Bradford District Care NHS Foundation Trust

Community health services for children and young people

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Community health services for children and young people

Requires Improvement 

We carried out this unannounced inspection of the community health service for children, young people and families, provided by this trust as we had concerns about the quality of the service provided.

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not have enough staff, there were several unfilled vacancies and staff were holding caseloads much larger than recommended by national guidance. Staff sickness and turnover levels were high.
- The service was unable to meet mandated contacts for children and young people. Aspects of the service were in business continuity which meant that not all services were being provided. There were waiting lists in place in the looked after children's team which meant that children waited for individual health assessments longer than they should, and this was not in line with national guidance.
- We reviewed 29 records during the inspection. Whilst the majority of records were detailed and consistent, we had concerns that five of the records did not meet the trust's standard in evidencing what action had been taken to address concerns in relation to risks such as domestic violence or mental health concerns. Managers were aware that this was an area of improvement for the service and were undertaking a records audit at the time of the inspection.
- The service worked on a risk-based approach whereby children were placed into four tiers dependent on need. We were concerned that in some cases late identification of health conditions and disabilities could occur for those children in lower tiers of need due to lower levels of oversight for these families.

However:

- Staff teams worked collaboratively and were encouraged to share ideas and give feedback on service development. Staff supported people to live healthier lives and thought of different ways to engage harder to reach service users.
- Staff treated children, young people and their families with compassion and kindness. Staff were passionate about the roles they performed and wanted to provide high quality care. Service users were encouraged to give feedback, which was largely positive. Staff recognised the importance of mental and emotional health as well as physical health and offered appropriate support and information to families.
- The service was beginning to consider and introduce some innovative ways of working to meet the needs of the local population.
- Leaders at all levels of the service were knowledgeable and passionate and sought to drive improvement. Strategies and development plans reflected the needs and challenges of the service and there were clear action plans in place detailing how improvement would be made. Staff were satisfied with their roles in the service and felt valued and supported.

How we carried out the inspection

During the inspection visit, the inspection team:

Our findings

• visited six locations

• carried out six home visits and one school visit

• spoke with the general manager and assistant general manager for the service

• spoke with 55 other members of staff including, service managers, school nurses, health visitors, staff nurses and nursery nurses

• spoke with nine service users including one young person

• observed the running of one baby clinic and one immunisation session

• looked at 29 care and treatment records of service users

•looked at a range of policies, procedures and other documents relating to the running of the service.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

During the inspection we spoke with nine service users, including one young person. We also observed interactions between staff, young people and their families during 10 appointments including at an immunisation clinic, school nurse clinic, baby clinics and home visits.

Service users told us that staff were friendly, helpful and approachable and would always give advice and respond to queries. They also told us staff were accommodating at rearranging appointments to support service users. We observed staff providing reassurance and support to those with concerns or worries. The majority of those using the service told us that staff were helpful, approachable and available to give advice and support. Staff took time to explain about the service and ensure service users knew what support was available to them. Service users were regularly requested to give feedback about the service to aid improvement, but staff were clear that they needed to do more to gain feedback from children and young people.

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing staff received and kept up to date with most of their mandatory training. However, there were two courses where compliance fell below the trust target of 80%; compliance with Safeguarding Children Level 3 (1 years) was 76%,

Our findings

and with Managing Aggression and Violence was 78%. Managers were aware of these shortfalls and indicated this was due to staff on long-term sickness leave and new starters who were in the process of completing induction, including training. Only staff of certain grades were required to complete Safeguarding Children Level 3 (1 years) and staff were up to date with all other Safeguarding Children courses, including Level 1 which was 98% compliant, Level 2 which was 86% compliant and Level 3 (3 years) which was 88% compliant.

Managers monitored mandatory training and alerted staff when they needed to update their training. Team leaders reported on staff mandatory training at monthly quality operations meetings with senior service managers. Managers were in the process of implementing a system to target staff who may be out of compliance and assign diary slots to training to ensure this was completed in a timely manner. Managers fed back that in some cases staffing pressures had affected capacity to attend training in a timely manner. We saw that managers were reminding staff of the importance of training compliance at team meetings.

The mandatory training was comprehensive and met the needs of children, young people and staff. Courses included basic life support, risk management, safeguarding and equality and diversity. The service also gave staff support and advice on sepsis as part of basic life support training as well as providing specific guidance on the trust intranet pages. Staff also attended additional mandatory training courses specific to the role, such as breastfeeding and relationship building, early language development and hip dysplasia.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. Staff undertook training in infant and perinatal mental health and could seek support from a mental health lead within the service. There were mental health pathways for staff to follow to support with identifying, assessing and supporting those at risk of poor mental health.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff completed mandatory training in safeguarding adults and children at several levels dependent on their role. Most staff were up to date with their training apart from those required to complete Safeguarding Children Level 3, where compliance was slightly below trust expectation.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act. We saw examples of safeguarding concerns being discussed during team meetings and actions being taken forwards.

