East Coast Community Healthcare C.I.C.

1-286186558

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-326347007	Hamilton House	Children's team	**NR32 1DE**

This report describes our judgement of the quality of care provided within this core service by East Coast Community Healthcare. 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 East Coast Community Healthcare and these are brought together to inform our overall judgement of East Coast Community Healthcare

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall, we rated East Coast Community Health as good for Children's and Young People's services because:

- Services delivered by the provider were safe. There were procedures in place to protect vulnerable service users, record keeping was safe and secure and registers of "at risk" children ensured they were easily identifiable. There were good infection control procedures in place and staffing levels were close to establishment.
- Services were effective, evidence based and focussed on the needs of children and young people. We saw examples of good multidisciplinary work. Care and treatment was evidence based, and there were policies and procedures in place to support staff and ensure that services were delivered effectively and efficiently. Parents told us that staff displayed compassion, kindness and respect.
- Services delivered by the provider were caring. Staff were dedicated to the families they supported and worked hard to ensure that patients received the best treatment and support possible. Patients were involved in decisions and understood the services being delivered to them. Staff undertaking home visits were dedicated, flexible, hardworking, caring and committed often going the "extra mile" to support the families in their care.
- We found the service was responsive to needs of children and families. Multidisciplinary team working, including external partners, ensured children and young people were provided with care that met their needs.
- Overall the children and young people's service was well led.The board and senior managers had oversight of the reported risks and had measures in place to manage these risks. Staff felt well supported by their local managers and felt being a shareholder was something that enabled them to take more control of their organisation.

However,

- Policies and procedures to keep staff safe at the end of the working day were not embedded, completion of the child's health record "red book" and note taking on home visits was inconsistent. There was little evidence of learning from incidents at team level and mandatory training levels were not meeting provider target.
- The numbers of people who responded to the Friends and family test were low and none of the people we spoke with were aware of how to raise a complaint. There was little or no feedback and sharing of incidents, audits, performance and local risks at team level and none of the staff we spoke to were aware of risks in their areas for their service. Staff satisfaction and morale within the service was low and 20% of staff we spoke with said they felt stressed.

Summary of findings

Background to the service

East Coast Community Health (ECCH) provides a range of community health services for children, young people and families for the area around Great Yarmouth, Gorleston, Lowestoft and Waveney. Services are provided from numerous locations across Norfolk and North Suffolk and include health visiting, breastfeeding support, school nursing and speech and language therapyamong others. Children and young people can be seen in school, health clinics or at home.

The ECCH breastfeeding team provides a breastfeeding support service in Waveney. The service offers seven-day and 'out of hours' advice and support for breastfeeding families across Suffolk. Peer Supporters assist ECCH specialist professionalsata network of free breastfeeding support groups where pregnant women, new mums and their partners can drop in for help and information.

The ECCH speech and language therapy team (SaLT) provides support to children and young people with speech, language and communication needs in their everyday environment such as at school, nursery or in a children's centre. ECCH therapists provide specialist support and training for others, including the child's family and teachers, to support the child's communication development closer to home.

The ECCH health visiting teams provide a universal service to all familiesof pre-school age childrenin their own homes and in clinics in the local community.

The ECCH school nursing team provides services to all children of statutory school age and their families and carers in the Waveney area. The school nursing team is comprised of Qualified School Nurses, Community Staff Nurses, Nursery Nurses and Team Assistants/Support Workers. Some of the school nursing team activities provided include: Height and weight measurements of reception year and year 6 pupils for the National Childhood Measurement Programme, hearing and vision testing, health, development and behavioural advice and support to children, young people and their parents/ carers including bereavement support, anger management, self-esteem and bullying issues.

The school nursing teams offer one to one confidential appointments and 'open access' clinics for young people in High Schools to provide support and advice on a variety of issues including contraception/sexual health issues, mental health, self-harm, relationships, diet, and smoking .

The looked after children team was made up of two registered nurses and an administrator. The team provides services to children in the care system.

Before our inspection, we reviewed a range of information we hold about the organisation and asked other organisations to share what they knew. We also received comments from people who had completed comment cards. We carried out our announced visits on 1, 2, 3 and 4 November 2016. During the visit, we spoke with 19 parents and saw 14 babies and children. We spoke with 37 staff across the service including administrators, health visitors, nursery nurses, school nurses, speech and language therapists and a student health visitor. We interviewed the executive and non-executive leads for children's services, the children's safeguarding lead, the leads for physiotherapy, speech and language therapy, breastfeeding, health visiting and school nursing.

We accompanied staff on five home visits to children and their parents, we attended "drop in" health clinics and looked at electronic care records for four children. We reviewed risk assessments, meeting minutes and a variety of team specific and service based documents and plans.

The inspection team comprised two CQC inspectors, a community nurse and a health visitor.

East Coast Community Healthcare C.I.C.

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated Children's and Young People's services as good for safe because:

- Staff understood and fulfilled their responsibility to raise concerns and report incidents and near misses. Incidents were investigated and staff were aware of the Duty of Candour regulation.
- Staff understood their responsibilities and adhered to safeguarding policies and procedures. There was a clear pathway for reporting and dealing with child protection and safeguarding concerns and nursing staff kept an electronic "register" of children who were identified as being vulnerable.
- There was an electronic record system which was secure and easy to navigate. We reviewed four electronic records and found they were detailed, up to date and included all expected information.
- The CYP service had effective infection prevention and control procedures in place. Clinic areas we visited during the inspection were visibly clean and there was evidence of good waste segregation. We observed nursing staff using alcohol hand gel between patients and cleaning equipment.
- There were systems in place to identify patients at risk. We saw risk assessments had been conducted to ensure staff and patient safety. Nursing staff assessed risks through discussion with parents, taking measurements of babies and children, and observing the child's home environment.
- There was a process to ensure lone worker safety at the end of each day although this was only an interim process awaiting the development of a more robust system.

Good

Are services safe?

