Locala Community Partnerships C.I.C.

1-256729774

Community health services for children, young people and families

Quality Report

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Date of inspection visit: 11-14 October 2016
Date of publication: This is auto-populated when the report is published

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)
1-285685765	Batley Health Centre	Services for children, young people and families	WF17 5ED
1-285685809	Cleckheaton Health Centre	Services for children, young people and families	BD19 5AP
1-285685783	Dewsbury Health Centre	Services for children, young people and families	WF13 1HN
1-584666529	Dewsbury and District Hospital	Services for children, young people and families	WF13 4HS

This report describes our judgement of the quality of care provided within this core service by Locala Community Partnerships C.I.C. 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 Locala Community Partnerships C.I.C and these are brought together to inform our overall judgement of Locala Community Partnerships C.I.C

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Overall, we rated this service as good because:

- There had been no never events or serious incidents reported between April 2015 and August 2016. Incidents were investigated and reported in line with policy. We saw evidence of the service sharing learning with staff and there was evidence of changes to practice in response to serious case reviews. There was a broad understanding of the duty of candour and evidence of it being implemented. Staff were experienced in safeguarding children and recognising risk, and safeguarding supervision took place on a regular basis. Staffing levels and caseloads were appropriate for the services provided and were in line with commissioned levels. However, there had been problems recruiting staff in children's therapy services resulting in capacity issues. The risks had been mitigated by temporary actions.
- Staff practised evidence based care and treatment and there was good evidence of effective multi-disciplinary working within the service and with external partners. There were clear and accessible routes into other services. Information technology supported mobile working and a single electronic patient record that was accessible to the multidisciplinary team. Immunisation rates and health visiting performance indicators met the expected targets. We saw optimum completion rates of health assessments for vulnerable children including looked after children and youth offenders. Most staff groups in the service had appraisal rates of between 90% and 100% and the overall rate for the service was 88%. Staff were aware of the principles of consent and we observed this in practice when attending clinics and home visits.
- We observed compassionate care being delivered in clinic, school and home settings. Children used the word 'kind' frequently in their feedback on care. Parents told us that they felt they could ask for advice and trusted the information that they were given. The Family and Friends test results demonstrated that children, young people, carers and parents were extremely likely or likely to recommend the service.
- Staff we spoke with had a clear focus on the needs of children, young people, carers and parents. The service planned and delivered services that met the requirements of current child health programmes. Therapy services including physiotherapy, occupational therapy and speech and language therapy, achieved 100% of assessments and interventions starting within 18 weeks. We saw that there was consideration of the diverse communities and public health needs. There was access to translation and interpreting services and staff were aware of local links into services for new migrants and the lesbian, gay, bisexual and transgender community. Services were easily accessible for children and their families and there was flexibility in how these were provided to suit individual need. There were minimal complaints about the service and these were dealt with in a timely manner.
- The service vision and aims were aligned with the corporate vision and staff were passionate about delivering a high quality service. The governance structure had been revised and was in the initial stages of implementation. Executive and service level leadership was visible and open to staff engagement. There was evidence of surveying staff regularly and acting upon negative feedback. Staff were involved in decision-making to support the significant changes planned to integrate health visiting and school nursing services. There was strong engagement with families and children in the community and evidence of acting upon feedback.

However:

- We noted and reported safety and cleanliness issues in the child development centre to management, which were acted upon immediately. There were no child-friendly furnishings or decorations except in the playrooms. Alternative accommodation was being sought at the time of inspection and this issue was listed as a service risk.
- We observed medicines for several children being prepared for administration at the same time in a clinical area. This was highlighted at the time of inspection and procedures were changed immediately as a result. We confirmed that practice had changed during the follow-up unannounced inspection.

Summary of findings

- Lack of capacity in the therapy services meant that follow-up appointments could be delayed.
- The escalation route for risks from front-line staff to the board and the criteria for submitting a risk for escalation were not clear.

Summary of findings

Background to the service

Locala Community Partnerships CIC provides community services to the population of Kirklees and Calderdale including health visiting, Family Nurse Partnership (FNP), looked after children, children's community nursing, child health information systems, children's immunisation, youth offending teams, pupil referral unit, school nursing, paediatric speech and language therapy, paediatric occupational therapy, paediatric diabetes service and paediatric physiotherapy.

Specialist nurses provide care to children in the community at health centres and via outreach services. At the time of inspection, the health visiting, school nursing and FNP services were in the process of service redesign to incorporate the 0-19 health care partnership model.

Kirklees Unitary Authority has a population of 428,000 and children and young people under the age of 15 years make up 20% of the population of Kirklees; 37% of school children are from a minority ethnic group. In Year 6, 18.3% of children are classified as obese. Levels of teenage pregnancy, breastfeeding and smoking at time of delivery are worse than the England average. Infant mortality is worse than the England average (Kirklees Unitary Authority Health Profile, Public Health England, 2015).

During our inspection, we visited four registered locations and seven further locations from which services were delivered. We visited services including health visiting, school nursing, community nursing, the youth offending team, the FNP, the looked after children team and therapy services at the Child Development Centre at Dewsbury and District Hospital. We attended home visits and observed clinics with the health visiting team, nursery nurses, paediatric diabetes nurse and speech and language therapy team. We attended vaccination sessions with the immunisation team. We spoke with 34 members of staff and 38 parents, carers and young people. We reviewed eight sets of records on SystmOne and held a focus group with health visitors, specialist nurses and school nurses.

Our inspection team

Our inspection team was led by:

Chair: Carole Panteli, Director of Nursing (retired)

Team Leader: Berry Rose, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a safeguarding specialist, a governance specialist, professional lead nurse for children's integrated therapy and nursing service, district nurses, a community matron and an occupational therapist. Additionally, there was an expert by experience who had experience of community health services.

Why we carried out this inspection

We inspected the following community health services as part of our comprehensive community health services inspection programme:

- Community adults services (including end of life care)
- Community inpatient services
- Community dental services
- Community services for children, young people and families

How we carried out this inspection

Locala Community Partnerships CIC provides a range of primary care and community services. These are GP services, community health services (as listed below), sexual health services and primary dental care. We didn't

Summary of findings

inspect all of these services in October and November 2016. In October and November 2016 we inspected the following community health services provided by Locala Community Partnerships CIC:

- Community adults services (including end of life care)
- Community inpatient services
- Community dental services
- Community services for children, young people and families

We have not rated Locala Community Partnerships CIC as a provider for each of the five key questions or given an overall rating because we did not inspect how well-led the organisation was in relation to all the services that it provides.

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

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

Before visiting, we reviewed a range of information we hold about the four community health core services that we inspected and asked other organisations to share what they knew. We carried out an announced visit from 11 to 14 October 2016. We carried out unannounced visits on 27 and 28 October 2016 and 4 November 2016. During the announced inspection we held focus groups with a range of staff who worked within services we inspected including nurses, therapists, doctors and support staff. We also interviewed senior staff in each of the core services we inspected and executives. We talked with people who use the services. We observed how people were being cared for, talked with carers and/or family members, and reviewed care or treatment records of people who used the services.

