homes.
- We saw evidence that appropriate hand hygiene audits had taken place in the community, however staff were unclear about results and whether there were links to the infection control team.

Mandatory training

- Children's community services had good figures for the completion of mandatory training. We saw that all service reached the 90% trust target for staff receiving mandatory training. Staff and managers told us that they were up to date with this.
- Health visiting teams also kept a log of their own training. All mandatory training data was held centrally on the Oracle Learning Management (OLM) system. 8 of the 10 mandatory training subjects were e-learning packages. Once these modules were completed within the OLM platform, an individuals' compliance was logged automatically by the system.
- PREVENT training was a classroom based session. Attendance at these sessions was confirmed by a signed delegate list, which was returned to the Workforce Development Team to manually inputted into the OLM system .Fire safety training was logged through a self declaration form which was available on the trust intranet. Once completed by the individual this is then returned to administrative colleagues in the estates and facilities division and then manually inputted onto the OLM system.In the light of the above , we noted that current training figures do not reflect the electronic record

Good

Are services safe?

- All staff we spoke with were aware how to access training via electronic learning. Health visitors also knew how to book face to face level 3 safeguarding training. Staff told us that managers supported them in completion of training.
- The electronic record could be accesses by managers. The system had a facility to provide e-mails to staff to highlight when training was due to be completed. Staff told us that they had received an e-mail if training was not complete.

Assessing and responding to patient risk

- The local child health profile highlighted a number of factors which made some children in the community more vulnerable. This included the number of children living in poverty with related problems. Staff showed that they were aware of this in their own practice and could help families access other services.
- Clear pathways were seen to refer to paediatric services where there were deviations from the normal limits of health and development. This included child protection medicals in association with other agencies as part of child protection investigations.

Staffing levels and caseload

- Staffing ratios were in line with local population needs and demographic information. Caseloads of individual teams were worked out by staff themselves at a weekly allocation meeting. This enabled staff to provide continuity of care and use local knowledge. Skill mix was also considered and newly qualified health visitors did not hold significant child protection cases. There was not a recognised acuity tool used in this process. Managers told us that there was ongoing work about this and they had looked at different models.
- As of January 2016 there were 59 whole time equivalent in post against an establishment of 59.80 health visitors. There were 12 child health development workers in post against an establishment of 12. The Family Nurse Partnership had 5 nurses in post against an establishment of 5. The immunisation team were staffed at a level of 10.2 whole time equivalent as planned. Sickness rates across the service was 3.7 % which was lower than the trust average of 4.5%.
- At the time of inspection we found health visiting caseloads were within Lord Laming's recommendations in 'The Protection of Children in England, a Progress Report (2009) which stated that there should be caseloads of fewer than 400. They were also in line with the 'National Health Visitor Plan 2011-2015' and staffing guidance from the Royal College of Nursing 'Defining Staff levels for Children and Young Peoples Services' (RCN 2015). No health visitor had a caseload over 300 at the time of our inspection.
- The Family Nurse Partnership had a maximum caseload of 25 families per nurse with 5 nurses including a supervisor. This is a prescriptive programme delivered with licence conditions. The programme provides specialist care and advice for teenage mothers less than 19 years of age having their first pregnancy. On our visit there was a nurse on sick leave. One of the nurses stated that they were at 'full stretch' but that they coped with the situation and had management support. The visits were undertaken by other nurses in the team and the situation was assessed regularly. The current caseload which took sickness into account was still within the guidelines at 25 families per nurse.
- The service had identified a shortfall of therapists working with children. This risk had been included on the services risk register. There had been a series of meetings and an action plan in progress. Actions included addressing recruitment and retention problems. Therapy services had a number of temporary contracts to fill vacancies. Sickness rates across therapy service were 2.7% which was lower than the trust average of 4.5%.
- Staff we spoke with were broadly happy with staffing levels and caseload numbers. They felt their caseloads were manageable and fair in the division of vulnerable families amongst their teams. They told us that at times completing their input into serious case reviews took up a considerable amount of their time.