- Staffing levels were close to establishment with recruitment underway to fill the small number of vacancies.

However,

- Whilst there was clear evidence of reporting incidents there was very limited evidence of sharing and learning from incidents with all staff.
- Mandatory training was slightly below target at 88% against a target of 90%.
- There was no documentation regarding the distribution of multivitamins in line with the Governments "Healthy Start Programme" though this was addressed during our inspection. .
- Completion of the child's health record, "red book", was inconsistent.
- The security of patient information was compromised at SaLT Shrublands when domestic staff unlocked all doors within the clinic, including the administrator's office door then left the area leaving patient information and other sensitive information vulnerable.

Safety performance

- Systems were in place to ensure that incidents were reported and investigated but there was limited evidence of discussion and learning from complaints and incidents at team meetings.
- Between 7 December 2015 and 23 May 2016 there were no serious incidents relating to CYP services reported.
- Board data and minutes showed there to be few reported incidents and consistent harm free care to patients.
- Safety performance data was monitored by the integrated governance committee and data discussed monthly with commissioners at a contracting oversight meeting.

Incident reporting, learning and improvement

- Clinical staff felt they were encouraged to report incidents, patient concerns and risks to the organisation. Staff were confident that if concerns were raised to local managers action would be taken.
- Clinical staff used an electronic incident reporting system to report incidents. All the staff we spoke with were aware of how to report incidents. However, none of the staff we spoke with could describe any improvements because of learning from incidents. There was no evidence of learning from incidents being shared across all staff grades in CYP services.
- We reviewed meeting minutes from the Team Leader Meeting (October 2016) and saw risks, incidents, complaints and safeguarding issues were discussed.
- The SaLT team held monthly team meetings. We reviewed the minutes of the meeting dated 2 November 2016. Topics discussed included staffing, hours, administration cover, triage rota, lone worker policy, clinical pathways, CPD and students, quality assurance, partnership working, income, training, governance, complaints and the date of next meeting. However, we reviewed the minutes of the health visitor and school nurse whole team meeting (September 21 and October 20) and the minutes of the looked after children team meeting (11 August and 17 October 2016) and saw no evidence of learning and sharing of feedback from incidents.
- Two health visitors who had recently reported incidents said they had received good one to one verbal feedback from their managers.
- We reviewed an incident investigation. The root cause analysis and action plan were lacking in detail and did not assure us that a thorough investigation had taken place.

Duty of Candour

- ECCH had a Duty of Candour Policy. All the staff we spoke with were aware of the duty of candour regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person as well as offering an apology.
- We saw posters displayed in staff offices describing the duty of candour and procedures to follow in the event of a notifiable safety incident.
- There had been no incidents that triggered duty of candour in children's and young people services.

Safeguarding

- There were systems and processes in place to keep people safe. Staff understood their responsibilities and adhered to safeguarding policies and procedures. There was a clear pathway for reporting and dealing with child

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

- The Safeguarding Committee provided a consultative forum that addressed all child and adult safeguarding matters within the remit of East Coast Community Healthcare. The committee oversaw all activity within the organisation relating to Children and Adult Safeguarding including Looked After Children (LAC) and oversaw all training and development plans. The committee had oversight of all policy and protocol development within ECCH, ensuring that related safeguarding issues were clearly represented.
- We reviewed records of safeguarding children training which showed 92% of nursing staff were compliant with safeguarding children level one and two training. No level three data was included on the mandatory training compliance record. All the nursing staff we spoke with said they were up to date with their safeguarding training and were level three trained in child safeguarding. Data provided at our unannounced inspection showed that 92% of staff who required level 3 safeguarding training received this.
- There was a named safeguarding lead for children. The safeguarding lead had level four safeguarding training, all other clinical staff were trained to safeguarding level three.
- Clinical staff attended face to face safeguarding level two training and three additional sessions, of their choice, annually to maintain safeguarding level three. Sessions included modern slavery, domestic abuse, female genital mutilation (FGM), honour based violence, child exploitation and sexual abuse and were all two hour classroom based sessions.
- There was a system in place to identify children subject to child protection plan by using a symbol on their electronic care record. All school nurses and health visitors had access to this record.
- Nursing staff kept an electronic "register" of children who were identified as being vulnerable so other members of staff including GP's and other health care professionals could easily identify the children if a staff member should be unexpectedly absent.
- We saw posters in staff offices describing the procedures to follow in the event of a safeguarding concern.

Medicines

- The medicines management committee ensured the optimal safe and effective use of medicines provider wide, in line with best practice consistent with relevant legislation to enable patients to get the best outcome from their medicines.
- Health visitors gave expectant mothers a bottle of multi vitamins and Folic acid at their antenatal appointment. This was part of the Government "Healthy Start" programme. We did not see any policies or guidance around the distribution of the vitamins. We queried this with senior managers who were unable to assure themselves or us that they were in line with Government recommendations and withdrew the practice pending investigation. At our follow up inspection we saw the email received by all health visitors instructing them not to issue vitamins.
- We saw the multi vitamins and folic acid bottles were stored in an open fronted cabinet in an open office. The vitamins were all in date and the room was secured when not in use.
- We raised our concerns with the lead for the service who immediately instigated a review of this practice.
- Data showed that a number of staff were prescribers though there was small numbers of prescriptions issued.

Environment and equipment

- The CYP service utilised a number of medical centres and community venues such as Sure Start centres. The venues used were suitable for the clinics or appointments held there and we found that the environments were visibly clean, tidy, and suitable for children and their families.
- We observed the waiting area for children and their families attending speech and language therapy (SaLT) at Shrublands was not child friendly, there was a lack of toys and books and no children's seating. Children using the waiting area had easy access to stairs through a set of double doors, which were not secured. However, the clinic did give access to wheelchair users and those with pushchairs, as it was accessible by a lift. There was a large accessible toilet with baby changing facilities.

Good

Are services safe?

