Provide Community Interest Company

1-168055209

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-1479296015	Provide Community Interest Company HQ	Community health services for children, young people and families	CO4 9YQ

This report describes our judgement of the quality of care provided within this core service by Provide Community Interest Company. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Provide Community Interest Company and these are brought together to inform our overall judgement of Provide Community Interest Company

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
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

We rated the specialist children's service and the children's public health service as good because:

- There were arrangements to minimise and mitigate the risks to children and young people receiving care.
- The organisation had met the 2015 staffing target in response to the National Health Visitor Implementation plan. The National Health Visitor Implementation Plan 'A Call to Action' aimed to expand and strengthen Health Visiting services.
- Staff met the organisations mandatory level three safeguarding training target of 95%. There was a good awareness of safeguarding procedures, which meant staff had the ability to protect children and young people from abuse and avoidable harm.
- Staff reported and investigated Incidents appropriately; however, learning from incidents was inconsistent.
- There were care pathways and transition arrangements for young people with complex care needs moving to adult services.
- Staff had achieved the organisations target (90%) for appraisals, meaning staff had their learning needs identified and/or supported to undertake training and development.
- There were policies and procedures in place to support staff and ensure they delivered services effectively and efficiently.
- We saw effective multi-disciplinary working including with external partners and good arrangements around consent.
- Staff treated children, young people and their families with dignity and respect and were involved as partners in their care.
- Staff provided children with Information about care and treatment in such a way they could make informed choices.
- Staff were dedicated to achieving the best care for their patients and worked hard to achieve this.
- Emotional support was available for patients in need. Staff were compassionate, committed and flexible to meet the needs of their patients.
- Services were planned and delivered for children and young people, to meet the needs of the local population.
- Services were flexible and staff took into account the needs of different people.
- The service had a clear vision and strategy.
- We found a positive, patient-focused culture, leaders were supportive and staff felt valued.

Summary of findings

Background to the service

Information about the service

Provide community interest company (CIC) delivers community services to a population of approximately 1.9 million across Essex, Cambridge, Peterborough and the London boroughs of Waltham forest and Redbridge.

Mid Essex has over 88,000 children and young people aged between nought to 19 years, the majority of which live in Chelmsford. Overall, the children and young people of Mid Essex experience a good health compared with other areas of the country. This reflects the relatively low levels of social and economic deprivation in Mid Essex, despite 9,300 children classed as living in poverty.

Mid Essex has a predominately white population and therefore there is potential for social exclusion and unmet specific health needs within ethnic minority groups.

The organisation delivers community based services to children and young people, which included a specialist children's service and a children's public health service. It provides a range of health services including a diabetic service, occupational therapy, specialist healthcare training, community paediatricians, continence and enuresis, speech and language, audiology, physiotherapy, children's community nursing, health visiting and school nursing.

The service operates through skill-mix teams providing care to people in their own homes, in schools and in clinics across all of the geographical areas.

Our inspection team

Our inspection team was led by: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

Team Leader: Simon Brown, Interim inspection manager, Care Quality Commission

The team included CQC inspectors, inspection managers, an inspection planner and a variety of specialists including: paediatrics and child health professionals, specialist nurses, community matron, safeguarding lead, director of nursing, physiotherapist and a strategic lead for equality and diversity.

The team also included three experts called Experts by Experience. These were people who had experience as patients or users of some of the types of services provided by the organisation.

Why we carried out this inspection

We inspected this core service as part of our comprehensive independent community health services inspection programme.

How we carried out this inspection

We inspected this service in December 2016 as part of the comprehensive inspection programme.

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?

Summary of findings

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

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced between 12 to 15 December 2016. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists.

During our inspection we visited a variety of services at children's centres, schools, physiotherapy, occupational therapy and podiatry services, speech and language therapy, continence and enuresis clinics, specialist healthcare training and transport team, children's community nursing team, diabetic transition clinic, child development clinics, child health and baby clinics. We also observed home visits undertaken by health visitors, school nurses and multi-disciplinary team around the child meetings.

We looked at 60 individual plans for children, personal child health records (red books), risk assessments, care pathways and a variety of service-based documents, for example risk assessments and referral forms.

