Anglian Community Enterprise Community Interest Company (ACE CIC)

1-165291700

Community health services for children, young people and families

Quality Report

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Date of inspection visit: 5, 6 and 7 December 2016
Date of publication: 26/04/2017

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)
1-289640064	Kennedy House	team	CO15 4AB
1-289609440	Harwich Hospital	unit	CO12 4EX
1-289608590	Clacton Hospital	unit	CO15 1LH

This report describes our judgement of the quality of care provided within this core service by Anglian Community Enterprise Community Interest Company. 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 Anglian Community Enterprise Community Interest Company and these are brought together to inform our overall judgement of Anglian Community Enterprise Community Interest Company

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

We rated this service good because:

- Mandatory training compliance across children and young people's (CYP) services was above Anglian Community Enterprises (ACE) target of 95%, achieving 98.5% in November 2016.
- Staff knowledge and understanding of safeguarding children and young people was good. Staff undertook regular safeguarding training.
- We found staffing was sufficient for the workload. Senior managers reviewed staffing using an evidence based tool and reallocated staff accordingly.
- Documentation on patient's electronic records was detailed, accurate and timely.
- Policies and guidelines were evidence based and in line with current national best practice.
- Staff received yearly appraisals.
- We found evidence of effective and consistent multidisciplinary working across CYP services.
- Staff had good knowledge and understanding of the Mental Capacity Act 2005. The looked after children team showed a good knowledge of Deprivation of Liberty Safeguards and the Mental Health Act.
- Staff were caring, compassionate and considerate towards children, young people and their families, and included them in care decisions.
- Staff demonstrated a thorough understanding of the communities and families that they worked in.
- Staff planned services in accordance with the needs of the communities and schools they worked in.
- Staff were positive about local leadership and we found a culture of openness and learning.
- The integrated care managers showed a strong understanding of the risks within the service

However:

- Not all clinical staff had received safeguarding children level three training, in line with the intercollegiate document.
- Environmental infection control procedures were not consistent across all areas. We found carpeted floors and fabric chairs in clinical areas without risk assessments or cleaning schedules.
- Staff did not consistently update standard operating procedures, which could lead to staff using out of date best practice guidance.
- Knowledge of risk and risk management within local teams and amongst team managers was limited.

Summary of findings

Background to the service

Anglian Community Enterprise (ACE) provides a range of health services for children, young people and their families. ACE provides services across north and east Essex covering Colchester, Clacton-on-Sea, Harwich, Frinton-on-Sea and the surrounding areas.

ACE provides multiple services for children and young people including health visiting, school nursing, looked after children services and therapy services (physiotherapy, occupational therapy, and speech and language therapy). ACE does not provide medical care.

ACE employs a variety of staff as part of a commitment to a diverse skill mix in teams. Staff included clinical support workers, nursery nurses, Nursing and Midwifery Council registered staff and Health Care Professionals Council registered therapists.

During the inspection we spoke to 39 staff including 17 health visitors, two school nurses, four nursery nurses, five support staff, five therapists, two looked after children's nurses and four managers. We spoke to 10 relatives and two patients. We reviewed 11 patient records, two 'red books' and directly observed six treatments or interactions between staff, patients and relatives.

We attended four clinics and six home visits with health visitors. We reviewed information supplied by ACE before the inspection and looked at policies, documentation, audit data and meeting minutes during and following the inspection.

The children and young people's inspection team had three inspectors (one of which was still a registered health visitor) and two community nurses.

Good practice

ACE were the first community care provider to receive the Baby Friendly UNICEF Accreditation. This showed that the serviced worked proactively to support breast-feeding and parent and infant relationships

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider should consider the level of safeguarding training provided to non-registered staff providing clinical care.
- The provider should ensure that all relevant standard operating procedures are updated and implemented across the organisation.

Anglian Community Enterprise Community Interest Company (ACE CIC)

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 safe good because:

- Staff were aware how to report incidents. We saw evidence of learning from incidents.
- Staff had a good understanding of duty of candour, despite not using the Regulation often.
- Staff compliance with safeguarding training was 98% for level two and 100% for level three across children and young people's services in November 2016.
- External companies serviced equipment within the required period and staff stored equipment securely.
- Mandatory training compliance across children's services was above Anglian Community Enterprises target of 95%. Colchester had a compliance rate of 98% and Tendring had a compliance rate of 99%.

However:

- Staff did not meet their target of 95% for Prevent training compliance, achieving 66%.
- The cleaning of equipment, including toys, was inconsistent across all areas visited.
- Two of the clinics visited had furniture and flooring that could not be wiped clean, with no risk assessments in place.

Safety performance

- We found, overall, services for children and young people were safe.
- The provider monitored safety performance monthly. The integrated care managers fed into the Board through service summery reports. Wider performance was monitored through specific groups and committees within the governance framework.

Good

Are services safe?

Incident reporting, learning and improvement

- CYP services reported 147 incidents since between 1 December 2015 and 5 December 2016. Accidents (excluding falls), administrative incidents and communication problems were the three most commonly reported incidents during this time. All reported incidents had descriptions of what happened and immediate actions documented. These included informing senior management, speaking with relatives and contacting other professionals, for example social services. We asked staff about reporting incidents and all staff asked knew how to report incidents and gave appropriate examples of what should be reported.
- Children and young peoples (CYP) services reported no serious incidents or never events between January and November 2016. A serious incident can be identified as an incident where one or more patients, staff members, visitors or member of the public experience serious or permanent harm, alleged abuse or a service provision is threatened. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- A team manager gave an example of when a parent became agitated during a meeting and threatened staff. Following this incident, staff now have access to a panic alarm and have a direct number to the head of security at the location concerned should they need help in an emergency.
- We reviewed two investigation reports from 24 February 2015 and the 30 December 2015. Both reports were detailed and we could see documented learning from the incident and evidence of an appropriate response from the provider.