What people who use the provider say

We spoke with 38 parents and children over the inspection period and heard many positive comments from families and carers of children and young people about the services provided. Parents told us that they felt respected and treated in a compassionate manner by friendly and caring staff. While on home visits, two mothers with children requiring complex care told us about the importance of the help and support they had received from the community nurses with caring for their children at home. In the immunisation clinic, parents told us that they felt they could ask for advice and trusted the information that they were given. We saw schoolchildren seeking reassurance from the school nurse and being happy with the support received.

Good practice

- Staff we spoke with had a clear focus on the needs of children, young people, carers and parents.
- Information technology supported mobile working and a single electronic patient record that was accessible to the multidisciplinary team.
- Health visitors provided rotational cover between 5 to 8pm for telephone contact with families for a variety of problems, with the aim of reducing the number of families who attended the accident and emergency departments at local NHS trusts.
- Staff were able to access leadership and management courses to develop their leadership role and have influence on the development of service specifications.
- The youth offending nurses had developed a pathway with the youth offending psychologist to identify those young people who had unrecognised mental health problems. This was instrumental in young people being diverted from custody to community programmes.
- The looked after children service was communicating with the local adult asylum health team to support a small number of unaccompanied asylum children who had come into care and presented challenges around medical and family information.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider **MUST** take to improve –

- Ensure that there are in operation effective risk management systems so that risks can be identified, assessed, escalated and managed.

Locala Community Partnerships C.I.C.

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- From September 2015 to August 2016, thirteen incidents involved errors in administering vaccinations. We saw evidence that appropriate actions took place in response to the investigation of these individual incidents; however, no root cause analysis had been done to identify trends or improvements to the process for administering vaccinations.
- We noted and reported safety and cleanliness issues in the child development centre to management, which were acted upon immediately. There were no child-friendly furnishings or decorations except in the playrooms. Alternative accommodation was being sought at the time of inspection and this issue was listed as a service risk.
- We observed medicines for several children being prepared for administration at the same time in a clinical area. This was highlighted at the time of inspection and procedures were changed immediately as a result. We confirmed that practice had changed during the follow-up unannounced inspection.

However,

- There had been no never events or serious incidents reported between April 2015 and August 2016. Incidents were investigated and reported in line with policy. We saw evidence of the service sharing learning with staff and there was evidence of changes to practice in response to serious case reviews.
- There was a broad understanding of the duty of candour and evidence of it being implemented.
- There were safeguarding systems in place to protect children and young people from harm. Staff were experienced in safeguarding children and recognising risk, and safeguarding supervision took place on a regular basis.

Requires improvement

Are services safe?

- Staffing levels were appropriate for services provided and were in line with commissioned levels. There had been problems of recruitment in children's therapy services; however, the risks had been mitigated by temporary actions.

Safety performance

- Locala Community Partnerships CIC ('Locala') was involved in the investigation of two Serious Case Reviews during 2015/2016. We saw evidence of learning being identified, shared and acted upon in response to the findings and staff we spoke with were aware of these changes. Changes included strengthening and auditing reflective supervision arrangements.

Incident reporting, learning and improvement

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. No never events were reported by the service between April 2015 and August 2016 and there were no severe harm incidents during the reporting period.
- Policies relating to the management of incidents were in place and all staff we spoke with knew how to report incidents via the electronic reporting system. Staff told us they were confident that incidents were acted upon promptly, investigated thoroughly and the outcome fed back to the teams.
- The service reported 630 incidents between September 2015 and August 2016. There were 623 no harm incidents, four low harm and three moderate harm incidents. None of the moderate harm incidents was relevant to the Duty of Candour as none related to harm to a patient. Two of these incidents related to staff and one to an incident not directly involving the service.
- Themes and trends resulting from incidents were monitored and appropriate action was taken. The most common theme concerned communication errors and the failure to receive or late receipt of an antenatal referral from the local midwifery service. This was related in part to midwifery services not having access to the community electronic patient record system. However, we were told that local midwifery services notified the health visiting team by phone of mothers of concern, had read-only access to the Locala incident reporting system to alert them of late or omitted referrals and had direct meetings with the Heads of Midwifery to strengthen communication. Arrangements were made for mothers and babies to be visited as soon as a problem was identified.
- We saw examples of managers investigating incidents and appropriate action taken to alert staff to incidents and the outcomes. Feedback was provided by emailing staff via the electronic reporting system, discussions at team meetings and at one to one meetings with staff members.
- Staff told us that they would learn about an incident in another team if it was considered useful for professional learning. This would be through monthly bulletins, team meetings and safeguarding supervision.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health services to notify patients (or other relevant persons) of certain incidents and provide reasonable support to that person. Staff were aware of the need to be open and transparent but less aware of the implementation process for the requirements of the Duty of Candour. However, there was evidence of the Duty of Candour being implemented in relation to a serious information governance incident in November 2015 that involved the loss of personal identifiable information for a number of patients. This was reported to the Information Commissioner's Office, which was appropriate. All patients involved were notified with an apology and action was taken to cease keeping hard copy lists.

Safeguarding

- All staff we spoke with were clear about their roles and responsibilities regarding safeguarding children and young people and how to escalate safeguarding concerns. Locala 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 children safeguarding board procedures and all information was available to staff on the intranet.
- There was access to guidelines about female genital mutilation and staff demonstrated awareness of the

policy; however, there had been no known notifications. There had been extra local training on child sexual exploitation and staff we spoke with understood their roles and responsibilities in multi-agency planning and activities.

- Locala provided safeguarding children training in line with the Intercollegiate Document 2014 – Royal College of Paediatrics and had adopted an adult learning theory approach in 2016 to enable a flexible programme of safeguarding children learning based on individual learning needs. The new approach required staff to complete modules on the electronic staff record (ESR) and to self-declare they meet the required competences at the level to which they are assigned. The time taken to develop the modules and implement roll out of the new approach, accompanied by both national and local issues with ESR resulted in reporting issues.
- Training rates for the service in August 2016 were obtained from the safeguarding team. For safeguarding children Level 1, the rate was 65%, for Level 2, 78% and for Level 3, 71%. The training levels were below target for two reasons: the implementation of the new training approach in 2016 and data reporting issues on the electronic staff record (ESR). The reporting issues were still being resolved at the time of inspection and training levels were expected to meet requirements by March 2017.
- Safeguarding was strategically led by the head of safeguarding and the team contributed to Section 11 audits and challenge events on behalf of Locala. Locala'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.
- Safeguarding Named Nurses worked in partnership with the service and there were safeguarding champions and facilitators in every team. Staff received safeguarding children supervision in line with Locala policy. The policy indicated different levels of supervision dependent upon the role and clinical qualification of the practitioner. The supervisors were in turn supervised by the safeguarding team members. Safeguarding supervision rates for teams within the integrated children's business unit for Quarter One 2016/17 varied between 72% and 100%. We saw that peer auditing occurred in safeguarding and supervision records.
- The service was involved in the investigation of two Serious Case Reviews (SCRs) during 2015/2016. An SCR takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening in the future. We saw evidence of learning being identified, shared and acted upon in response to the findings and staff we spoke with were aware of these changes. These included strengthening and auditing reflective supervision arrangements.
- Staff reported that invitations to child protection case conferences had increased, particularly for school nurses. This had led to prioritising which conferences to attend and if not attended, there was a process whereby the relevant information was relayed to the conference chair.
- Staff could describe why it was important to document groups and relationships in the family in order to safeguard children. The computer system used a flagging system to indicate if a child was subject to a child protection plan or was looked after. This meant that practitioners were aware if there were any safeguarding concerns when they accessed a child's records. Staff showed us the flags and icons used to identify vulnerable families and children.