We spoke with 62 parents, 10 therapists, five children, 13 people from external agencies and 73 staff including school nurses, health visitors, community paediatricians, managers, assistant directors, community nursery nurses and administration staff.

What people who use the provider say

- Feedback from people who used the service and those close to them were continually positive.
- During our inspection, we gave people the opportunity to comment on the care they had received by completing CQC comment cards. Out of the 103 cards received, all were positive about the staff within children's specialist and public health services.
- We reviewed the NHS Friends and Family Test results in the children and young people's service for the period June 2015 to June 2016. The Friends and Family Test (FFT) is a single question survey, which asks patients whether they would recommend the NHS service they received to friends and family who need similar treatment or care. Data from the organisation showed the average FFT score for this period was 98.1%.
- We spoke with parents, children and carers about the different services they received from the organisation. Everyone we spoke with was positive about the staff, services and the care they received. Some of the comments included 'I don't know how I would have coped without them', ' happy, healthy child, amazing service, great support' and 'health visitor really wonderful', 'always available, keeps in contact, fabulous, always supports me with everything', 'doctors are a fantastic support'.

Good practice

- The specialist healthcare team delivered child specific training to professionals and carers. This service contributed to the safety, health and wellbeing of children with complexed needs across mid Essex.
- There was a sensory room at Moulsham Grange clinic, which provided a stimulating environment for children with additional needs. Parents could reserve a time slot for their child to use at the families convenience. Parking was directly outside of the clinic to enable easy access to the external ramped entrance.
- Therapy staff at Moulsham Grange clinic used motorised wheelchairs to chest children's motor functions. Staff offered children with mobility issues the opportunity to move when other children were developing and learning to walk.

Provide Community Interest Company

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated this service as good for safe because:

- Staffing levels were adequate and the organisation had met the 2015 staffing target in response to the National Health visitor Implementation plan. The National Health Visitor Implementation Plan 'A Call to Action' aimed to expand and strengthen Health Visiting services
- Staff reported and investigated incidents appropriately.
- As of October 2016 96% of staff had received level three children's safeguarding training which was above the organisational target of 95%.
- Data showed for mandatory training, 96% of staff was up to date with the training, against the organisation target of 95%. Staff felt supported to undertake mandatory training.
- The organisation had clearly defined and embedded infection control processes across the service.
- Staff used a wide range of risk assessments across the services to manage individual risks to children and young people.

Safety performance

- The service did not report on The NHS Safety Thermometer. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Staff collected data on a single day each month to indicate performance in key safety areas.
- Staff attended the harm free care panel regarding pressure ulcer care for children. The lead nurse for tissue viability who worked with adults and children visited the child's home with community children's nurses. They carried out a full assessment of all aspects of pressure ulcer prevention and care. The organisation said there had only ever been one reported pressure ulcer for children's services. The organisation said feedback following the visit would be fed back to the panel.

Good

Are services safe?

Incident reporting, learning and improvement

- The organisation had an incident reporting and management policy (review 2018).
- Staff reported incidents through an electronic reporting system. Discussions with staff demonstrated they had an awareness of the incident reporting policy. Most staff knew how to report an incident; however, some staff told us they would report the incident to their manager first and seek guidance. Some managers told us they would assist staff in completing the incident report or they would do this for them.
- Overall, staff felt they were encouraged to report incidents and near misses, concerns from patients and identified risks to the organisation. Staff were confident the organisation would take action if they raised concerns in relation to patient safety.
- We spoke with allied health professionals such as occupational, physiotherapy, speech and language therapists who told us they had little experience of reporting incidents. They received minimal feedback however, there was some feedback and learning in team briefings but this was not always relevant to the children's service.
- Some staff gave examples of when incidents had been reported and told us they received an automated receipt of this through the incident reporting management system. Some staff told us they received feedback from their manager but others did not.
- Feedback from incidents was inconsistent, we reviewed a range of meeting minutes from the children's public health team which included a locality meeting (December 2016), managers meetings (10 and 23 November 2016), team leads meetings (September 2016, October 2016 and November 2016) and team meetings (October 2016, November 2016 and December 2016). Incidents were a standard item on the managers and team leads meeting minutes, however, there was no evidence to suggest staff had discussed incidents at the team and locality meeting.
- A senior manager told us there was feedback three monthly from the senior management team however, feedback to the person who raised the incident could be improved.
- For the reporting period, November 2015 to November 2016 children's specialist services and children's public health services reported 14 incidents of moderate harm, 28 incidents of minor harm and 67 incidents of no harm. There was no detail about the incidents from the data provided therefore we could not identify any trends or themes.
- Between October 2015 and November 2016, there was one reported serious incident for children's public health and children's specialist services. Information submitted by the organisation demonstrated a full review, which included investigation, lessons learnt, recommendations and action plans. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents, which affect patients directly and include incidents, which may indirectly affect patient safety or an organisation's ability to deliver ongoing healthcare.
- The organisation reported no never events across the children's public health or children's specialist services. Never events are serious patient safety incidents that should not happen if the healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious harm or death but neither need have happened for an incident to be a never event.
- A quality and safety committee met monthly where incidents for services were a standing item on the agenda. We reviewed minutes for February 2016, March 2016, April 2016 and May 2016 where staff discussed risks and incidents.