Staff knew how to identify adults and children at risk of, or suffering, significant harm but did not always take action to protect them. We saw examples within care records of staff working alongside staff from the local authority to safeguard children and young people. In most records we saw good examples of staff working together to identify and manage risks, but within five of the 29 records we reviewed, it was not clear that staff had taken enough action when concerns were identified. For example, within one of the 10 care records we reviewed in the children's specialist service we found that recommendations from the trust's safeguarding team had not been followed up despite staff documenting in records that they were uncomfortable with the parent-child relationship observed during a visit. We raised these

concerns during inspection and staff assured us action would be taken to address this. In four records in the Bradford Health Visiting team there were concerns including no partner details being recorded when domestic abuse risk was identified and no follow up to GP concerns regarding a parent's agitation despite the case being stepped up in terms of tier allocation.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. In the six months prior to inspection staff made 198 safeguarding referrals. The service had a safeguarding team who supported staff with any concerns or with completing referrals. This team also had sight of all referrals to allow them to capture themes and trends.

Staff could access group safeguarding supervision to discuss cases of concern and those with caseloads of children and young people with known safeguarding risks present had to attend at least four of these sessions each year. Staff were also able to access support and advice from the safeguarding team at any time and could plan individual case supervision sessions as required.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were observed to wear masks when in direct contact with service users and followed appropriate hand hygiene techniques.

Staff ensured equipment was appropriately maintained and we observed staff cleaning equipment after patient contact.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. When providing care in children and young people's homes staff took precautions and actions to protect themselves and children, young people and their families.

Staff carried out appropriate checks of specialist equipment and staff had access to enough suitable equipment to help them to safely care for children and young people.

The service had suitable facilities to meet the needs of children and young people's families. Most visits took place in family homes, but clinics also ran in environments including schools and family centres. Schools ensured staff had access to private spaces to meet with young people, and clinics were observed to be appropriately clean with access to necessary equipment.

Staff disposed of clinical waste safely.

Staff had access to a lone working policy and could clearly describe lone working practices including the use of twice daily huddles to ensure staff safety.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff were not able to identify and quickly act upon children and young people at risk of deterioration due to low staffing and high caseloads.

Our findings

Staff completed risk assessments for each child and young person using a recognised tool. Staff undertook holistic assessments to understand what risks may be present.

Staff knew about, but did not always deal with, any specific risk issues. Staff had access to the same electronic system as GPs, and were able to share information with GP's and be informed by them. Known risks were flagged on the system under a specific tab so staff were clearly aware of them. Staff were given training and advice on how to discuss certain areas of risk with families, for example around safe sleep. However, within two of the records we reviewed we were concerned than an inconsistent safe sleep message was documented as being given to families. Staff were also given advice and guidance around domestic violence and how to make routine enquiries in relation to this, but it was not clear from this guidance how staff should act and explore this area when the partner was present. We observed a visit where routine enquiry was not completed due to a partner being present and were concerned that partner details were not documented in a record where domestic violence risks were present.

The service worked on a risk based approach whereby children were placed into four tiers. Universal children, universal plus children, children in need, and children in need of protection. The tier that children were placed into was dependent on the level of service they needed, focussing on children who were the most disadvantaged. We were concerned that this approach meant that the vulnerabilities of some children may be missed and that it would be more common for late identification of health conditions and disabilities to occur. The trust continued to work towards moving away from this model, and in May 2022 staff transferred back to providing care to all tiers of children rather than only to a specific group. The trust told us that work was ongoing from a strategic programme to build on a relational approach.

The service was following business continuity plans as a result of staffing risks and offered development pathways to staff to support with filling vacancies. For example, as the service was finding it difficult to recruit qualified health visitors and school nurses, they employed staff nurses with the agreement that the trust would support them through the Specialist Community Public Health Nursing (SCPHN) course to develop them to this level.

The service had good access to mental health liaison and specialist mental health support if staff were concerned about a child or young person's mental health. During working hours staff could seek advice about both perinatal and infant mental health from the service's perinatal mental health lead. Staff could also seek support from both adult and child and adolescent mental health teams within the trust, including crisis and first response services. However, staff told us that waiting lists for child and adolescent mental health services were long, particularly for Looked After Children, and that this could cause some difficulties in accessing the right care for them.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. There were specific service pathways in place to guide staff with escalating concerns and making referrals to other teams and services where necessary.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. Information was stored electronically and was easily accessible to service users' GPs. Staff also shared relevant information with others, such as with local authority colleagues in relation to child protection conferences.

Staffing

The service did not have enough staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment.