Medicines

- Locala had a medicines management team and systems in place to manage the ordering, storage, administration and disposal of medicines. There were procedures for the safe handling and use of vaccinations, packing and transport of vaccines and monitoring of fridge temperatures. We saw staff following the guidelines appropriately and evidence of good practice, for example, fridge temperature checks and an immediate response when the temperature was found to be above the upper limit.
- There were 31 medication incidents between September 2015 and August 2016. Eight incidents involved a break in the cold chain for vaccination storage and 14 incidents involved administration of vaccinations. We saw evidence that appropriate actions took place in response to the investigation of these incidents; however, no root cause analysis had been done to identify any trends or potential improvements to the process for administering vaccinations.
- Medicines were securely stored and handled safely in most areas. Nursing staff were aware of the protocols for

handling medicines to ensure the risks to people were minimised and told us that their processes had been validated by the medicines management team. However, we observed medicines being prepared for several children at once in a school treatment room "to save time". This increased the potential for risk of giving a drug to the wrong patient and this had occurred in May 2016 (with no harm caused). The nurses told us that the action taken following this incident was to introduce the use of a trolley to place one basket of medicines on the trolley at a time while giving medicines. The remainder of the baskets were kept ready and prepared on the counter.

- We reported this risk to management and the practice was immediately changed to ensure that medicines were prepared for one patient at a time. We observed medicines being prepared for one patient at a time during the subsequent unannounced inspection.
- 'Rescue' medications (as needed medicines) to treat episodes of conditions such as asthma or epilepsy accompanied children to school each day. These were locked in the treatment room and administered by the community nurses as and when required according to the prescription. Education staff received annual training to administer these medicines if nursing staff were not on site. Similarly, an injection to reverse anaphylactic shock was readily available to administer if required and education staff were trained to do this.
- We saw that prescription forms (FP10) were kept in a locked cupboard in between visits and were not kept in cars.
- Information provided to us by the service stated that all health visitors were nurse prescribers and had access to training updates provided by the local university. This meant children and young people had timely access to medicines and treatment.
- We saw evidence that patient group directions (PGD's) were in use and up to date. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor (or dentist).

Environment and equipment

- We found the environments were clean and tidy but not all were suitable for children and their families. The child development centre (CDC) had no child-friendly furnishings or decorations and uncovered low-level electrical sockets were observed in the waiting area. This was reported to the manager who had socket covers put in place immediately. The front door lock had not been working properly prior to the inspection and there was open access to children and their families in the reception area at the time of inspection. The reception area was not directly monitored or attended by staff.
- We saw a fire risk assessment for the CDC building, which was undertaken in September 2016. Recommendations included improving evacuation signage and placing evacuation aids at appropriate locations. There were no members of staff trained as fire wardens at the time of our inspection but there were plans in place to address this.
- A health and safety assessment had also taken place for the CDC building prior to our inspection. Recommendations included securing the window blinds so that they did not pose a ligature risk to children and the disposal of equipment which was not fit for purpose.
- Integrated Children's Services was liaising with the building owner to implement the fire, health and safety assessment recommendations for the CDC. The environment at the CDC was recorded as a risk for the service and management was planning to relocate the CDC to premises that were more suitable.
- We observed a broken window in the health visiting office at a health centre. This had been reported to the facilities management company who work for the owner of the building.
- We found all the equipment in use was clean and had been safety tested and serviced where required. Weighing equipment was calibrated every six months and staff were aware of the process to follow if they needed to report any faults. The majority of staff told us they had enough equipment to deliver safe care and had no problems ordering equipment.

Quality of records

- We reviewed eight records on the electronic SystmOne database used by all the teams working within Integrated Children's Services including health visitors, school nurses, community children's nurses, FNP nurses, youth offender nurses and therapists.
- Staff had appropriately completed records with client details, demographics, clinical information, and communication with other professionals was fully

documented. All records were in line with professional guidance. They contained factual and comprehensive client information plans for care, which were clearly documented and showed evidence of family involvement. There was evidence of evaluation and chronologies of significant events.

- We saw clear documentation of liaison with other agencies and plans of action logged. In addition, nurses who were based in the multi-agency support hub had access to and documented in SystmOne in addition to viewing social care databases. We saw that the nurses based within the youth offending service also accessed SystmOne and the youth offending electronic systems, which facilitated appropriate information sharing.
- Records were audited in a number of ways including peer audits in the different services and the annual record-keeping audit. Staff we spoke with felt this had been constructive.
- Staff had access to mobile phones and laptop computers for offsite working but there were problems with connectivity reported in some areas. Staff were unclear if they could download patient records to work offline but reviewed records prior to visits and completed updates after the visit if necessary.

Cleanliness, infection control and hygiene

- Staff were aware of safe infection prevention and control (IPC) measures and knew how to access the IPC policy on the intranet. The clinics we visited were visibly clean and tidy. We observed staff using hand gel to clean their hands and adhering to the bare below the elbows guidance, in line with national good hygiene practice.
- All clinical staff were required to undertake hand hygiene audits every quarter following the 'Five Moments for Hand Hygiene' (World Health Organisation, 2009) which outline the five key moments when hands should be cleaned during care delivery such as before touching a patient. The audits are recorded electronically for each staff member. Compliance scores were monitored via performance and service managers within the Business Unit, alongside the IPC operational group and were reported to management quarterly.
- The majority of staff had undergone infection control training in the last 12 months. The level of compliance across the service in June 2016 was 89%, below the expected target of 100% but anticipated to improve before the year-end.
- We reviewed hand hygiene audits carried out within the service and noted the overall compliance rate was 68%. This was due to 87 out of 252 staff not having their audit either completed or results uploaded at the time of inspection. For the 165 results uploaded, compliance was 97%. The overall compliance rate was anticipated to improve once audits were completed and results uploaded.
- We saw personal protective equipment was readily available for staff to use and we observed staff using it appropriately. In baby clinics and on home visits, we saw that equipment was cleaned after every use using cleaning wipes. Toys were cleaned using antibacterial sanitary wipes after every use in the playroom at the CDC. However, the sensory room at CDC did not appear to be clean. This was reported to management and action was taken immediately to improve the cleanliness.

Mandatory training

- All staff we spoke with were aware of the mandatory training programme and how to access it. The overall compliance rate for the completion of mandatory training for integrated children's services was 99% in 2015/16. The compliance rate across the service in August 2016 was 85% with the expectation that this would rise by the end of the year. The target mandatory training completion rate was 100%. Staff told us that managers supported them to complete their training.
- The electronic system recording training compliance for each employee could be accessed and monitored by managers. The system had a facility to provide emails to staff to highlight when training was due to be completed. Staff told us that they received a reminder email when training was due.
- Staff received a taught face-to-face course which incorporated both adult and paediatric life support. As of August 2016, the service was at 78% compliance. Staff were expected to have completed or to have booked on training by the end March 2017 with the exception of those on maternity or long-term sickness leave.

Assessing and responding to patient risk

- In the eight sets of health visiting records, we observed patient risk assessments were completed appropriately and updated as required. These included child health and the environment in which the child was living.