Duty of Candour

- The organisation had a being open and duty of candour policy (review 2018). The Duty of Candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. All staff we spoke to demonstrate an awareness of the Duty of Candour.
- Allied health professionals felt they were open and honest with patients. Managers said they contacted complainants and patients if staff made a mistake, however staff could not give any examples of this.

Good

Are services safe?

- We reviewed one serious incident between October 2015 and November 2016, it demonstrated the organisation had applied the Duty of Candour.

Safeguarding

- The organisation had policies, which included safeguarding children and young people (review 2017), domestic abuse and multi-agency risk assessment conference (review 2018). Staff knew them and understood their responsibilities. The policy included the reference of 'Working together 2015'; this was in-line with The Department of Health best practice guidelines.
- Data provided by the organisation demonstrated three serious case review (SCR) investigations from November 2015 to November 2016 two of these were completed one was still outstanding. Information provided demonstrated the unresolved case had two outstanding recommendations related to learning from SCR's and multi-agency case audits. We saw actions for these dated November 2016, which the organisations were being working on. Serious case reviews are undertaken when a child or young person dies or is seriously injured, and abuse or neglect is known or suspected to be characteristics of the death.
- We observed staff responding to domestic abuse notifications received from the police in line with the safeguarding policy and the domestic abuse pathway.
- We saw evidence of a female genital mutilation (FGM) work plan including organisational requirements such as staff training, access to statutory guidance, record keeping standards and how the organisation was going to meet these. FGM is a violation of the human rights of girls and women and comprises of partial or whole removal of the external female genitalia for non-medical reasons.
- Staff received training on female genital mutilation (FGM) as part of their safeguarding training. As of December 2016 staff who have received training was above 95%. FGM is a violation of the human rights of girls and women and comprises of partial or whole removal of the external female genitalia for non-medical reasons.
- The safeguarding team report (October 2016) to the Quality and Safety committee board demonstrated that between April 2016 and September 2016, six children/ young people had been reported and recorded as being at risk or a victim of Child Sexual Exploitation (CSE). The safeguarding team raised awareness of CSE through training and supervision. There was additional free CSE online trainings promoted throughout the organisation. CSE is a form of sexual abuse involving the manipulation and/or coercion of Young People under the age of 18 years into sexual activity in exchange for things such as money, gifts, accommodation, affection or status.
- The total number of children on a child protection plan as of the 31 October 2016 was 438.
- All staff we spoke with told us they were up to date with their level three safeguarding children's training. As of October 2016 96% of staff had received level three children's safeguarding training which was above the organisational target of 95%. Staff said the organisation incorporated learning from serious case reviews into the training. Level three knowledge of child protection teaches how to recognise and know what actions to take if it is believed a child is at risk.
- Safeguarding adults and children level one to three training was part of the Fitness to Practice Compliance programme and was mandatory based on the Intercollegiate Standards for the Royal College of Paediatrics and Child Health (RCPCH, 2014).
- All new staff including temporary and volunteer staff received basic safeguarding awareness training as part of their induction.
- There was a safeguarding telephone advice line manned by a safeguarding named nurse, which practitioners could access for advice and support. Staff told us they found this a useful resource, however, sometimes it was busy but a call back system was in operation.
- The organisation delivered one to one safeguarding supervision to all health visitors and school nurses on a quarterly basis. The organisation delivered group or one to one safeguarding supervision to allied health professionals on a quarterly basis.
- Data submitted by the organisation demonstrated as of September 2016 99% of staff from the children's public health service and 95% of staff from the specialist children's service were compliant with attending safeguarding supervision. This organisations target was 100% and 95% respectively.
- Staff told us they accessed safeguarding supervision three monthly but were also able to request this if required in the meantime. We saw evidence of a safeguarding supervision record completed by the

practitioner and the safeguarding named nurse within the patients electronic care record. Staff were confident about the safeguarding procedures within the organisation and the local authority.

