London Borough of Newham Children's Health Service 0-19

Quality Report

Newham Dockside
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Date of inspection visit: 29 to 30 January 2019
Date of publication: 24/04/2019

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	**Good**
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Newham Children's Health Service 0-19 is operated by the London Borough of Newham. The service has approximately 200 staff operating within teams in four localities across the borough.

The service provides a range of health services for children and young people aged 0-19 years, and their families. These include health visiting, school health nursing, family nurse partnership, a child development team and perinatal mental health team. We inspected services for children and young people.

Summary of findings

We inspected this service using our comprehensive inspection methodology. We carried out our announced inspection on 29 to 30 January 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

This is the first time this service has been inspected. We rated it as **Good** overall.

We found the following areas of good practice:

- Safeguarding processes were in place to protect children and young people from harm. The service had good multi-agency working to identify and share risks. Staff received regular safeguarding supervision and had access to support from safeguarding advisors attached to each locality.
- Equipment used by school health nurses and health visitors was readily available, with electrical safety testing undertaken on all the equipment we checked.
- Comprehensive risk assessments were undertaken with care plans developed to address risks identified.
- Recruitment following the transition of the service to the local authority had meant staffing levels and skill mix had improved.
- Staff were aware of their responsibilities for incident reporting, and many were able to describe lessons learnt from incidents within the service and from serious case reviews.
- Children and young people's needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence based guidance.
- Staff were competent and had the right skills to do their job. There were good training and development opportunities open to staff.
- We saw a range of multi-disciplinary and collaborative working relationships with other professionals and agencies.
- All parents and carers we spoke with said they were happy with the service provided by the health visiting and school nursing teams. Staff were described as kind and caring, and service users were treated with dignity and respect.
- Service pathways and provision were targeted to the needs of the individual, and the service met the needs of those that were vulnerable in a variety of ways.
- School nurses and health visitors worked flexibly with children, young people and their families to encourage engagement with the service.
- Despite many significant issues facing the service since its' transition to the local authority senior managers had taken steps to address these, and there was ongoing continuing improvement.
- Managers told us they felt listened to by senior managers and staff felt well supported by clinical leads and integrated team managers.
- Staff were engaged through several groups and forums. Service users had been involved in staff recruitment and a service user feedback forum was being introduced.

However, we also found the following issues that the service provider needs to improve:

- The service was not meeting their mandatory training targets for nine out of the 18 training modules. Staff were not meeting compliance rates for conflict resolution (30%), sepsis (41%) and fire safety (62%).
- There was no written formal guidance for escalating complex safeguarding concerns, although there were systems in place for good communication exchange, and staff were able to describe how they would escalate any concerns.
- The safeguarding policy was not easily accessed by staff. The document was saved under clinical policies on the intranet. Several staff found it difficult to locate and open the policy in a timely manner.
- Staff received training in the Mental Capacity Act (2005), however at the time of our inspection

Summary of findings

compliance was 67% falling below the service target of 90%. We saw Mental Capacity Act (2005) training was scheduled in the two months following the inspection which staff were expected to attend.

- Health promotion information was available on several topics. However, leaflets were much more widely available in some locations compared to others and were mainly provided in English and standard print size.
- Most service users we spoke with said that it was not clear to them how to provide feedback or raise a complaint. Senior managers acknowledged there was still work to do to make the complaints system clearer.
- The service was not always able to extract the relevant data from the system to run reports on the key performance areas of delivery. Managers were liaising with the relevant parties to ensure that the correct reporting requirements were in place and at the time of inspection, we were told this was still work in progress.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South East)

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Good

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Services we looked at

Community health services for children, young people and families;

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Background to London Borough of Newham Children's Health Service 0-19

The London Borough of Newham Children's Health Service 0-19 registered with CQC in February 2017, and has a registered manager. This was the first inspection following registration. The service is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury

The London Borough of Newham provided a range of services to children and young people from 0-19 years old across the borough of Newham including:

- Health visiting.
- School Nursing.
- Family Nurse Partnership – a home visiting programme for first time young mothers 19 years or under.
- Child Development Service – supporting children with disabilities up to the age of five years.
- Perinatal Mental Health Team.
- Safeguarding Advisors Team.

Practitioners deliver care and treatment to children and young people in their own home, in schools, in health centres and children's centres across the local area.

Health visiting and school nursing within Newham was previously provided by a local NHS Foundation Trust. The school nursing service transitioned from the NHS to the London Borough of Newham in February 2017 followed by the health visiting team and family nurse partnership in August 2017.

Staff worked together in integrated teams, each led by a clinical lead and integrated team manager, and were based in four localities: West, South, East and Central across the borough of Newham.

Demographic data about the London Borough of Newham:

- 85,755 children living in Newham in 2018.
- 94% school children were from a black and minority ethnic group (School Census 2017).
- 19.8% children were living in poverty which was above the national average.
- Infant mortality rates were lower than the England average, whilst child mortality rates were higher than the England average (2014-2016).
- Family homelessness was the worst recorded within England (2016-2017).
- The number of children recorded as obese was higher than the England average (2016-2017).

Our inspection team

Our inspection was overseen by Terri Salt, Interim Head of Hospital Inspections (North London).

The team that inspected the service comprised two CQC inspectors, a specialist advisor in health visiting, a specialist advisor in school health nursing and a specialist advisor in child safeguarding.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed a range of information we held about the service. We analysed service-specific information provided by the organisation, and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive, and well-led.

We carried out an announced inspection between 29 to 30 January 2019

Summary of this inspection

During the inspection visit, the inspection team:

- Visited all four localities across Newham: East, West, Central and South.
- Spoke with staff within the health visiting and school nursing teams, family nurse partnership, perinatal mental health team and child development service.
- Spoke with the safeguarding team including the safeguarding named nurse and safeguarding advisors.
- Attended clinics at children's centres and health centres and observed home visits.
- Observed health assessments at one primary school, one secondary school and one special school.
- Attended meetings and focus groups.
- Spoke with nine service users.
- Interviewed clinical leads and integrated managers.
- Interviewed senior managers.
- Looked at 14 care and treatment records of patients.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Children, young people and their parents and carers were all positive when providing feedback about the health visiting and school health teams.

Service users described staff within the service as respectful, caring, kind and compassionate.

Between 7 November 2018 and 13 February 2019, the service collected 441 responses from service users and their parents and carers of the health visiting service. Of the respondents, 95% said they would always recommend the service and 4% said they would sometimes recommend the service.

In November 2018 22 responses were collected from service users and their parents/carers of the school health service. Of the respondents 86% said they would always recommend the service and 9% said they would sometimes recommend the service.

Service users felt that staff provided good emotional support, with parents and carers saying they could raise concerns when necessary and felt listened to.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- Safeguarding processes were in place to protect children and young people from harm. The service was well integrated with the Multiagency Sharing Hub (MASH) which optimised information sharing where risks were identified.
- Staff received regular safeguarding supervision and had access to and support from safeguarding advisors attached to each locality.
- Equipment used by school health nurses and health visitors was clean and readily available, with electrical safety testing undertaken on all equipment we checked.
- Despite major challenges to the service since its' transfer to the local authority in relation to staff being appropriately located and connection to the electronic records system, the majority of staff acknowledged there had been improvements. Ongoing work was being undertaken to ensure further progress.
- Staff carried out comprehensive risk assessments and developed plans of care accordingly, with risk managed effectively.
- Recruitment following the transition of the service had resulted in improved staffing levels for both the school health and health visitor teams with low vacancy levels and increased skill mix.
- Records we checked contained height and weight measurements, risk assessment and comprehensive care plans for children and young people using the service.
- Staff were aware of their responsibilities for incident reporting, and many were able to describe lessons learnt from incidents within the service and from serious case reviews.

However:

- The service was not meeting their mandatory training targets for nine out of the 18 training modules. Staff were not meeting compliance rates for conflict resolution (30%), sepsis (41%) and fire safety (62%). An action plan was in place for improvement to be monitored by senior managers.
- There was no written formal guidance for escalating complex safeguarding concerns, There were systems in place for good communication exchange, and staff were able to describe how they would escalate any concerns.

Summary of this inspection

- The safeguarding policy was not easily accessed by staff. The document was saved under clinical policies on the intranet. Several staff found it difficult to locate and open the policy in a timely manner.
- We saw mixed adherence to infection control protocols. Some staff showed good compliance with hand hygiene and equipment cleaning, whilst others were seen not following national guidance.

Are services effective?

Good

We rated effective as good because:

- Children and young people's needs were assessed and treatment was delivered in line with current legislation, standards and evidence based guidance.
- Policies and procedures were based on guidance produced by the National Institute for Health and Clinical Excellence (NICE) and other nationally recognised guidelines.
- Staff were competent, and had the appropriate skills to deliver safe care and interventions. Staff told us they were actively supported to access additional training and development opportunities.
- We observed a range of positive multidisciplinary working arrangements with school nurses and health visitors working alongside other professionals to ensure the health and social care needs of children and young people were met.
- We saw school nurses and health visitors providing health information on a variety of topics. New service information packs had been developed by the service. These provided parents and carers with relevant health information following the birth of a baby and when their child was starting school.

However:

- The service under performed for the 12-month reviews with only 32% being completed by 12 months against a target of 55%, and 72% being completed by 15 months against an 80% target.
- Development of a dashboard to monitor the delivery of key performance standards was still a work in progress. For example, the service included antenatal contacts as a measure within the dashboard, but there were no locally agreed targets set for the service to aspire to. However, there are no set national targets for this measurement.
- Staff received training in the Mental Capacity Act (2005), however at the time of our inspection compliance was 67%

Summary of this inspection

falling below the service target of 90%. We saw that there was training in the Mental Capacity Act (2005) scheduled in the two months following the inspection which staff were expected to attend.