Duty of Candour

- We asked six members of staff about duty of candour. They were all aware of duty of candour, explained what was involved and gave appropriate examples of when the regulation might be applied.
- 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.

Safeguarding

- Across CYP services, 98% of staff had completed level two safeguarding training (in line with ACEs requirements) and 100% of staff had completed their level three safeguarding training (in line with ACEs requirements) between December 2015 and November 2016.
- We spoke to 11 staff about safeguarding patients and safeguarding procedures within ACE. All of the 11 staff knew their responsibilities in reporting safeguarding concerns and all had completed the required level of safeguarding training.
- ACE trained all registered members of staff in children's safeguarding level three and all clinical unregistered members of staff in children's safeguarding level two. Both groups of staff completed adult safeguarding level two training. This was not in line with the intercollegiate document 'Safeguarding Children and Young People: roles and competence for healthcare staff'. The document states staff who "potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns" should receive level three training. Although unregistered staff had been upskilled with clinical competencies, the provider had not considered including safeguarding children level three within the additional training.
- Nursery nurses were undertaking baby weigh clinics and home visits independently and clinical support workers (CSW) undertaking the National Child Measurement Programme (NCMP) within schools with remote supervision from a registered member of staff elsewhere. Both nursery nurses and CSWs had received additional competencies to assess, plan and implement care without always consulting with a registered practitioner. For example, the CSWs referred children and young people to weight management clinics (where required) following their participation in the NCMP.
- We reviewed health records from baby weigh clinics ran by nursery nurses and found documentation that showed the assessment of mothers and babies and advice given. For example, one record showed an

assessment of gross motor skills of a baby and one had advice regarding breast care following concerns with feeding. Nursery nurses were undertaking six month checks independently, completing the assessment and providing advice and support in line with the Health Child Programme.

- Health visitors did assess individual families for home visits to ensure that nursery nurses attended homes and families deemed low risk. All nursery nurses asked knew when and how to escalate concerns to a registered member of staff.
- Staff had safeguarding supervision every three months with a team leader. Safeguarding supervision was mandatory for all registered staff. Safeguarding supervision gave staff the opportunity to raise concerns and provided a governance structure to support improved care delivery. Staff spoke positively about safeguarding supervision and told us it helped them focus and improve. All staff spoken to confirmed they had safeguarding supervision every three months.
- Prevent training (training for staff to identify individuals at risk of radicalisation) compliance in November 2016 was 66% against a target of 95%.
- Health visitors and school nurses had monthly one to one sessions with their line manager where caseloads were discussed. This ensured line managers were aware of families at risk and the interventions required. We saw white boards in each base visited with the number of at 'risk families' and those children on protection plans within the team's geographical area. Staff knew the children and families currently on their caseload that required additional support and input.
- Between July and September 2016, staff made 42 referrals to the local safeguarding children's authority. No LADO referrals were made over the same period (the management of allegations against staff working with children).
- Children at risk or on a protection plan had this documented within their electronic records. This was accessible to all health visitors and school nurses. The provider had oversight of the number of families and children on protection plans or at risk and senior staff reported this quarterly through the safeguarding governance report.
- We saw evidence in the quarterly report of the safeguarding team implementing and reviewing action plans following serious case reviews (SCR). The quarter two report (July to September) detailed outstanding actions for three previous SCRs. These included the need to update the domestic violence policy within six months and the implementation of an audit for monitoring safeguarding supervision. We found the audit had begun at the time of the inspection. This showed continued progression and learning from the SCRs.
- ACE was involved with one active SCR at the time of inspection and the ICMs and safeguarding team showed a good understanding of the case.
- The children's safeguarding lead nurse participated in SCR, missing and child exploitation meetings and multi-agency case audits for the local safeguarding boards.
- Staff attended case conference as required for families and children within their caseload. Within quarter two (July to August) 2016, staff attended 78 case conference.
- Staff were aware of their responsibilities and legal duty to report suspected cases of female genital mutilation (FGM). ACE developed an action plan in 2014 to ensure those at risk of FGM were identified and safeguarding appropriately. The action plan was in line with the Tackling FGM in the UK: Intercollegiate recommendations for identifying, recording and reporting. All required actions had been completed except one, which was still ongoing and related to how GPs can successfully implement the intercollegiate guidance.
- Posters were available in each location with the process for referral documented. Staff had a good knowledge of the referral process

Medicines

- Within children and young people's services, no member of staff dispensed medication to children or young people.
- Health visitors and nursery nurses did give vitamin supplements to parents at baby clinics, which do not require a prescription.

Environment and equipment

- Staff provided children and young people's services in remote locations, for example schools or parents homes as well as clinics.
- We visited multiple locations during the inspection which were wheelchair and push chair accessible. All locations were bright and child friendly.
- We found the design of clinical areas and waiting areas ensured the safety of patients and families. For example,

the clinical area at the Primary Care Centre in Colchester had a buzzer entry system and a door release button to exit. This ensured only authorised people entered children's treatment areas and prevented children leaving unaccompanied.