Requires improvement

Are services safe?

- We saw evidence of school nurses using the 'Team Around the Family' (TAF) assessment framework. This allowed for early identification of additional needs. For example, if a parent had mental or physical health issues that required hospitalisation, staff used the TAF to coordinate the response and prevent escalation of needs.
- There was a commissioned sexual health clinic run by the school nurses at one secondary school to support young people with sexual health issues. Young people were referred to the Contraceptive and Sexual Health Services if required.
- Where limitation of treatment agreements were in place, the ambulance service were made aware of these. These agreements are in place when decisions have been made to limit treatment in life-limiting and life-threatening conditions in children.
- 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 medical examinations in association with other agencies as part of child protection investigations.
- Locala did not employ a paediatrician but community nurses told us they could contact the GP and paediatric consultant staff at the local NHS trust for medical advice if needed.
- In the children's community nursing team and health visiting teams, daily handovers took place. One purpose of the meeting was to highlight any risks and allocate resources appropriately. Health visitor handover was face-to-face if the child was changing health visitor within the service. Information was also transferred on SystmOne. If a child moved out of area, then the handover was electronic supported by a phone call if the child was vulnerable and in universal-plus services.
- The local child health profile highlighted a number of factors that made some children in the community more vulnerable. This included the number of children living in poverty with related problems and recent problems with child sexual exploitation. Staff showed that they were aware of this in their own practice and could help families access other services. We saw child sexual exploitation and domestic abuse assessment templates included as part of the patient record.

Staffing levels and caseload

- 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 cases. They were also in line with the 'National Health Visitor Plan 2011-2015' and staffing guidance from the Royal College of Nursing 'Defining Staffing Levels for Children and Young People's Services' (RCN 2015). No health visitor had a caseload over 300 cases at the time of our inspection. The health visiting team had a demand and capacity tool, which would produce allocations by using data from SystmOne inputs; however, this was under review to make it more effective at distributing the workload. Each day a duty health visitor who managed referrals and coordinated activity when required.
- However, the August 2016 risk register referred to the health visiting service being down by 12 whole time equivalents including two team leaders with a further expected reduction of three wte health visitors. Managers were monitoring the impact of reduced capacity and escalating the issue to the Director of Quality.
- The Family Nurse Partnership previously had a maximum caseload of twenty-five families per nurse with five nurses including a supervisor. This was a prescriptive programme delivered with licence conditions. The programme provided specialist care and advice for teenage mothers aged less than 19 years of age having their first pregnancy. At the time of inspection, there were significant changes planned and awaiting ratification within the national FNP programme. These included a reduction to 3.6 whole time equivalent (wte) nurses over the last year and a reduction in caseload to ten mothers in the new model of proposed working in line with the new Integrated Kirklees Healthy Child Programme Service Specification. We were told that the rationale to reduce the caseload was to ensure that those in the most vulnerable of circumstances were given more clinical time where necessary. It was planned for each locality to have an attached FNP nurse who would cover several teams and provide a source of expertise and training to health visitors and other professionals.
- The school nurses reviewed the numbers of children on child protection plans, children in need or being looked after on SystmOne at least monthly and allocated cases to ensure the work was fairly distributed. The school

nurse team leader liaised with the operational manager if there were issues with work demands. The team used the capacity and demand tool but were awaiting a review of the tool.

- Health visitors 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 reported that there had been an increase in the number of vulnerable families within their caseloads but understood that this was a national picture. The team monitored the overall caseload on SystmOne and aimed to keep work within the cluster areas. Work was allocated on a weekly basis to team members on a pro-rata basis. A duty system was in place daily to manage information and referrals into the service.
- The children's community physiotherapy service transferred from the local NHS trust in November 2015. Due to difficulties recruiting to a vacancy, staff had had an increased workload since that time. This was documented by management as a risk and efforts to recruit continued at the time of the inspection. Staff had raised concerns about achieving follow-up appointments in a timely manner and this was being monitored by management.

Managing anticipated risks

- Each service had a business continuity plan in place and staff were aware of actions to take such as in the event of adverse weather.
- Health visitors and school nurses could document on the electronic record system an alert to inform other practitioners of any potential risks in a household, for example domestic violence.

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 effective as good because:

- Staff practised evidence based care and treatment and there was good evidence of effective multi-disciplinary working within the service and with external partners. There were clear and accessible routes into other services.
- Information technology supported mobile working and a single electronic patient record that was accessible to the multidisciplinary team.
- Immunisation rates and many of the health visiting performance indicators met the expected targets.
- We saw optimum completion rates of health assessments for vulnerable children including looked after children and youth offenders.
- Most staff groups in the service had appraisal rates of between 90% and 100% and the overall rate for the service was 88%.
- Staff were aware of the principles of consent and we observed this in practice when attending clinics and home visits.

However:

- Key indicators for the recording of breast-feeding rates and completion of maternal mood reviews were low and we did not see these listed on the service's risk register document as a risk or addressed in improvement plans.
- We saw that there were problems with connectivity for professionals when mobile working, which intermittently affected the completion of work.

Evidence based care and treatment

- Children and young people's needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence based guidance. Policies and procedures were based on guidance produced by the National Institute for Health and Clinical Excellence (NICE) or other nationally or internationally recognised guidelines.
- All health visitors, school nurses and the family nurse partnership nurses we spoke with were aware of the guidelines relevant to their practice. They followed the national initiative called the Healthy Child Programme (0-5 years). This is a Department of Health programme of early intervention and prevention for health visitor contacts with babies and children. It offers regular contact with every family and includes a programme of screening tests, immunisations and vaccinations, development reviews and information, guidance and support for parents.
- Health visitors used Ages and Stages Questionnaires (ASQs) as part of their assessment of children. This is an evidence-based tool to identify a child's developmental progress, readiness for school and provide support to parents in areas of need.
- Family Nurse Partnership (FNP) is a voluntary health-visiting programme for young and first time mothers. It is underpinned by internationally recognised evidence based practice. The FNP team used a nationally recognised assessment tool - Dyadic Assessment of Naturalistic Caregiver – Child Experiences (DANCE). This is a validated clinical tool, which a family nurse uses to assess the quality of a parent/child relationship and identify areas of strength and areas for growth in parenting behaviours. It formed the basis of programmes of work with mothers and their babies.

Nutrition and hydration

- Health visitor care pathways included those to monitor children with faltering growth or obesity. Staff referred children to the appropriate service if support was required such as the GP, dietician and paediatric specialist care.
- We observed baby clinics led by nursery nurses. The information and advice provided followed national guidance, for example, not introducing solid foods until six months of age.
- Training was available for staff on the use of feed pumps to support those children who were tube fed.

Technology and telemedicine

- Staff told us and we observed that all patient records were managed on an electronic patient record management system. Each nurse had a laptop to

Good

Are services effective?

facilitate mobile working and many of the staff we spoke to were positive about the advantages of mobile working and communicating electronically rather than by phone where that was appropriate. They said that it had made a positive difference to the way they worked. For example, activity and tasks were managed electronically and staff used electronic meeting software for some meetings to reduce travel and use work time more effectively.