- Not all the venues we visited were used for the provision of children's services, some were offices used by the clinical teams and their managers. All the office venues we inspected had secure access. This meant staff and confidential information was kept safe.
- We saw evidence that specialist equipment such as baby weighing scales, were appropriately checked and calibrated to ensure their accuracy. Health visitors each had their own set of scales, which they took with them to clinics and on home visits. We saw staff wiped scales with antibacterial wipes between uses.
- Speech and language therapists (SaLT) used games and equipment to aid their treatment of children and make it fun. Staff told us they had all the equipment required to undertake their work, and that it was in good order.

Quality of records

- There was an electronic record system called SystmOne which was secure and easy to navigate and was available to health professionals including GP's and safeguarding teams at acute hospitals.
- We reviewed four electronic records and found they were detailed, up to date and included all expected information around contact details, midwife referrals, visit details and any safeguarding alerts.
- Health visiting record audits were undertaken monthly. September 2016 audit looked at 31 health records and showed 100% compliance with recording contact details, signing records and a clear care plan. This was the same for the LAC health record audit.
- We reviewed the Data Protection Policy and found it was out of date. The policy stated "guidance on handling personal info specific to your area is followed". Nursing staff we spoke to about this did not know of any specific local data handling guidance.
- Record keeping when health visitors were attending home visits was inconsistent, some health visitors made notes in note books or on loose sheets of paper and transferred this information to the electronic patient record system when they returned to base. This raised information governance and patient confidentiality concerns. At our follow up inspection we saw health visitors had been given padlocks for their bags to ensure any notes they had were secure. We saw the email that all health visitors had received advising them to use "one Note" on their mobile phones instead of taking notes on loose paper. This process was not fully embedded.
- We reviewed eight child health records "red books" at "drop in" clinics and found completion was inconsistent in six of them. The baby's weight was not always plotted, contact details for the named health visitor were not always seen and the location where the meeting had taken place, clinic or home, was not recorded.
- We listened to a speech and language therapist undertaking the telephone triage role. There was no triage template in use to ensure consistency during triage phone calls
- Patient information was not secure at SaLT Shrublands. At the end of the afternoon, domestic staff unlocked all doors within the clinic, including the administrator's office door. All the domestic staff then left the area leaving patient information and other sensitive information vulnerable, as the clinic areas were not secure and therefore accessible to anyone. We informed the SaLT manager who immediately contacted a member of the domestic team who returned and secured the administrator's office door.

Cleanliness, infection control and hygiene

- The infection control and prevention committee had representation from all ECCH departments and experts from commissioners & Public Health England.
- The CYP service had effective infection prevention and control procedures in place. Clinic areas we visited during the inspection appeared visibly clean and there was evidence of good waste segregation.
- We observed nursing staff using alcohol hand gel between patients and cleaning equipment such as weighing scales and head circumference tapes with antibacterial wipes between patients.
- Staff had access to personal protective equipment (PPE) and were aware of how to dispose of used equipment safely, and in line with infection prevention and control guidelines.
- During the home visits we attended with health visitors, we observed good infection control practices throughout.
- At the clinics we visited, there were adequate arrangements for the management of waste, sharps and clinical specimens and the environments were visibly clean.
- Health visiting teams performed hand hygiene audits quarterly. Results from January 2016 to September 2016 showed 100% compliance.

Good

Are services safe?

Mandatory training

- Mandatory training was delivered online and face to face. Training covered health and safety, manual handling, safeguarding, infection prevention and control and prevent among other topics.
- Mandatory training compliance for health visitors (HV) and school nurses (SN) was at 88% for October 2016. Mandatory training figures for SaLT Suffolk were 90%, SaLT Norfolk (Great Yarmouth) 80% and SaLT Norfolk (New Areas) 75% compliant. This was against a provider target of 90%.

Assessing and responding to patient risk

- There were systems in place to identify patients at risk, such as vulnerable children. Details were recorded on the child's electronic record, which all nursing staff had access to. We saw an example of this for a safeguarded child.
- We saw risk assessments had been conducted to ensure staff and patient safety. For example, risk assessments with regard to lone working of staff.
- Nursing staff advised parents on risk factors for sudden infant death and safe sleeping. We observed staff have this conversation on antenatal visits and visits to new-born babies.
- We witnessed a telephone call where a mother was concerned about her babies breathing, the HV advised her to attend the Emergency department at the local hospital and confirmed they would follow up on the child the next working day.
- Nursing staff assessed risks through discussion with parents, taking measurements of babies and children such as weight and head circumference, and observing the home environment for children. Staff recorded risks in patient records and recorded them as incidents on the electronic reporting system. If staff identified health risks, they made referrals to GPs and other health professionals. In the case of emergencies, staff used the relevant emergency services.
- Child protection medical assessments were not performed by ECCH CYP services but were referred to an external NHS provider.

Staffing levels and caseload

- Staff we spoke with from health visiting, school nursing and SaLT told us the method of calculating caseloads was based on demographic information and individual caseload rather than the acuity of children and young people. Acuity is the measurement of the level of care required by a patient. The provider had recently won tenders for additional work in other geographical locations. This had increased the caseloads of some teams. Managers were addressing this by restructuring teams.
- There were no bank or agency staff used to provide CYP services.
- Nursing staff across SaLT, school nursing and health visiting consistently told us that staffing levels felt unsafe especially in the SaLT teams despite CYP being at establishment.
- There were 84 SaLT staff looking after a caseload of 150 – 200 children per whole time equivalent (WTE) speech and language therapist. This was worse than the Royal College of Speech and Language Therapy (RCSLT) guidelines of 50 children per WTE but the provider was still exceeding national targets for therapy outcomes. There were two vacancies in the SaLT team and recruitment to the posts was underway.
- We discussed the high caseloads with executive staff. There were implementing a new model of matrix care to manage referrals into speech and language therapy in response to increasing demand and commissioning.
- There were 19.8 WTE health visitors looking after a caseload of 6350 children aged zero to five years. This is approximately 300 children per WTE. One health visitor we spoke with had a case load of approximately 450 children. The Lamming Report (2009) recommends caseloads should not exceed 300 families per WTE but data gathered showed the provider performance was meeting targets set for the health child programme. There were no nursing staff vacancies in the health visiting team.
- The school nursing team consisted of staff nurses and nursery nurses as well as four school nurses. The school nursing team was covering 50 schools, including special needs schools and sixth form colleges, and looking after children aged 5 to 19 years. There were no vacancies in the school nursing team.
- The looked after children (LAC) team was made up of two registered nurses and one administrator and looked after a caseload of 550 children. There were no vacancies in the LAC team. However, the LAC team were not meeting their target of 100% of all initial health assessments within 20 days. According to LAC team