Our findings

The service did not have enough nursing and support staff to keep children and young people safe as the number of staff did not match the planned numbers. Staff working across the teams included health visitors, school nurses, staff nurses, nursery nurses and healthcare assistants but only qualified health visitors and school nurses held their own caseloads.

Managers calculated and reviewed the number of staff needed, in accordance with national guidance but struggled to recruit to some roles such as qualified health visitors and school nurses and had high vacancy rates in some areas. In Bradford it was calculated that the service required 93 full time equivalent Health Visitors and 16.6 full time equivalent School Nurses for the service to run effectively. However, at the time of inspection there were 22.4 full time equivalent Health Visitor vacancies and 9.9 full time equivalent School Nurse vacancies. In Wakefield it was calculated that the service required 51.6 full time equivalent Health Visitors and 8.9 full time equivalent School Nurses for the service to run effectively. However, at the time of inspection, there were five full time equivalent Health Visitor vacancies and two full time equivalent School Nurse vacancies.

The service had high turnover rates across the service. In the 12 months prior to inspection the turnover rate was 12.4%, with 67.4 full-time-equivalent staff leavers. Managers shared that there had been a high turnover in the Wakefield service due upcoming re-procurement of the service in this area. Managers were planning to introduce exit questionnaires for staff leavers to better understand the reasons for turnover. Whilst turnover was high, the trust had employed more staff in the last 12 months than had left, with 95.8 full-time-equivalent staff joining the service.

The service's overall sickness rate was 6.3% which was above the trust target of 4%. Managers recognised that levels of anxiety and stress were high amongst staff and were working to address this. Staff could access support through the trust wellbeing offer which included restorative supervision, mental health first aid and yoga. Managers were also conscious that stress levels were affected by workloads and were working on various recruitment initiatives to enable the pressure to be relieved from substantive staff.

The service had low rates of bank staff and did not utilise agency staff. Bank staff followed the same trust induction as permanent staff.

Due to low staffing levels staff across all teams were holding large caseloads. The Institute of Health Visiting recommends that caseloads should not exceed 250 children per full-time-equivalent health visitor, but staff in the Bradford teams were holding between 417 and 625 cases and staff in the Wakefield team were holding an average of 421 cases. Additionally, the Royal College of Nursing states that with regards looked after children there should be no more than 100 cases per full-time-equivalent nurse, but staff in this team were holding between 18 and 60 cases above this threshold. We were concerned about the ability of staff and managers to adequately manage and monitor the changing risks to children with caseloads significantly higher than national recommendations. Staff with high caseloads have less time to spend with children and their families and therefore early identification of risks and concerns may be missed.

Records

Staff kept detailed records of children and young people's care and treatment, but they were not always completed to a high standard across all teams. Records were up to date, stored securely and easily available to all staff providing care.

During inspection we reviewed 29 care and treatment records of service users.

Patient notes were not consistently completed to a high standard across all teams. We found that most records were detailed, demonstrated professional curiosity, and contained clear care and treatment plans. However, we also

Our findings

identified areas of concern in some records including staff not recording partner details when a risk of domestic violence was highlighted, and professional curiosity and challenge not being consistently evident. For example, where substance misuse and domestic violence were known risks, and inconsistent safe sleep messages were being documented. Some staff told us that they would complete notes in their own time due to being so busy, which could account for some of the quality concerns found.

Improving the quality of record keeping was one of the service's quality goals for the current financial year. Managers were in the process of auditing three records relevant to each staff member, and were discussing any areas for improvement with them individually. Managers were looking to collate results once complete to understand any themes or trends or specific areas for improvement and feed this back to the trust board, but had already identified improvement was required around documentation of action planning and voice of the child and were putting training in place to support staff. However, it was not clear how managers had come to the decision to only audit three records per staff member, and whether this was enough to identify all areas of concern considering some staff members had caseloads of up to 625.

Staff used standard templates to record information about patient care, but we found that the majority of records were still personalised.

Records were stored securely on an electronic system and all staff could access them easily through personal log-ins.

When children and young people transferred to a new team, there were no delays in staff accessing their records. The service used the same electronic system as other services within the trust, as well as GP services, which staff felt was very supportive in terms of information sharing.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Some health visitors had the required training to prescribe medicines for minor ailments such as oral thrush or skin conditions. Managers told us that from September 2022 non-medical prescribing would no longer be covered in basic training for health visitors and as such the trust were in the process of considering whether to cease non-medical prescribing activity in the service going forwards. Medicines other than those for minor ailments would be dealt with by professionals external to the service such as the service user's GP.

Staff who were non-medical prescribers had access to a medicines policy and non-medical prescribing framework as well as being invited to various teaching sessions on topics such as skin conditions and catheter care. Non medical prescribers received supervision, and audits were in place. However, supervision requirements were not clear in the policy and framework. Following the inspection, the trust confirmed that a further audit process to include dip sampling would be brought into action.