Managing anticipated risks

- We saw that the trust had a lone working policy on the trust intranet. All staff we spoke with explained that that there was a process in place so that visits were risk assessed and that potentially aggressive families could be flagged on the electronic recording system.
- Staff sometimes attended homes in pairs and all staff spoken to said colleagues were always helpful in this situation. Staff kept information of their visits on their electronic calendar so that staff could see where they were.
- Staff carried mobile phones so that they could contact colleagues. Staff we spoke with knew of and could show

Good

Are services safe?

us the trust's agile working emergency assistance guide. This had been developed with the help of West Yorkshire Police. Staff had also received security training as a lone worker. There had not been any significant security incidents over the last year.

Major incident awareness and training

- The health visiting service and family nurse partnership had a major incident policy in place. The service displayed the policy in sites we visited and these were easily accessible.
- Staff were aware of how to locate the policy and that this contained details of how to handle a variety of situations. We saw good evidence that staff had dealt with the recent flooding in the area very competently, reorganising clinics and helping families who had lost possessions.

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.

Summary

We rated the effectiveness of this service as good because;

- We observed that staff practiced evidence based care.
- The service used technology to contact hard to reach groups of service users.
- There were good examples of effective multi agency working with external partners.
- Staff were aware of the principles of consent and we observed that they used this in practice.
- There were clear and accessible routes into other services.
- Staff told us that the school nursing services were now under the umbrella of a social enterprise organisation and that this did sometimes impact upon smooth transitions from health visiting to school nurses.

Detailed findings

Evidence based care and treatment

- In all services the National Institute for Health and Care Excellence (NICE) guidelines were followed. We saw minutes of a recently established patient quality and safety group for the community which stated that it was the community division's responsibility to ensure compliance to NICE guidelines by audit. The newly appointed quality and standards manager was to link with the main trust audit process.
- The family nurse partnership followed the programme as per licence (DH) to improve child health and development and improve parents economic self-sufficiency. There was a strict criteria and was aimed at first time mothers 19 and under. Staff at our inspection had been upset about some recent research which suggested that the programme had few short term gains in this country. This however had not affected their work ethos and they considered their work had long term benefits.
- The Healthy Child Programme was well established within the health visiting service (DH 2009). This programme was evidence based which focussed on pregnancy and the first 5 years of life. This was included in the trust's health visiting guidelines (2015). Additional services based on evidence were provided, including post-natal support groups and the positive impact on perinatal mental health (Public Health England 2009). Breast feeding rates were above the national average for initial feeding after delivery.
- The health visiting service provided through specially trained staff the Care of the Next Infant (CONI). This provides extra support to parents who have previously lost a baby to sudden death infant syndrome. This is a recognised national programme with a strong evidence base and audit system. This was collaboration between the NHS and the Lullaby charitable trust. In the period of 2015-2016 there were 7 cases of sudden infant deaths in Calderdale and 6 in Kirklees (CDOP 2016) which were monitored through the child death overview panel and there were identified links between this process and health practice. We saw evidence of advice given to parents against sleeping in the same bed as their baby.

Technology and telemedicine

- Both the health visiting service and family nurse partnership regularly used texting to contact parents.
- The 'first feeds' is now accessible on Twitter and a code was present on posters so that information could be scanned on a mobile phone and linked through an app.
- Staff were now agile working and there was a policy about this seen on the intranet. We saw staff using laptops to record information and mobiles to contact families and colleagues.
- We saw that agile working was still on the community risk register as some staff needed follow up training and did not feel confident in using their laptops. This was being addressed appropriately. New staff had training on induction.
- We heard mixed views on whether staff used laptops in homes as some staff felt it was a barrier to good communication. There was no definitive directive on this.

Patient outcomes

- The trust had achieved re-accreditation as United Nations Children's Fund (UNICEF) Baby Friendly status.

Good

Are services effective?