members, breeches were due to lack of clinic availability and delays in receiving documentation from social care providers. LAC were also not meeting the national target for the "over fives" annual health review.

- During the six months from 1 June 2015 to 31 May 2016 staff sickness was between 3.5% in the SaLT team rising to 9.7% in the breastfeeding team.
- During the six months from 1 June 2015 to 31 May 2016 staff turnover was 23% in the SaLT team (nine staff), 39% (two staff) in the breastfeeding team and 33% (19 staff) in the health visiting team. However for the breastfeeding and health visiting team this was due to a change to a new provider in October 2015 for the Great Yarmouth locality and staff being transferred to the new provider.
- Due to ongoing staffing issues related to a staff grievance, health visitors in the Waveney area were providing the breastfeeding service. Health visitors received additional training to support them in this role. Interviews were taking place on 14 November to replace the breastfeeding team.
- Information provided by ECCH stated that recruitment was ongoing service-wide through presence at careers fairs and interactions with higher education institutions.

Managing anticipated risks

- The provider was continuously reviewing caseloads and skill mixes of teams across children's services. Minutes from the commissioning meetings showed that anticipated demand in services was mapped against caseload size and a decision made about additional or reallocated staffing.
- In line with the new model of working in SaLT, senior staff were regularly reviewing capacity and patient management to ensure that minimum standards were met in the care and treatment of patients. We saw that concerns about waiting times for some services were escalated to commissioners and that local leaders had taken action to address this.
- We reviewed the Lone Worker Policy and found it was out of date. We raised this at the time of inspection and the provider took immediate action to review this.
- Health visitors used an electronic diary system to indicate where they intended to visit. Staff marked their names as "in" or "out " on a board so their movements could be traced if needed. We were not assured that staff were formally accounted for at the end of each working day and raised this with ECCH executives. At the time of our follow up inspection there was a temporary procedure in place to ensure the safety of all health visitors. At the end of day the team manager telephoned the duty health visitor to confirm all staff had returned to base or contacted the office to confirm they had gone home. Any health visitor who was not accounted for was contacted directly. If the health visitor could not be contacted the duty executive was contacted who could then attempt to contact the health visitor's next of kin to ensure they were safe. Two health visitors told us this process had been working but team mangers wanted to implement a more robust system.

Major incident awareness and training

- There was a full business continuity plan and major incident plan in place for the provider.
- None of the nursing or administration staff we spoke with were aware of a major incident plan.
- We reviewed the Fire safety management Manual which evidenced the monthly testing of emergency lighting at the Milton Road office. There was a record of a failed test and evidence of it being repaired within two working days.

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 Children's and Young Peoples' Services as good for effective because:

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services.
- Staff were qualified and had the skills to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training was put in place to meet these learning needs. Staff were supported to maintain and further develop their professional skills and experience through regular one to one and appraisal.
- There was good multi-disciplinary and multi-agency working within the organisation and externally. Multi-disciplinary working included all necessary professionals in all aspects of children's lives. Nursing staff worked together to plan ongoing care for children as they moved between services.
- Nursing staff obtained consent to care and treatment in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004.

However,

- LAC were not meeting targets for initial health assessments and annual reviews.

Evidence based care and treatment

- People had their needs assessed, their care goals identified and their care planned and delivered in line with evidence-based guidance, standards and best practice such as those developed by the National Institute for Health and Care Excellence (NICE).
- Health visiting and school nursing teams aimed to work in accordance with the Healthy Child Programme. The Healthy Child Programme is an early intervention and prevention public health programme that offers every family a programme of screening tests, immunisations, developmental reviews, information and guidance to support parenting and healthy choices. The programme also identifies key opportunities for undertaking developmental reviews that services should aim to perform.
- Health visitors used Promotional Guides during antenatal and post-natal visits. However, not all health visitors used it consistently. One health visitor did not cover domestic abuse despite having the opportunity to speak about it, another did not cover shaken baby or outline the schedule of visits.
- Health visitors used 'Whooley questions' to identify signs of post-natal depression in parents. The Whooley questions were developed by NICE in 2007.
- The LAC team followed Promoting the Quality of care of Looked After Children guidelines.
- We observed staff giving evidence-based advice to a mother about introducing solid food to her baby at the correct age. The staff member giving the mother a leaflet supported this.
- We saw evidence-based information produced in line with UNICEF guidance by the infant feeding co-ordinator, which included detailed information concerning breastfeeding and set out the benefits to both baby and mother.
- ECCH's breastfeeding support team was awarded UNICEF Baby Friendly Stage 3 (full) accreditation in 2014 and given an award at the House of Lords for innovative services to breastfeeding. This accreditation had lapsed at the time of inspection.
- ECCH had recently implemented a Practice Development Group (PDG) to look at current practice and NICE guidelines and ensure good practice is developed across CYP services. We reviewed the minutes of the first PDG meeting held in October 2016 and found a clear action plan.

Nutrition and hydration

- Staff gave parents up to date and relevant advice about breastfeeding, weaning and nutrition and hydration in

children and monitored breastfeeding and weaning rates. Staff provided extra visits or put on extra clinics when they could to provide extra nutritional support to parents who had requested it.