- We observed a safeguarding supervision session with a member of staff and a safeguarding lead. This included an overview of the situation, needs of the children and family, identified risks and management of these with an action plan completed. Staff documented this on a safeguarding supervision template within the child's electronic care record. We observed the safeguarding lead was supportive, responsive and caring towards the member of staff during the session.
- Staff had robust knowledge of serious case reviews and the necessary actions and recommendations from them. For example, all of the staff we interviewed were very knowledgeable about their caseloads and could identify any children who were on a child protection plan.
- The organisation had a domestic abuse specialist nurse and looked after children's (LAC) specialist nurse. Staff told us they were aware of this resource. Children (under 18) may be 'Looked After' by Local Authorities under a number of legal arrangements. Authorities place looked after children and young people in a variety of placements: from foster care to kinship care, children's homes, specialist units/centres and young offender institutes. The organisations record showed there were 390 looked after children on their records.
- Staff should action domestic abuse notifications received by the organisation within five days. The organisation set a key performance indicator (KPI) of 95% of notifications to be actioned. Information provided by the organisation demonstrated for May 2016 92% were actioned within the timescales, 3% actioned outside of the timescales and 5% not actioned. We saw a detailed action plan (June 2016) to address this shortfall. As of September 2016, information provided demonstrated a review of the action plan, which demonstrated an increase of response to 94% with further analysis for continued improvement.
- We reviewed a patient electronic care record and saw evidence of the school nurse responding to a domestic violence incident using the domestic abuse pathway of care and recording the actions as required. Domestic abuse is the abuse of one partner within an intimate or family relationship. It is the repeated, random and habitual use of intimidation to control a partner.
- We saw evidence of safeguarding alerts within the patient's records used as a quick reference for staff to identify vulnerable children such as children or young people on a child protection plan or looked after status. Staff knew where to look for alerts and how to record them on patient records.

Medicines

- There was a medicines policy (review 2017) for staff to access on the intranet.
- There was a standard operating procedure for the transcribing of medicines in the home and in community hospitals (review 2018) available for the children's specialist service to access from the internet.
- The specialist healthcare team provided child specific competency-based training in healthcare intervention including artificial feeding and medicines administration. The training helped carers and professionals working with children with complex conditions deliver care and treatment. This helped children live a life, which did not necessarily revolve around spending time in hospital. The team had ongoing accountability for staff delivering training in accordance with the local authority Medication and Related Tasks Policy and the Royal College of Nursing (RCN) Delegation of Tasks document.

Environment and equipment

- The organisation had systems and processes to ensure equipment was regularly serviced and maintained. We saw evidence of service agreements for the maintenance of weighing scales (April 2016) and blood pressure monitoring equipment (May 2016).
- We reviewed 11 pieces of equipment; of those, the organisation had reviewed and tested 10 in accordance with organisational policy. We informed a member of staff of the one piece of equipment requiring testing which they removed from the area.
- The children and young people's service used a number of medical centres and community venues such as Sure Start centres. The venues used were suitable for the clinics or appointments held there and we found the environments were visibly clean, tidy and suitable for children and their families.

Good

Are services safe?

- The organisation leased some buildings from other organisations, some staff told us repairs were difficult to resolve. However, of the premises we visited all environments were well maintained and suitable for children and their families.
- At all the clinics we visited, there were adequate arrangements for the management of waste, sharps and clinical specimens.
- Health visitors and school nurses each had their own set of scales, which they took with them to clinics and on home visits.
- Staff told us they had enough equipment to deliver care and they had no problems ordering equipment.
- Staff told us they had all of the equipment required to undertake their work, and it was in good order.