- The service carried out audits into the percentage of mothers who were breastfeeding. This showed that 79% of mothers were breastfeeding immediately after delivery. At the 6-8 week contact this had decreased to 43%. Staff told us that they felt the initial high figures were helped by the health visitors' antenatal visit. There was ongoing work between health visitors and midwives to prolong breastfeeding. Midwives visited mothers on day 2 and 5 post nasally and health visitors contacted them on day 7 in addition to the new birth visit.
- Health visiting initiatives were linked to public health needs as defined by the local child health profile (Child and Maternal Health Observatory CHIMAT 2015). These included working with children's centres in accident prevention and dental health. Accidental injuries and poor dental hygiene locally were above the national average figures and services were aimed to identify children at risk of poor outcomes. These initiatives were ongoing as children presenting to hospital with accidental injuries increased in 2015 from the previous year.
- We observed that a health visitor corroborated information from the emergency department with the G.P information system. The health visitor was aware of 3 recent emergency department attendances and the G.P held information about 2 other events from another area. There was a plan to visit the family as the mother had previously been anxious about the child's health. This was a good example of professional curiosity and joint working.
- The immunisation team undertook immunisations for looked after children of school age. This has been historically a difficult to reach group of young people. The current rate was 96.3% which was above the national average of 87%.
- Figures obtained from the trust showed that a significant number of developmental assessments were being completed late. This had been picked up as a complaint by one parent and the health visiting service used it as an example in their forum as an area for improvement. Recent public health data (CHIMAT 2015/ 2016) showed that the development stages of children leaving reception were significantly lower (55.3%) than the England average (60%).

Competent staff

- Staff appraisal rates were good. Health visiting staff had achieved 98.9%, child development workers 100% and the Immunisation team was 100%. Staff we spoke with told us they had received their yearly appraisals and felt that these made them feel valued. We saw a new model of health visiting appraisals trialled which contained health visiting specific issues including mentoring and nurse prescribing.
- We saw evidence that appropriate policies were in place concerning clinical supervision and safeguarding children supervision. However the named nurse safeguarding children for the community was on sick leave. The potential risk of this had been logged upon the risk register and we saw steps taken to mitigate that.
- All staff we spoke with told us that this had not impacted on the care given to families currently.Group supervision took place weekly. Family nurse partnership nurses had supervision from their supervisor on a weekly basis. This was evidenced and staff told us that they had received this.
- Additional training was available to staff. Staff told us that they were encouraged to apply for specialist courses appropriate to their role. New knowledge from training was rolled out at the health visiting forum. One health visitor told us that she had recently attended a 'train the trainers' course about effective working with parents who had alcohol problems.
- There were good links to the local university. A number of health visitors were practice educators and took health visiting students. Other staff also came on placements including student midwives, G.P registrars and student social workers. Staff told us that this had led to an active learning environment and brought in new research based ideas. Some health visitors were also registered as mentors for new staff and this was encouraged by managers.
- There was a well-established preceptorship programme in place for newly qualified health visitors. We spoke to 4 of these who told us that they had found the process consolidated their training.

Multi-disciplinary working and coordinated care pathways

- We saw good examples of multi-disciplinary team working in the service and with external agencies.
- We saw a clear pathway between health visiting services and midwifery. There had been occasions when this had

been problematic as community midwives did not use System 1. The current system was using a paper form. Staff told us that this had much improved over the last two months and helped by co-location in some areas.

- A clear pathway was observed for referral to school nursing service and vulnerable families were discussed face to face on transfer. There had been some problems when school nursing had gone to be managed by a social enterprise organisation. This was felt to be in the main because staff were no longer co–located and health visitors we spoke with felt that it was day to day contact which had been lost. Staff told us that this could be difficult in child protection case conferences as school nurses rarely attended due to capacity.
- We observed effective joint working between a health visitor and a child development worker on a home visit. They had the knowledge and skills for their roles and communicated well between each other and the family.
- We saw information sharing on System 1 between health visitors and GPs. There were monthly meetings between health visitors and GPs to discuss clinical issues and plans around vulnerable families. Some GPs used a different electronic system which made information sharing not as effective.
- Joint developmental assessments of children of two and three and a half years of age in conjunction with nursery staff were established with the benefits of two professional perspectives. In addition, the health visitors met with nursery staff on a quarterly basis to discuss plans for children in their joint care with parental consent.
- We observed a child protection core group with the consent of the parents. This was a complex meeting where a child protection plan was being moved forward. There was evidence of good communication between professionals and family members. The plan was clear to staff and family.