- ECCH monitored breastfeeding rates on a quarterly basis. Results showed 41% of mothers were still breastfeeding at six to eight weeks in Q4 2015, which fell to 36% in Q1 and Q2 2016. This was worse than the provider target of 50% which was based on NICE guidelines and the department of health's healthy child programme.
- The Breastfeeding team used volunteers to help deliver some of the care. There were 14volunteers on the breastfeeding team. Volunteers were mothers that were currently breastfeeding or had recently stopped. All volunteers were DBS checked, interviewed and had monthly appraisals. Volunteers helped at breastfeeding cafes and peer support sessions held at a nearby external provider.

Technology and telemedicine

- Health visitors provided follow up by telephone call to families they supported.
- SaLT provided a telephone call back and triage system.
- Breastfeeding mothers could access support from the breastfeeding team by text message.

Patient outcomes

- ECCH CYP services were monitoring their performance in relation to the Healthy Child programme (HCP).
- The Healthy Child Programme stipulates that a new baby review should take place by 14 days with mother and father in order to assess maternal mental health and discuss issues such as infant feeding and how to reduce the risks of sudden infant death syndrome.
- ECCH health visiting team saw 96% of expectant mothers before 28 weeks in Q2 2016. This was better than the 90% provider target and was an improvement from 81% in Q4 2015.
- ECCH was performing consistently better than the target of 90% with 93% of all new babies seen before day 14 in Q4 2015 to Q2 2016.
- The health performance report 2016 showed the 12 month review by age one completion rates were 67% in Q4 2015 rising to 96% in Q2 2016. This was better than the 90% target. We spoke to the executive lead for children's services who explained the improvement in performance was due to changes in procedures around inviting parents to the review. This demonstrates quality outcomes being used to drive improvements to services.
- Documentation showed the age two to two and a half review completion rates were consistently better than the 90% target from Q4 2015 to Q2 2016.
- Speech and language therapists used the East Kent Outcome scales to measure outcomes of patients attending SaLT and was exceeding the national target (65%) with 94% of patients meeting the last set of outcomes for August 2016.
- The LAC services saw only 9% of children for their initial health assessment within the stipulated 20 days. This does not meet the provider target of 100%. They were also not meeting national targets for annual reviews of children aged five years and over.

Competent staff

- All the staff we spoke with said they had received a robust induction.
- At 5 August 2016, 60% of SaLT Norfolk team members and 73% of SaLT Suffolk team members had received their appraisal against a provider target of 90%. In October 2016 health visitors, school nurses and the looked after children team had all exceeded the 90% target for staff receiving appraisal. All the nursing staff we spoke with said they had received their appraisal.
- Learning needs of health visiting staff were identified at appraisal and at three monthly one to one meetings. The LAC nurses had monthly one to one supervision.
- Three members of the breastfeeding team had received additional training to undertake tongue-tie assessments on babies. If tongue-tie was suspected three health visitors could refer babies to a local NHS provider for review by a paediatrician.
- Three members of health visiting staff were attending the UNICEF Conference in Manchester to enhance their knowledge on breastfeeding. Executives told us that the health visitors would disseminate this knowledge throughout the team on their return.
- Several staff from children's services had been supported to undertake additional qualifications.

Multi-disciplinary working and coordinated care pathways

- There was good multi-disciplinary and multi-agency working within the organisation and externally. Health

visitors, physiotherapists, speech and language therapists regularly liaised. Nursing teams regularly communicated with external local and national health providers.
- There were referral pathways in place for the further assessment of children if required though many were referred to the GP for further referrals.
- Children's continuing healthcare was completed as required by the team which included multi professional assessment of children with complex needs. This ensured that all their social and health needs were considered.
- Multi-disciplinary working included all necessary professionals in all aspects of children's lives, including nurseries, school and social care.
- There was access to child and adolescent mental health services (CAMHS) and there was involvement of a named nurse and a named Medical director.
- Health visitors had monthly meetings with midwives where they discussed caseloads and handovers of patient care.
- The LAC team liaised with other LAC care providers and CAMHS.

Referral, transfer, discharge and transition

- Nursing staff were able to describe robust safeguarding referral procedures.
- There were policies and procedures in place to ensure that as children transferred from health visiting to school nursing, information was provided accordingly.
- We saw "health passports", health records for looked after children in Norfolk and Suffolk. Children left care on their 18th birthday, each child had an assigned social worker. Transition planning began when the child was 16 and involved social care services and other external support providers.
- There was evidence of nursing staff working together to plan ongoing care for children as they moved between services. This included regular meetings between different professionals to determine future care pathways.

Access to information

- ECCH used an electronic patient record system, which meant staff could access patient records from offices and clinics. However, staff were unable to access records when on visits. This meant that staff made paper records and copied them onto the electronic record when they were next at their computer.
- We reviewed the personal child health record or 'red book' being used; this was given to parents before being discharged from the midwife. The "red book" holds medical information about a child from birth to four years of age and recorded child, family and birth details, immunisation records, screening, routine reviews and growth charts.

Consent

- We reviewed the consent policy and found it was in date. The policy stated that the "…health professional undertaking the procedure… must be the person who gains consent".
- At antenatal appointments we saw staff asking the mother for consent to share information with relevant external agencies. This was verbal consent and it was not always recorded in the health visitor's notes.
- We saw health visitors always seek verbal consent from parents before handling the baby.
- We listened to a speech and language therapist undertaking the telephone triage role. The therapist documented the referral details and that consent had been given by the family of the child.
- Nursing staff understood and were able to explain both Gillick competency and Fraser guidelines. Gillick competency and Fraser guidelines refer to a legal case, which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16 year olds without parental consent.
- School nurses explained how parents were sent forms to sign to "opt out" of their child having access to the school nurse.

Good

Are services caring?