Nurses in the vaccination and immunisation service (VIS) team had access to adrenaline should a child or young person react negatively to a medicine.

Staff stored and managed all medicines and prescribing documents safely. Vaccines were stored safely in fridges at central locations and temperature of fridges was monitored daily.

Staff learned from safety alerts and incidents to improve practice.

Our findings

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents, serious incidents and near misses in line with trust policy.

Staff received feedback from investigation of incidents, both internal and external to the service and met to discuss the learning and feedback and look at improvements to children and young people's care. Staff could give examples of learning from serious incidents such as developing multi-agency information sharing procedures, and we saw examples of learning from serious incidents shared within safeguarding newsletters. The service had no never events.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. We saw examples of incident reports whereby children and their parents were given an apology and explanation when an error had been made at immunisation sessions.

We saw examples of lessons learnt from incidents and changes to practice required being shared within team meetings.

There was evidence that some changes had been made as a result of feedback. For example, following an informal complaint from a service user the process for monitoring upcoming assessment visits was amended to include more oversight and a more streamlined process.

However, during the inspection, we found that not all recommendations from a recent national child safeguarding review (into the unexpected death of a child involved with the service) were sufficiently embedded at the time of the inspection. For example, the review specifically recommended practice improvements in relation to domestic abuse yet we found that guidance for staff was unclear and we observed practice which did not address concerns about relationships.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident. Staff attended 'critical incident stress debrief' sessions and told us they felt very supported by managers following a recent serious incident, with a culture of learning rather than blame.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Our findings

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people in their care.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service pathways in place reflected the latest guidance from the National Institute for Health and Care Excellence (NICE) and were reviewed regularly to ensure they reflected the most up to date guidance. Staff also utilised guidance from the Lullaby Trust in relation to safe sleep and aligned workstreams according to The Department of Health, Healthy Child Programme framework with regards mandated contacts with children, young people and families. However, the service was struggling to meet these mandated contacts and business continuity plans had been put in place to reduce the number of visits staff conducted.

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families. During observations of interactions staff clearly placed a focus on all of a child's needs other than medical needs, such as maternal mental health and emotional wellbeing.

Patient outcomes

Staff monitored the effectiveness of care and treatment and outcomes met expectations.

The service participated in relevant national clinical audits. For example, the service had submitted information on the Healthy Child Programme mandated contacts for Bradford to Public Health England who had published the data on their website. It was unclear why figures for Wakefield were not made available.

Outcomes for children and young people were positive, and met expectations, such as national standards and staff used the results to improve children and young people's outcomes. The service used outcome measures in various areas of the service. For example, where concerns about perinatal mental health were present outcome measures were used to understand what service to offer and whether onward referral was required. The service also used audits, such as of breastfeeding mothers, to understand if interventions had been successful.

The service was striving for re-accreditation by the UNICEF Baby Friendly Initiative. Both Wakefield and Bradford teams had received assessments within the last 12 months. Wakefield were told they only had one action which was required before they could be fully re-accredited in the gold standard. Bradford had several actions which were required and had developed a comprehensive action plan to support them in reaching this goal.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was an audit schedule in place to ensure audits were repeated in a timely manner.

Managers used information from the audits to improve care and treatment. For example, through audit of care records managers identified that the voice of the child was not consistently considered and recorded. As a result, managers had arranged several training sessions for staff to build their knowledge and confidence in how to complete this part of the record.

Our findings

Managers shared and made sure staff understood information from the audits. Findings were shared both on an individual basis with staff members and at team level through business meetings. Staff were also given the opportunity to feedback on audits, for example the Quality Lead undertook an audit to review the use of newly created templates on the electronic system, and as part of the audit went to teams and asked for feedback and what they would find useful. Action plans were also shared with staff, so they were clear where improvements were required.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The clinical educators supported the learning and development needs of staff.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families.

Managers gave all new staff a full induction tailored to their role before they started work. Induction documents were detailed and provided information about the service as well as other relevant services within, and external to, the trust. They also included team specific competency frameworks and space to develop individual learning plans. There were also specific induction documents for preceptors to support their development.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of inspection 87% of staff across the service had received an appraisal in the last 12 months.

Managers supported staff to develop through regular, constructive clinical supervision of their work. At the time of inspection 87% of staff across the service had received clinical supervision as per the provider's policy. Staff also had access to restorative supervision through Professional Nurse Advocates (PNA) within the teams, and those holding more complex caseloads, typically children on Child in Need or Child Protection Plans, spoke of the benefits of this type of supervision as a safe space for discussing challenges and their feelings about them. Staff spoke positively about access to supervision and felt this was prioritised by managers. We saw supervision compliance discussed in team meetings with staff encouraged to ensure they were up to date.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings were taking place virtually and so recordings of meetings were also made. Staff also engaged in daily huddles, allowing the sharing of key information and ensuring staff were well and supported.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers were keen to develop staff internally and offered a variety of different career development and training opportunities dependent on role.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge through regular clinical supervision.