Are services caring?

Good

We rated caring as good because:

- All parents and carers we spoke with said they were happy with the service provided by the health visiting and school nursing teams.
- Staff were described as kind and caring, and that service users were treated with dignity and respect.
- We observed good age appropriate interaction and communication, putting children and young people at ease and encouraging a good rapport.
- Health visitors were sensitive to the needs of the population and showed empathy and offered assurance to parents and carers facing challenging situations.
- Between 7 November 2018 and 13 February 2019, of 441 service users who provided feedback, 99% said they would always or sometimes recommend the health visiting service. In November 2018 of 22 service users who left feedback, 95% said they would always or sometimes recommend the school health service.
- A perinatal mental health team provided support for women following birth, undertaking appropriate risk assessments and making referrals and signposting as necessary.
- Staff prioritised listening to the child and their family, explaining that the child's view must be integral to the service provided. A mandatory field had been added to the records for staff to enter the 'voice of the child' at each contact made.

Are services responsive?

Good

We rated responsive as good because:

- Managers and staff were aware of the complex demographics of the local population, and were committed to tailoring support to the health needs of the individual.
- The children's health service was integrated into neighbourhood teams which allowed better communication with other staff and external agencies. This supported the aim of improving the overall provision of service for children, young people and their families.

Summary of this inspection

- Service pathways and provision were targeted to the needs of the individual. For example, looked after children and those on the child protection register had involvement from a number of agencies and receive regular face to face visits.
- The service met the needs of vulnerable people in a variety of ways, for example the child development service assessed and supported the needs of children with complex or additional needs.
- Staff used interpreters to provide advice and support to families whose first language was not English.
- School nurses and health visitors delivered the Healthy Child Programme, working flexibly with children and their families to encourage engagement.

However:

- Health promotion Information was available on several topics. However, leaflets were much more widely available in some locations compared to others and were mainly provided in English and standard print size.
- Most service users we spoke with said that it was not clear to them how to provide feedback to the service, and how to make a complaint. Senior managers acknowledged that there was still work to do to make the complaints system clearer.

Are services well-led?

Good

We rated well-led as good because:

- There were clear lines of reporting and accountability within the service.
- Despite many significant issues facing the service since its' transition to the local authority, senior managers had taken steps to address these and there was ongoing work for continuing improvement.
- Managers told us they felt listened to by senior managers and staff felt well supported by clinical leads and integrated team managers.
- A development programme had been in place for Band six health visitors and school health nurses which had been popular, and the service were now introducing a similar programme for staff between Band three and Band seven.
- Staff we spoke with said that the service offered a friendly place to work with supportive colleagues. All staff welcomed collaborative working within and between teams.

Summary of this inspection

- Governance structures were in place so key risk and performance issues were reviewed by senior managers, and key messages cascaded to frontline staff via managers in team and locality meetings.
- There were a variety of platforms by which staff were engaged including staff forums, away days and representation on sub groups. The director had organised workshops with staff to discuss any issues and the way forward following the transfer of the service.
- Service users were involved in staff recruitment panels and had been invited to the staff away day to provide feedback. A service user feedback forum was in the process of being introduced.

However:

- The service was not always able to extract the relevant data from the system to run reports on the key performance areas of delivery. Managers were liaising with the relevant parties to ensure that the correct reporting requirements were in place and at the time of inspection, we were told this was still work in progress.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children, young people and families	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Community health services for children, young people and families

Good

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are community health services for children, young people and families safe?

Good

Mandatory training

- **The service provided mandatory training in key skills to all staff, however not everyone had completed it.**
- Following the transfer of the children's health service to the local authority in February 2017, a training gap analysis was completed to identify staff training needs. Training modules provided included infection control and basic life support.
- The service had a training target of 95% for one off training in General Data Protection Regulation (GDPR) and annual training in fire safety, information governance (under GDPR), infection control (level 2 clinical) and basic life support (paediatrics and adults). The service was meeting the target for all modules apart from fire safety where the compliance rate was 62%.
- A target of 90% was set for two yearly and three yearly training. The service provided data to demonstrate that staff were meeting the target for training in infection control (level 1), safeguarding adults and safeguarding children level 2 and 3. However, targets were not being met for eight modules with poor compliance in conflict resolution (30%), sepsis (41%), health and safety (62%) and manual handling (62%).
- The service provided us with an action plan for improvement in mandatory training compliance across areas. This included protected time to be given to all staff, staff to be given time to attend locations where connectivity is stable to complete training and training to be discussed at weekly team meetings and during 1:1 conversations. An updated report was to be provided to the senior management team in March 2019.
- Mandatory training formed part of the induction process where the line manager signed off completed training. Training was completed online and face to face both in house and externally. Training compliance was monitored by the learning and development manager who sent a list to managers highlighting staff training that had expired or was due to expire. A reminder was emailed to the staff member and checked during supervision. Staff were given protected time to undertake training, with school health nurses allocated a training week.
- Training opportunities for staff were identified during appraisal and supervision. Staff said that where training was considered appropriate for their role it was normally approved, and there were few barriers for training and development.
- Learning from training was shared during team briefings where staff were updated and provided with the latest information.
- Integrated working was emphasised through joint training events. The local authority had undertaken joint training with children's health, social workers and police in use of the Graded Care Profile tool which is designed to help identify when a child is at risk of neglect.

Safeguarding

Community health services for children, young people and families

Good

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.**
- A named nurse for safeguarding children was employed by the service who reported to the head of service, and was the lead for safeguarding. The named nurse received supervision from the designated nurse at the local clinical commissioning group. Their role was to ensure that staff had the right processes, training and support in place to protect children from harm.
- The service did not have an escalation policy for safeguarding concerns. As there were no medical staff within the service, the organisation did not employ a named doctor. However, systems were in place to facilitate good communication and exchange when concerns arose with a specific doctor based at the local acute hospital. Safeguarding concerns were escalated to the designated nurse and doctor. Staff could describe how they would escalate any concerns but said there was no formal guidance or procedure to follow.
- A paediatric liaison post was provided by the safeguarding advisors team on a rotational basis. The liaison role worked in the local hospital alongside the hospital named nurse and other acute professionals. There were ongoing discussions about improving the paediatric liaison input on the wards and during discharge planning. This was a recommendation from a recent serious case review.
- The named nurse provided safeguarding supervision for the clinical team leads. Health visitors and school nurses received safeguarding supervision every three months, and nursery nurses had group supervision. School health nurses also had a dedicated group supervision slot to discuss safeguarding. Integrated team managers also reviewed high risk cases and provided safeguarding supervision on a one to one basis with staff. There were weekly meetings and regular updates from the safeguarding team to keep staff informed. The service had an up to date policy for safeguarding children supervision.
- The percentage of staff receiving safeguarding supervision between July and September 2018 was 60%, this had risen to 88% between October and December 2018.
- Safeguarding advisors were linked to locality teams and provided safeguarding advice when required. One safeguarding advisor was based at the local acute hospital and attended psychosocial meetings there three times a week. Staff told us the safeguarding advisors were easily accessed.
- Safeguarding referrals to the school health team were triaged by the duty system. The school health nurse was sent a notification and a health assessment triggered.
- The special school health nurse had oversight of the requirements for any student on a child protection plan. Due to the need for them to stay on site, they would liaise with the social worker prior to any case conferences and send a report and one of the school members of staff would attend.
- The children's health service was well integrated with the multi-agency safeguarding hub (MASH) with two safeguarding advisors and an administrative officer based on the same floor as other partnership organisations. MASH meetings were held to enable information sharing between teams. The 'Signs of Safety' methodology was used. This is a model used in child protection casework to assess each case to consider what they were worried about, what was working well and what needed to happen. Referrals were RAG (Red, Amber, Green) rated, with those rated as red discussed at a multiagency strategy meeting held daily.
- Safeguarding audits were undertaken by the service. This included a clinical audit report of discharge summaries from the local acute hospital. The audit demonstrated that there was a good information sharing process between the acute hospital and community health service when children with safeguarding issues were identified. We saw the safeguarding audit plan for 2019 which included the audit of referrals to children's social care and an audit of discharge planning meetings.
- Monthly data was provided to the named nurse on the number of safeguarding cases held by each staff member. The named nurse undertook spot checks of cases to ensure child protection cases were discussed at supervision and ensure appropriate action plans were in place. Any gaps in practice were discussed with the staff member and supervisor.