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

Summary

We rated Children and Young peoples' services as good for caring because:

- Feedback from people who used the service was positive about the way staff treated people. People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive.
- Staff spent time talking to people and providing information in a way that they could understand. People and staff worked together to plan care and there was shared decision-making about care and treatment.
- Staff responded compassionately when people needed help and supported them to meet their needs. People had their privacy and confidentiality respected at all times.
- Staff helped people cope emotionally. People had their social needs understood. People were supported to maintain and develop their relationships with social networks and community. People were enabled to manage their health and care when they could, and to maintain independence.
- Health visitors regularly went above and beyond their roles to improve the lives of the families they supported.

However, we found

- Friends and family response rates were low.

Compassionate care

- Staff treated parents and children with kindness, dignity, respect and compassion. We observed good relationships between the staff and the parents and children. Care was family centred. During our observation of home visits by health visitors, we saw warm and compassionate behaviour towards parents and their families.
- ECCH's breastfeeding support team was awarded UNICEF Baby Friendly Stage 3 (full) accreditation in 2014 and given an award at the House of Lords for innovative services to breastfeeding. At the time of our inspection, this accreditation had lapsed. The breastfeeding service is being inspected for re-accreditation in March 2017 and is working towards this being successful.
- The service evaluation report for June 2016 showed 100% of children and young peoples' service users, 36 responses, thought the staff were friendly and helpful, were happy with the length and time of their appointment and felt health visitors treated them with dignity and respect.
- The service evaluation report for June 2016 showed 100% of SaLT users thought the staff were friendly and helpful, were happy with the length and time of their appointment and felt they were treated with dignity and respect. However, these findings were based on a low response rate of four.
- Friends and Family test data (FFT) for the CYP service August 2016 showed 100% of services users would recommend the service based on a response rate of 20 people. In September 2016, this dipped to 97% of services users based on a response rate of 30 people and in October 2016 FFT data showed 100% of users would recommend the children and young peoples' services based on a response rate of 20 people. All the parents we spoke with said they would recommend the service.
- FFT data for SaLT showed 80% of service users would recommend the SaLT service in August 2016 based on six responses. In September 2016 and October 2016 this had risen to 100% based on a response rate of one person and six people respectively.
- Parents spoke positively about health visitors and the health visiting service. One parent said "they (Health visitors) are professional, helpful and friendly"
- Health visitors regularly went above and beyond their roles for the families they supported. We heard examples of health visitors (HV) liaising with Church charities to provide furniture and essentials for families in financial difficulties.
- One health visitor described how she was supporting a vulnerable lady to attend the GP to organise contraception. A LAC nurse regularly rearranged her shifts to ensure she was available to attend MDT to support children who were on her caseload.

Good

Are services caring?

- On occasions, health visitors met families at Sure Start Children Centres to ease their anxiety about meeting new people.
- One parent described how she had been concerned about her baby but had been unable to get an appointment with the GP despite trying for three days. The parent explained how she contacted the HV who arranged her a GP appointment for the same day.

Understanding and involvement of patients and those close to them

- We observed good staff interactions between parents, babies and children. Staff listened to parents' concerns and gave them evidenced- based advice which was backed up with leaflets. Staff ensured that the parent had understood the information given by using reflective conversations.
- Staff asked questions in a sensitive and non-judgemental manner, and built a positive relationship with parents. Parents appeared to be open and honest with staff as a result.
- Health visitors gave expectant mothers a selection of leaflets relating to pregnancy, birth and breastfeeding services available from the HV team. We saw a HV write their contact details in the "red book".
- The service evaluation report for June 2016 showed 100% of children and young peoples' service users, 36 responses, felt they were involved in decisions around their care.
- The service evaluation report for June 2016 showed 100% of SaLT users felt they were involved in decisions around their care. This was based on four responses.
- Speech and language therapy treatment sessions could be provided on a weekly or monthly basis in any environment to suit the parent and their child for the duration of their six sessions.
- We listened to a speech and language therapist undertaking the telephone triage role. The therapist then tasked another therapist with the referral and sent out leaflets and handouts to the referrer so the child's therapy could begin while waiting for an appointment.

Emotional support

- We observed staff giving holistic care often having an awareness of all family members and any additional support that the family may require. Holistic care means considering the complete person, physically, psychologically, socially, and spiritually, it is underpinned by the concept that there is a link between our physical health and our more general 'well-being'.
- Staff discussed sensitive issues such as post-natal depression with parents. Staff provided emotional support, asked if parents were all right, as well as providing information on support services.
- Nursing staff enquired about the welfare of the parent. Health visitors used 'Whooley questions' to identify signs of post-natal depression in parents. The Whooley questions were developed by NICE in 2007. One parent said, "If I'm feeling down, I can speak to health visitors".

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 Children's and Young People's services as good for responsive because:

- Services were planned and delivered in a way that met the needs of the local population. Facilities and premises were appropriate for the services being delivered and flexibility, choice and continuity of care was reflected in the services.
- Care was coordinated with other services and other providers with adjustments made and action taken to remove barriers when people found it hard to use or access services.
- There was support for people with learning difficulties, mental health issues and those people who did not speak English as a first language.
- People could access the right care at the right time. Access to care was managed to take account of people's needs, including those with urgent needs. Waiting times were minimal and services ran on time.

However,

- Some people were unaware of how to raise a complaint or concern.

Planning and delivering services which meet people's needs

- Child health clinics were held in people's homes or community venues, which meant there was easy access for parents. Children could be weighed and a health visitor was available for parents to talk with.
- The ECCH staff worked with other providers, including children's centres and voluntary organisations, to provide support and services to parents and their families. Clinics and support groups were set up and based in local communities to meet the needs of local people.
- The breastfeeding support service offered breast-feeding support groups facilitated by breast feeding coordinators, breast-feeding peer supporters and health visitors.
- Women had 24 hour, seven day a week access to support from the breast-feeding support service.
- ECCH delivered a paediatric resuscitation course to parents in response to parents requesting them. All courses were fully subscribed.
- FFT data forms were printed in the six foreign languages prevalent in the area.
- Between April 2016 and September 2016 SaLT had a did not attend (DNA) rate of 1%. This was 109 missed appointments from a total of 8971. Staff described how they followed the DNA policy when children missed appointments.
- The looked after children team referred 100% of all children who DNA to social services. This was in line with the DNA policy.