- We saw staff appropriately segregate waste before disposal. All locations providing clinical care and had separate 'household' waste bins and 'clinical' waste bins. Where appropriate sharps boxes were available.
- We looked at nine pieces of equipment during the inspection including scales, gym equipment (used during physiotherapy sessions) and lighting equipment within sensory rooms. All equipment had been serviced within the last 12 months.

Cleanliness, infection control and hygiene

- Staff participated in hand hygiene audits at regular intervals.
- We observed staff washing their hands in line with the World Health Organisation's Five Moments of Hand Hygiene and saw staff using alcohol gel at appropriate times. For example, we saw staff using hand sanitiser before and after home visits.
- The infection control policy was in date following implementation in July 2015, and for review on July 2017.
- Cleaning rotas for equipment, including toys and distraction equipment were in place across all areas visited. However, these were not consistently completed. For example, staff at the Primary Care Centre in Colchester had 'ticked' to denote they had cleaned four of the nine items listed in November. Senior staff could not show us previous cleaning schedules, as they were not kept on site.
- The cleaning schedule at the baby weigh clinic at Fryatt Hospital, had not been completed consistently in the month of November. We raised this with a member of staff at the time who could not tell us why it had not been completed.
- We were not assured that staff cleaned all used toys and equipment sufficiently or regularly to reduce the risk of cross infection due to the inconsistent completion of records. We also saw one nursery nurse not clean equipment following a home visit.
- All areas visited were visibly clean, including floors, seating and clinic rooms. Staff and services users had access to hand washing facilities at all areas visited.
- A hand sanitiser dispenser was on the wall in the waiting room at Fryatt Hospital; however, it was empty and contained no gel. On raising our concern with the team leader, they escalated it to the domestic staff to refill the dispenser.
- At Fryatt Hospital, we found all chairs within the waiting room and clinic room were fabric covered and not wipe clean. Senior staff told us no risk assessment had been completed for the chairs. The inability to sufficiently clean the chairs between uses could result in the spread of infections. This was not in line with the Department of Health: Health Building Note 00-09.
- At the Primary Care Centre in Colchester, we found the sensory room had a carpeted floor. This was not in line with the Department of Health: Health Building Note 00-10. Senior staff were unable to explain the process for cleaning the carpets. Staff had not completed a risk assessment for the carpeted flooring. We were not satisfied sufficient staff knew how to clean the carpeted areas appropriately. The lack of a risk assessment and knowledge of staff increased the risk to patients using the carpeted floors from cross-infection.
- Although independent providers do not have to follow the Department of Health: Health Building Notes, they must consider the recommendations when planning services.

Quality of records

- Staff used an electronic patient record system. We reviewed 11 electronic records and two child health records (known as 'red books') during the inspection.
- We found that all documentation reviewed was detailed and contained all required and relevant information relating to the child, young person or family.
- For example, we reviewed one record with documentation from the looked after children's (LAC) team. The LAC team had clearly documented the concerns and had completed a body map to show marks and injuries on the young person.
- We reviewed a record regarding a premature baby. Health visiting staff had completed the record in detail with further follow up dates clearly documented.
- When nursery nurses attended clinics without a health visitor, they recorded information in children's electronic records and we saw them updating child health records ('red books') at the baby weigh clinics'. We reviewed five clinic records. All records were detailed, accurate and up to date.

Good

Are services safe?

Mandatory training

- Mandatory training covered multiple areas, included safeguarding adults and children, basic life support, Mental Capacity Act 2005 and infection control.
- Children and young people's services were split into two areas, Colchester and Tendring. Compliance data for Colchester in the month of November 2016 was 98.6% against a target of 95%. Data for Tendering was 99.1% for the same month.

Assessing and responding to patient risk

- Children and young people's services had systems in place to identify children at risk and minimise that risk.
- ACE did not undertake medical examinations for child protection concerns. Staff referred children and young people into the local children's acute NHS services for paediatrician input.
- Team leaders kept an overview of all caseloads through monthly one to one meetings with staff. This ensured that at times of sickness or sudden absence, senior staff were aware of caseloads and those children and young people at particular risk. ACE also monitored the number of families on the MESCH programme each month, including new and current families. This allowed managers to have oversight of the demands on individual teams. For example, in October 2016, there were 470 families on a MESCH programme, with 177 being new month.
- Staff across all bases could access patient records. For families that moved within the area, this ensured staff had access to health records, alerts and risks. During times of absence, this allowed other team members to 'pick up' workloads and provide a continuous service.
- Staff could summon emergency help from the emergency services when out on home visits or in community clinics. Staff could access resuscitation equipment in all clinics held in ACE buildings, for example Fryatt Hospital and Colchester Primary Care Centre.
- Health visitors and school nurses could escalate urgent concerns throughout the day to a senior team leader or integrated care manager for support and guidance.