Quality of records

- We reviewed the management of children's records across the service and saw staff completed records in accordance with the organisations record keeping policy.
- All teams used a secure, electronic patient record system. Staff demonstrated a high level of competence and understanding of the system.
- The organisation undertook a yearly audit of records. The latest audit compiled in January 2016 showed 1364 records were reviewed across the organisation as a whole, of which 94% were electronic records. Although this information was not detailed, enough to provide results for the individual community teams, the data showed an overall improvement in the quality of record keeping across the organisation for the period 2015/16 compared with a similar audit in 2014/15. For example, there was an improvement in the recording of groups and relationships including the next of kin within the electronic record, however, the organisation acknowledged these results were lower than required at 66.7% (compared with 56.18% in 2014/15). The organisation planned to continue with training and repeat the audit.
- All practitioners had a facility to send each other requests, up-dates and changes within the electronic patient's notes system. Staff said this aided communication across the caseloads.
- All professionals within the service had access to their caseloads through a secure electronic patient record system using a dedicated card. We observed all staff maintaining safe and secure access to the system.
- We reviewed six personal child health records, also known as 'red books'. Three out of the six were completed and signed in line with the Nursing and Midwifery national record keeping guidance; however, the remaining three were completed and signed with the initials of the practitioner but not with the full name in capital letters. Red books are a national standard health and development record given to parents or carers at the child's birth.

Cleanliness, infection control and hygiene

- The service had effective infection and prevention control procedures in place. Clinic areas we visited during the inspection appeared visibly clean and there was evidence of cleaning regimes displayed.
- There were infection prevention and control community guidelines (review 2018) available for staff to access electronically.
- There was a systematic programme of clinical and internal audit, which monitored quality and identified where action should be taken.
- We saw evidence of a number of hand hygiene audits between January 2016 and November 2016 all demonstrated 100% compliance.
- Information provided by the organisation showed they had undertaken infection control environmental audits in eight premises. The audits included clinical environment, clinical equipment, waste and sharps management. Overall these showed a 92% compliance rate overall.
- There was a requirement for practitioners to demonstrate compliance of handwashing, infection control and the cleaning of equipment embedded within the patients' electronic record. We saw staff completed this within the care record.
- Staff had access to personal protective equipment (PPE) and knew how to dispose of used equipment safely, and in line with infection and prevention control guidelines.
- We observed staff cleaning equipment, including toys with approved wipes after use.
- Staff told us the organisation gave them hand hygiene packs to maintain hand hygiene when undertaking home visits. Not all staff we asked could show us these.
- Staff cleaned mats; scales and other equipment between use, and staff washed their hands or used hand-cleansing gel before handling each baby.

Good

Are services safe?

- Hand cleansing gels were available and were mostly used in the areas we visited, including between home visits.
- All staff were observed to be adhering to the dress code, which was to be 'bare below elbows'.

Mandatory training

- The organisation used an electronic monitoring system to manage staff mandatory training. Staff also had access to a training matrix.
- Staff told us they were responsible for making sure they were up to date with all of their training. They accessed their training records online and the organisation sent reminder emails when training was due to expire. Their managers also monitored training who prompted staff if it was required.
- Staff told us the organisation placed a high importance on training and managers made sure staff attended mandatory training. Staff felt supported to undertake mandatory training.
- Data showed for mandatory training, 96% of staff was up to date with the training, against the organisation target of 95%.
- Training was a combination of electronic learning and face to face, classroom based learning.
- Mandatory training included a number of different topics, including basic life support for both children and adults, information governance, conflict resolution, domestic violence, looked after children, safeguarding, infection prevention, moving and handling.