Equality and diversity

- The organisation had an equality and diversity inclusion policy, which included information on the trust's commitment to building a workforce, which reflected the wider community. It also covered the Equality Act 2010.
- Services were designed with the needs of different people in mind. For example, staff were able to access interpreters for people whose first language was not English, or for those who had a hearing disability.
- There were leaflets available in a range of different languages in the areas we inspected. Buildings we visited where clinics took place were easily accessible and adhered to the requirements of the Disability Discrimination Act 1995 and the Equality Act 2010.
- Nursing staff could arrange translation services. This could be face to face or by language line.

Meeting the needs of people in vulnerable circumstances

- We asked nursing staff about support for parents with learning difficulties and mental health problems. Staff told us about multiple ways they supported parents (particularly mums) with learning difficulties. Health visitors used videos to demonstrate good baby handling techniques, pictures and flash cards, and the use of "tummy balls" to demonstrate the size of a baby's tummy to reduce the anxiety of how long feeding should take.

Good

Are services responsive to people's needs?

- At September 2016, the CYP service had 122 children subject to a child protection plan. In the preceding three months there had been seven referrals to children's social services.
- Nursing staff were knowledgeable about their caseloads and kept a separate "register" of any vulnerable children they were responsible for.
- The looked after children's team met all looked after children and conducted review assessments face to face.

Access to the right care at the right time

- Parents could access speech and language therapy services (SaLT). Referrals to the service came from health visitors, school nurses, and parents could refer their own children. Parents could access information on referring their children to SaLT through the trust website.
- Speech and language therapy (Norfolk) offered drop in sessions with a speech and language therapist on the last Friday of every month. Parents who had concerns about their child could access advice, have their child's speech assessed and be given access to the SaLT services if required.
- All the parents we spoke with told us they could access services when they needed it. Staff were responsive and could see parents the same day or following day if the situation was urgent. Staff said if parents called, they would always respond and see them at the earliest opportunity.
- The service had guidance for staff on what to do when parents did not attend appointments, had withdrawn from service, or when staff could not get access on a visit. Staff knew about the policy and used it to recognise early signs of disengagement, and the subsequent risks this posed to a child or family.
- The Healthy Child Programme stipulates that a new baby review should take place by 14 days with mother and father in order to assess maternal mental health and discuss issues such as infant feeding and how to reduce the risks of sudden infant death syndrome. ECCH was performing consistently better than the target of 90% with 93% of all new babies seen before day 14 in Q4 2015 to Q2 2016.
- ECCH health visiting team saw 96% of expectant mothers before 28 weeks in Q2 2016. This was better than the 90% target and was an improvement from 81% in Q4 2015.
- The health performance report 2016 showed the 12 month review by age one completion rates were 67% in Q4 2015 rising to 96% in Q2 2016. This was better than the 90% target. We spoke to the executive lead for children's services who explained the improvement in performance was due to changes in procedures around inviting parents to the review. This demonstrates quality outcomes being used to drive improvements to services.
- Documentation showed the age two to two and a half review completion rates were consistently better than the 90% target from Q4 2015 to Q2 2016.
- Speech and language therapists used the East Kent Outcome scales to measure outcomes of patients attending SaLT and was exceeding the national target (65%) with 94% of patients meeting the last set of outcomes for August 2016.
- SaLT audited call back times for triage. In July, August and September 2016 98% of all triage calls were made within 72 hours. This was in line with the target.
- SaLT was meeting the 18 week referral to treatment time (RTT) target in July and September 2016 with one patient breaching the 18 week RTT in August.
- The LAC services saw only 9% of children for their initial health assessment within the stipulated 20 days. This does not meet the provider target. The LAC service were also not meeting targets for annual review of children aged five years and over.

Learning from complaints and concerns

- In the reporting period June 2015 to May 2016, there were 10 complaints about children and young peoples' services. Three were upheld which related to an inappropriate referral, a complaint about the children's' activity session and the time it took to receive urgent support from health visitors.
- Speech and language therapy described how they had recently changed their self-referral procedure because of parents complaining it was too difficult to use. This evidenced learning from complaints and feedback from parents so far was positive.
- Information was displayed in the clinics about how patients and their representatives could complain. There were posters promoting patient advice and liaison service (PALS).
- We spoke with 19 parents and none knew how to raise a complaint.

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 Children's and Young People's services as good for well led because:

- All the staff we spoke with knew the ECCH values. Staff felt people lived by them.
- There were clear lines of governance and all the staff we spoke with told us they felt valued and supported by their local managers, the CEO was visible and attended meetings on an ad hoc basis.
- All the staff we spoke with told us the service had an open and honest culture and staff were passionate about providing the best service possible for the people they supported.
- The service proactively engaged and involved all staff as shareholders and ensured that the voices of all staff were heard and acted on. The leadership actively promoted staff empowerment through shareholder involvement.
- Staff felt confident to raise concerns.
- There was a process in place to identify, understand, monitor and address current and future risks and the Executive leaders were knowledgeable about risks faced by the service.

However,

- There was no feedback and sharing of incidents, audits, performance and local risks at team level. None of the staff we spoke to were aware of risks in their areas for their service.
- Staff satisfaction and morale was low in some teams.

Leadership of this service

- The CYP service had a clear leadership structure and all the staff we spoke with knew the name of their team leader, local manger, director of children's services and the chief executive.
- The service was lead by a director with area managers responsible for the
- All the staff we spoke with told us they felt valued and supported by their local managers.
- Staff told us the CEO was visible and had visited their office base and attended meetings on an ad hoc basis.