Managers made sure staff received any specialist training for their role. For example, those working with families and young babies were given training on breastfeeding.

Managers identified poor staff performance promptly and supported staff to improve. Staff described a culture of supportive development rather than blame or chastisement.

Our findings

Managers recruited, trained and supported volunteers to support children, young people and their families in the service. For example, the service had utilised volunteers in baby clinics and parenting support groups. Managers told us about the trust's 'volunteer to career' pathway which supported with recruitment for those volunteers looking to work for the trust in paid roles.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit children, young people and their families. They supported each other to provide good care and communicated effectively with other agencies.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Staff in several teams highlighted that it was positive to have a base from which to work in order to support one another. However, not all teams had identified bases to work from and so often staff worked entirely remotely. Some staff shared it was hard to build good relationships due to capacity and being too busy.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. Staff reported positive relationships with external colleagues such as those within schools but did share that it could be difficult to obtain information from the local authority when this was required. Staff reflected they were able to have positive and supportive information sharing with GPs as both used the same electronic system.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health. The service had specific pathways and referral documents that staff could utilise for guidance and support.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support. Staff utilised the service's social media accounts to promote information on healthy living to children and young people. They shared information on immunisations including when service users could access drop-in clinics, posted about mental and emotional health, and shared relevant information from other bodies such as the emergency services. Staff signposted service users to the service's website where there was a variety of health promotion advice. Staff also conducted face to face health promotion work, such as giving sun safe information within school assemblies and getting involved with Bradford 'baby week'. Staff in the Bradford vaccination and immunisation service team had also created an immunisation preparation programme to desensitise and support better health outcomes for those with autism, learning disabilities, anxiety and/or challenging behaviour.

Staff assessed each child and young person's health and provided support for any individual needs to live a healthier lifestyle. For example, staff provided information to parents on safe sleep and how to cope with a crying baby and provided individual support to students in schools in relation to concerns including sleep and anxiety.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care.

Our findings

Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance and clearly recorded consent in the children and young people's records.

Staff made sure children, young people and their families consented to treatment based on all the information available. We observed staff in the vaccination and immunisation service team checking consent forms along with individual identification before administering any medicines.

When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of inspection 96% of staff had completed this training.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

During inspection we spoke with nine service users, including one young person. We also observed interactions between staff, young people and their families during 10 appointments including at an immunisation clinic, school nurse clinic, baby clinics and home visits.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. We observed staff providing reassurance to a concerned parent and offering them appropriate guidance and advice. Staff spoke passionately to us about their roles and were clearly motivated to provide high levels of care and support.

Children, young people and their families said staff treated them well and with kindness. Service users told us that staff were friendly, helpful and approachable and would always give advice and respond to queries. They also told us staff were accommodating at rearranging appointments to support service users. However, one carer told us that whilst they could contact staff for support, they were disappointed with the lack of regular clinics that were previously in place but had stopped due to COVID-19.

Staff followed policy to keep care and treatment confidential.

Our findings

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. Staff were observed to discuss mental health and wellbeing with parents during antenatal visits and promoted the importance of being open and discussing feelings.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it.Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. We observed an immunisation clinic at a local school and staff were seen to spend time reassuring an anxious young person and sitting with them afterwards to ensure they were supported.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their family's, wellbeing.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

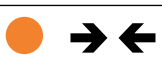
Staff made sure children, young people and their families understood their care and treatment. We observed staff taking time to explain the purpose of the service and options available and to give leaflets to support understanding.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. Staff told us they could easily access interpreters and leaflets in languages other than English. The service's internet page could also be accessed in different languages.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. Those we spoke to gave largely positive feedback about the service. Only one carer raised a concern about access to clinics and timeliness of mandated health checks. The main way to provide feedback directly to the service was via the Friends and Family Test. Managers told us they were looking at ways they could develop methods of gaining feedback, particularly from children and young people.

Staff supported children, young people and their families to make informed decisions about their care. However, the voice of the child was not consistently clear within records across the different teams. Staff indicated they did not always complete the session of the record because they were unclear what they were meant to include. Managers were in the process of arranging training for staff to support with this.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Our findings

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Staff spoke of being more responsive than proactive due to capacity issues but felt this was starting. Teams were developing new ways of engaging with service users to meet existing and emerging needs. For example, the Wakefield team had introduced nursery nurses to the duty system to allow them to provide virtual time-limited interventions, such as around behaviour management, toileting and sleep, as there was a notable increase in demand for support due to the pandemic. Staff in the Youth Justice Team had also identified a need to provide education around knife crime to those children identified as at risk, and had been involved in a pilot to deliver the 'Behind the Blade' programme in schools, with the aim of reducing the risk of offending behaviours. Staff in the vaccination and immunisation service team were also looking at ways they could engage the travelling community and increase uptake of vaccinations following the pandemic.