Staffing levels and caseload

- The 0-19 service was an integrated service of health visitors and school nurse, supported by nursery nurses and clinical support workers.
- The 0-19 service had 105.2 whole time equivalent (WTE) registered nurses. This included health visitors and school nurses. There were 15.1 registered nurse vacancies for the month of November 2016.
- There were 20.3 WTE non-registered staff, including clinical support workers and nursery nurses. This was slightly above establishment, to enable a more flexible workforce.
- The Benson Model was used for calculating staffing across children and young people's services following NHS England's "Call To Action" review between 2011 and 2015. One senior nurse described how they were relocated due to caseload sizes changing and the needs of the service users within a particular area.
- Each health visitor had between 400 and 500 children on their caseload. The Laming Report 2009 (and reaffirmed by the Royal College of Nursing in 2013) recommended that caseloads should not exceed 300 families or 400 children per health visitor, and staffing should be increased when a greater number of families are identified as being at risk.
- The school nurses had between two and four secondary schools, special needs schools and or grammar schools (if within their area). School nurses also had links with primary schools and any private schools within their geographical working area. There is currently no national guidance on caseload sizes for school nurses. However, staff told us that their workload was manageable and they were able to provide the input required.
- The looked after children (LAC) team had a caseload of 584 children and young people. The Royal College of Nursing (RCN) in 2015 found that nationally LAC team's caseloads ranged from less than 100 to over 5000, with ACE being in the lower 40% of providers. The RCN also found that the 85% of organisation had one WTE specialist LAC nurse. ACE was performing significantly better with two WTE specialist LAC nurses and four additional WTE nurses within the LAC team to support the specialists.
- Within children's speech and language therapy, there were 18.9 WTE therapists to a caseload of 2589. Children physiotherapy had 8.57 WTE staff to a caseload of 1274. Children's occupational therapy had 5.7 WTE staff to a caseload of 750. The Royal College of Speech and Language Therapists, College of Occupational Therapy

Good

Are services safe?

nor the Chartered Society of Physiotherapy had produced guidance on caseload sizes for their relevant professions. No other national body has produced guidance on therapist's caseload sizes

Managing anticipated risks

- A Lone Working Policy was in place at the time of the inspection. All staff spoken to were aware of the policy. Teams undertaking mobile working ensured that any staff not returning to a base office telephoned the team leader or duty health visitor to inform them they had left safely.
- Staff had access to an emergency system called Guardian 24. This allowed staff to discretely telephone for help if they were in a compromised situation. All staff spoken to were aware of the system. However, none of the four staff asked could demonstrate the systems use.
- Staff were able to alert other colleagues of a difficult situation via their laptops. A built in feature allowed staff to send a blanket message that would appear on all connected staff laptops.
- During adverse weather conditions, visit lists were adjusted to reduce the length of travel by staff.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We rated effective as good because:

- We found evidence of staff adhering to national best practice and used evidence based bundles of care.
- The provider had good technology embedded within its services.
- Staff received a yearly appraisal. All staff asked told us that the appraisal process was useful.
- We saw good evidence of multidisciplinary working across children and young people's services.
- Staff had a good knowledge and understanding of consent and how to obtain it. Staff undertook Mental Capacity Act 2005 training and could explain how to establish if a person had capacity.
- The Looked After Children's team understood the principles of the Mental Health Act 2007 and could explain how and when to seek further advice.
- Non-registered staff had a comprehensive competency package for undertaking all required duties within the integrated 0-19 year's service. The competencies were in line with the Healthy Child Programme and National Child Measurement Programme.
- Registered staff had access to a preceptorship programme, which was comprehensive and detailed. All staff asked spoke positively about the preceptorship programme.
- Services did not always meet key performance indicators (KPI). However, services had implemented KPIs where concerns were highlighted and improvements needed. For example, breast feeding at six to eight weeks.

However:

- Staff did not routinely update standard operating procedures in line with their agreed review date. This could lead to staff using outdated guidance

Evidence based care and treatment

- Staff assessed the needs of families, parents and young people in line with current national guidance and best practice, for example from the National Institute of Health and Care Excellence (NICE) and the Department of Health.
- We saw health visitors using NICE guidance CG 192 'antenatal and postnatal mental health' (known as Whooley questions) to identify those mothers at risk of post-natal depression.
- Staff were aware of NICE guidance CG111 'bedwetting in under 19s' (published October 2010), despite not providing enuresis ('bed wetting') service.
- Staff had recognised within some geographical areas that there was a high instance of parents sleeping with their babies in the same bed. NICE CG37 post-natal care up to eight weeks after birth details the risks of co-sleeping, including an affiliation to sudden infant death syndrome. Staff recognised that parents continued despite informing them of the risks, so implemented a scheme supplying parents with a small crate type box that baby could sleep in. This helped keep baby safe from injury but allowed parents to keep baby in the same bed.
- Health visitors and school nursing services worked in accordance with the Health 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.
- ACE were the first community care provider to receive the Baby Friendly UNICEF Accreditation. This showed that the serviced worked proactively to support breast-feeding and parent and infant relationships.
- There were a number of standard operating procedures (SOPs) in place for a variety of care delivery activities. However, staff did not routinely update all SOPs in accordance with the agreed review date. For example,

the "testing reception children's hearing" and "testing reception children's vision" were due for review in August 2016, but had not been reviewed at the time of inspection.
- However, there were a number of SOPs that were well referenced and in line with current national guidance and best practice. For example, policies and SOPs referenced the Healthy Child Programme 2009, NICE guidance on neonatal jaundice and NICE CG89 Child Maltreatment guidance.

Technology and telemedicine

- All staff had a laptop and telephone issued to them to enable remote working. Staff could update patient records when not connected to the network. Records would update automatically once reconnected.
- ACE was using smart phone applications to help parents and young people with health advice and support.
- All staff spoken to were competent in the use of ACE issued technology, including navigating ACE's intranet site.