- The service regularly used texting to contact families to remind them of appointments, for example for therapy and immunisation appointments. Staff told us that this had reduced the Did Not Attend (DNA) rate.
- The diabetes specialist nurse could carry out consultations with young people and their parents or carers by using a video link, which reduced the need for a journey to the clinic.
- We were told that connectivity to the Locala system could be a problem in some areas and this meant that records had to be updated once a connection was available or at the end of the shift. We observed this happening when accompanying nurses and health visitors on home visits. Staff were unsure whether records could be downloaded to access information prior to visiting but reviewed records prior to visits and updated these as soon as possible after the visits.
- We saw from meeting minutes that a user group was in place to support ongoing development of the electronic patient record system.

Patient outcomes

- We saw evidence that patient needs were thoroughly assessed before care and treatment started and there was evidence of care planning. This meant children and young people received the care and treatment they needed.
- From April 2015 to March 2016, the immunisation rate for the measles mumps and rubella (MMR) diphtheria, tetanus, polio and pertussis in children was 98%.
- 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 immunisation rate for this group at the time of inspection was between 84% and 87% (England average rate 87%). The Locala target for this indicator was 95%.
- The number of mothers who received a first face-to-face antenatal contact with a Health Visitor at 28 weeks or above as a percentage of new birth visits was 88%. This was better than the target of 80%.
- Data provided showed that between July 2015 and June 2016, 87% of birth visits were done within 14 days against an England average of 87.6%. Reasons for visits not done within 14 days included babies who were still in hospital, parents cancelling appointments and mothers moving to stay with relatives.
- In the same reporting period, 68% of babies received a six to eight week visit by the time they were eight weeks old. The England average was 81.6%. We were not aware of a plan to address this performance.
- 89% of children received a 12 month review by the time they were 15 months old (England average 82.1%) and 87% of children had received a two to two and a half year assessment (England average 76.3%), (Health Visitor Service Delivery Metrics Quarter 1, 2016/17, Public Health England)
- The rate for breastfeeding at six to eight weeks from April to June 2016 was 21%, which was worse than the England average of 42.2%. However, the percentage of infants for whom the breastfeeding status was recorded at the visit for the same period was 47%. Team Leaders had started to monitor this being recorded more closely through monthly reports.
- The maternal mental mood review is completed between six and eight weeks after delivery. The service followed NICE guidance to assess mothers' emotional health and the percentage of mothers who received a maternal mood review by the time the infant was aged eight weeks was an average of 88%% from April to September 2016.
- Looked after children receive statutory health reviews to identify health interventions and engage in their own care. The initial review takes place within twenty days of a child coming into the care of the local authority. The number of reviews completed within the twenty day timeframe was between 96% and 100%, which was better than the key performance indicator (95%).
- The number of further review health assessments completed for looked after children ranged between 80% and 100% (Kirklees area had a target of 98%). The catchment area received looked after children from

other local authorities. These children had a review completion rate of 70%. This rate was explained by some children being seen by health workers from their own area if within a reasonable distance.

- The number of looked after children who accessed a dentist in the area varied between 50-100%. The Locala target was 100% for looked after children over eighteen months of age; however, systems were still developing to ensure there was accurate data on attendance.
- We saw that 100% of children who were on the caseload of youth offending service nurses had received health assessments, which met with standards of the youth justice board.
- The safeguarding team undertook audits of documentation of groups and relationships on SystmOne and monitored the quality of safeguarding referrals to social care and safeguarding supervision. We saw that improvement had been seen in the documentation of relationships, which informed safeguarding referrals.

Competent staff

- We were told that all staff new to Locala underwent a corporate induction followed by a local induction within the relevant service. There was a preceptorship programme in place for new health visitors and school nurses.
- Staff we spoke with told us they had received their yearly appraisals and felt that these made them feel valued. Most staff groups had appraisal rates of between 90% and 100% and the overall rate for the service was 88%. Review meetings were held twice a year. Additional training needs were identified through supervision and appraisals. Staff we spoke with were encouraged to seek additional training as necessary to develop their roles and they were supported in doing this by the management team.
- Examples of personal development objectives, which linked to overall service objectives included attaining dual qualifications as school nurse and health visitor to support and prepare for the introduction of the 0-19 service. Four health visitors and four school nurses were applying for dual qualification training. We spoke with a school nurse and health visitor who had already started training and were looking forward to achieving the dual qualification and future opportunities.
- Coaching and mentoring were provided and shadowing opportunities were arranged where there was an identified need. Nurses, therapists and clinical leads told us they received regular formal and informal supervision from line managers and peers. Informal supervision occurred on a daily basis. We saw evidence that appropriate policies were in place concerning clinical supervision and safeguarding children supervision. Staff told us that this was embedded practice and took place at least quarterly. Nurses from the family nurse partnership had weekly supervision meetings with their supervisor.
- We were told that Band 6 nurses in the school nursing service all had a specialist qualification in school nursing.
- There were good links to the local university. A number of health visitors were practice educators and took health visitor students. Other staff also came on placements such as nursing students.

Multi-disciplinary working and coordinated care pathways

- A tender had been submitted for operating an integrated 0-19 service. In preparation, the health visiting and school nursing services were planning a service redesign and review of care pathways.
- We saw good examples of multi-disciplinary team working in the service and with external agencies. For example, nurses who were based in the multi-agency support hub (MASH) worked with social care, sharing information according to clear guidelines in order to safeguard children and young people. We observed them following a family from referral to social care to the decision to hold an immediate strategy meeting to take immediate action to safeguard a child. They could demonstrate links to other agencies such as education, police and the youth offending service.
- The youth offending nurses had developed a pathway with the youth offending psychologist to identify those young people who had unrecognised mental health problems. This was instrumental in young people being diverted from custody to community programmes.
- Therapy services worked as part of a wider multidisciplinary team. The paediatric diabetes specialist nurses participated in a weekly multidisciplinary meeting with the local NHS trust.
- There was close liaison between health visiting and midwifery services and they were working together to improve communication between the services. There had been occasions when this had been problematic as

community midwives did not use the same electronic system and submitted referrals using a paper form, which was then scanned on the system. Health visitors took part in 'Team around the Family' assessment meetings, case conferences and professional meetings with a range of local services including the GPs, social services, safeguarding, specialist nurses and the local NHS trust.

- Many of those involved in the care of children, young people and families were able to access the same electronic record. All of the electronic records we reviewed had evidence of input from members of the multidisciplinary team.

Referral, transfer, discharge and transition

- Clear policies and pathways were documented and in place for referral, transfer, discharge and transition of patients. A review of eight electronic records demonstrated effective pathways for referral to and between services and agencies.
- The family nurse partnership transferred families to the health visitor when the child became two years of age. This was a face-to-face handover in addition to completing electronic information. However, we saw changes to the service, which meant a number of children were transferred to the care of the health visitor at an earlier stage and we were unclear as to the criterion used.
- Family nurse partnership staff told us that they could refer to specialist services such as domestic abuse workers and there were no significant waiting times for these referrals.
- All pregnant women should be offered contact with a health visitor in preparation for the transfer to health visiting services. Health visitors were informed by midwifery services of pregnant women at the time of initial booking and again at twenty-eight weeks of pregnancy so that they could arrange an antenatal visit. However, from September 2015 to August 2016, 142 referrals were reported as late or not received. We saw arrangements were made for mothers to be visited as soon as this was identified. Maternity and health visiting services planned to discuss ways to improve the service.
- There were clear processes for the transfer of records if a family moved, by using the electronic patient records system. If a family was identified as vulnerable, there were additional telephone contacts and occasionally joint visits if the area was not far away. There were specific identified services for children and young people moving if there were safeguarding concerns, a child was on a child protection plan or had become looked after.
- Those children in universal services were transferred from the health visiting service to the school nursing service electronically. Those children who were in universal-plus services had a face-to-face to handover.
- There was a gap for young people between the ages of 16 and 18 years to transition from paediatric to adult services. This was due to the commissioning arrangements in place at the time of inspection and was a recognised and documented risk in the service. We saw evidence that children in need of continued services did continue to be treated until transfer to adult services could be negotiated with the relevant NHS trust. This would change if the tender for operating 0-19 services was successful.