Facilities and premises were appropriate for the services being delivered. Most appointments took place in service user's homes or in shared spaces such as schools and health centres which meant that services were accessible for those using them.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. The service included children's specialist teams who provided to support in the areas of children in care, vaccination and immunisation, and special needs school nursing and children's learning disabilities. The service also employed a breast-feeding coordinator who offered support to families and provided training to staff in UNICEF's Baby Friendly Initiative.

Managers monitored and took action to minimise missed appointments and ensured that children, young people and their families who did not attend appointments were contacted.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. Staff worked alongside professionals external to the service, such as from the local authority, to ensure service user's needs were met.Staff had the opportunity to attend training sessions on maternal mental health and could seek advice from a perinatal mental health lead to establish when support may be required.

Staff used transition plans to support young people moving on to adult services. For example, there was a school nursing special needs pathway in place to support young adults with learning disabilities moving on with the local transition team.

The service had information leaflets available in languages spoken by the children, young people, their families and local community. Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. Staff gave examples of using visual aids to support those with learning disabilities.

Our findings

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers and staff worked to make sure children and young people did not stay longer than they needed to. The service was provided to children from birth up to 19 years old, or longer if they had additional needs, such as those detailed within an Education Health Care Plan (EHCP). Staff supported young people with transitional arrangements when they were ready to transfer to adult services. The service was in the process of changing the way cases were allocated to staff. Originally, cases were tiered and then staff were allocated cases specific to a tier. This meant that some staff were only working with very complex cases, such as those on child protection plans and others were working with more universal cases, but this meant numbers on their caseloads could be very high. Managers were working to have more equity in caseloads, with each staff member holding a variety of tiered cases.

Managers monitored waiting times but did not make sure children, young people and their families could access services when needed and we found treatment was not received within agreed timeframes and national targets. Staff were not completing all contacts as mandated by The Department of Health, Healthy Child Programme. For example, antenatal visits had been limited and instead of being carried out for all expectant mothers they were only being carried out for first time mothers, or where a risk had been highlighted on the electronic system by practitioners from services external to the trust. Latest figures provided by the trust showed that staff were still struggling to meet visit targets, even with the business continuity plan in place. Figures from January to March 2022 show that staff in the Bradford teams were only completing 36% of antenatal visits, with the trust target being 55%. Staff in both the Bradford and Wakefield teams were also only completing 88% of 12-month developmental reviews and staff in the Bradford team were only completing 88% of 2-2.5-year development reviews. To relieve pressures on staff in the looked after children team, staff were only attending child protection review meetings and child in need meetings where specific health input was required. Additionally, the Department of Health states that there should be easy access for children of all ages to audiology services but in the academic year 2020/2021 only 0.3% of reception children were screened for hearing by the service. The service told us that this was impacted by the pandemic.

The only team within the service operating a waiting list was the Looked After Children team. Statutory Guidance from the Department for Education and Department for Health states that an initial health assessment should be undertaken as soon as practicable after a child becomes looked after, ideally within 20 working days of the child entering care. At the time of inspection there were 79 children on the waiting list for this assessment and the average length of time from a child becoming looked after to the assessment taking place was 64 working days. Additionally, in May 2022 only 38% of review health assessments were completed within timescale (statutory guidance states that a review of the child's health plan must take place every six months before a child's fifth birthday and every 12 months after the child's fifth birthday). Managers highlighted that waiting lists were impacted by the requirement for external medical staff involvement. The trust had taken action to improve timeliness of assessments by employing GPs with a special interest in this area to create extra capacity in the workforce. Additionally, staff in the team conducted triage meetings to prioritise children according to need to ensure those most in need were not waiting too long for an assessment.

The service had a single point of access in both Wakefield and Bradford which was run by administrators. Qualified staff within the service would be allocated to being on-duty and they would be responsible for responding to calls and allocation of work. In Wakefield the system was more advanced, with nursery nurses also allocated to being on-duty in order to increase capacity and reduce pressure on staff. Nursery nurses offered time-limited interventions virtually to support families with lower level concerns or needs for support via set interventions. The Wakefield team had originally

run this as a three-month pilot and in this time had received around 78 contacts and only seven families had called back or sought additional support elsewhere. The Bradford team were looking to also implement this approach going forwards. Service users we spoke to were positive about the responsiveness of staff when they contacted the service for support and advice.

Managers worked to keep the number of cancelled appointments to a minimum. Each team had a virtual handover meeting each morning where they discussed any staff sickness and rearranged appointments in staff diaries where feasible.