Referral, transfer, discharge and transition

- The health visitors were informed of pregnant women at the time of them booking for midwifery care and again at 28 weeks so that they could arrange the ante natal visit. All pregnant women were offered this service. Staff told us that on occasion this had not been smooth and last year there had been an incident where the health visiting service had not been informed of a woman with complex care needs. We saw that there had been 7 incidents where referrals had not been made to the health visiting service.
- There was a documented process for children transferring from health visiting to school nursing based within a social enterprise organisation. Managers told us that staff handed over the care of children with active cases or child protection plans face to face. The information about all other children was captured on an information form which passed onto the school nursing service. Staff told us that the process to contact the school nurses could be difficult as they rang a single point of contact which then generated an e-mail to the school nurse.
- Referrals between professionals in the health visiting service came in through the trust's electronic record system. The transition from the care of the family nurse partnership to the health visiting service when the child was 2 years of age was face to face with additional electronic information which we saw. We observed clear plans for families around the transfer of care.
- Family nurse partnership nurses told us that they had access to a number of specialist services for example substance misuse and domestic abuse. There were no significant waiting times for these at the time of our visit.
- For families who had recently transferred into the area and had been assessed in the previous area as being at universal plus tier of health visiting, then the two health visitors completed a verbal handover and where appropriate undertook a joint visit to the family. A joint visit promoted a seamless service. We saw guidance in the trusts health visitor guidance (2015).
- There were clear processes to refer in to therapy services. Referrals templates were on System 1. These had to be printed off and sent manually. The speech and language form included guidance on completion. Information shared between hospital and community services was by telephone or letter due to hospital services that did not have access to System 1.

Access to information

- The trust provided policies for staff on the trust's intranet. All staff we spoke with told us that these were easily accessible and we saw examples of these.

Good

Are services effective?

- Staff had access to laptops with wireless connectivity. This allowed staff to access the trusts record systems remotely. Staff told us that there were sometimes local signal problems.

Consent

- All staff we spoke with understood the principles and difference between the Gillick competencies and the Fraser guidelines. We were given examples how staff approached consent in practice. On an ante natal visit it was explained clearly to the mother about consent for immunisations and development checks.
- We saw evidence of patient consent that had been appropriately taken and recorded. When children were accessed in nursery care for their two and three and a half year development checks, parents were not always present, but had consented previously. This had been documented.
- During visits we saw that parents were shown their child's health records to ensure they agreed that they were accurate and that they understood the plan.
- Staff told us that they knew the trust had a consent policy. We saw this on the intranet. Guidance regarding children and young people was clear and the policy was in date.

Good

Are services caring?

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

Summary

We rated caring as good because;

- We spoke with families and observed care taking place. We found evidence that staff delivered compassionate care and provided emotional support to families and other professionals.
- Families told us that they felt involved in their care and understood the advice that was given to them.

Detailed findings

Compassionate care

- We observed compassionate care being delivered in clinic and home settings. One mother we spoke with told us that the health visitor had been very supportive when her baby had been recently seriously ill. They told us that that the health visitor had been concerned around their health and not only that of her baby.
- We spoke with 14 mother and 6 fathers over the inspection period. They told us that they felt respected and treated in a compassionate manner by friendly staff. One young father told us that they felt valued in their own right and had not expected to be included.

Understanding and involvement of patients and those close to them

- We attended a baby clinic at a health centre on three occasions and observed the care given to mothers, fathers and their young children. We spoke with parents who told us that they could ask any questions that they wished.
- We accompanied health visiting staff on ten home visits. We observed respectful and appropriate care. Parents told us that they felt they could ask for advice and trusted the information that the health visitor gave them. We observed parents being involved in the future plans for their children and being shown what was documented.
- Parents in one area were involved in the planning of a parenting group highlighting their own learning needs such as weaning and child development.
- Women were actively involved in the 'first feeds' programme to prolong breastfeeding and being asked their opinions in planning the programme.
- Young mothers using the family nurse partnership programme told us that they felt valued and that the service was flexible.

Emotional support

- Parents we spoke with at clinics and within home settings told us that they we were given emotional support by the staff that cared for them.
- We observed staff in clinics and home settings providing emotional support when parents or their child's care was discussed. We saw in clinic that a mother was not getting much support from her partner and said that she was tired. The health visitor dealt with this sensitively and offered a home visit the following week.
- We listened to telephone conversations from staff to parents where advice was required. We heard this being given in a friendly and supportive manner.

Good

Are services responsive to people's needs?