Access to information

- Staff we spoke with told us they were able to access the information they needed to ensure they provided safe and effective care to children and young people. There were systems to manage and monitor care records and we saw this in practice with electronic patient care records.
- The intranet was available to all staff and contained links to current guidelines, policies and procedures. This meant staff could access advice and guidance easily. All staff we spoke with knew how to access the intranet and the information contained within.
- All staff had access to their work email and we were shown that they received organisational information on a regular basis including updates and changes to policy and procedures. Some policies such as safeguarding directed staff to inter-agency procedures and information.
- There were times when information was not accessible when mobile working due to signal issues but this was a known problem and Locala was working to improve connectivity. Staff were able to access information prior to attending appointments.

Consent

- Locala had a consent policy, which included specific preferences to children and young people. Staff told us that they were familiar with the policy, understood the principles of the Fraser guidelines and Gillick

competencies and applied these in practice. The Fraser guidelines refer to the guidelines set out by Lord Fraser in his judgment of the Gillick case in the House of Lords (1985), which apply specifically to contraceptive advice. Gillick competence is concerned with determining a child's capacity to consent.

- Consent was obtained from parents and children at each stage of their care. We observed a health visitor on a post-natal visit explaining clearly to the mother about consent for immunisations and development checks. We also observed staff using the consent process with parents and children during immunisation clinics and speech and language therapy sessions.
- School nurses worked within the guidelines to make decisions about whether young people had the maturity, capacity and competence to give consent themselves. Staff from all services told us they took into consideration the voice of children and young people when obtaining consent.

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 observed compassionate care being delivered in clinic, school and home settings. Children used the word 'kind' frequently in their feedback on care.
- Parents told us that they felt they could ask for advice and trusted the information that they were given.
- Children and young people gave positive feedback about the way in which staff listened to them and supported their needs.
- The Family and Friends test results demonstrated that children, young people, carers and parents were extremely likely or likely to recommend the service.

Compassionate care

- The Family and Friends test (FFT) was completed by children and families within each of the services. For health visiting, 98% of mothers were extremely likely or likely to recommend the service. For school nursing this was 91%, for the immunisation service, 99% and for community nursing 99%. We were not supplied with response rates for children's services.
- 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 she separated from her partner shortly after the baby's birth and that that the health visitor had been concerned about her health and not only that of her baby. The health visitor had given the mother contact numbers and had made suggestions about support services.
- We spoke with 38 parents and children over the inspection period. Mothers told us that they felt respected and treated in a compassionate manner by friendly staff. Feedback in the FFT survey included comments such as: "The health visitor has been fantastic and very supportive". School nursing was a "fantastic service and help", the youth offending team were "helpful, understanding, open-minded" and "helped open my mind to other options to help me". Children used the word 'kind' frequently in their feedback on care.
- We observed counselling sessions between the school nurse and schoolchildren and saw that the approach was caring, with opportunities for talking, listening and silent reflection.
- We saw children's community nurses interacting in a humorous and compassionate way with schoolchildren with complex health needs and the children enjoying and returning banter. We also observed the sensitive manner in which the community nurses interacted with mothers of very young children with complex health needs. The mothers reacted positively to the reassurance and support offered.

Understanding and involvement of patients and those close to them

- We attended a baby clinic at a health centre and a local library on two 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 spoke with two fathers who said that they felt involved and valued in planning their child's care.
- A child responding to a survey asking about their appointment with looked after children healthcare staff stated: "It was very informative and I felt safe and confident to ask questions". Three children rated the appointment positively because "She listened to what I said".
- Parents told us that they felt they could ask for advice and trusted the information that they were given. We accompanied health visiting staff on six home visits and community nursing on two home visits. We observed respectful and appropriate communication by the nurses and parents being involved in the future plans for their children.

Emotional support

- We observed staff in clinics and home settings providing emotional support to parents when their child's care was discussed. We saw on a home visit that a mother was struggling with her two young children and that strategies and referrals to other agencies were put in place with the mother's consent to help her.

Good

Are services caring?

- The immunisation team received feedback including: “My daughter has severe needle phobia. The nurse was aware in advance and was very calm, re-assuring and patient with her. It didn't matter how long it took to calm her and we got there in the end. Well done”.
- We listened to telephone conversations from staff to parents where advice was requested. We heard this being given in a friendly and supportive manner.
- Some staff said they did not use their laptop when visiting families if there was a sensitive issue to discuss as they felt it was a barrier to communication.

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 responsive as good because:

- Staff we spoke with had a clear focus on the needs of children, young people, carers and parents. The service planned and delivered services that met the requirements of current child health programmes. We saw that there was consideration of the diverse communities and public health needs.
- There was access to translation and interpreting services and staff said that they had knowledge of Locala's interpreting policy. Staff were aware of local links into services for new migrants and the lesbian, gay, bisexual and transgender 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.
- Therapy services including physiotherapy, occupational therapy and speech and language therapy, achieved 100% of assessments and interventions starting within 18 weeks.
- The service had tendered to operate the 0-19 years programme to improve services offered to children and young people. The commissioning gap in services to children 16-18 would also be resolved.

However:

- Capacity in the therapy services meant that follow-up appointments could be delayed.

Planning and delivering services which meet people's needs

- Locala had submitted a tender to operate a 0-19 service for children and young people. It was envisaged that this would provide a seamless service for families without the need for transition from health visiting services to school nursing. Benefits include improved outcomes for children and their families and early identification of difficulties and intervention (Public Health England 2016).
- The pupil referral service sought to make contact with young people and partners in education by attending breakfast clubs and assemblies at units to increase visibility and accessibility.
- The paediatric diabetes team led clinics in local health centres to provide an accessible service outside of the hospital setting.
- The paediatric physiotherapy department assigned two therapists to the new patient clinic so that one therapist could assess the child while the parents discussed their concerns with the second therapist. This reduced the length of the appointment and helped the needs of the child, particularly for children with reduced concentration or behavioural difficulties.
- We saw health visiting services responded to local need and offered integrated care into the local community. In North Kirklees, a pilot was underway to provide integrated assessments using Ages & Stages Questionnaires for all two year olds who attend childcare. The assessment involved the child, parents, child care provider and allocated health visitor.
- We observed a well-baby weighing session in a local library in a rural area at the same time that there was a story session for pre-school children. This allowed for mothers and fathers to see a health visitor close to home and bring an older sibling for story time. We spoke with three mothers who thought this was a valuable service and allowed them to meet with other parents.
- Duty health visitors and school nurses were assigned each day. This practitioner was available in the office during the day to deal with any issues that arose rather than having to wait until the named practitioner returned to the office, meaning calls from parents, social workers and other practitioners were dealt with straight away.