Community health services for children, young people and families

Good

- We reviewed the safeguarding policies held within the service which were found on the intranet under the clinical policies section on the shared point. We found policies for safeguarding children, domestic abuse and harmful practice, and a policy for safeguarding children's supervision all of which were in date. We noted that there was no policy for escalation of complex safeguarding cases. Staff were not always able to locate and access the safeguarding policy in a timely manner. For example, when we asked staff to access the safeguarding policy several staff found it difficult to locate and open, which at times led to the system timing out.
- Where families were identified as having several Do Not Attend (DNA) appointments staff worked flexibly with an aim to engage them. Health visitors would contact the triage team to find out if a family was known to other agencies and if the contact details on record were correct. Staff also notified GPs and made opportunistic home visits. Where safeguarding concerns were raised a referral was made. We saw the 'Was Not Brought' Policy for Children and Young People's service 0-19 which had been approved in December 2018. The policy clearly set out the actions for professionals to take and their responsibilities should a child or young person not be brought for appointment with a health visitor.
- Updates from the National Society for the Prevention of Cruelty to Children (NSPCC) were provided to supervisors every two days so that they could use the guidance during their work and whilst supervising staff.
- The children's health service had been involved and contributed to serious case reviews (SCRs) with external stakeholders. Lessons learnt from the reviews was disseminated to staff during multi-agency workshops as well as during staff briefings. Learning from a recent SCR had identified that staff required training in undertaking Section 47 assessments (where a child is at risk of significant harm). Clear thresholds had been introduced and two training sessions for staff had been undertaken.
- Following the transition to the local authority there had been difficulties for staff in viewing notifications from the local accident and emergency department as the correct information sharing protocols had not been in place. Arrangements had been agreed with the local acute trust and systems were now in place so that staff could see when children and young people had attended accident and emergency and were therefore able to follow this up where necessary.
- Staff undertook risk assessments prior to going on visits in line with the lone working policy. Where any concerns were identified they took a colleague with them. Staff completed electronic diaries and signed an in/out board so that colleagues were aware of their location and when they were due back.
- Separate risk assessment tools and pathways were used for service users at risk of female genital mutilation (FGM) and domestic violence. An up to date policy was in place for Domestic Abuse and Harmful Practices. This outlined staff responsibilities and actions to be taken where a child or young person was identified as being at risk of FGM, modern day slavery and honour based violence. Staff also worked from practitioner guidelines for "Working with children who are or likely to suffer harm through exploitation".
- There was a school health nurse who specialised in risk assessment questionnaires. Risk assessment tools were being used where there were concerns regarding child sexual exploitation and domestic violence. A new risk assessment 'Graded Care Profile 2' had been introduced, intended to explore neglect and the home environment. Staff were in the process of booking training to use the tool.
- The named nurse for safeguarding had developed an Integrated Safeguarding Assessment tool for staff to use which set out the type of safeguarding category, assessment tool to be used, and linked to key learning from serious case reviews. This was in draft form at the time of inspection.
- We saw safeguarding alerts were flagged on records so that they could be easily identified for example when children were on the child protection record or a female was at risk of female genital mutilation.
- At the time of our inspection safeguarding training for staff within the children's health service exceeded the target of 95%, with compliance for level 2 at 99% and level 3 at 96%. The service confirmed that agency staff were up to date with safeguarding training at the time of booking.

Community health services for children, young people and families

Good

Cleanliness, infection control and hygiene

- **There were some inconsistencies with the way in which the service controlled infection risk.**
- All clinics we observed were visibly clean and free from clutter.
- Standard operating procedures were in place for the cleaning of equipment in clinics. We saw health visiting staff adhere to the guidance, cleaning equipment between each use. At home visits we saw staff cleaning baby scales with wipes and applying clean roll to the scales before they were used.
- There was less consistency with school health nurses, and we noted that on three occasions hand gel was not used between health assessments, and weight and height measuring equipment was not wiped down on two occasions.
- Personal protection equipment was available and the majority of staff we observed adhered to the bare below the elbow guidelines.
- Clinics had toys available to keep children occupied whilst they waited, and to use during health reviews. The toys were wiped down with antibacterial wipes between each contact. The service had a procedure for the cleaning of scales, baby changing mats and toys which detailed roles and responsibilities.
- We saw the service Infection Control Protocol which was in draft, awaiting ratification. This set out expected guidelines for staff to follow in relation to cleaning equipment, hand hygiene and training. All staff were expected to sign the document to show they had read and would comply with the standards.
- The protocol stated that compliance with clinical and environmental practices would be audited twice a year and reported to the quality and governance board. The service had commissioned an external organisation to report on infection control within the service's children's centres in July 2018. The report covered areas including health visitor activities, hand hygiene, equipment cleaning, environmental cleaning and waste disposal. The report provided a summary of recommendations which included that mop heads should be washed after each clean and that staff should receive annual infection control training. An action plan was in place to be reviewed by the senior management team on a quarterly basis.
- We saw an audit for the cleaning of equipment, toys used during health reviews and height measuring scales between October to December 2018. This showed that cleaning schedules for equipment were completed 89%, 89% staff were aware of the spill kit and 100% staff had discussed their understanding of the procedure. The audit included recommendations for areas where improvements could be made.
- Staff undertook training in infection control level 1 (non-clinical) and infection control level 2 (clinical). Training compliance for infection control was at 98%, above the service target of 95%.

Environment and equipment

- **Premises and equipment did not always meet the needs of the service. There was ongoing work to improve this.**
- The children's health clinics that we visited during the inspection were welcoming, safe and child friendly environments. However, we noted in one location there were uncovered plug sockets that could be reached by a small child.
- Senior managers told us that the health and safety department completed environmental assessments on the locations on an annual basis. Further assessments were undertaken if teams moved to a different location.
- Following the transition of the service to the local authority the service had replaced all equipment for health visiting staff and school nurses. Staff said that equipment was readily available and spoke positively about the new equipment available to use within clinics and schools; for example, height measuring equipment, weighing scales and changing mats.
- Equipment used for measuring weight and height during school assessments were clean and appropriate. We noted however, there was no date of calibration for a new set of weighing scales being used by a school nurse.
- We saw the asset register of equipment for the family nurse partnership team that detailed each item held,

model, make and serial number and the date of last calibration. The register identified that of eight sets of weighing scales, one set had failed its calibration and that a new set of scales was missing the date of its last calibration.

- All the equipment we checked had received electrical safety testing.
- A range of new toys and activities were available in some locations to keep children occupied whilst waiting to be seen by staff and used to help inform the child's development during assessments.
- Estates, including the location of where staff were based and problems with Wi-Fi connectivity in several buildings, had been significant challenges facing the service since its transition. Some teams were not based centrally in the areas they covered. Poor connectivity meant there was inconsistent access to the electronic records system. This was particularly problematic for staff who were worked remotely. Some staff said that at times it could take up to 30 minutes before they gained access to the system, although most staff acknowledged there had been improvements. One school health nurse we spoke with said that their ability to find information and document their review had greatly improved. There was ongoing work to have new Wi-Fi connections installed although the leases in place for some properties had complicated matters.
- There was also an ongoing project to move teams to more appropriate locations. Some teams that had moved to a new location said that this had improved their Wi-Fi connectivity, but one team said that service users found it more difficult to travel to the new site and therefore they were unable to see them as often as they would like.
- Many staff worked remotely and had been provided with a laptop and mobile telephone. Two factor authenticity was needed to log on to the system and a smart card was required to access patient records.
- During visits, health visitors wore a lone working device. This had a GPS tracker and sent details of the staff location to those monitoring the system and enabled staff to be contacted. Staff told us they had a password to use if they felt at risk which alerted managers. The service had an up to date lone working policy in place.
- Following a manual handling risk assessment school nurses had been provided with a wheeled rucksack to carry scales, laptop and other equipment to reduce any associated health and safety risks.
- Staff were aware of the fire evacuation procedures and confidently able to explain these.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.**
- We checked 14 records of people using the service. We found that comprehensive risk assessments were carried out in all cases with plans of care developed accordingly, and risk managed effectively.
- Health visitors completed a common assessment framework tool which considered parental capability, social and environmental factors and child development. The framework is a national, standard approach to assessing any additional or unmet needs a child or young person may have and for deciding how any such needs can be identified and met effectively.
- The family health needs assessment (FHNA) was undertaken by health visitors at new birth visits. This considered the strengths, needs, vulnerabilities and risks of the children, parents and households. As part of the assessment the mother was assessed for postnatal depression, and actions put in place where this was identified.
- Health visitors completed maternal mood assessments during post-birth visits with new mothers.
- Practitioners told us they reviewed all accident and emergency attendances to monitor the children on their caseload, and follow up when an attendance was flagged.
- Staff used the two-item generalised anxiety disorder scale (GAD-2) to identify service users with a potential anxiety disorder so that appropriate referrals could be made to the relevant mental health service.
- The school health nursing team delivered the National Child Measurement Programme (NCMP). Staff visited school age children in reception and year six to record their weight and height. The team were implementing vision and hearing screening tests which would be undertaken by nursery nurses.

Community health services for children, young people and families

Good

- We observed good interaction between school health nurses and children and young people. During health assessments we saw school nurses discuss health issues including dental hygiene, sleep and diet. Nurses asked children about, "How life was" and "Any particular worries they had".
- Children were also asked to complete a questionnaire about themselves which included questions about whether they felt safe and who they could talk to when they were sad. This gave the school nurse a more holistic picture of the child's situation and any potential risk factors.
- School nurses based on site in special schools carried walkie talkies with them to enable them to respond immediately to any emergency situations. A defibrillator was available for the nurse to use in the special school, which had been serviced annually.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- Between December 2017 and November 2018 the service reported an overall vacancy rate of 12%. Within the same period turnover was reported as 11.4%. The service reported a sickness rate of 5.7%.
- The school health nursing team was funded for 24 WTE (whole time equivalent) school health nurses. Following the transition to the local authority there had been several vacancies within the school health team. However, recruitment to school nurse positions and clinical team leader for school health, meant that staffing levels were much improved. At the time of our inspection there were 3 WTE (whole time equivalent) vacancies for school nurses and 2 students. An advert had been out for recruitment to the school nursing posts just prior to the inspection.
- The team comprised of three Band seven clinical team leads, 10 Band six school nurses, two Band five associate nurses, five nursery nurses including one senior nursery nurse lead and five school health assistants. Two new public health advisor roles had been introduced. At the time of our inspection the integrated team manager post was vacant and the clinical team leader reported directly to the service manager.
- The school health team used three agency staff, one which covered a generic caseload and two agency staff that covered special schools.
- The school health team had two staff members on long-term sick leave, a school nurse and an administrator that were covered by bank staff. Managers told us that staff were used across all localities to cover short-term absences and any immediate work required.
- The health visiting team had a planned establishment of 100 WTE staff. At the time of our inspection there were 93 WTE health visiting staff in post with seven WTE vacancies. The service used agency staff to cover the vacancies and were looking to develop their own bank internal staffing cover.
- Health visiting teams told us several staff had left prior to, and at the time of the transfer to the local authority, resulting in a high number of vacancies. However, staff felt that numbers had improved following a recruitment programme.
- Health visiting and school health staff were also positive about the skill mix within the team with the recruitment of community nursery nurses and health visitor assistants and welcomed these new roles. Nursery nurses were supporting with the 2-2.5 year reviews and with the implementation of the vision and hearing screening.
- The service was using the Benson framework. This was a staffing and resource tool that estimated demand and workload, staffing and resource allocation. Commissioners had set a maximum ratio for health visiting caseloads of 1:350 cases. Managers told us that staff were normally working at approximately 1:300 cases, which is just above the Community Practitioners' and Health Visitors' Association (CPHVA) guidelines and the Institute of Health Visiting who advised an optimum ratio of 1:250.
- Cases were shared across health visiting teams with health visitors expected to have five universal

partnership plus cases that included looked after children, children in need and children on the child protection register. Regular visits were required for these cases every four to six weeks.