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

Summary

We rated the responsiveness of the service provided as good because;

- It planned and delivered services that met families' needs and were responsive to the changing needs of a diverse population and hard to reach groups. This included signposting to new migrants to services and ensuring full access to translation and interpreting services.
- Health visiting staff responded to local public health needs. One health visitor had protected time of one day per week to work with pro-actively with other agencies to provide services for those vulnerable parents who misused substances.

Detailed findings

Planning and delivering services which meet people's needs

- The health visiting service had identified initiatives in high impact areas. There had been proactive work with parents in the antenatal contact as regards breast feeding. Health visitors we spoke with told us that this was a factor in the high levels of breast feeding rates initially of 77% decreasing to 46% on discharge from maternity services. There was a slightly higher figure in Greater Huddersfield of 51%. Further work was under way to improve rates with close joint working between health visiting and midwifery services.
- The number of substance misusing young people who may also be parents was above the national average. This had been acknowledged and a health visitor had been given a days protected time to work along the specialist midwife for substance misuse to develop a service called 'positive recovery and midwife support' (PRAMS). This was a specialist role and the health visitor offered advice to other health visitors who supported substance misusing parents. A number of additional services were offered and included mindfulness sessions, contraception advice, mental health wellbeing, and assisting with established recovery programmes.
- There had been an initiative for health visiting staff to attend training regarding working with parents who misused alcohol. Local figures showed that these were above national average numbers. This training was being rolled out to other health visitors who had been unable to attend training.
- We observed individual requests for advice and support being responded to promptly. We accompanied a child development worker on a visit requested by a mother to discuss weaning and transfer of care to another area. Appropriate advice was given clearly and documented.
- We saw evidence of discussion with stakeholders and commissioners about planning and delivery of services in divisional and service meeting minutes.

Equality and diversity

- Children and young people under the age of 20 years made up 24.3% of the population of Calderdale. 22% of school children were from minority ethnic groups.
- Statistics from the trust showed that 90.4% of health visitors had up to date quality and diversity training in place at the time of our inspection and other staff over 85%. This was against a national average training rate of 67%. This training had been extended to include cultural awareness. The trust measured this in terms of a reduction of reported incidents of discrimination.
- The trust overall were moving equality and diversity issues forward, including its responsibilities in relation to the workforce racial equality standards which came into force July 2014 (NHS Equality and Diversity Council). These standards were set to ensure that staff members from black and minority groups had equal access to career opportunities and to encourage better board representation.
- The CEO had set up a BME network to oversee actions which included regular focus groups to contribute to the broader workforce strategy.
- We heard good examples that staff accounted for equality and diversity in their practice and ensured families received the right services to support them. For example new migrants from Eastern Europe were referred through to a local children's centre for support.
- Access to telephone interpreting services was available from a recognised provider, as was face to face interpreting services which were pre-booked. Staff told us that there were 47 languages spoken in the area so

Good

Are services responsive to people's needs?

that at times it was difficult to access timely translation face to face. We saw one reported incident where the interpreter had not arrived for a routine health visiting appointment so that the telephone service had to be used. The interpreting service was informed and addressed the problem.

- Staff told us that they knew how to access specialist services for those families where there were issues of sensory impairment. This included health staff and those in other agencies who were able to provide access to British Sign Language. We observed the hearing loop in clinics we visited.
- Staff told us that they knew of links into lesbian, gay, bisexual and transgender (LGBT) services. We observed a visit to a family where children had been born to same sex parents and there were no issues of discriminatory practice raised.
- The immunisation team held specific sessions in schools with translation services in order to inform parent choice and improve immunisation figures. This included evening sessions and linking into school activities. We were told that these were effective.

Meeting the needs of people in vulnerable circumstances

- The family nurse partnership provided care to vulnerable young mothers and their babies using the nationally established programme which started in the ante-natal period.
- The looked after children's services provided a service to young people who were looked after by the local authority under the umbrella of the social enterprise service. Younger children in foster care had initial assessments by the looked after children paediatrician and then by the health visitor where the foster carers lived. These were up to date and no backlog reported.
- The health visitors we spoke with were aware of the local public health problems which impacted on families' vulnerable circumstances. This included substance and alcohol misuse. There were ongoing initiatives to address these which included an alcohol information training programme and protected time for a health visitor working with other agencies to address health needs of this group in a non-judgemental way.
- The universal plus tier of the health visiting services provided a rapid response when a specific problem arose such as a sleepless baby or post-natal depression.
- Speech therapy service provided a group for children awaiting individual treatment so that advice for parents could start prior to a programme of work.
- Staff we spoke with told us that they thought the closure of Ebdon Health Centre had had a negative effect on some of the vulnerable families who may not have transport. There were other venues which could be attended and universal plus families were offered home visits.