Equality and diversity

- Locala had an Equality and Diversity Group, which developed the Locala strategy for equality and diversity. Training data provided by Locala showed that Integrated Children's Services had achieved 59.4% for equality and diversity training as at August 2016. The target level for this training was 100% by March 31st

2017. Staff could describe the ethnic and religious diversity of the people who used their services and explained how they could make modifications to ensure they were culturally sensitive.

- Access to translation services was available from a recognised provider, as was face-to-face services, which were pre booked. Staff told us that there were more than thirty languages spoken in the area so 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 translating service was informed and addressed the problem.
- Staff told us that they did not routinely hold leaflets in other languages due to the high volume of different languages and that information soon went out of date. However, they knew where to access information in other languages on the intranet to print out.
- 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 availability of the hearing loop in clinics we visited.
- A small number of unaccompanied asylum children had come into care, which presented challenges around medical and family information. The looked after children service was communicating with the local adult asylum health team to support each other as necessary in maintaining the healthcare of asylum seekers. There were also links into schemes to assist eastern European families to reduce isolation and introduce them to local services.
- Staff demonstrated that they had links to support services for lesbian, gay, bisexual and transsexual (LGBT) families. School nurses told us that several pupils had attended their drop in service at school requesting this help.

Meeting the needs of people in vulnerable circumstances

- The family nurse partnership was undergoing significant change. Caseloads were reduced to a maximum of ten mothers and their babies from twenty-five. The family nurses were a source of expertise for other staff working with vulnerable young mothers.
- We observed that the nurses who worked in the multi-agency support hub (MASH) were able share appropriate information and health advice to other members of the multi-agency team with which to assess and plan care in a timely manner
- We observed that the nurses working in the youth offending team were part of the planning for vulnerable young people and were flexible in their approach.
- We spoke with the looked after children's team who in addition to ensuring statutory assessments were completed, were able to work with other agencies such as social care and children and adolescent mental health services.
- The pupil referral service aimed to address the needs of those children and young people, who could not maintain mainstream school attendance. We were told by management that health interventions such as smoking cessation contributed to the programmes to improve educational access and prevent anti-social behaviour

Access to the right care at the right time

- The health visiting service had recently established a duty system which operated from a base from 5 to 8pm to provide advice and support to families out of hours. Although an evaluation was still being completed, staff told us anecdotally that they thought this system may reduce accident and emergency attendances as most of the calls taken were regarding the management of minor illness. We observed a telephone call to the health visitor from a mother who was vulnerable and an appointment was made for a home visit the same day.
- The children's community nursing team were scoping the need to provide extended hours due to the local NHS children's assessment unit reducing hours of operation. This would allow the service to identify children who could be managed in the community and reduce hospital visits.
- Therapy services including physiotherapy, occupational therapy and speech and language therapy achieved 100% of assessments and interventions starting within 18 weeks. However, we were told by therapists that capacity issues meant that follow-up appointments could be delayed. The operational manager was undertaking a service review to assess accuracy of coding, performance reporting and capacity estimates. Capacity was supported by use of agency therapists and staff doing additional hours.

Good

Are services responsive to people's needs?

- The Pupil Referral Service offered out-of-hours visits if appropriate for families, for example for education, health and care needs assessments at home.

Learning from complaints and concerns

- Locala had a complaints policy and staff we spoke with knew how to access it. Staff felt the process was open and honest. Staff were aware of actions to take when concerns were raised and this included trying to resolve problems as they were raised.
- Integrated Children's Services received six formal complaints from September 2015 to August 2016. These were around staff attitude and the quality of service.
- In response to a complaint, a more robust process for communication was put in place if a child had a problem such as fainting after an immunisation. Any problem was recorded on the child's consent form and the nurse who cared for the child was responsible either for contacting a parent or ensuring that the school contacted the parent.
- We saw that complaints were a standing agenda item at clinical governance meetings in order to discuss lessons learned which were cascaded to staff through team meetings.

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:

- The service vision and aims were aligned with the corporate vision and staff were passionate about delivering a high quality service. All staff we spoke with told us that they were proud to work for Locala. Individual staff and those we met in focus groups told us that there was a good team culture.
- Leaders at executive and service level were visible and open to staff engagement. There was evidence of monitoring staff morale regularly and acting upon negative feedback. There was evidence of involving staff in decision-making to support the significant changes planned to integrate health visiting and school nursing services.
- There was strong engagement with families and children in the community through a variety of mechanisms and evidence of acting upon feedback.
- The governance structure had been revised and was in the initial stages of implementation. We saw evidence that the agenda for clinical quality was structured around risk and patient safety and meetings were well-attended.
- A comprehensive report was produced for the Business Unit Assurance Group which covered risks and mitigation for each of the operational areas and was supported by information on finance, business development, patient experience and human resource data.
- There was a designated non-executive director with responsibility for linking with the Integrated Children's Services Business Unit.

However:

- The escalation route for risks from front-line staff to the board and the criteria for submitting a risk for escalation were not clear.
- We did not see evidence that errors in administering vaccinations were considered for listing as a risk on the risk register or addressed in action plans.
- The KORS (key opportunities, risks and successes) template did not incorporate the date the risk was first recorded, the responsible officer or a target date for completion or review.

Leadership of this service

- Staff told us that members of the service management team were visible and accessible to staff. One specialist nurse described submitting an idea to the chief executive by email about specific training and received support to take the project forward. However, nursing staff we spoke to were unclear who the corporate professional lead was for nursing.
- Staff we spoke with individually and in focus groups were positive about their operational managers and felt that they were well supported. We saw that these managers were visible and would attend team meetings. They were aware of the uncertainty that staff felt around changes in the national Family Nurse Partnership programme and the potential changes that would be brought about by the transition to the 0-19 Healthy Child programme, if the tender for this service was won. They were also aware of the impact of recruitment difficulties leading to high workloads in some services. Action plans to manage these areas were clear and communicated to staff and staff were able to tell us about some of the expected changes such as the integration of health visiting and school nursing to increase the flexibility of the team and support the 0-19 programme.
- Staff were able to access leadership and management courses. A specialist community public health nurse (SCPHN) attending a leadership course described how they were being encouraged to develop their leadership role and have influence on the development of service specifications to ensure the principles of the SCPHN role was embedded in all specifications.

Service vision and strategy

- The service vision and aims were aligned with the corporate vision and for example, sought to 'exceed expectations' in the standard of service and 'work with service users to ensure an early intervention approach'.

Good

Are services well-led?

We found that staff were not always aware of the values of 'be caring, be inspirational, be part of it' as statements but in discussion and in practice evidenced their use. We saw the Locala vision statements displayed on the wall in the clinics we visited.

- The Integrated Children's Business Unit had a strategic plan (December 2015) which outlined in detail the objectives supporting each aim and included an action plan with milestones.