- Early Help cases were allocated under the universal plus caseload and staff were not given additional time to complete this work. Staff told us that the work created by these cases could differ substantially involving up to three months' work with several different partner agencies, and this could result in pressure due to time constraints.
- Within the school health team Band five nurses were allocated five primary schools and Band six nurses allocated three primary schools and up to two secondary schools. The service was currently undertaking a profile of each school within the borough to build up a picture of each school's health and safeguarding needs. This would enable the service to ensure a more equal share of the workload based on needs.
- The service had five health visitors and two school nurse students who they were hoping to recruit, once qualified.

Quality of records

- **Staff kept detailed records of patients' care and treatment. Records were clear and up-to-date, however they were not always easily available to all staff providing care.**
- The service used an electronic patient record system. It was the same system used by the previous provider of children's health services, and had been commissioned so that school nurses and health visitors could access them on the first day following transfer of the service without any disruption to service.
- Staff reported inconsistent access to the electronic patient record system and this had been flagged high on the service risk register. This impacted mainly on staff working remotely and in localities where Wi-Fi connection was poor. There was dedicated IT support for use of the system and all incidents and issues were logged. Ongoing work was being undertaken to ensure better access to the system, and staff said that improvements had been made.
- We checked 14 records and found that weight and height measurements were taken during the relevant contacts and recorded appropriately within the electronic records system.
- Appropriate risk assessments and family health needs assessments were documented clearly and in date.
- We saw evidence of comprehensive care plans being completed for children and young people with clear actions. We looked at three care plans completed in the special school we visited and saw that all had been reviewed in a timely manner. The plans we looked at included an emergency plan, details of epileptic seizure (where relevant), medication plan, drug record and contact details. One child had two care plans, one for management of their gastrostomy and one for epilepsy so that the information and guidelines for each could be accessed easily.
- The level of service provided by health visitors was dependent upon an individual's need. Staff made it clear on records when the level of service was being changed, for example where a service user's service was moving from the 'universal' to the 'universal plus' pathway.
- Alerts were placed on records where children had long-term medical needs and/or allergies to help make staff aware. However, we saw two records where the appropriate alerts were not in place.
- The service undertook a quality audit of records every quarter. We looked at the audit completed between October to December 2018. The service had made improvements in several areas including health assessments being age appropriate, care plan actions are followed and records are written contemporaneously. Two areas identified for further improvement were families being linked on records and records being synchronised. We saw that actions were in place with a deadline to review progress.
- We found staff had access to the relevant documents they required during health assessments for the majority of cases. However, during an observation of a school health assessment we saw a school nurse was not aware of a child who was new to the school as the transfer records had not yet been uploaded to the system.

- We saw a child's red book was updated during clinic visits with health visitors and checked to ensure that immunisations were correct and up-to-date. Where a parent had forgotten to bring the red book outcome of the review and health information was provided on an advice slip.

Medicines

- **The service followed best practice when giving medication, however the fridge and room temperature where medicines were stored was not recorded.**
- Community practitioners are able to prescribe a limited amount of medicines such as skin preparations. Following the transfer of the service to the local authority the decision was taken that health visitors and school health nurses would no longer prescribe medicines until the system to support ongoing prescribing was reviewed.
- Staff members and the school nurse were responsible for administering medication in special schools. We saw that all medicines were stored in locked cupboards secured to a wall. We checked a sample of medicines and found them all to be in date.
- When emergency medicines were required a member of staff would collect them overseen by a nurse and record this in an in/out book. We found that all records were accurate. Parents were notified by the nurse when a medicine was administered to their child.
- Medicines kept within the locked fridge at the special school were in date. However, there was no mechanism for monitoring and recording the temperature of the fridge. Temperature monitoring is a method of assuring that medicines have been stored at the correct temperatures and remain suitable for use. We found a lack of ambient temperature monitoring in the medicines storage room.

Safety performance

- A summary report of incidents was produced for the risk management group that met monthly. The group reported to the governance and quality board where incidents, complaints and the risk register were reviewed.
- The service was in the process of developing an improved dashboard for the health visiting, school health nursing and family nurse partnership teams. This would provide information on key mandated contacts, safeguarding training and supervision, case conferences number of cases help of children on child protection plans and looked after children, incidents and complaints.

Incident reporting, learning and improvement

- **Staff recognised incidents and reported them appropriately.**
- Incidents were reported on an electronic reporting system. Staff said there was clear guidance for how the incident reporting system worked and were able to demonstrate its' use. An up to date incident policy was available and could be accessed by staff on the shared point on the intranet.
- Incidents were sent to the integrated team manager who was responsible for investigating the incident, creating an action plan and reporting back to the individual. Incidents were reviewed at the senior manager's meeting on a monthly basis.
- We saw a summary report of incidents reported by the service between August 2017 and July 2018 which showed 137 incidents had been reported during the period. Incident category levels were recorded as unscored (9%), low (46%), moderate (27%) and high (18%). Staff told us that managers encouraged them to be open and honest, and to raise any concerns about practice so that improvements could be made.
- Whilst some staff told us they consistently received feedback about incidents they had raised, other staff said that they received acknowledgment that an incident had been reported but did not receive any feedback in respect of it. Managers said that incident feedback was a standard agenda item at the team meetings. We looked at team meeting minutes for three localities and found that incidents were discussed during two of the meetings. Lessons learnt from incidents from within the service and throughout the local authority were also shared within the school health bulletin. Many staff we spoke with could provide examples of lessons that had been learnt from incidents or serious case reviews.
- Never Events are serious incidents that are wholly preventable, where guidance or safety

Community health services for children, young people and families

Good

recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. The service did not report any Never Events in the reporting period October 2017 to September 2018.

- The service reported that there were no serious incidents for which it was accountable between October 2017 and September 2018.
- One serious incident had occurred within the service just prior to our inspection. Root cause analysis investigations (RCA) were completed as part of the investigation of significant or serious incidents. We reviewed the RCA of an incident involving a serious breach of General Data Protection Regulations within the school health team. A root cause and contributing factors were identified, with lessons learnt and an action plan in place. The investigation and RCA had been undertaken in a timely manner with the relevant authorities informed.
- The service had contributed to the learning around 12 child deaths within the borough. For example, following the death of an infant that choked whilst sleeping, the service was placing an emphasis on providing safer sleeping guidance to parents with top tips and had a training video to send out to all children's centres. We saw health visitors giving safe sleeping advice during home visits. The service acknowledged that further work needed to be done around strengthening bereavement conversations.
- The communications group had been involved in producing posters which were displayed in clinics reminding parents of their responsibility to supervise their children following near misses where infants had been left unsupervised on changing mats.
- Staff were aware of their responsibilities under the duty of candour requirements. 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 those persons. We saw an example where the duty of candour had been applied.

Are community health services for children, young people and families effective?

(for example, treatment is effective)

Good

Evidence based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.**
- Children and young people's needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence based guidance. Policies and procedures were based on guidance produced by the National Institute for Health and Clinical Excellence (NICE) and other nationally recognised guidelines.
- Policies and standard operating procedures were reviewed at the clinical effectiveness group. New and updated policies were developed by the polices and pathways group when new guidance was introduced by NICE. All new documents were sent to the quality and governance board for approval before release.
- Managers were working to embed the delivery of the Healthy Child Programme (HCP) within the service. The HCP is an early intervention and preventative public health programme that offers every family a programme of screening tests, immunisations, developmental reviews, information and guidance to support parenting, wellbeing and healthy choices.
- There were numerous pathways built into service user's health care records with each child assessed and the appropriate pathway identified as required. For example, for people using the health visiting service there were pathways for universal, universal plus and universal plus partnership. The universal pathway was used to deliver the key components of the Healthy Child Programme to all children. The universal plus pathway identified and supported children, young people and their families at an early stage with specific health

concerns such as a sleepless baby or weaning. The universal partnership plus pathway involved a multiagency approach for children with complex and/or additional needs.

- Health visitors used evidence based tools to underpin their assessments. For example, staff used Ages and Stages Questionnaires (ASQs) as part of their assessment of children. This is an evidence-based tool to identify a child's developmental progress and readiness for school, and to provide support to parents in areas of need. In addition, health visitors used the two-item generalised anxiety disorder scale (GAD-2) to identify service users with a potential anxiety disorder so that they could be signposted to the appropriate services.
- The service had achieved UNICEF baby friendly accreditation stage 1 and was in the progress of being reviewed for stage 2. This is a global programme of the World Health Organisation and UNICEF, which encourages health services to improve the care provided to mothers and babies so that they can start and continue breastfeeding for as long as they wish. Two areas had been identified for improvement and an action plan had been put in place. A review was to be undertaken in March 2019.