Assessing and responding to patient risk

- There was a lone working policy (review 2018) available for staff to access electronically. Staff we spoke with knew their responsibilities surrounding this. We observed an example of staff following the policy when a staff member was delayed returning to the office.
- The service had a wide range of risk assessments to assess and manage individual risk to children. For example, lone working, child sexual exploitation and environmental risk assessments. We saw staff conducted risk assessments to ensure staff and patient safety.
- The organisation had mechanisms to identify patients at risk, such as vulnerable children. Staff recorded details in electronic records, which all clinical staff could access. We saw an example of this for a child on a child protection plan, the details of which staff recorded as an icon on the electronic record.
- Staff advised parents on risk factors and sudden infant deaths. We observed all staff have this conversation on visits to newborn babies.
- Staff assessed risk through discussion with parents, taking measurements of children such as height, weight and head circumference, and observing the home environment for children. Staff recorded risks in patient records and recorded them as incidents. If staff identified health risks, they made referrals to GPs, support services and other health professionals.
- All staff we observed asked questions about children's and young people's physical, cognitive, and emotional development.
- We requested a policy related to recognising and responding when a child's condition deteriorates. A statement provided by the organisation demonstrated there was no specific policy, however, all clinicians and health professionals received basic paediatric resuscitation training annually and if a child were unwell, a clinician would contact an acute paediatric service or call the emergency services and transfer to the local emergency department.
- Information provided by the organisation demonstrated the service does not undertake child protection medicals for physical abuse. However, the organisation delivers an Essex wide service at Sexual Assault Referral Centres (SARC's) for children under the age of 13 years who present with a possible sexual assault.
- Specialist child healthcare staff trained local authority and voluntary sector staff assessed risks to children with severe conditions or complex needs so they could deliver the correct training to staff. For example, we saw a completed risk assessment for a child who required maintenance of nasopharyngeal airway (a tube used to bypass airway obstructions). Risk assessments included background to the condition, what staff should do in certain situations and reasons for the required training. Risk assessments were clear and signed off by a multi-agency panel and senior local authority staff.

Staffing levels and caseload

- The organisation used the Benson Model for children's health to plan and allocate health visiting and school

nursing staff. The Benson Model assesses and optimises the workforce requirements for each locality team with reference to population size, complexity and other demographic considerations.

- As of November 2016 there were 71.88 whole time equivalent (WTE) health visitors providing services.
- Data provided by the organisation demonstrated between November 2015 and November 2016 health visiting services had a staff turnover rate of 5% with a vacancy factor of 2% as of December 2016.
- As of December 2016, there were 34.36 whole time equivalent (WTE) school nurses, 10.53 WTE were Specialist Community Public Health School Nurses (SCPHSN) providing services.
- Data provided by the organisation demonstrated between November 2015 and November 2016 school nursing services had a staff turnover rate of 15% with a vacancy factor of 15% as of December 2016.
- There was a corporate caseload policy (review December 2016). Staff told us they managed there caseloads corporately which meant there was a shared approach to the workload, however, a named school nurse or health visitor would be accountable for decisions and actions made on any given case.
- The organisation divided both the health visiting and school nursing teams into three geographical boroughs. They then allocated staff into staff bases across the boroughs. For example, health visiting had 12 staff bases with corporate caseloads between 686 to 2555 children.
- Staff told us individual caseloads were between 250 and 350 clients, these were reviewed regularly in meetings with the team, with their managers and if required at any time. Staff told us they supported each other with their caseloads if they were absent from work or other unexpected demands were placed upon them, for example, a complex child protection case. Staff told us they delivered a comprehensive service.
- The National Health Visitor Implementation Plan 'A Call to Action' aimed to expand and strengthen Health Visiting services. The organisation had met the 2015 trajectory target of employing 72 whole time equivalent (WTE) additional health visitors in response to the plan.
- Data provided by the organisation demonstrated between November 2015 and November 2016 specialist children's services had a staff turnover rate of 16.05% with a vacancy factor of 0% as of October 2016.
- Actual staffing levels met planned staffing levels across the majority of departments for specialist children's services. The services with shortfalls were speech and language therapy (2.8 WTE), children's community nursing (1.8 WTE), Moulsham Grange Children's centre (1.27 WTE), occupational therapy (0.2 WTE) and audiology (0.1 WTE).
- A statement provided by the organisation demonstrated there was no use of bank or agency staff from November 2015 to November 2016.
- Planned staffing for the community paediatric service was 9.8 WTE. Data provided by the organisation showed four WTE consultant paediatricians, two WTE associate specialist paediatricians, 0.6 WTE specialist registrars and 1.8 WTE paediatric clinic assistants. This meant there was a shortfall of 1.4 WTE specialist registrar posts, 0.6 WTE due to rotating shift work at the local hospital and 1 WTE due to long-term sickness.