Nutrition and hydration

- ACE monitored the number of mother's breastfeeding at 48 hours, 10 days and six to eight weeks. The target for breastfeeding at six to eight weeks was set at 48.2 %. In October 2016 compliance with this target varied across areas ranging from 21% to 68.5%.
- An action plan had been developed to address this variation, particularly in the low uptake areas. The action plan including additional training for staff, information cards to ensure consistent sharing of information with parents and implementing practitioners with special interest (breast feeding) roles within each team. The actions were ongoing at the time of the inspection.
- We saw staff give up to date and relevant breast feeding advice to new mothers. We also observed staff provide up to date weaning advice for mothers. ACE discussed weaning with 43% of mothers at the six to eight week baby check. This was against a target of 90%. This key performance indicator had been implemented after staff raised concerns that they were not seeing babies later in life and therefore missing the opportunity to discuss weaning. ACE had developed an action plan to improve compliance.

Patient outcomes

- The provider monitored its performance against the Department of Health Healthy Child Programme. ACE produced monthly key performance tables to show compliance.
- ACE had a predominantly positive performance against those outcomes with KPIs attached to them. The percentage of antenatal visits achieved was 88%, against a target of 80%, in October 2016. The percentage of new babies seen within 10 to 14 days of birth was 91.6% against a target of 90%, in October 2016.
- ACE exceeded their own targets of 90% of 1 year checks completed (achieving an average of 95.7% in October 2016) and 95% for 15 month checks (achieving an average of 95.1% in October 2016).
- The five to 19 teams had met or exceeded all KPIs for August, September and October 2016. For example, 100% of overweight or obese children had been referred to a weigh management programme against a target of 100%. ACE had weighed and measured 97% of 10 and 11 year olds, in line with the National Child Measurement Programme, against a target of 95%.
- ACE had implemented KPIs outside of the Healthy Child Programme framework where it had identified areas for improvement. For example, discussion around weaning and breastfeeding rates. The additional KPIs reflected national best practice and guidance, for example NICE PH11 maternal and child nutrition and the UNICEF Baby Friendly Initiative.
- Children's services participated in two national research projects, CDI project for health visitors, and Couple Dynamics and Maternal Smoking during Pregnancy, both in 2014. However, the project had not been published at the time of the inspection and the maternal smoking research had been put on hold. We saw evidence of updates being provided to the board on a quarterly basis.

Competent staff

- All staff starting at ACE participated in an induction process.
- Between August 2015 and July 2016 92.3% of staff had received an appraisal, against a target of 95%. Training needs were discussed and actions set during appraisals

and reviewed in monthly one to ones. Four members of staff told us they had received an appraisal within the last year, and felt that the appraisal process was productive for their development.

- Health visitors completed an 'induction framework' when starting employment. The induction framework was broken into week blocks and guided staff through multiple areas of health visiting. For example, weeks seven to 12 looked at universal and core service delivery, health promotion and policies and procedures. We found the induction framework to be thorough, holistic and covering all expected areas of competence.
- Registered staff undertook a preceptorship programme. The programme was comprehensive and covered relevant topics. For example, one section discussed caseload management including dealing with conflict whilst on home visits.
- Unregistered staff completed locally based competencies workbooks. We spoke with six clinical support staff, and out of these four had completed the competencies with two new to the team and still on supervised on visits.
- Nursery nurses completed a comprehensive competency framework to allow them to undertake aspects of the Health Child Programme, for example undertaking home visits and providing ongoing support and monitoring at baby weigh clinics. In December 2016, 88.6% of nursery nurses had completed the 18 part competency assessment framework.
- All staff received monthly 'one to ones' with their line manager or supervising health visitor. Staff told us that these happened and found them useful.

Multi-disciplinary working and coordinated care pathways

- We found evidence of multidisciplinary working across all teams within children and young people's services, with a number of different teams such as therapies, health visitors and nursing staff being co-located at central bases.
- The looked after children team worked closely with external agencies, such as local and national safeguarding children boards, mental health services and family support staff.
- One senior school nurse provided an example of their team working closely with schools to provide tailored services to target particular issues, for example smoking, sexual health advice or radicalisation.
- GPs could access health visitor and school nurse records through an integrated computer records system, providing a joined up approach to information sharing.

Referral, transfer, discharge and transition

- Staff were able to describe the process for referring a child, young person or family where they suspected safeguarding or domestic violence concerns and this was seen within children's electronic records. Staff were able to refer directly into the local acute hospital for review by a paediatrician where staff had concerns.
- Health visitors and school nurses described the process of referring children with additional requirements or conditions into the local acute service for specialist nurse or medical assessment. For example, one senior manager explained the process for referring children and young people with enuresis ('bed wetting') into the specialist enuresis service.
- The provider's standard operating procedures (SOP) detailed the referral criteria and process for staff concerned about a child. For example, the national child measurement programme SOP detailed when and how to refer to a management programme and the 'testing reception children's vision' had a clear referral flow chart for staff to follow.

Access to information

- ACE used an electronic patient record system. This was a national system adopted by many community providers, including GPs within the Essex area.
- Health visitors and school nurses were able to access patient information and care records during home visits. Staff were able to update patient records electronically during home visits.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- All staff we spoke to understood their responsibility in gaining consent prior to undertaking an examination or treatment. Staff could describe the differences between Gillick competence (the judgement of children to consent to medical treatment) and the Fraser guidelines (guidelines specifically associated with contraception and sexual health advice) and knew when each was applicable.
- One member of staff gave the example of a young person, who was deemed competent, refusing to have

their height and weight taken as part of the healthy schools programme. The member of staff told us that they would respect the young person's wishes and not proceed.