Nutrition and hydration

- We saw health visitors and school nurses providing advice about healthy eating and lifestyles to children, young people and their parents/carers. Health visitors discussed feeding options with mothers during their new birth visits. A range of information was available throughout the borough on feeding and healthy diets. Some parents told us they would have liked to receive more information in relation to weaning.
- There was support for new mothers who were breastfeeding including information guides and a breastfeeding workshop that was being piloted. The service had breastfeeding champions and a breastfeeding lead. We saw health visitors offering breastfeeding support and advice to new mothers.
- School nursing teams delivered the National Child Measurement Programme (NCMP) to all school aged children in the area. When height and weight measurements from a school health assessment indicated a child was overweight or obese a letter was sent to the GP and parents to inform them of the outcome. The service also contacted the GP for a referral to a dietician and one to one work would be undertaken by the nursery nurse with the child.

Patient outcomes

- We saw evidence of health visitors and school nurses thoroughly assessed service user's needs before care and treatment started. This was also recorded in the care plans we reviewed. This meant children and young people received the care and treatment they needed.
- The service monitored its performance against several outcomes, including those set by commissioners and those set within the Department of Health's Healthy Child Programme. Performance was monitored by commissioners every month and reviewed at the quality and governance board meetings.
- A dashboard for health visitors, school nursing and family nurse partnership was in development and being tested by clinical team leaders. We were shown the template dashboard for health visitors which showed measurements including staffing levels, antenatal contacts, health visitor mandated contacts, early help and maternal mood, safeguarding training and supervision, record audits and complaints.
- We looked at performance data for the health visiting service between April and December 2018. The service was performing well for newborn visits conducted within 14 days, achieving 94% of the 96% target set. The service was meeting the 60% target of 6-8 week reviews completed within the month.
- The service under performed for the 12-month reviews with only 32% being completed by 12 months against a target of 55%, and 72% being completed by 15 months against an 80% target. However, performance improved by the 2-2.5 year review where the service consistently met the target of 55%. Data provided by the service suggested a gradual improvement in performance generally from before pre-transfer.
- The percentage of children who received a 2-2.5 year review using an ASQ 3 (an Ages and Stages questionnaire used at part of the child assessment) was at 98%, close to the service target of 100%.

Community health services for children, young people and families

Good

- Between April and December 2018, 42% of women receiving an antenatal visit from a health visitor at 28 weeks or more. A locally agreed target had not been set by the service. However, there are no national targets for this measurement.
- Between October and December 2018, the percentage of infants being breastfed at the newborn visit was 82%, falling to 78% at the 6-8 week review which was higher than the England average. No target had been set on the service dashboard.
- For health visiting mandated contacts commissioners and senior staff said that there had been no drop off in performance since the transition of services. Whilst performance for the 12 month contact could be improved, the 15 months and 2 years were in line with other London boroughs.
- The school health team delivered the National Child Measurement Programme for reception and year six students undertaken by nursery nurses. Between October 2017 and September 2018, 96% assessments had been achieved at both reception and year six.
- At the time of our inspection vision and hearing screening was being implemented across the borough for students in reception and year six. The service was being delivered by nursery nurses who had been provided with new equipment for the screening.
- The service had an audit plan in place for 2018-2019. This included audits for record keeping, safeguarding, infection control, infant feeding and complaints and incidents. The schedule was a work in progress, with the aim of monitoring and improving the service delivered.
- The Early Help co-ordinator audited all records for families where the Early Help programme was being delivered. This ensured care plans were appropriate for the family's needs and that outcomes had been met before closure. This had resulted in a significant rise in the number of families within the borough receiving the Troubled Families payment.

Competent staff

- **The service made sure staff were competent for their roles.** An induction process was in place for all staff which involved training, induction to the local area and a corporate induction.
- A preceptorship programme had been developed for newly qualified nurses and health visitors who were allocated a preceptor and a mentor. The individual worked with their mentor on a day to day basis and the preceptor would oversee the preceptorship.
- Training needs were identified during appraisals and supervision. Staff described good training opportunities with staff being able to access external training where it was relevant to their role, for example training provided by the National Society for the Prevention of Cruelty to Children (NSPCC).
- An internal development programme had been in place for Band six health visitors and school nurses. This included training in leadership, management, supervision and communication skills. One member of staff we spoke with had been promoted to Band seven after taking part in the programme.
- Staff had regular supervision. Band seven health visitors had responsibility for providing supervision to Band six health visitors, who in turn supervised Band five health visitors. This gave health visitors valuable opportunity to develop leadership skills and share knowledge and expertise. School health nurses reported receiving supervision on a termly basis with access to advice and support when required.
- Staff in the family nurse partnership and perinatal mental health teams had supervision with a psychologist provided through a service level agreement.
- In November 2018, 63 of 196 (32%) staff had not had an appraisal. Of these, 51 staff (81%) were new starters, on maternity or long term sick leave.
- Staff had the opportunity to join a variety of forums where they could put forward their ideas, for example the recruitment and retention forum. This enabled staff to develop additional skills and become more knowledgeable about service provision.
- Forums were in place for different staff groups including nursery nurses, health visitors, school nurses and practice teachers. These were led by practice development facilitators and provided a platform for staff to discuss best practice, lessons learnt, and learning and development opportunities. We observed a case study presented at the health visitor forum which

outlined the journey of a vulnerable service user. We saw evidence of risk assessments and individualised targeting of services, resulting in the child being taken off the child protection register.

- Staff working within the family nurse partnership team shared their specialist skills and expertise in working with young vulnerable parents with other health visitors. They were involved in delivering communication training and were in the process of planning the delivery of training in "adult brain and attachment".
- We were told that 50 staff including health visitors and school health nurses were trained as nurse prescribers. However, health visitors were not prescribing medication since the transfer of the service and some expressed that they felt this had led to them being deskilled. Managers said that this was under review and considered it important that staff kept up to date with the relevant practice through training updates.
- All Band six and Band seven school nurses were Specialist Community Public Health Nurse (SCPHN) qualified.
- School nurses provided training to teaching assistants on asthma, epilepsy and allergies so that they could attend to a child's health needs. The nurse was responsible for signing off competencies and keeping a record of those teaching assistants that had completed them with the aim of achieving asthma and allergy friendly schools across the borough of Newham by September 2019.
- Two school nurses had been trained in mental health first aid. These staff were responsible for training additional school staff members as part of a national initiative so that they were able to recognise the signs and symptoms and relevant agencies to refer to.
- Nursery nurses were trained in growth and development which explored assessment outcomes, equipment calibration and how to document growth on a chart. As other staff had shown an interest, the training was being rolled out to other grades on an annual basis.
- The school health nurse role for special schools was covered by two agency members of staff who were job sharing. This had been in place since the time of transition and there were ongoing discussions between senior managers and commissioners about future provision. We found that the agency nurses had the appropriate expertise and experience to fulfil their role. Mandatory training was provided by the agency and this was up to date at the time of inspection. Senior managers told us that safeguarding training compliance was confirmed with the agency at the time of booking. Both agency nurses received supervision from the community children's nursing service via a service level agreement, and had the same access to the electronic record system as permanent staff. A second appropriately trained nurse was available to cover should either of the agency nurse be absent. The situation had been flagged on the children's health service issue log with a report sent to the departmental management team with mitigating actions to reduce the risks.

Multi-disciplinary working and coordinated care pathways

- We saw staff working well alongside other professionals involved in the care delivery. Since moving teams to new locations, it had become easier for health visitors and school nurses to access social workers and other professionals. Staff told us communication had improved as a result.
- School health nurses felt well integrated with the school teams. The school health nurse met with the school safeguarding adviser at least termly to discuss any concerns. During our inspection we observed a discussion in relation to looked after children and the type of health issues the child would need support with.
- Senior managers attended forums for SENCOs (Special Education Needs Co-ordinators) and head teachers to discuss staffing levels and any other challenges faced by the service.
- Health visitors were linked to GP practices and had regular meetings with practice staff to share information in relation to healthcare for a particular family.
- Health visitors reported receiving good feedback from midwives who provided essential information during antenatal visits and carried out early referrals to the home visiting team. Joint visits with the relevant midwife were arranged where it was deemed necessary, and this enabled health visitors to form a good rapport with the woman before the birth of their baby.

Community health services for children, young people and families

Good

- The child development service supported the development and inclusion of children with complex needs or disabilities up to 19 years old. The team was based with other professionals including occupational therapists, speech and language therapists, physiotherapists, dieticians and audiologists. This meant additional expertise was easily accessible and promoted a holistic approach to care delivery. Professionals from each discipline met on a regular basis to agree which service would take the lead role on each case.
- We observed collaborative working relationships between the children's health service Early Help co-ordinator and partners delivering the Early Help programme within the borough. The programme provided opportunities for staff to work together and share information, for example health visitors contributed to stay and play sessions within children's centres.
- A new system was in place on the electronic records system which enabled health visitors to see entries made by other professionals and teams. For example, staff could view contacts made with the GP, midwifery services and clinic attendances.

Health Promotion

- School nurses provided information packs to parents of children starting school to raise awareness of the type of advice the service could provide help with. The packs included advice on sleep, headlice, accident prevention, childhood illnesses, exercise and details of the service that was offered. School staff indicated that the packs which had recently been introduced were extremely informative and welcomed by parents. Posters were displayed within schools to explain the role of school nurses.
- School health nurses were involved in work at youth centres supporting the transition to adulthood. The "Living Your Best Life" programme offered a drop-in service to youths and explored areas including sexuality, sexual health and youth violence. The work was undertaken alongside staff from pupil referral units, GP practices and youth centre staff.
- Health visiting staff shared relevant health information with parents and carers during new birth visits including information in relation to breastfeeding, sudden infant death syndrome, safe sleeping, immunisations, mixed feeding, brain development and safe home environments. The new birth pack included the personal child health record (red book), an introduction to the health visiting service and all the relevant information guides. This could also be found on the website for parents/carers and other health professionals to access.
- During clinic visits we saw staff providing health advice on topics including dental hygiene, fine motor skills, speech, diet, play and stimulation. Health information shared was recorded on the electronic records system.
- Parenting groups were held monthly to provide advice and support, with talks given by partnership and external agencies. There was a programme of baby feeding groups facilitated by the health visiting teams and children's centres along with a pilot for breast feeding workshops. Clinics and workshops were also being provided on practical aspects including toilet training and sleep.
- The service had developed a booklet of common childhood illnesses to inform parents of symptoms and how to manage them with the aim of reducing the attendance rate at the accident and emergency department at the nearby hospital.
- A wide range of information leaflets was available in clinics and children's centres across the borough. Examples of the information provided included, information on health and safety, immunisations, breastfeeding and bottle feeding, starting solids, safe sleeping, emotional support, healthy diet, sexual health along with advice about the support groups on offer. We found that information was more widely available in some clinics and children's centres than others.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- On the records we checked we saw that consent was obtained for information sharing by health visitors during new birth visits and transfer in visits. Consent was not revisited during other visits undertaken by the health visitor.
- When consent was discussed with children and young people, and their parents/carers it was documented

within the progress notes. A mandatory field within the electronic records system was not yet active to indicate that consent had been obtained, however we were told that work was in progress to implement this.

- Consent was obtained by the school health nurses on the referral document used by the school. If this had not been signed the school nurse would contact the parent to advise that they were visiting the school and to obtain consent to see the child and share information. During one school health assessment we saw a school nurse ask consent from a child to discuss her situation with the school welfare officer.
- Health visitors and school nurses we spoke with understood the Fraser guidelines and Gillick competency. Fraser guidelines and Gillick competency must be considered when offering treatment to children less than 16 years old, to decide whether a child is mature enough to make decisions about their own care, or where they cannot be persuaded to involve a parent.
- Guidance on the Mental Capacity Act (2005) could be found on the electronic records system. Staff received training in the Mental Capacity Act, however at the time of our inspection compliance was 67%, falling below the service target of 90%. We saw that there was training in the Mental Capacity Act (2005) scheduled in the two months following the inspection which staff were expected to attend.

Are community health services for children, young people and families caring?

Good

Compassionate care

- **Staff cared for patients with compassion.** All parents and carers we spoke with told us they were happy with the service provided. They said that staff were respectful and caring, and treated them and their families with kindness and compassion. We observed this during a home visit to a family made by a health visitor.
- Parents and carers felt that the health visitors they met were skilled at what they did and felt reassured that they could contact the health visiting team should they need to ask a question about their child.
- During a new birth home visit made by a health visitor we observed good interaction between the staff member and parent. The health visitor gave advice and provided relevant information about the service. Contact details were exchanged with the parents should any questions arise in the future.
- Staff were sensitive to the needs and difficulties parents were facing. For example, during a 12 month review we observed a nursery nurse showing empathy towards the mother who had a child with allergies and a skin condition, listening attentively to the challenges that this presented.
- One service user spoke highly of the service they had received from a specialist health visitor, assisting in additional practical tasks such as support with housing and obtaining benefits which had saved the service user time and had reduced their anxiety.
- During the school health assessments, we saw school nurses showing good age appropriate communication with children and young people, building a good rapport which helped the young person relax and confide in the professional.
- Rooms in which school health assessments were undertaken were mainly private and provided a confidential space. We noted one room which had a glass panel in the door which would enable other students and teachers to see in to the room.
- Feedback forms were provided to children and young people at the end of their health assessments for them to indicate whether they would recommend the school health service to others with an optional comments section that could be completed. Feedback forms were also available within clinic areas and children's centres enabling parents and carers to provide feedback to the service.
- Between 7 November 2018 and 13 February 2019, the service collected 441 responses from service users and

Community health services for children, young people and families

Good

their parents and carers of the health visiting service. Of the respondents, 95% said they would always recommend the service and 4% said they would sometimes recommend the service.

- In November 2018, 22 responses were collected from service users and their parents/carers of the school health service. Of the respondents, 86% said they would always recommend the service and 9% said they would sometimes recommend the service.

Emotional support

- **Staff provided emotional support to service users to minimise their distress.** The perinatal mental health team provided support for women requiring emotional and mental health input following the birth of their baby. We observed the team providing appropriate care during a home visit where a risk assessment of the current situation was undertaken. Both parents were present and were involved in planning the care. Due to ongoing concerns with regards to the mother's mental health a referral to the safeguarding team and early help team was completed.
- Health visiting staff were supportive towards families taking a holistic view of each situation and ensuring appropriate support was put into place when risks were identified. Service users told us that health visitors provided extra support and made appropriate referrals, for example during times of anxiety after the birth of a baby and where relationships came under stress.
- Guidelines were in place for staff to refer service users to a service for 10 to 16 year olds who would benefit from additional support with their wellbeing, or when a referral to the Community Adolescent Mental Health Service (CAMHS) was more appropriate for more moderate to severe mental health concerns.
- A post diagnosis support group was run for parents/carers with children with complex needs or disabilities. The group offered practical and emotional support as well as an opportunity for parents to network with others who were having similar experiences.

Understanding and involvement of patients and those close to them

- **Staff involved service users and those close to them in decisions about their care and treatment.** During new birth visits parents were given several opportunities to ask questions, and we saw staff providing reassurance to new mothers.
- Parents were included in the development of care plans, and where amendments were made following a change in the child's health.
- Staff we spoke with said that listening to the children and families they came in to contact with was a priority for them, and had been a focus after a lesson learnt from a serious case review that the child's view must be integral to the service provided. A mandatory field had been added to the records for staff to enter the 'voice of the child' at each contact made.
- There were isolated cases of parents we spoke with who said that there was not enough information regarding weaning and caring for children with allergies, and that advice given by health visitors was inconsistent.

Are community health services for children, young people and families responsive to people's needs?

(for example, to feedback?)

Good

Planning and delivering services which meet people's needs

- **The service planned and provided services in a way that met the needs of local people.**
- The school health team transferred from a neighbouring NHS Foundation Trust to the London Borough of Newham in February 2017, followed by the health visiting team and family nurse partnership in August 2017. The decision was taken to create a seamless continuum of health provision and streamline services to improve the outcome of children and their families within the borough.
- The Joint Strategic Needs Assessment and the Children's and Young Persons Strategic Needs Assessment were used to inform and plan the health services within the local community. Managers and staff

understood the complex demographics of the local population including the high birth rate, mobile population, significant numbers of residents living in temporary accommodation and a substantial number of houses having a high occupancy rate. There were specific groups of children, young people and families within the borough whose personal, social and economic and social, circumstances would put them at higher risk of poor health outcomes. Staff were committed to tailor support on a needs basis and use resources where they were most needed and would have greatest impact.

- Newham had introduced integrated neighbourhood working, with teams in four areas of the borough: East, West, Central and South. This brought together the 0-19 children's health service, early help partnership, families first, safeguarding and specialist services. The integrated neighbourhood teams maintained close working relationships with services within each area including children's centres, education settings, health centres, police and leisure organisations. The aim was to have seamless working across all agencies to improve the journey for children and families within Newham.
- Service delivery was based upon the "4-5-6" model (Healthy Child Programme) with four levels of service depending upon need, five mandated elements of service at key stages of a child's life, and six high impact areas including transition to parenthood, maternal mental health, breastfeeding, healthy weight, managing minor illnesses and health and development at two years.
- The health visiting team provided a service to all families in Newham with a child the age of up to five years, although there were different levels of intervention depending upon the need. Universal services were provided to all families and involved the delivery of the Healthy Child Programme. Families were also signposted or referred to community resources. Universal Plus services were provided to families with an additional need on a time-limited basis. Universal Partnership Plus services were offered to vulnerable families requiring ongoing and additional support for a range of needs.
- The children's health service 0-19 formed part of the Early Help offer provided by Newham local authority. Early Help involved offering effective help to families as soon as difficulties emerged and whilst they were still at a low level. It aimed to provide a preventative service and avoid escalation to specialist or statutory services unnecessarily. Neighbourhood Action Meetings were attended by different professionals including school health and health visitors where cases were allocated to the appropriate services. Team Around the School model involved a range of professionals working collaboratively to identify when children required Early Help.

Meeting the needs of people in vulnerable circumstances

- School health nurses completed health assessments for children in need, looked after children, those on supervision orders on a termly basis and recorded all information within the patient record. Health visitors visited looked after children and those on the child protection register on a four to six week basis to assess their needs.
- The perinatal mental health team was a new team which had been created after the transfer of services to the London Borough of Newham. The specialist health visitors within the team provided support to women with moderate to severe mental health concerns from antenatal through to one year following the birth of their baby.
- The family nurse partnership (FNP) team supported first time young mothers, and their families, up to the age of 19 providing information and support about having a healthy pregnancy and improving their child's health and development. The FNP was an evidence based, intensive, structured home visiting programme delivered by specially trained nurses, working with vulnerable young families from early pregnancy (before 28 weeks gestation) until the child is 2 years old. We were told by staff that the criteria were due to change in the month following the inspection to accept mothers up to the age of 22 years.
- The child development service provided support for children with developmental and complex needs. We saw that staff were located on a site with other professionals so that care was planned and coordinated.
- The Early Help programme targeted the needs of the local community to improve outcomes. For example, a

more coordinated approach between children's health, midwifery and GP services aimed to reduce the number of late antenatal bookings within the area and target services for these women. Early Help champions were aligned to each locality to help support colleagues deliver the programme.

- Staff were aware of the diverse needs of the local population. There were many languages spoken within the borough, and a high number of service users had English as a second language. The service had a diverse workforce with staff speaking a variety of languages. Staff could book interpreters or use language line for translation purposes and described these as being easily accessed.
- We observed a home visit undertaken by a health visitor in the family nurse partnership team visiting a young mother who did not speak English. An interpreter was used to ensure that all information was understood by the mother and to provide an opportunity for questions to be asked. This enabled clear and accurate risk assessments to be completed and for the staff member to build a good rapport with the family. Pictures were used alongside explanation to describe safe sleep positions.
- Leaflets were available on a wide range of topics including healthy eating, breastfeeding, immunisations and safe sleeping. From the clinics and children's centres we visited we found that leaflets were much more widely available at some locations compared to others. Leaflets were mainly provided in English and standard print size.
- Staff within the service were aware of changing priorities within the population, and there was now a focus on early interventions with those children and young people who were identified as being potentially involved with violent crime.
- Health visitors worked with third sector organisations to meet the needs of their service users, for example referring individuals to a local charity for housing provision.

Access to the right care at the right time

- The first point of contact for the service was the CHIS (Community Health Information Systems) team where all new births were recorded. From there, a new record would be generated on the system and then allocated to the appropriate team.
- Each team used a monthly planner. The electronic diary system was used so that all staff could see how work was planned. Staff could see what work was allocated to themselves and allocated to the team.
- School nurses provided drop in sessions at schools so that students could attend and seek advice and support. Parents and students could also access school nurses by booking an allocated appointment time.
- Health visitors were flexible, arranging appointments that suited the parent/carer where possible. A health visiting clinic ran on a Saturday for those parents/carers who were not able to attend clinics on week days.
- During the new birth visit, parents were reminded of the 6-8 week GP appointment and advised that some GPs would automatically send out appointments while others would require parents to book it.
- Specialist health visitors within the child development service had forged close links with the local acute hospital visiting the neonatal unit. This meant there was a process to identify babies born with any additional needs so that interventions could be implemented as early as possible.
- Staff recognised the challenges of working with a highly transient population and made efforts to ensure that family contact details were current and built positive relationships with parents and carers. Health visitors explained that where families were reluctant to engage with different agencies and more intense levels of service they would still be offered the universal service package and encouraged to attend key contact appointments.
- The service was working on introducing a text messaging service to remind service users of their next appointment.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**

Community health services for children, young people and families

Good

- Complaints could be made to the service verbally, by telephone or by using the online form on the local authority website. Feedback forms were kept at clinics and children's centres and taken out by health visitors during visits.
- Most service users we spoke with said that it was not clear to them how to provide feedback to the service, and how to make a complaint. Senior managers acknowledged that there was still work to do to make the complaints system clearer to those that used the service, particularly within school health. There was work currently being undertaken to make the feedback forms specific to each service area of provision.
- Complaints were received by the head of service or through the central complaints team. Where required this would be allocated to the relevant integrated team manager who would log it on to the incident reporting system and undertake an investigation. Key themes from complaints were discussed at the risk management group with key messages placed on the shared point, and discussed with individuals during supervision as necessary. Complaints were also shared corporately through the departmental management team.
- Between November 2017 and November 2018, the children's health service received six complaints. These were mainly concerns in relation to advice and support parents/carers had received from health visitors. We saw a log where complaints were listed with outcome of the investigation.

Are community health services for children, young people and families well-led?

Good

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- The head of service for the children's health team, reported to the director of delivery, compliance and transformation, who in turn reported to the executive director of strategic commissioning.
- The school health team and each health visiting locality had an integrated team manager and clinical team leader. At the time of our inspection there was a vacancy for the integrated team manager for the school health team. The managers reported to the service manager providing an update monthly.
- The service had faced many significant issues, particularly in relation to estates and IT connectivity, at the time of, and following the transition of the service to the local authority. The consensus amongst staff was that senior managers were taking steps to address the difficulties. We saw evidence that actions had been implemented and improvements made, and that work was ongoing to further progress this work.
- Managers told us they were able to overcome several challenges facing the service through close working and supportive teamwork from the front line to the most senior levels of staff.
- Senior managers said they took a 'back to the floor' approach and visited staff in localities when their diary permitted, but tried to do this at least once a month. Staff confirmed that they often saw senior managers at different localities.
- Managers said they felt listened to and that senior managers took action where improvements were needed. For example, where one team was based in an unsuitable building which was outside of the service geographical area, a project was undertaken which resulted in the team moving to a more appropriate site.
- Staff felt well supported by their clinical team leaders and integrated team managers saying that they were always accessible. In addition, we were told that wellbeing support was available for staff involved in serious case reviews.
- Senior managers told us they had an open door policy to all staff. Although many staff we spoke with said they felt the senior management team were visible and approachable, there were some staff who felt their voice

had not been heard at the time of transition, though acknowledged that this had improved and that there was opportunity to meet with them at larger team events and away days.

- There were development opportunities for Band six health visitors and school health nurses which had been popular, and the service was now introducing a similar programme for staff between Bands three and seven. Staff were encouraged to consider the NHS Leadership Academy and we were told that some staff had successfully completed the Mary Seacole Leadership Programme.
- Senior staff in the special school we visited talked positively about the school health service and the collaborative relationship they had had with the special school health team manager to discuss ways of taking the service forward.
- Commissioners spoke of a productive relationship with senior managers within the service and said they had responded well to their requirements around implementing vision and hearing screening and school profiling.

Vision and strategy

- The vision within the service was, "Putting people at the heart of everything we do". Staff at all levels that we spoke with were passionate about placing the child at the centre of their work and ensuring that their interventions were person focused. We were told that improving the lives of children and young people was a high priority for staff holding senior positions within the local authority
- The service maintained the NHS 6Cs core values of care, compassion, competence, communication, courage and commitment. The service also had nine quality assurance principles which included accountability, transparency, improving outcomes, safeguarding children and working collaboratively and staff could identify with these in their day to day work. We saw posters displayed showing the vision and values of the service.
- We saw the Newham Children and Young People's Plan 2015-2018 which held a key theme of improving healthy lifestyles and emotional wellbeing. The "Evaluation, Recommendations and Future Strategies for the CYP 0-19 Health Service System" was in draft at the time of inspection.
- Senior managers told us the strategy for the service was to further improve integration with the wider children and young people's programme. The service was involved in collaborative work with health and social care partners and quality improvement work was progressing with the local mental health trust. Multiagency work within the council had been embedded, for example the service played an active part within the multiagency safeguarding hub (MASH), as well as working alongside social work and education colleagues.
- Staff were involved with development of the strategy, and locally this was being fulfilled through their commitment to the Best Start in Life programme and Early Help offer, and bringing together all staff at the away day to encourage cross team working.
- Senior managers had set priorities going forward which included continued work on estates and IT to ensure staff were based in the appropriate locations and were able to access electronic records, continuing to develop co-operative working with those involved in children and young people's services and the wider sustainability and transformation partnership, and increasing skill mix within the service.
- A workforce strategy 2017-2019 was in place which outlined its approach to have a sustainable and capable workforce. Key priorities were set out around recruitment, retention and development, setting standards, learning and development, leadership, partnership working and involvement of service users. The workforce and development subgroup were responsible for updating the strategy.
- The service used the Joint Strategic Needs Assessment to inform their planning around health. Youth safety had been made a high priority within the service, with an aim of identifying at an early stage those children and young people who might become involved in violent crime, so that the right interventions and resources could be put in to place.

Culture

Community health services for children, young people and families

Good

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Staff we spoke with said that the service offered a friendly place to work with supportive colleagues. All staff welcomed the collaborative working within and between teams, and the accessibility of other colleagues, such as those working within social care.
- We observed and heard staff describing a real sense of pride about being part of a team, and working together to ensure the optimal health and safety of children.
- The corporate management team within the local authority were reviewing the current state of equality, diversity and inclusion within the workplace. We saw a report produced for the February 2019 meeting which outlined progress that had been made. This included a review of recruitment processes and policies, cultural workshops had been set up to consult with staff over organisation restructure, and an analysis of the equality reporting data.
- Within the children's health service 0-19 all staff involved in recruitment had undertaken training in recruitment and selection. An unconscious bias training course was offered for staff development in addition to the mandatory equality and diversity training.
- Staff indicated that they could raise concerns with their managers and suggest improvements, with most staff saying that they felt listening to and valued.
- The local authority had a whistleblowing policy which detailed how employees could raise concerns about service provision, conduct of officers or members of the council. There was a commitment to raise staff awareness of the whistleblowing policy through team huddles.
- Following the transitional period, senior managers brought in an external facilitator to enable staff to discuss what was needed to move the service forward and meet the needs of service users. All staff we spoke to said they found the intervention useful, and that senior managers took on board the issues raised which included payroll, estates and IT, and thereafter considered a plan for improvement.
- The service had commissioned a Freedom to Speak Up Guardian Service. This is an independent and confidential service established to support staff to discuss any matter relating to patient care, patient safety and work related concerns.
- Staff said they felt valued by managers and hard work and effort was recognised during conversations with managers and appraisals.
- The service had an employee assistance programme to support with emotional and welfare issues. This had been helpful to staff at the time of transfer.

Governance

- The senior management team held a quality and governance board (QGB) every six weeks. The board included two independent advisors, a community paediatrician and an expert lead. The QGB was the central point within the directorate structure for identifying, monitoring and escalating patient safety and quality incidents and service user feedback. We saw the Terms of Reference for the QGB which included standard agenda items of quality and safety report including risk register and incident reporting, serious incidents and action plans, audit update, complaints, staffing and reports from QGB subgroups. The senior management team met every two weeks to discuss key issues arising from the board.
- Several subgroups met on a monthly basis including risk management, clinical effectiveness and audit, workforce development, user engagement and communication, policies and pathways and record-keeping. Subgroups included representatives from health visiting and school health teams so that feedback from the frontline could be shared. The subgroups reported to the quality and governance board.
- The quality and governance board reported to the children and young people's departmental management team (DMT) board on all matters relating to clinical and operational safety, quality and standards across the service. The DMT was chaired by the executive director of strategic commissioning, and in turn reported to the corporate management team.
- Operational meetings were held monthly with attendance including the service manager, integrated

team managers, clinical team leaders, nursery nurse lead, training and development manager and school health adviser. The meetings involved discussions about performance, incidents and training and included feedback from the senior management team.

- Locality meetings were held monthly, with weekly team meetings so that key messages could be cascaded to staff. The safeguarding team met each month. We saw the most recent minutes from the safeguarding meeting which showed actions to be taken forward and individual responsible.
- The Newham Safeguarding Improvement Board was attended monthly by the head of service and/or the named nurse for safeguarding and a quarterly report produced by the named nurse for the quality and governance board. In addition, there was a joint safeguarding board chaired by the clinical commissioning group and attended by the named nurse. The service also had representatives on the subgroups of the Local Safeguarding Children's Board. We saw the Safeguarding Children 0-19 report October to December 2018 completed by the named nurse for safeguarding, which provided information on training, updates to legislation, performance and significant incidents.
- An external review had been undertaken of the service between December 2017 and April 2018 to review the function and delivery of the service and the governance arrangements in place. Several areas were reviewed and an action plan devised for the development and improvement of the service. This was monitored by the senior management team and at the governance and quality board. We saw an update report to the DMT in October 2018 detailing steps that had been taken to implement the recommendations.

Managing risks, issues and performance

- There were assurance systems and service performance measures, which were reported and monitored with action taken to improve performance. This included a risk and issue log, a risk management group and a quality and governance board where any risks or performance issues were escalated. The clinical effectiveness and audit group reviewed performance and reported to the quality and governance board. Senior managers met with commissioners monthly to discuss performance and incremental steps for improvement.
- The service had a risk log which identified potential risks that could happen and an issues log which listed the current pertinent issues for the service. Both the risk log and issues log showed details of the risk/issue, risk owner, risk rating, mitigating actions and controls put in place and date of last review, and fed in to the corporate risk register.
- There were nine risks on the risk register with the highest rated listed as connectivity to the electronic record system. Inconsistencies with connectivity was also on the issues log. There had been ongoing work to improve the infrastructure and to move teams to new locations with better connectivity. A business change management was overseeing the project. Improvements had been reported in those as teams had moved location.
- We found under performance in the 12 month child health review was not listed on the risk register or issues log, although managers told us there had been gradual improvement over time.
- Provision of nursing at special schools was also flagged as a high priority issue as there was no dedicated special school nursing service through the local authority, and cover was through an agency. We saw a paper had been produced for the departmental management team with mitigating actions to reduce clinical risks.
- Both the risk log and issues log were discussed at the senior management team meetings every fortnight with reports produced for the divisional management team.
- A project officer within the service led on incident reporting and was a system supervisor for the electronic reporting system. The officer ensured incidents were reported under the correct category and drew out themes from incidents. They coordinated the risk management group which had a representative from the health visiting and school nursing teams and was chaired by the service manager. The group discussed themes from incidents and lessons learnt, complaints

and compliments. The risk management group reported to the quality and governance board. One of the most frequently reported incidents was related to IT connectivity.

- The service had a Business Continuity Plan 2018-2019 which set out evacuation points, chain of command contact details and alternative ways to deliver functions.
- There was positive joint working observed between senior managers of the children's service, Local Safeguarding Children's Board (LSCB) and Youth Offending Team. Managers indicated that since the children's health service had moved to the local authority there had been wider involvement and higher awareness between the teams. Whilst this at first had thrown up some challenges, with regarding to maintaining confidentiality, this had resulted in an information sharing protocol being agreed.

Managing information

- Newham local authority had a Caldicott Guardian who was responsible for protecting the confidentiality of health and social care information within the organisation.
- Following the transfer of the service, the local authority had commissioned the IT requirements used by the previous provider of children's health services so that staff could continue to use the electronic records system without disruption to service.
- The service had worked collaboratively with the local acute NHS trust, mental health trust and GP Federation to agree a core data set and to enable access to electronic records and joint working to support the tracking of children and young people across boroughs.
- The service was not always able to extract the relevant data from the system to run reports on the key areas of delivery. Through a contractual agreement, managers were liaising with the relevant parties to ensure that the correct reporting requirements were in place. At the time of inspection, we were told this was still work in progress. In the interim, integrated team managers had been undertaking a dip sample from their team case records to report on performance. An audit had taken place in November 2018 to ensure the information was of the correct quality.
- Senior managers told us there had been discussions about using an alternative records system which would link with the social care records within the organisation, although no firm decisions had been made.
- Commissioners met with senior managers of the service once a month to review performance. They told us that whilst there had been issues since the transition of the service they were now reasonably confident about the accuracy of the data provided and, in particular that pertaining to the mandated key contacts.
- The service had been developing an improved dashboard which would show key performance data for health visiting, school nursing and family nurse partnership teams. The dashboard was at testing stage with feedback to be provided by the integrated team managers.
- All information related to the children's health service including policies and procedures were kept on the shared point, a central area on the intranet that all staff within the service could access.

Engagement

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services.**
- Staff surveys had been undertaken twelve weeks (62 responses) and one year (71 responses) following the transition to the local authority to seek their views as to what had worked well and what could be improved. Staff rated staff conversations and team meetings to be the most helpful interventions during the transition period, with issues in relation to accessing the electronic patient record system and management support being the most unhelpful interventions. After the first year, staff rated their happiness as 2.7 out of 5, and most staff said they felt either welcome or sometimes felt welcome to the London Borough of Newham.
- Senior managers produced "You said, We did" reports to show what actions they were taking in response to the surveys. This included a process of candid ongoing conversations for staff as standard practice, and continuing to work on improving communication from the senior management team through regular messages from the director and head of service and keeping all documents relevant to staff on a shared point.

Community health services for children, young people and families

Good

- Following the transition of the service the executive director had spoken with all staff through 'Towards Excellence' workshops to hear their concerns and talk about the way forward for the service.
- All staff spoke positively about two away days that had been recently arranged for school health and health visiting teams, and had enabled staff to come together and network, undertake team building exercises and hear feedback from service users regarding the service.
- Information was provided to staff by a variety of means. Key messages from managers were delivered at staff team meetings which were rotated at each locality to enable the maximum amount of staff to attend. Information from the senior leadership and safeguarding team was shared with staff by email.
- Paper feedback forms were located in clinic areas and children centres so that service users could leave feedback about their experience, and indicate whether they would recommend the service. Child friendly forms were provided to students to leave feedback after their visit to the school nurse.
- Service users could also leave feedback electronically via the online feedback form found on the local authority website. Work was being undertaken so that service specific feedback could be given.
- Service users had been invited to provide feedback at the away day recently held by the service. This was a valuable opportunity to meet frontline staff and managers to discuss ways in which the service could be improved. Likewise, staff told us that this had been a helpful exercise in understanding what was working well, and what changes they could make.
- The service was in the process of implementing a service user feedback forum. Interest was currently being gauged amongst potential attendees, and training provided.
- Service users were included on interview panels when staff were recruited. One service user we spoke with who had been involved in this process felt that their views had been listened to and taken seriously.
- School health nurses and health visitors had attended a community fair to increase awareness about health issues and raise the profile of the service with the local community.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**
- Health visitors worked in conjunction with a local charity who provided practical support and advice for mothers and children under the age of five living in temporary or insecure accommodation. In recognition of this work health visitors had been short listed for the Health Service Journal award for innovative projects.
- Senior managers were committed to a continuing improvement journey, and embraced ongoing review of the service, both internally and externally, providing them with an opportunity to reflect on what was working well and what might be improved.
- The service was working with Public Health England through ongoing work with local dentists to improve outcomes in oral health, with health visitors providing guidance during visits.
- Three school health nurses had been given the opportunity to participate in a European research project, sharing best practice with other health and social care professionals looking at working methods for better family assistance and public service.

Outstanding practice and areas for improvement

Outstanding practice

- Being the first London borough to bring the children's health service within the remit of the local authority required drive and effective leadership from the senior management team to ensure the service was delivering in key areas. Senior managers were committed to a continuing improvement journey, and embraced ongoing review of the service, both internally and externally, providing them with an opportunity to reflect on what was working well and what might be improved.
- In developing the Early Help health pathways the service had introduced a template for GPs so that information could be recorded, coded and shared between service areas.

Areas for improvement

Action the provider SHOULD take to improve

- The service **should** monitor the action plan to improve mandatory training to ensure compliance rates are met.
- The service **should** have formalised guidance for the escalation of complex safeguarding concerns and ensure that it is readily available to staff.
- The service **should ensure** that staff comply with infection control best practice guidance. This particularly relates to hand hygiene and cleaning equipment.
- The service **should ensure** that there is a mechanism in place for monitoring and recording the temperature in rooms and fridges where medication is stored.
- The service **should ensure** that the environment where care is provided is safe for children at all locations.
- The service **should** take action to improve its performance at the 12 and 15 month child health review stage.
- The service **should ensure** that information is available in different languages and alternative formats such as large print.
- The service **should ensure** that service users have clear mechanisms to give service feedback or make a complaint.
- The service **should ensure** it has systems and processes to manage and report key performance indicators.