Access to the right care at the right time

- The service used texts for communicating with some families and this had proved popular especially with some young parents.
- We saw that services had clear care pathways in place with easy to interpret care pathways documents. These provided clear guidance to staff on the correct service for the identified needs of the child. All staff we spoke with told us that they were flexible as was feasible in terms of venue and timing of appointments.

Learning from complaints and concerns

There had been 6 complaints since April 2015. The subject matter was varied and no themes had emerged. All staff we spoke with were aware of how to escalate complaints to managers. Managers we spoke to had experience and had dealt with complaints previously. The policy and process had recently been reviewed so that it was easier for families. There were no live cases to consider.

- All staff we spoke with told us that complaints and concerns were discussed and shared at team meetings and the health visiting forum. There had recently been a presentation regarding learning from complaints in the Dec 2015 and used examples from practice to discuss. This included a 2 year development assessment which was late. This had been resolved to the families satisfaction.
- Staff we spoke with felt that there was an open culture in the services in which they felt confident that complaints and concerns were addressed appropriately.

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.

Summary

We rated well led as good because;

- There was a clear vision within the health visiting service as to the provision of care developing within local and national guidelines.
- There was evidence of engagement with families and staff. We saw examples of innovation aimed at increased access to health care and multi-agency working. We observed evaluations of projects taking place to ensure that staff could learn from successes and failures.
- The vision of the services aligned with the wider vision and strategy of the trust and were implicit in the practice and the care we observed. There had been an effective response to the recent flooding which required a high level of reorganisation of services and support to families and staff members affected. The CEO had been out to visit flood affected areas and support staff.
- Staff we spoke with told us that the current interim management structure caused some anxiety as to long term stability. This included the concern that the service would go to the management of a social enterprise group as had happened with the school nursing service. Staff told us that these concerns were mitigated by the current interim managers having a broad understanding of the service and local knowledge. Despite uncertainties, this did not impact upon leaders who supported and drove services.

However;

- There were difficulties in the provision of children's therapy services reflecting national and local recruitment problems. The trust were sourcing an independent person to undertake a workforce review.

Detailed findings

Service vision and strategy

- The service was aligned with the trust vision, values and strategic goals. We found that staff practiced these and there was evidence of staff being empowered to provide innovative and progressive care.
- Staff told us individually and in a focus group that they were aware of the trust's vision and strategy. They gave us comments about the service, or example; 'in Calderdale we have a good, strong health visiting service and have managed to hold onto the health promotion programme even when we were short staffed prior to the health visiting implementation plan. This put us in a better place to build upon the health promotion plan rather than having to re-establish it".
- All staff we spoke to had been involved in aspects of the development of services. Where mitigating actions were required, for example with therapy services, staff felt involved in decisions.
- Staff had concerns about the long term future of the health visiting service, family nurse partnership and immunisation team given the interim management structure. However, there was no evidence that this affected innovation and development.

Governance, risk management and quality measurement

- The service had clinical governance and assurance systems in place. There was a new interim safety and quality lead in post that had developed a risk, governance and compliance plan (February 2016). This included development and training for staff in audit skills and to demonstrate practice assurance. This action was a response to a risk in the community division which raised a concern that compliance assurance and improvement frameworks were not embedded in practice.
- There was a system for linking governance, risk management and quality between service level and the board. There was a director of community services, to whom the leader in health the health visiting service reported represented the service on trust clinical and corporate governance bodies
- We saw that the divisional risk register contained other identified risks within the service. Where the service identified risks, we saw that mitigating action was in place. An example of this was in relation to the community safeguarding children named nurse being on sick leave. There were alternative supervision

strategies in place and at the time of our inspection, interviews took place to recruit for a temporary secondment. There was no evidence of common themes across risk although there had been no harm incidents of poor communication between midwifery and health visiting services.