- The specialist team for looked after children for 16 to 19 year olds, demonstrated an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2010. The Mental Capacity Act 2005 applies to everyone from the age of 16 and Deprivation of Liberty Safeguards 2010 can apply to anyone 18 years or older who lacks capacity.
- An example given was of a young person with a mental health problem who may need to be detained to keep them safe. Staff could explain the differences between the Mental Capacity Act 2005, Deprivation of Liberty Safeguards 2010 and the Mental Health Act.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Staff displayed a kind, compassionate approach when talking to parents.
- Children and young people's Friends and Family Test results were above 98% since April 2016.
- Staff involved parents and carers, and children and young people in care decisions.
- Staff supported families to manage conditions at home and make improvements to their health.
- Staff supported families using the Maternal Early Childhood Sustained Home Visiting programme.

Compassionate care

- Staff treated children, young people and families with respect, dignity and compassion. We observed friendly and professional relationships between families and staff. Staff were considerate of family homes and situations when on home visits.
- During the inspection, we spoke with 10 relatives, two patients and observed care delivery on six occasions.
- One relative told us that staff at the baby weigh clinic were "approachable, friendly and interactive". Another relative at the baby weigh clinic told us it was "a good service" and they enjoy the "interaction" with staff.
- During one home visit, we observed a health visitor reassure a mother who was worried about her baby not sleeping. The health visitor was kind and compassionate in their response and the mother felt reassured following the discussion.
- We observed health visitors and nursery nurses using paper towels on scales before weighing babies. This ensured that staff did not place babies onto cold scales, which could cause additional distress to the baby.
- Friends and family test data for April to June 2016 showed 98.6% of 843 respondents were "likely" or "highly likely" to recommend children and young people's (CYP) services. Between July and September 2016, 99% of 836 respondents were "likely" or "highly likely" to recommend CYP services.

Understanding and involvement of patients and those close to them

- We observed health visitors involving parents and family members in the decisions about care. We observed a health visitor discuss options regarding feeding. The health visitor took the wishes of the mother into account whilst promoting the benefits of breastfeeding.
- We observed a health visitor discuss the sleep pattern of a baby. The health visitor discussed the importance of sleep, and was empathetic and understanding to the other needs of the family. For example, the mother needed to take and collect other children from school.
- We spoke to two families receiving treatment from speech and language therapists. One parent told us that they were kept "fully informed" before and during the treatment process. The parent told us that staff talked to their child and encouraged them to be fully engaged in the treatment process, despite their young age. The parent told us that staff discuss the most appropriate time for clinic appointments and will work around the needs of the child, for example outside nursery hours to limit the disruption to their education.

Emotional support

- Staff provided ongoing support to both parents and carers, children and young people.
- We saw health visitors providing emotional support to mothers struggling with breast feeding to enable them to continue with breast feeding and feel confident in doing so.
- Staff could refer families to local and national charities for additional advice and support. One national charity worked closely with the health visiting service providing a presence at some baby weigh clinics. This provided an additional point of contact for non-medical support and guidance.
- Health visitors provided advice over the telephone to parents to manage simple conditions at home. Staff arranged follow up calls to ensure that parents were coping and provide reassurance to families.
- The LAC team provided an example of a young person who had not received any school age vaccinations, as they were afraid of needles and hospitals. The LAC team spent time with the young person and took them twice

to the clinic where the vaccines were administered before they were given to the young person. The LAC team accompanied the young person during the vaccinations

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- Staff planned services to meet the needs of the local communities they serviced. All staff demonstrated a thorough understanding of the populations they served and the health needs associated with them.
- School nursing teams assessed schools to understand the health concerns specific to individual schools and tailor teaching sessions and health promotion advice accordingly.
- We found evidence of staff referring mothers at risk of domestic violence to other support services, for example women's refuges.
- The looked after children's team provided support to young people in care. For example, staff supported young people to access clinics to receive childhood immunisations.
- Health visiting teams had adopted the Maternal Early Childhood Sustained Home Visiting (MECSH) programme to support struggling families. We saw examples of families using the MECSH programme and the progress made.
- Children's speech and language (SALT) services demonstrated flexibility in providing additional therapy sessions to children and young people. For example, SALT staff offered one family additional therapy sessions over and above those normally provided, as they had not been filled by new referrals.
- Children and young people's services received a low number of complaints. Senior staff gave an example of a change in practice following a complaint.

Planning and delivering services which meet people's needs

- Anglian Community Enterprise (ACE) serves an area of mixed deprivation. The 0-19 year's services provided care to areas of high deprivation, particularly around the coastal towns and communities. However, there were areas within the ACE catchment that had very low levels of deprivation. Staff demonstrated an understanding of the needs of each local community they served and planned services in accordance with that.
- All staff that we spoke to were able to explain the risks associated with their communities and families within them. These included high instances of teenage pregnancy, an increase in gang related violence, high levels of domestic violence, high levels of alcohol and drug misuse amongst parents and secondary school pupils and a high level of mental health conditions. Staff told us that there was a significant immigrant and refugee population within the area.
- School nursing teams undertook 'health profiles' to establish the needs of each school and target health promotion and training as required. For example, one school nurse told us how they undertook relaxation sessions within a school due to high levels of stress and anxiety amongst the pupils. A school nurse told us how some schools have higher instances of sexually transmitted infections and teenage pregnancy rates. School nurses planned sexual health advice and teaching sessions within these schools during assembly time to reach the largest possible audience.
- Health visiting teams recognised that families within areas of significant deprivation were less likely to engage with health services, particularly if they had to travel. Health visiting teams had set up community clinics for baby weighing. Staff told us that this had increased the attendance and engagement with health teams; however, ACE had no formalised statistics to support this.