Managers monitored that children and young people's moves between services were kept to a minimum. Families may be seen by different staff members throughout their journey in the 0-5 service, for example if no issues were identified at early visits with the Health Visitor then subsequent visits may be allocated to a staff nurse or nursery nurse to reduce the burden on Health Visitors. These staff members had full access to previous notes and would only be allocated cases where there was low, or no risks identified.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Children, young people and their families knew how to complain or raise concerns, and staff understood the policy on complaints and knew how to handle them. In the 12 months prior to inspection there had been four complaints made to the trust about the service. One was partially upheld, one was not upheld, and two were ongoing at the time of inspection. Complaints were categorised appropriately, and no themes were found for the complaints received. The service also received 54 informal concerns with the most common reasons being attitudes of staff and waiting times for a service. Concerns were managed locally, and apologies given where appropriate. There were also four compliments received.

The service did not clearly display information about how to raise a concern in patient areas as most interactions were in patient’s homes or in buildings shared with other services.

Managers investigated complaints but due to the small number of complaints there were no themes identified.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. We could see that resolutions to informal concerns and complaints were shared with families.

Managers shared feedback from complaints with staff and learning was used to improve the service, for example where concerns related to individual members of staff it was clear feedback was given and any learning needs identified. More general concerns and compliments were shared with staff in team meetings. Managers ensured learning was cascaded down from quality and operations meetings.

Staff could give examples of how they used patient feedback to improve daily practice, such as feedback being used to inform ongoing training.

Our findings

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service was led by a general manager and assistant general manager, both of whom were very knowledgeable about the service, including the challenges it was facing, and were passionate about improvement projects taking place. They were then supported by several service managers who directly managed teams of service user facing staff, as well as service managers responsible for transformation and quality.

Staff in all the teams told us that managers were visible and approachable. Staff gave examples of speaking with board members and the chief executive of the trust and described them as open and responsive. Staff spoke proudly of opportunities to develop within the trust, and we saw numerous examples of staff receiving training to advance their skills or being promoted into roles with more responsibility. The service had specific pathways available to encourage and promote staff development and retention, such as preceptorship pathways for nursery nurses and staff nurses.

Staff were involved in service developments and felt their voices and contributions were recognised. For example, quality leads utilised staff feedback to create electronic documents that met the needs of the staff and service.

Leaders met regularly to discuss challenges and make plans for the service. Leaders had been successful in obtaining additional financial input to support with ongoing recruitment and were highly supportive of teams and new initiatives.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had its' own vision which aligned with the overall trust vision. Staff were involved in creating these values during an away day and felt that they met the needs of the service.

Managers in the service worked closely with commissioners to share concerns about the service's capacity to meet targets, such as those mandated by the Healthy Child programme. Managers had negotiated with commissioners in relation to current business continuity plans which relaxed these mandated visits and managers regularly shared relevant figures and updates with them.

Our findings

The service had a vision to strengthen collaborative working within and across service for children and young people in the trust. As a result, the trust had prioritised a strategic piece of work focusing on the development of an integrated children's pathway from birth to 25 years of age. Various working groups were in place and being convened, and at the time of inspection work on the first 1001 days pathway was in progress, with other working groups set to start looking at other pathways in the near future.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff described an open culture where they were able to raise concerns or give feedback without any fear of retribution. Staff told us managers were approachable and responsive and involved them in decision making in relation to the service.

Staff gave examples of how they were supported by managers during periods of sickness and were supported appropriately when they were ready to return to work. Staff felt supported through the ongoing re-tender of the Wakefield based teams and felt managers had kept them involved and informed.

Some staff felt there was a lack of team spirit due to there being no face to face team meetings but generally staff felt well supported and positive about the roles. Managers were working on bringing teams back into hubs so they could meet face to face. Some teams were further ahead with this, such as the children's specialist services teams who were already based back in offices and spoke highly of the importance of this especially for being able to support one another following difficult visits or conversations.

Managers shared compliments with staff in team meetings and organised events such as a student Health Visitor celebration event to recognise the contributions of staff.

Managers recognised the importance of retaining staff. They encouraged staff to develop their knowledge and provided opportunities for them to access additional training courses. Managers recognised the impact work could have on staff wellbeing and were recruiting Professional Nurse Advocates (PNA) within the teams to allow staff a safe space to discuss challenges and their feelings about them. Managers were supporting staff in the Wakefield teams during re-tender to remain in employment with the trust if this is something they wanted.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a clear governance structure and processes in place to ensure staff at all levels were aware of challenges and what the service was doing to improve. There were systems in place to ensure pertinent information including staffing, training, supervision, and safeguarding was discussed with the wider team. Monthly quality and operations governance meetings allowed managers to review the quality and effectiveness of the service and put clear action plans in place.