- Management staff had access to electronic information that highlighted key performance data for their service. This included mandatory training figures and key performance indicators. This helped them to identify risk and monitor quality.
- The trust encouraged services to form part of the local clinical networks. The health visiting service also encouraged staff to be part of multi-agency forums so that learning could take place.

Leadership and culture within this service

- All staff we spoke with told us that they were proud to work for the trust and children's service. Individual staff and those we met in focus groups told us that there was a god team working culture. We observed sharing of knowledge and experience in teams.
- Staff were encouraged to access additional and specialist training at university level. They told us that managers were supportive of study leave.
- Staff we spoke to had an understanding of the changing NHS, commissioning and the current uncertainties around tendering for services. Managers were aware of the worries staff had around this.
- There was a clear appraisal process which health visiting managers had devised to acknowledge health visiting roles in addition to the trust process. This included nurse prescribing and role specific mentorship.

Public engagement

- Staff had a clear understanding of public engagement and showed us that they did that in a number of ways. There had been an engagement process prior to the launch of the 2 year old integrated assessments.
- All staff we spoke with were aware of the 'your opinion counts' form used by the trust. There would be a re-launch of this over the coming year as response rates generally across the trust were low.
- The health visiting service was developing the 15 steps challenge process to ask at the first contact with families what they thought were their first impressions of the service.
- In accordance with the family nurse partnership licence, young mothers who had been cared for the family nurse partnership took part in the interviews by prospective team members.
- Parenting education included parents highlighting their own needs and setting their own programmes. Staff told us in one team that they were planning regularly monthly sessions 'ask the nursery nurse' also known as child development workers in the trust.
- We saw that the immunisation team had developed their own public website which was easy to access and included feedback forms. It also included the use of Twitter.

Staff engagement

- The latest friends and family test survey showed that 49% of staff would recommend working at the trust and that 77% of staff would be happy to receive care.
- The trust generally had low levels of staff leaving the health visiting service, family nurse partnership and the immunisation team.
- Staff we spoke with individually and in the focus group felt engaged by the service. We heard examples of staff involvement in service development. For example health visitors were involved in the Building Community Capacity initiative. This work focussed on work with communities to improve health and build self-reliance. This included regular 'buggy walks' which had evaluated well with positive feedback such as "good to get out there and meet other mums. Good for physical and mental wellbeing".
- We saw evidence of a 'back to the floor' plan where senior staff had planned visits to work areas over the services. This had followed an action from the 2015 staff survey.
- The chief executive engaged with staff via regularly updated e-mails. All staff we spoke with knew who he was and several had met him in community engagement meetings. Two health visitors had e-mailed him and had received a personal reply. There was an 'ask the CEO' button on the intranet for easy communication.
- We found evidence of regular team meetings for the health visiting service and family nurse partnership and therapy services. We reviewed the minutes of these meetings and found that they were well attended by all grades of staff and there was evidence of open discussion of all issues.

Good

Are services well-led?

Innovation, improvement and sustainability

- The health visiting service had achieved the implementation plan 2011-2015: a call to action (DH 2011) to improve access to services and identifying vulnerable children.
- We saw examples of innovation within the service. There was a culture that supported and sought improvements. Examples we saw were directly aimed at improving care and indirectly through staff support. Examples included;
  - Integrated two year and three and a half assessments along with nursery staff. This allowed for assessments to have both health and education input. Health visitors also met with nursery providers on a quarterly basis to discuss the health and social needs of children in their joint care.
  - Additional tools to provide health visitors' appraisal system in addition to trust documentation. This included mentorship and nurse prescribing. Managers told us that this was being evaluated and had good feedback from staff.
  - Protected time for a health visitor to work alongside the substance misuse specialist midwife in the positive recovery programme (PRAMS). The aims of the programme were to improve access to antenatal and postnatal care with a group of women who often felt stigmatised.
  - The 'first feeds' initiative with midwives which included getting opinions from women to prolong breast feeding.
  - Health visitors had won a second place in the trust's award 'celebrating success' for their antenatal work with parents. This included an awareness programme 'what to expect in the first few weeks with baby'. We saw the training materials for this and it was very informative. Health visiting staff were proud of their achievement. The feedback from families was positive. One young father stated that it was the most useful course that he had ever been on.