Governance, risk management and quality measurement

- The governance structure for the Integrated Children's Business Unit (ICBU) had recently been revised and from August 2016 held monthly meetings for three groups: Clinical Quality and Patient Safety, Finance and Performance, and Assurance. The terms of reference for these groups were being finalised at the time of the inspection.
- The Clinical Quality and Patient Safety group membership included quality, customer engagement, youth engagement, pharmacy, safeguarding, infection control, communication, estates and operational management from the ICBU. We reviewed two sets of minutes of the Clinical Quality and Patient Safety Group and saw that the meeting reviewed all aspects of patient safety including management of incidents, complaints, medicines management, information governance, safeguarding and infection control.
- The Clinical Quality and Patient Safety Group reported to the Business Unit Assurance Group where risks, controls and assurance were discussed for all operational areas within the unit such as quality, finance, performance and operational services. The agenda template for this meeting was being revised at the time of inspection.
- We saw two ICBU Assurance Reports written for the Assurance Group. This was a comprehensive report that covered the risks and mitigation for each of the operational areas plus information on business development, finance, patient experience and human resources. The report identified a number of risks relating to ICBU including recruitment challenges in therapy services, the lack of a formal service commissioned for 16-18 year olds, the possibility of relocating the children's development centre and the increasing safeguarding workload. From the Assurance Group minutes, it was not clear what the Assurance Group intended to report as key messages to the Scrutiny Committee.
- We did see evidence of ICBU risks being presented to the Scrutiny Committee but saw no criteria being applied to the threshold of risk that was brought to that committee.
- There was a designated non-executive director with responsibility for linking with the ICBU. Activities included regularly attending the quarterly business unit reviews and shadowing staff while they undertake their clinical roles.
- Risks were documented on a KORS (key opportunities, risks and successes) framework. The framework recorded risks, their grading for likelihood and impact, and a brief description of the action to be taken, but did not include the date the risk was first recorded, the responsible officer or a target date for completion or review.
- Each service within the ICBU had a KORS framework and risks were escalated to the business unit KORS. We were told by managers that risks were escalated from the business unit to the corporate KORS framework with agreement of the senior management team; however, we did not see evidence of this process in action.
- We did not see evidence that errors in administering vaccinations were considered for listing as a risk on the risk register or addressed in action plans.
- Team meetings were held regularly in all ICBU services and minutes taken. The agendas included updates on relevant incidents, complaints, audit and risk issues. Staff were being encouraged to participate in risk identification to add to the KORS document.

Culture within this service

- All staff we spoke with told us that they were proud to work for Locala. Individual staff and those we met in focus groups told us that there was a good team culture. We observed sharing of knowledge and experience in teams.
- Staff told us that they found it easier to implement changes in Locala, as there was not the level of 'red tape' found in other organisations.
- Staff we spoke with told us that they felt that they were kept informed and supported about the tendering and development of the 0-19 services. Staff had concerns about the long-term future of the health visiting and

school nursing services given the proposed changes. However, there was no evidence that this affected motivation and staff told us that they would accept change and support each other.

- The family nurse partnership had undergone significant change and staff told us that they had some anxieties about this but understood the constraints to deliver the service and felt involved in the process.
- Individual staff we spoke with could explain how their teams kept safe by team members calling the team leader to confirm their whereabouts and safety at the end of the day. They also informed each other if a visit was anticipated to be complex. Staff sometimes attended homes in pairs and staff we spoke to said colleagues were always helpful in this situation.
- Staff kept information of their visits on their electronic calendar so that others could see where they were and it was possible to indicate on SystmOne when the visit had concluded. Staff also carried mobile phones so that they could contact colleagues if needed. To support staff safety, there was a list of staff personal contacts details on SharePoint with protected and limited access.
- However, staff were less familiar with the Lone Working Policy and where to find it; we were shown a stand-alone flowchart that did not appear to be linked to the policy. The Lone Working Policy was under review at the time of the inspection.

Public engagement

- The service engaged with patients, carers and families in service developments in a number of ways. The public website had a facility to submit a feedback form directly to the customer liaison team and also published blog articles written by young people as part of the Young People's Network web page. The network was for 11-19 year olds and had over 90 members at the time of inspection. A Youth Engagement Coordinator had been appointed to support the various initiatives to engage with children and young people.
- Schoolchildren had been involved in designing new feedback methods that are more appropriate for children and young people. As a result, the wording was changed for some questions on the Family and Friends test and a new survey introduced for younger children. Children had also been consulted in the redesign of information literature on managing diabetes.
- The health visiting team had engaged with parents through a Healthwatch survey and through focus groups led by the Parents' Panel. Improvements included an extension to the advice line to 8pm, the development of self-weigh clinics and the introduction of a health visiting software application or 'app'.
- School immunisation and speech and language therapy services engaged with education representatives from 25 schools to discuss proposed service changes and how things could be done better. Improvements were proposed for training for teachers, managing referrals and the process for flu immunisation sessions in primary schools.
- The health visiting team, school nursing team and the family nurse partnership team each had a Facebook page. These were used to inform and update carers, parents and young people about the services provided. Family members used the site to give feedback on the services.

Staff engagement

- Staff received communication and fed back their views to management in a number of ways. There was an all staff newsletter sent out by email and a monthly team brief that was cascaded through the management structure and team meetings. We saw that team meetings within the service were held regularly, were well attended by all grades of staff and there was evidence of open discussion.
- Senior management attended individual team meetings with a set brief to share and the Integrated Children's Business Unit held a forum quarterly to discuss professional and organisational issues. Team leaders met as a group on a monthly basis to share updates and support each other. Weekly video link calls had been introduced with members of the management team so that staff could ask questions and receive updates.
- The Locala executive team engaged with staff directly and via quarterly staff surveys. We spoke to staff who had emailed the chief executive directly with ideas and had received a positive response. Staff had been asked to participate in choosing the quality priorities for Locala in 2016/17.
- The service was planning to have an engagement session in November 2016 to address the most recent staff survey in the Integrated Children's Business Unit, which indicated increased challenges around capacity and demand and the impact on working conditions.
- Staff we spoke with individually and in the focus group felt engaged by the service. We heard examples of staff

Good

Are services well-led?

involvement in service development for example participation in workshops on the redesign of school nursing and health visiting services where ideas were discussed and considered and updates on the process sent out to all staff.

Innovation, improvement and sustainability

- We saw examples of innovation, improvement and sustainability within the service. These included integrated two year and three and a half year assessments that involved nursery staff. This allowed 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.
- Health visitors provided rotational cover between 5 to 8pm for telephone contact with families for a variety of problems. It was envisaged over time that this would reduce the number of families who attended the accident and emergency departments at the local NHS trusts. Staff were positive about this development which was initiated by themselves. Locala was the only organisation and service in the local area to be offering out of hours advice for children and families.
- In some areas baby weighing sessions were being established in local libraries and linked into the libraries' toddler story-telling sessions to assist those families with preschool children.
- Nurses were established in the multi-agency support hub (MASH) situated in social care and demonstrated effective working with other agencies and a shared focus on children's safety and welfare.
- The youth offending team nurses were working with other professionals to identify those young people with conduct disorders so alternatives to custodial sentences could be considered.
- The pupil referral service identified those children who were struggling in education and sought to work with other agencies to prevent anti-social behaviour and unwise health choices.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (2) (b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity** **How the regulation was not being met** • Risks were not appropriately escalated and managed within the organisation. • Risk management tools were not robust. • There were not always robust and comprehensive action plans in place to mitigate risks.