Whilst there were not always enough staff on duty and caseloads were high, managers were taking actions to rectify this, not only through ongoing recruitment but by offering development opportunities to existing staff. Managers were also

thinking about how they could utilise the skills of existing staff to lessen the burden, for example utilising nursery nurses and staff nurses to carry out some assessment visits where no risks were identified, and introducing more virtual support options, such as having nursery nurses on the duty rota. Managers were also in the process of changing the way in which caseloads were allocated, as previously staff would be allocated to a tier, meaning some staff only held a caseload of universal, or low risk, cases and some staff held caseloads of only very high risk cases, such as those on child protection plans. Staff were positive about this change and felt it would make workloads more equitable across the teams. Managers clearly discussed staffing concerns with commissioners and other relevant stakeholders and maintained an open and honest dialogue.

Staff told us they felt happy in their roles and it was clear to see the passion they had for the service. Staff felt well supported by their teams and senior leaders and described an open culture where they were encouraged to share ideas and to innovate.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had risk registers which reflected staff concerns. Managers held daily lean management calls and monthly quality and operations meetings where they discussed these risks and plans to manage and mitigate them. For example, staff spoke of the difficulties with accessing support from the child and adolescent mental health service due to the lack of collaboration with creation of a pathway. Managers had taken this on board, and this was being reviewed and developed as part of the strategic piece of work focusing on the development of an integrated children's pathway.

Managers were well sighted on risks associated with low staffing numbers and had taken actions to mitigate risk and support staff, such as by recruiting additional staff, skilling up existing staff, and putting business continuity plans in place to reduce the burden on staff. There were ongoing recruitment drives in place and managers supported staff to consider ways in which they could work differently, such as offering virtual support to service users where appropriate. Whilst the service had reduced some of the mandated contacts it was carrying out, such as antenatal visits, managers ensured that a risk review was undertaken by staff before a decision was made for a service user not to be seen face to face.

However, considering the high caseload numbers of over 600 for some staff, it was unclear how managers were aware of individual risks on caseloads. The responsibility was placed on individual staff members to take high profile or concerning cases to group safeguarding supervision or individual clinical supervision, but it was unclear how managers ensured oversight of all risks.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Managers could easily access performance data to support them in their roles. They had access to a performance dashboard which showed data including compliance with supervision, appraisal and training, figures relating to staff sickness, and staff caseload data. Managers could use this data to see where improvement was needed and to benchmark their teams against others within the service.

Our findings

Staff submitted notifications as required to the CQC and other notifiable bodies.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff were able to give feedback on the service and gave examples of being involved in working groups to improve aspects of the service, such as electronic templates.

The main way for service users to give feedback was via the Friends and Family test. Feedback was high on the service agenda and staff were regularly reminded about asking service users to provide feedback. We observed staff requesting feedback from families and sending them links via text message to enable them to provide this. Service users were also asked to feedback following the introduction of new initiatives such as the ICON managing infant crying programme and the pilot of the Maternal Early Childhood Sustained Home-Visiting (MECSH) programme.

Managers acknowledged that engaging children and young people in giving feedback was an area for service development and this was part of the service's improvement plan.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Managers encouraged all staff to be involved in service development and improvement. Whilst staff felt that the pandemic had resulted in more reactive rather than proactive workstreams they felt it had also given them scope to consider different ways of working going forwards. Whilst many programs were still in their infancy or were yet to begin or be evaluated it was clear that staff were passionate about driving improvement for service users. An example of innovative practice due to be launched was nursery nurses offering virtual school readiness sessions to support parents with young children due to start school learn necessary practical skills such as toileting and dressing. Additionally, staff in the service had piloted the MECSH programme with several families which provided sustained nurse home visits for families at risk of poorer maternal and child health and development outcomes. Staff were passionate about increasing proactive work with the aim of ultimately reducing the burden on the service in the future.

Our findings

Areas for improvement

Action the trust MUST take to improve:

We told the trust that it must take action to bring this service into line with 3 legal requirements.

- The trust must ensure that there are sufficient numbers of suitably qualified staff employed to meet the needs of the service. (Regulation 18)
- The trust must ensure that waiting times are reduced and that mandated contacts and assessments are carried out in line with national guidance. (Regulation 9)
- The trust must ensure that the risk management approach considers how risks to universal children are monitored and mitigated. (Regulation 12)
- The trust must ensure that recommendations and learning from child safeguarding reviews are embedded in practice. (Regulation 12)
- The trust must ensure that staff are acting in relation to any safeguarding concerns identified. (Regulation 12)

Action the trust SHOULD take to improve:

- The trust should ensure that policies relating to non-medical prescribing have clearly defined supervision arrangements.
- The trust should ensure that all staff are up to date with mandatory training.
- The trust should ensure that care records are maintained to a consistent standard across the service.
- The trust should consider how staff in specialist services are able to access child and adolescent mental health service support in a timely manner.

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
Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing