Barnet, Enfield and Haringey Mental Health NHS Trust

RRP

Community health services for children, young people and families

Quality Report

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Date of inspection visit: 30 November – 4 December 2015
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRPXX	Trust Headquarters		N15 3TH

This report describes our judgement of the quality of care provided within this core service by Barnet, Enfield and Haringey Mental Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Barnet, Enfield and Haringey Mental Health NHS Trust and these are brought together to inform our overall judgement of Barnet, Enfield and Haringey Mental Health NHS Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Good l

People we spoke to on the telephone and met in clinics spoke positively of the caring and kind staff, and the way they listened to their concerns. Staff ensured people experienced compassionate care, and care that promoted their dignity. Staff coordinated care for the whole family and were committed to helping meet people's emotional, social and welfare needs as well as their health needs.

Staff delivered programmes of assessment, care and treatment in line with standards and evidence based guidance. There was a multidisciplinary, collaborative approach to care and treatment that involved a range of health and social care professionals. Staff felt well supported in their teams and able to contribute to service development. Some staff recognised the benefits of reorganising services into borough based service lines and the integrating mental health services and community based services.

Clinics and services were located in places where people could access them, and delivered at a range of times to accommodate people's different preferences. Overall, children, young people and families received timely community health services. With a few exceptions, services met their performance targets and where there were waiting lists these were now being managed effectively.

Staff were encouraged to report incidents and raise concerns. Learning from incidents was shared with staff through regular team meetings. There were robust safeguarding policies and procedures in place. Staff received regular safeguarding supervision and were knowledgeable about their responsibilities regarding safeguarding people.

The service experience a low level of complaints, complaints from people using the service were learned from and used to improve the service. However, guidance on how to make complaints was not readily available in the clinics we visited.

There was a governance framework and a clear reporting structure from local team meetings to monthly management meeting which fed into the clinical governance meetings. Staff were positive about the skills, knowledge and experience of their immediate managers and felt they were well supported. Risks to the service were identified and action taken to mitigate the risks.

However, health visitors were carrying higher a higher than recommended case load level per health visitor. Unfilled shifts due to sickness, absence and vacancies were often not covered by bank or agency staff. The trust was not able to fully deliver the healthy child programme.

Electronic patient records were not always complete. Staff working remotely had to keep paper records and transfer the information to the electronic records. Accessibility to electronic records and clinical record keeping were compromised for staff based at non NHS locations, such as special schools. Some staff who were fully dependent on mobile working had no comnnectivity access on laptops.

The appraisal rate for staff within children's community services was lower than the trust's target of 85%. The majority of nursing staff employed in the role of school nurse did not have or were not working towards a relevant qualification.

Staff did not consistently understand the principles of consent.

Summary of findings

Background to the service

The trust provided a wide range of community health services for children, young people and their families. This included health visiting, school nursing, specialist nursing, 'looked after' children, and safeguarding children, as well as paediatric speech and language services, physiotherapy and occupational therapy.

Children and young people under the age of 20 years make up 27.7% of the population of Enfield. 77.5% of school children are from a minority ethnic group. The health and wellbeing of children in Enfield is mixed compared with the England average. The infant and child mortality rate is similar to the England average.

The level of child poverty is worse than the England average with 29.6% of children under 16 years living in poverty. The rate of family homelessness is worse than the England average. Children in Enfield have worse than average levels of obesity: 12.2% of children aged 4-5 years and 24.8% of children aged 10 – 11 years are classified as obese.

The trust worked closely with a range of partners including other acute and specialist acute hospitals, GP organisations and local practices, local authorities, schools across Enfield and other teams within the trust.

Services are generally provided in health centres as well as schools, community buildings and in the patients' own home.

Our inspection team

The team that inspected services for children, young people ad families consisted of CQC inspectors and a variety of specialists including a school nurse, a health visitor, a nurse specialist and an Expert by Experience.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive hospital inspection programme.

How we carried out this inspection

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

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

We visited Cedar House, two community health centres; Forest primary care centre and Moorfield. With their consent, we observed young people and their families receiving services and accompanied staff on home visits to children and their parents.

We also:

- Looked at 15 clinical records
- Spoke with 33 parents and young people using the service
- Held a focus group with a range of staff who worked within the service

Summary of findings

- Spoke with 54 staff cross the service including the clinical director for Enfield and the assistant director for the children and young people services. We also spoke with health visitors, school nurses, specialist nurses, administrative staff, physiotherapists, occupational therapists, and speech and language therapists.

Prior to and following our inspection we analysed information sent to us by the trust and a number of other organisation such as local commissioners and Healthwatch.

What people who use the provider say

Parents we spoke with were positive about the staff that provided their care and treatment. They told us they had confidence in the staff they saw and the advice they received. Their comments included: "amazing, supportive, always answers all my questions", "friendly and caring", "go above and beyond their role; very comforting, very reassuring and very supportive during a difficult period".

Good practice

The paediatric physiotherapy service had developed new innovated ideas to improve their practice. This included a screening clinic for under-fives with lower limb/gout concerns, a hypermobility group to help educate children and families and promote self-management and an information leaflet for doctors and health visitors on feet and lower limb development.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure there are sufficient health visitors in post to deliver the 'healthy child programme'.

Action the provider SHOULD take to improve

- The trust should ensure that all current patient clinical records are all records are regularly maintained and updated when staff leave and that staff working remotely have access to a desk and internet services.
- The trust should ensure infection control and hand hygiene audits take place across the services.
- The trust should ensure that staff working in the community services for children, young people and families have completed appraisals in line with the trusts target.
- The trust should create a child friendly environment at Cedar House.
- Thye trust should ensure in clinic environments that information is available for people on how to make a complaint
- The trust should ensure that staff complete mandatory training in line with the trusts targets, especially outliers such as the paediatric dietetic service.
- The trust should review school nursing staffing levels to ensure the full core service can be delivered to schools
- The trust should ensure that school nurses are offered the opportunity to access specialist community public health nurse training.
- The trust should continue to work with the trust that provides paediatricians to ensure there are enough staff available.
- The trust should ensure that all the immunisations levels are monitored to ensure the trust is reaching the necessary levels.
- The trust should ensure that it always follows the necessary process for obtaining consent prior to carrying out health checks.

Summary of findings

- The trust should continue to take the necessary steps to maintain the reduced waiting times for paediatric occupational therapy input.

Barnet, Enfield and Haringey Mental Health NHS Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

We rated safe as **requires improvement** because:

- Health visitors were carrying higher a higher than recommended case load per health visitor. Unfilled shifts due to sickness, absence and vacancies were often not covered by bank or agency staff. The trust was not able to deliver all aspects of the 'healthy child programme'. They delivered 3 of the 5 mandated contacts. The ante-natal contact and 8-12 month review were targeted at the high risk patients.

However, staff were encouraged to report incidents and raise concerns. Learning from incidents was shared with staff through regular team meetings. There were robust safeguarding policies and procedures in place. Staff received regular safeguarding supervision and were knowledgeable about their responsibilities regarding safeguarding people.

Detailed findings

Safety performance

- There were no never events related to children, young people and families in the community in the last 12 months. These are serious, largely preventable patient safety incidents that should not occur if available preventable measures have been implemented.
- For the period 1 September 2014 to 30 September 2015 the trust reported 35 incidents related to children's community services. The most frequently occurring types of incident related to consent, communication or confidentiality (6), documentation (5) and implementation of care and ongoing monitoring and review (5). There were no emerging themes and inappropriate reporting was also being followed up.

Incident reporting, learning and improvement

Requires improvement

Are services safe?

- Incidents were reported through a trust wide electronic reporting system. This allowed for the management overview of incident reporting and an ability to analyse any emerging themes or trends.
- Staff knew how to report incidents although some school nurses acknowledged that they did not always report when they were bitten or scratched by a child. Staff told us that incidents were discussed as part of team meetings or on an individual basis. Team meeting minutes we looked at showed incidents were discussed as part of the meetings.
- Incidents were also reviewed as part of the children and young person's services quarterly "deep dive" meetings.

Duty of Candour

- Staff had a limited understanding of their responsibilities under duty of candour. Staff advised us that they had not had any training. The senior management team within children's services had attended training on this topic in October 2015 and training for staff had been planned for early 2016.

Safeguarding

- The trust had children's safeguarding policies and procedures available on the intranet. These were due to be reviewed in May 2014 which meant that staff could be following guidelines that did not reflect the latest guidiance and best practice.
- There was a dedicated safeguarding team for the children and young person's services. At the time of our inspection there was a higher number of children on the child protection register than normal. Staff said this was due to local authorities moving people from central London with child protection concerns and accommodation issues.
- The safeguarding team had strong links with external agencies such as local authority safeguarding teams, third sector providers and the police and were represented at the monthly multi-agency risk assessment conference (MARAC), the multi–agency sexual exploitation group (MASE) and on the local children safeguarding board.
- There was a system in place to highlight and monitor vulnerable children where there were safeguarding concerns. Staff demonstrated examples on the electronic records system identifying vulnerable and at risk children and families along with details of how they were being supported. There were systems in place to monitor and track looked after children.
- Staff routinely talked to mothers about domestic violence, and we observed a domestic violence support worker at a baby clinic speak to a mother about community based services that were available.
- A local protocol had been developed for health visitors and school nurses on female genital mutilation (FGM). Training about FGM had also been provided for practioners.
- Staff said that they had safeguarding supervision every three months with a member of the safeguarding team and case management supervision every six weeks. Staff were also able to use the team as a resource should they have any concerns they wished to discuss. The safeguarding team confirmed that they would provide supervision on a 121 basis or as group supervision and they also provided ongoing training for staff.
- The safeguarding team had key performance indicators (KPIs) to demonstrate that child protection supervision was being undertaken. In the period April to June 2015 the number of health visitor supervisions was lower (79%) than the trust target of 90%, and was achieved in the period July to September 2015. In the period April to June 2015 the target of 90% for school nurses having supervision was achieved.
- The trust's performance dashboard for Enfield community children's services showed 93% of the appropriate staff were up to date with level 3 safeguarding training and 91% up to date with level 1 and 2 safeguarding training against the trust's own target of 80%.
- In July 2015 81% of all staff working in the Enfield community services including childrens services had completed safeguarding adults training against the the trust's own target of 85%.

Medicines

- Medicines were kept secure and handled safely. Records were available to demonstrate that medication fridges were regularly checked to ensure that the optimal temperature for drug storage was not compromised.

Requires improvement

Are services safe?

However the trust's own audit of medicine safety in seven locations in children's community services during July 2015 showed room temperatures were not recorded 50% of the time and 17% fridge temperatures were not within recommended limits.

- Patient group directives (PGDs) were used by staff to support them to give the correct immunisations and vaccinations. The two PGDs we looked at had been reviewed and were up to date. Both PGDs had been ratified by the chief pharmacist, medical director, and director of nursing.
- All school nurses were supplied with anaphylaxis kits by pharmacy as part of immunisation pack. All school nurses had been trained to administer anaphylaxis.
- The trust had a policy and procedure to manage the cold chain for the storage and transportation of vaccines. We saw that health visitors and school nurses had access to cool boxes for the transportation of vaccines and the temperature was monitored.
- Two medication incidents were reported between 1 September 2014 and 30 September 2015.

Environment and equipment

- Clinics were provided at a variety of locations across the borough.
- There was a 'sensory room' that had been set up in the waiting area of Cedar House. There was a sign on the door stating that it was the responsibility of parents to supervise children using the area. Strings of LED lighting presented a potential ligature hazard. During our inspection we observed a child playing in the sensory room unsupervised.
- Staff reported that they could access the equipment they needed. We saw that scales for monitoring children's weight were calibrated annually.

Quality of records

- The trust used an electronic record keeping system.
- Staff working remotely had to keep paper records and transfer the information to the electronic records, which was time consuming and increased the risk of missing information in the electronic records. The risk register for children's services recorded (in August 2015) that a locum staff member had left without updating 28 patient electronic records.
- The records we looked at were comprehensive and demonstrated effective interagency working with multidisciplinary team members within the children's services. For example speech and language therapists (SALT) working with the liaison health visitors from North Middlesex hospital.
- The different professional staff completed a range of different electronic forms. The school nursing, speech and language, physiotherapy, occupational therapists and health visitors all having access to the same system. This enabled different professionals to share information.
- Where necessary, staff scanned in reports, letters and minutes from meetings to complete the chronology of people's care. Records we looked at showed a clear history of care.
- Staff advised that they undertook peer reviews of patient records, we saw that the outcomes of audits were discussed in team meeting and actions.
- The trust's performance dashboard for Enfield community children's services showed 100% of care plans were completed following health assessments against the trust's target of 95%.
- School nurses used Enfield Education Authority condition specific care plans, for example for asthma or epilepsy. School nurses advised that the care plans were there to support the school and that the school was responsible for updating and reviewing the care plans.
- Information provided by the trust for Enfield community services which included the adult community services showed that 74% of staff had received training in information governance which is below the trusts own target of 85%.

Cleanliness, infection control and hygiene

- Staff demonstrated a good understanding of infection control procedures.

Requires improvement

Are services safe?

- Personal protective equipment, such as gloves, aprons, and hand sanitiser gel were readily available to staff. We observed most staff used hand gel when they visited patients homes and in clinics staff washed their hand in between patients.
- In baby clinics we observed that cleaning wipes were used to clean surfaces, scales and toys following a patient's assessment. Clean towels were placed on baby mats and staff were observed to be bare below elbow.
- Information provided by the trust for Enfield community services which included the adult community services shows that in July 2015, 81% of staff working in the community had completed infection control training which was below the trusts own target of 85%.
- We saw cleaning schedules for the clinics where services were provided.
- Infection control and hand hygiene audits were not taking place in children's community services.
- Enfield community services risk register identified that although Cedar House was the main children's centre for the borough there were deficits in regard to hygiene code compliance in both the cleanliness of the building and non-compliant furniture and floor coverings.

Mandatory training

- Staff were required to keep up to date with a range of topics. These included equality and diversity, safeguarding adults, safeguarding children, basic life support, fire safety, infection control, conflict resolution, information governance and moving and handling. Information provided by the trust showed varying compliance against the trust's own target of 85%. For example, 90.4% for paediatric occupational therapists, 92.9% for specialist school nurses, 85.7% health visitors, 88.6% school nurses, 100% of staff in the family nurse partnership team and 94.5% for paediatric physiotherapists. The paediatric dietetics team were an outlier with 44.4% staff compliant with mandatory training.

Assessing and responding to patient risk

- We found a wide range of risk assessments in use to assess and manage individual risk. Examples included risk assessment for children who had been diagnosed with epilepsy, who were at risk of anaphylaxis due to an allergic reaction.

Staffing levels and caseload

- Health visitor caseloads averaged between 400 to 700 families. This was higher than the Lord Laming recommended case load level of 300 families per health visitor. Staff reported that the variation in caseloads across the teams was due to the complex nature of cases and that the staff holding the lower number of cases had a higher proportion of families with safeguarding concerns. The trust had managed to recruit and fill the 70 current health visitor posts. Senior staff we spoke with informed us that to enable the health visitors to fully deliver the 'healthy child programme' the numbers of staff needed to increase to 79. The community risk register identified that the health visiting service would not be able to delivery the 'healthy child programme' in full, due to insufficient numbers of staff. For the three months prior to the inspection 29 health visiting shifts were filled by bank or agency staff to cover sickness, absence or vacancies and 333 shifts were not filled. The health visitors prioritised the urgent work to minimize the risk of harm to children and families. This meant they were delivering 3 of the 5 mandated contacts and working towards delivering the rest. They provided the new birth visit by 14 days, the universal follow up by 6-8 weeks and the universal 2 year development reivew. The ante-natal contact and 8-12 month review were targeted at high risk patients.
- School nurses had an 0.5 whole time equivalent vacancy against an establishment level of 15. School nurses were unable to deliver a full core service to all schools due to the high level of safeguarding work. This was not included on the risk register for the service. Staff we spoke with told us their priority was safeguarding, immunisations and long term conditions and delivering against the national height and weight screening for children in reception and year 6. In the three months prior to the inspection 28 specialist school nursing shifts were filled by bank or agency staff to cover sickness,

absence or vacancies and 57 shifts were not filled. Also, 24 school nursing shifts were filled by bank or agency staff to cover sickness, absence or vacancies and 111 shifts were not filled

- The sickness rate was 6.2% for health visiting, 6.1% for speech and language therapy and 3% for school nursing for the 12 month period to 31 July 2015. This was higher than most other services in the trust.
- The turnover rate was 8.2% for speech and language therapy, 6.7% for health visitors and 2.7% for school nurses for the period 1 September to 31July 2015. This was lower that the trust's overall turnover rate reported for the same period of 12.8%.
- Enfield Community services risk register identified in May 2015 a shortage of paediatricians since 2013 due to ongoing vacancies and long term sickness absence. This had increased the waiting times for clinics and reviews for complex needs children who required regular monitoring to avoid deteriorating medical conditions. The paediatricians were provided by another trust and the Enfield community services had made the other trust fully aware of the impact of the paediatric input. They were also mitigating the impact through supporting this work with trust staff.

Managing anticipated risks

- The trust had a lone working policy and procedure in place. Staff told us how they were using the protocols for arranging and carrying out home visits. Staff were able to access shared electronic diaries which gave details of their appointments that had been booked. Staff recorded their where abouts on a white board in their office and used a 'buddy' system to report in after 5pm. Before 5pm staff would call into their office. Each team had an agreed telephone message that they would use if they needed assistance.
- School nursing staff were not aware if generic risk assessments had been completed in relation to aspects of the school nurse role. A school nurse gave an example where they had been verbally abused by a parent. The school nurse was alone in an office and isolated from other staff. The staff member advised that they had not reported this as an incident which would have provided an opportunity to learn from this incident.

Major incident awareness and training

- The trust had a major incident and emergency policy in place. Paper copies were available in offices; however we were not able to find a copy of the plan available on the intranet. Staff demonstrated a mixed understanding of what would be considered a major incident or what they would have to do in the event of a major incident, although in some locations staff did have local guidelines in place for maintaining services in adverse weather conditions.

Good

Are services effective?

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

We rated effective as **good** because:

- Staff delivered programmes of assessment, care and treatment in line with standards and evidence based guidance.
- There was a multidisciplinary, collaborative approach to care and treatment that involved a range of health and social care professionals.

However,the majority of nursing staff employed in the role of school nurse did not have or were not working towards a relevant qualification. The appraisal rate for staff within children's community services was lower than the trust's target of 85%. Accessibility to electronic records and clinical record keeping were compromised for staff based at non NHS locations, such as special schools. Some staff who were fully dependent on mobile working had no connectivity access on laptops.

Staff did not consistently understand the principles of consent.

Detailed findings

Evidence based care and treatment

- The trust had a number of policies and procedures in place which were based on the national institute for health and care excellence (NICE) or other nationally or internationally recognised guidelines. Policies and guidance were easily accessible for staff on the trusts intranet. Staff we spoke within the therapies, health visiting and school nursing were aware of the national guidance relevant to their practice.
- The trust undertook audits of case files, child protection referrals and case conference reports to ensure that they met quality standards. In the period July to September 2015 health visitors and school nurses' case files, child protection referrals and case conference reports were audited. The target for 90% or above of records meeting the quality standards were met in all cases except for health visitors case files, where 87% of the case files met the quality standards. Where the performance was below the trust target we saw that there were plans in place to address the issues raised.
- Children's services used the common assessment framework (CAF); a multi-agency tool used to identify the needs and to help support children with complex needs to access the necessary services.
- The trust offered a Family Nurse Partnership (FNP) programme providing an intensive, evidence based preventative programme for vulnerable first time mothers, from pregnancy until the child is two years of age. Family nurses delivered a licensed programme with a well-defined and structured service model. The performance of this programme was monitored to ensure compliance with the national FNP guidelines.
- School nurses delivered the national child measurement program (NCMP). The NCMP measured the height and weight of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight and obesity levels in children within primary schools. School nurses also offered the HPV (human papilloma virus)vaccination as part of the NHS childhood vaccination program. The vaccine protects against cervical cancer and is usually given togirlsin year eight (aged 12 to 13) in schools in England.
- The looked after children (LAC) team supported 'looked after' children, to improve their health and life chance; providing a holistic and health educational approach to health assessments; and contributing to strategic planning designed to raise the profile of children and young people within the care system.

Nutrition and hydration

- Quarterly audits during 2014/15 showed the number of infants recorded as being totally breastfed at 6-8 weeks was between 36.4% and 39.6%.

Patient outcomes

- The immunisation rates for measles, mumps and rubella (MMR), diphtheria, polio, tetanus, pertussis and HIB was worse than the England average. The England

average MMR rate at age two was 92.7%; in Enfield it was 81.2%. The England average rate for combined diphtheria, polio, tetanus, pertussis and HIB at two years was 96%; in Enfield it was 89%.

- Data for the last year on the percentage of girls in year 8 receiving a complete Human Papilloma Virus (HPV) vaccination and the percentage of children in reception year and years 6 and 8 weighed as part of the national children's measurement programme (NCMP) was not available for the trust.
- The service's performance dashboard showed between 79% and 100% of children attending speech and language therapy early years drop-in service achieved routine care plan goals between April and September 2015. The dashboard also showed between 94% and 100% of children attending speech & language therapy school age service achieved routine care plan goals between April and September 2015 and that 100% of children attending speech and language dysphagia therapy achieved routine care plan goals between April and September 2015.

Competent staff

- Staff had supervision sessions and annual appraisals. Staff told us that they had received training to prepare them for completing their appraisal. The appraisal rate for staff within community children's services was 75% in the last 12 months. This was lower than the trust's target of 85% and below most other teams across the trust.
- Five out of the 15 WTE school nurses were specialist community public health nurse **(**SCPHN) trained. The remaining nurses did not have or were not working towards a specialist qualification.
- Staff spoken with told us that the trust provided good opportunities for additional training which would be funded by the trust. Team meetings were used to share learning amongst colleagues.

Multi-disciplinary working and coordinated care pathways

- There was collaborative working within the multidisciplinary team (MDT). In electronic records we saw notes from other MDT members in children's services. These included, speech and language therapists, occupational and physiotherapists, school nurses and the liaison health visitor at North Middlesex hospital.
- Evidence of joint working included the integrated pathway for social communication for pre-assessment autism with involvement from occupational therapists, speech and language therapists and educational psychologists.
- The safeguarding children's team said there were good working relationships with external bodies and effective information sharing so that child protection concerns were responded to quickly to minimise risks to children. For example there was interagency working between the safeguarding team and a voluntary sector organisation. They were running a joint road show on domestic violence and visiting children's centres. Staff told us there were good working relationships with GP's, school staff, social services, and the police. Information was shared and cross agency working ensured that where there were concerns about vulnerable children, these were identified and managed.

Referral, transfer, discharge and transition

- We found that there was a clear process for transferring children from health visitors to school nurses. Transfer summaries would be provided where there were safeguarding concerns, child in need concerns and additional health needs.

Access to information

- The community services risk register recorded that accessibility to electronic records and clinical record keeping were compromised for staff based at non NHS locations, such as special schools. Four sites were identified where this was a particular issue. Some staff who were fully dependent on mobile working had no comnnectivity access on laptops. This was ongoing since October 2014. Some staff had access to mobile working and had lap tops with internet dongles so that they could link to the internet from different locations. This meant that practioners could update their records in real time.
- Staff told us that there were frequently issues with the electronic patient record system being slow. Staff described occasions when the system could be down for significant periods, the difficulty in getting internet connections at different locations and the notes written on the system failing to be saved due to the slow connections.

Good

Are services effective?

- The intranet was available to all staff and contained links to guidelines, policies and standard operating procedures and contact details for colleagues within the organisation. This meant that staff could access advice and guidance easily.
- Staff were issued with mobile phones, which meant that staff could have contact with their office base during working hours. We did hear that there were frequent occassions when the phones were not working reliably.

Consent

- Records showed evidence that consent was gained for care and treatment, and where appropriate information was shared with other health and social partners. We saw that consent forms had been signed and uploaded into electronic medical records.
- We found that school nurses were not always sure if consent from parents had been obtained before they undertook measurements (heights, weights and blood pressure). For example, a school nurse at a school for children with complex needs had not checked if consent had been given by the parents prior to a health check and thought that consent had been obtained by the paediatric consultant. Senior managers advised that school nurses would write to parents to gain consent for immunisation, and will let parents know about weight and other checks. Consent was seen to be implied if the child was at school.

Good

Are services caring?

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

We rated caring as **good** because:

- People we spoke to on the telephone and met in clinics spoke positively of the caring and kind staff, and the way they listened to their concerns. Staff ensured people experienced compassionate care, and care that promoted their dignity.
- Staff coordinated care for the whole family and were committed to helping meet people's emotional, social and welfare needs as well as their health needs.

Detailed findings

Compassionate care

- People using the service were treated with kindness and compassion.
- Parents we spoke with were positive about the staff that provided their care and treatment. They told us they had confidence in the staff they saw and the advice they received. Their comments included: "amazing, supportive, always answers all my questions", "friendly and caring", "go above and beyond their role; very comforting, very reassuring and very supportive during a difficult period".
- We observed the way children and their parents were treated both in the home and in clinic settings. Staff were kind, patient and informative. Parents were treated as individuals and we saw that staff and patients built up good working relationships. Staff we spoke passionately about their commitment to providing good compassionate care.
- The 'friends and family' test for Enfield community services showed that 99% of patients would recommend the service.

Understanding and involvement of patients and those close to them

- We observed staff helping children and their families understand the treatment and support available to them. Staff ensured parents understood what was going to happen and why at each stage of their child's treatment. This included adapting their style and approach to meet the needs of the child and involving their families in all the services and settings we visited.
- The 'friends and family' test for children's community services showed that 98% of people said they were treated with dignity and respect, and 93% of people were involved in decisions and 91% had information provided

Emotional support

- Staff showed a commitment to providing emotional support in addition to health care or treatment. Health visitors provided a range of examples of how they supported the wellbeing of the family, as well as the individual child. For example should further specialist support be needed staff were able to refer to other services such as physiotherapy and speech and language services**.** Families told us they felt supported by staff.
- Parents of children with complex conditions said the therapists were helpful and considered the needs of the entire family as well the individual child. They also welcomed the support given which helped the child progress to school.
- The parent we spoke with told us that there was effective communication from staff and if they contacted the team their calls had been responded to quickly and the staff had given clear advice.

Good

Are services responsive to people's needs?

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

We rated responsive as **good** because:

- Clinics and services were located in places where people could access them, and delivered at a range of times to accommodate people's different preferences.
- Overall, children, young people and families received timely community health services. With a few exceptions, services met their performance targets and where there were waiting lists these were now being managed effectively.
- The service experience a low level of complaints. Learning from complaints led to improvements in the service. However, guidance on how to make complaints was not readily available in the clinics we visited.

Detailed findings

Planning and delivering services which meet people's needs

- Clinics used by children's services were mainly set up in suitable and accessible locations to meet local needs. People attending the clinics said they were convenient and knew they could attend alternative clinics in different areas if they preferred. Often clinics were held in children's centres, with a range of additional facilities available for children and families.
- Staff advised that following feedback from mothers attending child health clinics they had changed how immunisation sessions were delivered to reduce the waiting times.
- Baby clinics were provided in different locations across the borough. One mother said that they liked the availability of clinics but would welcome a late afternoon / evening clinic so that would be able to attend after work.
- A few of the environments we visited were found to be cramped or afforded little privacy for parents and nursing staff when discussing issues related to children's health. For example on one visit we observed a school nurse taking heights and weights of two teenage children with a learning difficulty in a corridor in order that they could access to a plug for the electronic scales. This did not maintain the privacy or dignity of the young people.
- The environment at Cedar House was not child friendly; it provided no play area or toys in the waiting area. Senior staff raised concerns about the environment of Cedar House. This was also identified as a risk on the Enfield community services risk register.
- A patient experience survey identified no private area for breastfeeding in a children's health clinic. Staff introduced a secluded area to allow mothers to breast feed in response to, "you said, we did".

Equality and diversity

- The staff that we spoke with had a good understanding of the population who used the service and were able to explain the specific needs of the people they cared for.
- In each area staff reported good access to interpreting services for people whose first language was not English. Health visitors advised that they used family members to translate on an initial visit. A mother we spoke with told us that they had been advised of the availability of translation services during maternity care. We saw a variety of written information in different languages for people using the services but staff advised these were not regularly used.
- We observed staff being respectful of a family's culture of no shoes indoors. The health visitor was equipped with over shoes to cover their shoes.

Meeting the needs of people in vulnerable circumstances

- Looked after children were given health passports so that they could have record of their birth history, childhood immunisations, and details of their doctor and dentist. This meant that young people could take this with them when visiting a hospital or their doctor and they would be able to provide clinical staff information on their medical history.
- Drop-in clinics were also provided for families with children with special needs. Therapists provided support at these clinics and parents also found them useful for social support.

Access to the right care at the right time

- Overall, children, young people and families received timely community health services. Waiting times for

Good

Are services responsive to people's needs?

patients referred for treatment had improved. With a few exceptions, services met their performance targets and where there were waiting lists these were now being managed effectively.

- The health visiting service undertook 94% of new birth visits with in 10 to 14 days in 2014/2015 against the trust target of 95%. For the period April to October 2015, 95% of new births were visited with in 10 to 14 days.
- For the period April to October 2015, 44% of children referred to the clinical support service for occupational therapy (OT) had their initial assessment within 13 weeks against the trust target of 70%. This was an improvement on performance in the 12 months ending in March 2015 when 1% of children were seen within 13 weeks. The service were unable to manage the level of referrals received due to increased referrals and staffing capacity. This was included on the risk register. An improvement plan was implemented in June which included weekly monitoring, a directed daily team brief work allocation and one additional full time agency OT for one month. In July and August 2015, OT staff based in education were redirected to the routine waiting list and the package of care was refined. One new permanent OT commenced employment in August and locum staff continued to cover vacancies. The care pathway was redesigned and commenced in October 2015. By the end of November 2015 trust reported the service was stable and achieving it's assessment target.
- For the period April to September 2015, 85% of children referred to clinical support service for physiotherapy had their initial assessment within four weeks against the trust target of 75%. This was an improvement on performance in the 12 months ending in March 2015 when 67% of children were seen within four weeks.
- For the period April to September 2015, 98% of children referred to the physiotherapy neurodevelopmental service had their initial assessment within 13 weeks against the trust target of 95%. This was an improvement on performance in the 12 months ending in March 2015 when 89% of children were seen within four weeks.
- For the period April to September 2015, 100% of children referred to the speech and language early years drop in service had their initial assessment within 13 weeks against the trust target of 75%. This was an improvement on performance in the 12 months ending in March 2015 when 38% of children were seen within 13 weeks.
- The percentage of looked after children receiving immunisation between the period July to September 2015 was 83% which was lower than the previous quarter which was 86%. This was below the below the national uptake rate of 87%.
- For the period November 2014 to November 2015 the percentage of patients not attending appointments averaged at 12% and these were followed up where needed.

Learning from complaints and concerns

- The service experienced a low level of complaints. Information received from the trust showed that four complaints were received concerning children and young people in the community in the 2014/2015 and there had been two complaints for the period April to November 2015.
- When a complaint was made it was addressed and learned from and when applicable used to improve the service.
- The service was meeting their target for responding to complaints within 25 days.
- In local offices were saw information on staff notice boards on how complaints should be handled. Staff directed patients to 'Patient Advice and Liaison Service (PALS) if they were unable to deal with their concerns directly and advised them to make a formal complaint.
- Most of the people we spoke with told us that they were not aware of how to make a complaint. Guidance on how to make complaints was not readily available in the clinics we visited.

Good

Are services well-led?

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

We rated well led as **good** because:

- Staff felt well supported in their teams and able to contribute to service development. Some staff recognised the benefits of reorganising services into borough based service lines and the integrating mental health services and community based services.
- There was a governance framework and a clear reporting structure from local team meetings to monthly management meetings which fed into the clinical governance meetings. Staff were positive about the skills, knowledge and experience of their immediate managers and felt they were well supported.
- Risks to the service were identified and action taken to mitigate the risks.

Detailed findings

Service vision and strategy

- Staff were generally aware of the trust's vision and values in a general context. Some staff recognised the benefits of reorganising services into borough based service lines and integrating mental health services and community based services. However, this organisation structure was still being embedded at the time of the inspection.

Governance, risk management and quality measurement

- There were nine risks related to children's community services on the Enfield community services risk register.
- The clinical governance process within the children's community services was in the process of being established following the restructure of services in the borough which brought the management of the childrens services into one directorate.
- There had been two clinical governance meetings, with the terms of reference being discussed at an initial meeting in October 2015.
- We saw from the quarterly quality audit reports for children's community services that service areas with good results and service areas in need of improvement were identified.
- Regular monthly meetings for team managers and monthly team meetings had recently been established under this new structure. KPIs, workforce issues, complaints, training and learning from incidents were discussed at team meetings. There was a clear reporting structure from local team meetings to monthly management meetings which then fed into the clinical governance meetings.
- Individual services within the children, young people and families service had carried out audits relevant to their particular practice.

Leadership of this service

- Childrens community services were supported by a local management team which was led by a clinical director. The services were operated through borough based service lines.
- Staff knew their manager and the senior management of the children's community services, and some staff were aware of members of the trust executive leadership team.
- Staff were positive about the skills, knowledge and experience of their immediate managers and felt they were well supported. However, staff felt there was a disconnect between the trust board and staff providing community services for children, young people and families. Staff felt the board were not visable and that community services were not prioritised.
- In school nursing we found there was a lack of leadership. The school nurses were managed by the children's locality manager but we heard that they felt they had no voice and the service was not valued by the trust.

Culture within this service

- Staff reported that they were proud to work for children's community services; they were enthusiastic about the care and treatment they provided for the people who used their services.

Good

Are services well-led?

- The trust held an annual awards evening to which gave an opportunity for staff to nominate individuals and teams for outstanding performance. Some of the staff we spoke with were attending the awards evening having been recognised by their colleagues.
- Staff described the trust as having an open culture and described and 'open door' management style and felt they would be able to contact their line mangers or senior managers if they had concerns.

Public engagement

- Staff recognised the importance of receiving the views of people who used the service. 'You said we did …' posters were on display when we visited different sites. Online surveys were conducted with people using an iPad to provide feedback before they left clinics.

Staff engagement

- Staff told us they were encouraged to be involved in how the service was delivered and were able to feedback any comments or concerns they had.
- School nurses felt their skills were not being used fully, with the focus of their work being on safeguarding and immunisation and this caused disappointment and frustration. School nurses recognised the lack of investment in their service compared with the health visitor service, and felt they were 'firefighting'. Staff described school nursing as the 'Cinderella service'.

Innovation, improvement and sustainability

- The paediatric physiotherapy service had developed new innovated ideas to improve their practice. This included a screening clinic for under-fives with lower limb/gout concerns, a hypermobility group to help educate children and families and promote self-management and an information leaflet for doctors and health visitors on feet and lower limb development.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA (RA) Regulations 2014 Staffing** The trust had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff being deployed. The trust had not ensured there were sufficient numbers of permanent health visitors to deliver the 'healthy child programme'. Health visitors also had to manage very high caseloads. This was a breach of regulation 18(1)(2)