Equality and diversity

- Due to the geographical location, staff regularly visited families in deprivation or from non-British backgrounds (for example refugee families).
- All clinics visited during the inspection were disabled and buggy accessible. This ensured that all members of the community could access services.
- Staff had access to written, telephone and face-to-face translation services and four staff were able to explain how to access translation services. We saw posters and leaflets within clinic areas to inform families about the service.
- The health visiting team at Fryatt Hospital used story books in different languages (such as Polish) for children whose first language wasn't English.
- A senior school nurse told us that staff were sensitive to bullying in relation to young people who did not identify

as heterosexual or cisgender (denoting or relating to a person whose self-identity conforms with the gender that corresponds to their biological sex). The school nurse told us that they would provide confidential support and advice to the young person and a safe space.

Meeting the needs of people in vulnerable circumstances

- Staff regularly met families and children or young people who were or could become vulnerable due to their circumstances. For example, refugees, those at risk of domestic violence and parents with drug and alcohol dependence.
- The looked after children's (LAC) team provided support to children and young people living with someone other than their biological family, and those that cared for them, up to their 20th birthday.
- Health visiting teams provided support to parents at risk of domestic violence through individualised packages of care. For example, using alternative means of communication and meeting at a 'safe space'.
- All health visiting teams were using the Maternal Early Childhood Sustained Home Visiting (MECSH) programme to support families they identified as being at risk. MECSH was a programme designed to support families with complex needs or who were living in challenging and vulnerable situations. MECSH aimed to provide a structured and proactive approach to care delivery, rather than focussing on single health issues.
- We saw evidence within electronic records of staff referring families into the MECSH programme. Staff documented in detail and provided enough information for colleagues to follow up families. We observed care delivered within family homes for a family within the MECSH programme. We observed staff working together with families to implement an achievable care plan to enable families to move forward in a way that recognised individuality and personal preference, whilst safeguarding the child.

Access to the right care at the right time

- ACE monitored health visitor and school nurse interactions as recommended in the Department of Health Healthy Child Programme 2009. Health visiting teams across Colchester and Tendering met all of their targets for recommended visits. In October 2016 staff achieved 88% of antenatal visits, against a target of 80%, 91% of 10 to 14 day visits, against a target of 90%, and 96% of postnatal depression reviews, against a target of 95%
- The health visiting teams met and exceeded targets for 10 to 14 day reviews (91.6% against a 90% target), one year (95% against a 90% target), 15 month (95% against a 95% target), 18 month (100% against a 100% target) and 2.5-year (95% against a 90% target) checks in October 2016.
- The school nursing teams were on trajectory to meet their target of 95% of year six pupils undertaking the National Child Measurement Programme, achieving 23.3% between September and October 2016. This target was measured over school years (September to August).
- The school nursing team met their monthly target of 100% of children identified as overweight or obese having a referral to a weigh management programme in October 2016.
- The school nursing team met their target of 100% for the number of looked after children receiving a personalised self-management plan. ACE were just below their target of 100% for health assessment reviews being undertaken within 20 days of notification from social care of a looked after child, achieving 96% against a target of 100% in October 2016.
- Children and young people's (CYP) therapy service, including physiotherapy, occupational therapy and speech and language therapy (SALT), all offered timed appointments.
- We requested information from ACE regarding waiting times for all therapy services. ACE told us that due to these services not being consultant led, they do not formally collate and monitor wait times but do monitored at service level. However, they would be unable to provide accurate retrospective data in relation to appointment wait times. The integrated care managers reported 18 week breach data up to the Board on a monthly basis via their monthly service summary report.
- Two parents told us that their appointments generally run to time and there are few delays. Two parents told us that the booking process to make appointments was easy to use and took account of their needs.

Good

Are services responsive to people's needs?

- One parent told us that due to some SALT sessions not being filled, the SALT team offered an additional three sessions over and above the funded six sessions to ensure progress continued.

Learning from complaints and concerns

- CYP services received six complaints between July 2015 and June 2016. This accounted for 7.5% of the total complaints received by ACE. Of these, ACE upheld one complaint.
- Due to the low levels of complaints, staff across CYP services were not aware of the complaints that had been made.
- One integrated care manager told us of a complaint about the types of envelopes used to send written correspondents as personal information was visible through the envelope. As a result, children's services began using a different type of envelope.
- We saw complaints, concerns, compliments and comments leaflets and posters displayed throughout clinic areas. Staff were aware how to support a patient or family who wanted to make a complaint or comments on services.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated well-led as good because:

- Staff were positive about local leadership. Staff described managers as approachable and supportive.
- Children and young people's services were going through a period of significant change. Staff we spoke to told us that the senior leadership team and local management had been supportive and kept all staff fully informed of all progress.
- There was a limited vision and strategy for the service as it was being discontinued by Anglian Community Enterprise in March 2017. However, locally there was a commitment to continue providing high quality care to all families until March 2017.
- Staff were encouraged to make recommendations to managers. Staff were kept informed about the services through team meetings and monthly 'quality bulletins'.

However:

- Within local teams, knowledge and management of risk was limited; however, senior managers knew of the risks facing the service.
- We reviewed meeting minutes from team leaders and speech and language therapists. All meeting minutes lacked some detail and follow up to actions.