Service vision and strategy

- CYP did not have a local vision and strategy. All the staff we spoke with were aware of the ECCH provider wide vision and strategy.
- There was a clear strategy at executive level for the service but this was not communicated effectively with staff and teams within the service.
- The service had recently been successful in a bid to provide speech and language services in Norfolk. Senior managers were aware of the challenge to integrate the services.
- All the staff we spoke with knew the ECCH values. Staff felt people lived by them.

Governance, risk management and quality measurement

- ECCH recorded risks on an electronic reporting system (DATIX). We reviewed the corporate risk register dated 19 October 2016 and saw CYP service had three risks identified, the health visiting service, the breast-feeding service and the SaLT service.One of the health visiting teams was identified as high risk due to long term sickness. A health visitor had been seconded to the team to mitigate the risk. The breastfeeding service was identified due to staff grievance, health visitors had received additional training to enable the breastfeeding service to continue until the grievance had been resolved and the SaLT service was identified as a risk due to changes in service provision, there had been a change in management structure to address this risk. The risk register assured us that senior management had oversight of the risks faced by ECCH CYP.
- None of the nursing staff we spoke to were aware of a local risk register for their service. Staff explained that in May 2015 the risk register was changed to being a "DATiX Risk" on the electronic system. Staff submit a DATIX style form detailing the risk and send it to Beccles House. Staff were unaware of what happened to the risk then.

Good

Are services well-led?

- The health and safety (HS) committee oversaw the quality and governance of non patient performance and elements for health, safety, security and resilience through its monitoring of incidents and related inspections and audits. Policies, procedures and company safety standards for these areas were reviewed and approved at the HS Committee.
- The governance of Health, safety, security and resilience issues was communicated to the Integrated Governance Committee. This was through HS minutes being provided to the integrated governance committee (IGC) and a full bi-monthly report being made to the IGC by the Health and Safety Review Meeting.
- The SaLT team held monthly team meetings. We reviewed the minutes of the meeting dated 2 November 2016. Topics discussed included staffing, hours, administration cover, triage rota, lone worker policy, clinical pathways, CPD and students, quality assurance, partnership working, income, training, governance, complaints and the date of next meeting.
- Team leader meetings were held monthly, chaired by the deputy director of children's services and attended by local managers from HV and speech and language therapy as well as by the safeguarding lead for children. We reviewed the minutes of the October 2016 meeting. There was discussion of risks, incidents, complaints, safeguarding and audits. There was an action plan with named individuals assigned tasks and review dates.
- Whole service meetings were held monthly and chaired by the deputy director of children's services. These meetings were attended by HVs, nursery nurses, school nurses and administrators. We reviewed the minutes of the September and October 2016 meetings. Minutes of the previous meeting were not reviewed, safeguarding, risks, incidents and complaints were not set agenda items and were not discussed at either meeting. There was no action plan.
- Practice development group meetings were being implemented. The group would meet every other month and look at issues such as SystmOne, information leaflets and templates. We reviewed the minutes of the first meeting and saw clearly assigned actions.

Culture within this service

- All the staff we spoke with told us the service had an open and honest culture and we observed this during our interviews with staff throughout the inspection.
- Nursing staff were passionate about providing the best service possible for the families they supported.
- Staff morale was mixed across the CYP service. Some staff were positive about working for ECCH and others said the impact of the recent changes to services adversely affected them. Seven (20%) of the staff we spoke with said they had experienced low morale and increased stress due to the changes. This finding was reflected in the results of the 2016 provider wide staff survey which showed an increase in the number of staff responding yes to "feeling stressed every day, 2-3 times per week" compared to the 2015. Two clinical staff who had been given leadership roles told us they did not feel supported by senior managers.
- There was a lone working policy, however, interpretation amongst the health visitors varied, some staff knew the code word which identified they needed assistance and other staff had independent systems. There was no procedure for ensuring health visiting staff were safe at the end of the working day. At our follow up inspection we saw an email sent from the executives to all health visitors describing an interim process to be followed to address this in the short term.

Public engagement

- We observed HVs giving a feedback form to patients. The form was to be used to "give a compliment", "ask a question", "raise a concern" or "make a complaint".
- There were posters displayed in waiting areas promoting Patient Advice and Liaison service (PALs).
- ECCH held "Patients as Teachers" Forums where patients could share their experiences and ideas in order to improve services.

Staff engagement

- All the staff we spoke with were shareholders of ECCH. Staff felt becoming a shareholder was a positive thing to do. Shareholders were eligible to be involved in making some decisions.
- We asked 35 staff if they were aware they could attend the integrated governance committee meeting (IGC) only three staff were unaware. None of the staff we asked had attended the IGC meeting this was reportedly due to not being able to spare the time.
- Staff were able to nominate each other for an annual award in one of eight categories. Winners were chosen by a committee made up of shareholders and executives and were awarded a trophy and a gift

Good

Are services well-led?

voucher at an annual award ceremony and dinner dance. We spoke with the winner of the "Emerging Talent" award who told us they felt proud and pleased to have been recognised.

- We saw ECCH wide "you said we did" posters in response to the staff survey from 2015 describing changes which had been introduced based on staff feedback.
- A weekly brief was emailed to all staff on Thursdays. We reviewed a selection of weekly briefs from September and October. Topics covered included compliments, complaints, news and team meeting dates.
- At the time of our inspection the staff survey 2016 had just closed with a response rate of 61%. Results had not yet been collated.
- We reviewed the Stress Management Policy. The policy was in date and referenced "Appendix Two" which was missing from the document. A "Stress Risk Assessment Tool" gave staff a score on their stress level. However, there was no guidance on what the score meant or what staff should do after they had completed the assessment.

Innovation, improvement and sustainability

- The provider was addressing improvement and sustainability service wide recently winning tenders for more SaLT work across Norfolk and recruiting more staff to the breastfeeding team enabling expansion of the geographical area it supported.