Leadership of this service

- An assistant director for operations managed CYP services and was accountable to the director for operations and quality. Two integrated care managers (ICM) were in place, one to manage Colchester north and south and one to manage Tendring north and south. Each ICM took responsibility for cross area services. For example, one ICM took responsibility for occupational therapy, physiotherapy and half of the 0-19 years team and the second for looked after children, speech and language therapy and the second half of the 0-19 service.
- Locally, each team had a senior nurse or therapist to manage the day to day running of that team.
- We asked 13 staff about leadership and supportiveness of their line managers. All 13 staff told us that they felt comfortable and confident to approach their team leaders and the ICM for advice and support. Staff told us that senior management were visible and attended team meetings, both when invited and unannounced.

Service vision and strategy

- ACE had an overarching vision, values and mission for the organisation. Staff were aware of the organisations values and could explain them.
- The ICMs understood and could explain in detail the challenges facing the service and the strategies needed to resolve and improve the service.
- At the time of the inspection, the service was in the process of transitioning to another provider. However, managers were developing a plan for the transfer of services.
- Children's therapy service (physiotherapy, occupational therapy and speech and language therapy) were transitioning to a restructured adult team. The Board had not agreed a final strategy for the transition of therapy service at the time of inspection.

Governance, risk management and quality measurement

- The organisation had processes in place to escalate and discuss risk. Children's services escalated concerns to the Board through the integrated care managers (ICM). The ICMs disseminated information back to team managers.
- The ICMs produced monthly service summaries. We reviewed these for May, August and October 2016 and found they contained details of staffing, quality measures, updates to service risks and performance data.
- We reviewed Board reports from September 2016 and October 2016. Both reports discuss children and young people's service, including safeguarding concerns, staffing and the release of new and updated national guidance.

Good

Are services well-led?

- We reviewed Board meeting minutes from May 2016 and July 2016, which contained discussions around children's services. For example, the July 2016 meeting minutes showed a discussion regarding the future of 0-19 years services.
- Team managers within CYP services attended monthly meetings. We reviewed meeting minutes from 6 September, 3 October, 1 November and 29 November 2016. The minutes were brief and limited in detail. All actions documented did have a designated member of staff to complete. However, not all action had dates for completion attached.
- We reviewed speech and language therapy (SALT) team meeting minutes from 7 September and 9 November 2016. Both meeting minutes were documented with some detail; however, no follow up dates for actions were discussed or documented. For example, within the 9 September minutes it was documented that two members of staff are required to fulfil two separate additional roles. A lead had been identified but no deadline for completion or review had been set. Staff did not discuss who had been appointed or an update in the 9 November meeting minutes.
- Both team managers and SALT meeting did discuss risk and quality, including staffing requirements, caseloads and safeguarding concerns.
- The two integrated care managers had a good oversight of the risks affecting CYP services. The integrated care managers described the risks in detail and could explain the actions staff were undertaking to address the risks.
- The ICMs produced a 'service risks' document which contained nine risks associated with the service. Seven of the nine risks were associated with staffing and workload concerns, one risk concerned lack of car parking at a particular location and one risk concerned a lack of treatment rooms.
- The document was brief and lacked some detail. For example, one risk, concerning the lack of treatment rooms, did not state which services or clinics were affected. None of the nine risks had review dates with two risks added in April 2016. In addition, no staff were allocated risk reduction measures. This meant the integrated care managers could not hold individuals to account for no improve or resolution.
- The provider had an organisation wide risk register which did not contain any risks specific to children and young people's services.
- Staff, including local team managers, were unable to explain the risks associated with their specific locations. Team managers could not access the service risk document for CYP services or describe what was on it. Team managers told us that they did not receive feedback on submitted risks and were unaware of the outcome of these.
- ACE had an internal intranet where staff could access information, policies and guidance. The intranet had a specific section for local risk registers. However, this section of the intranet site was blank and contained no information or risk registers.

Culture within this service

- We found a culture amongst staff that promoted the needs of the families, communities and children and young people they cared for. Staff were proud that they put families first and felt they go the extra mile to help children and young people. For example, speech and language offering additional clinic appointments above those required to progress a child's development.
- Staff actively sought to change service delivery to ensure equal access to clinics and healthcare. For example, delivering baby weighing clinics within deprived communities rather than in central locations allowed families unable to travel the chance to access healthcare.
- We found collaborative working between unregistered staff, nurses and therapists across all areas we visited. Health visitors and school nursing teams worked within the same office bases allowing for communication and interaction between services.
- Staff demonstrated an understanding of the expectations and limitations of their roles within the organisation. For example, nursery nurses explained when and how they would escalate concerns regarding a child or young person to a registered member of staff.

Staff and Public engagement

- Staff were encouraged to share ideas and improvement strategies with their line manager. Staff told us they felt listened to and acknowledged when they did raise ideas or concerns. ACE had offered additional training to staff that wanted to gain further experience and skills, for example in leadership and management.
- Public feedback forms were available at each clinic location for families and young people to complete.

Good

Are services well-led?

- ACE participated in the Friends and Family Test programme, with positive results across children and young people's services.
- Staff took informal feedback from families, children, and young people during visits and clinics. However, this was not formally recorded or documented anywhere for audit and improvement purposes.

Innovation, improvement and sustainability

- ACE had signed up to care closer to home which incorporated children and young people's therapy services.
- ACE had plans in place to digitalise Friends and Family Test feedback by using tablet computers to gather feedback whilst on visits to improve return rates. This was due for implementation in quarter four (January to March) 2016/2017.
- Children and young people's service had a workforce development plan in place for each aspect of the service. We saw the workforce development plan for health visiting for 2016/2017. The plan was detailed and contained the areas for development, detailed action plans to achieve these using a red, amber, green (RAG) rating for each outcome. The RAG ratings were due to be updated in quarter three (October to December).