Managing anticipated risks

- There was a business continuity plan for children's services (October 2016). There was also individual business continuity plans for allocated bases and teams, all of which were in date. These contained specific actions for staff and key contacts in the event of an incident or potential disruption in service. Staff we spoke with knew where to access these.
- The organisation considered potential risks when planning services, for example seasonal fluctuations in demand.
- The organisation provided all staff with a personal alarm system. Practitioners could activate this to summon assistance if required. All staff we spoke with felt reassured and confident to use this system of personal security.
- The organisation used a vulnerability tool integrated into the electronic patient management system, which allowed practitioners to identify vulnerability factors within the patient record such as emotional health, alcohol abuse, drug abuse and domestic violence. This enabled an oversite of the vulnerability of all of the caseloads. Staff could obtain reports from the system for individual caseloads or within a team of professionals, which identified caseloads of high need requiring additional support and intervention.

Good

Are services effective?

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

Summary

We rated this service as good for effective because:

- Evidence based guidance was followed and care pathways were in place.
- There was a systematic programme of clinical and internal audits, which monitored quality and identified actions.
- Access to electronic patient information was good. Internal and external health professionals used secure, integrated IT systems to enable access to records.
- As of October 2016, 172 out of 190 staff (91%) had received an appraisal against an organisational target of 90%.
- We observed multi-disciplinary (MDT) working well across the service.
- There were care pathways and arrangements for children with complex needs in transition to adult services.
- Staff understood and could explain both Gillick competency and Fraser guidelines. Gillick competency and Fraser guidelines refer to a legal case, which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16 year olds without parental consent.

Detailed findings

Evidence based care and treatment

- Overall, we found care provided was evidence based and followed recognised and approved national guidance. Staff were clear about their roles in care pathways.
- Staff we spoke with knew the national guidelines relevant to their scope of practice. They told us the organisation supported them to follow this practice.
- The organisation followed the Royal College of Paediatrics and Child Health (RCPCH) guidance: The physical signs of sexual abuse and the examination of children and providing a medical report to social care and the courts.
- Staff used the Autism Diagnostic Observation Schedule (ADOS) scores in line with best practice. We saw staff discuss and evaluate scores with colleagues to ensure accurate assessment and evaluation. ADOS is an assessment for communication, social interaction and play for individuals suspected of having autism or other developmental disorders.
- School nursing and health visiting delivered services based on a national model of care delivery set within the Healthy Child Programme (2009). The Healthy Child Programme (HCP) is based on best evidence to promote and protect the health of children in the developing years. We observed patient contacts in line with the healthy child programme. The HCP stipulates when key contacts should be undertaken such as a new baby reviews by 14 days, age one-year review and age two to two and a half review.
- We saw documentation demonstrating the service was delivering the HCP 2009. The HCP is a public health programme for children, young people and families, focusing on early intervention and prevention. It offers a programme of screening tests, immunisations, developmental reviews, information and guidance on parenting and healthy choices.
- Health visiting and school nursing used the ages and stages questionnaire (ASQ) to assess a child's progress at certain stages in their development. ASQ is an evidence-based tool to help parents check their child's development. We observed a health visitor undertake a development check using the ASQ assessment tool. This was in line with the guidance.
- School nursing based there health assessments on NICE guidance (2005), health visiting used the common assessment framework (CAF) to assess the needs of the children to support early intervention. Both of these were embedded into the electronic patient record as a template for staff to complete. We saw evidence of both completed appropriately in the patient records we reviewed.
- We saw evidence staff assessed patient needs before care and treatment started and there was evidence of care planning. This meant children and young people received the care and treatment they needed.

Good

Are services effective?

- The organisation achieved stage one (January 2013) and stage two (December 2015) Unicef Baby Friendly Initiative Accreditation. Stage three was under assessment at the time of the inspection.
- The Baby Friendly Initiative is a worldwide programme of the World Health Organization and UNICEF. It was established in 1992 to encourage maternity hospitals to implement the Ten Steps to Successful Breastfeeding and to practise in accordance with the International Code of Marketing of Breastmilk Substitutes.
- The organisation communicated new policies and procedures to staff through staff intranet alerts, staff meetings, emails and weekly updates. All the staff we spoke with could demonstrate they received regular communication from the board, head of service and team leaders. This meant staff kept up to date with current practice and national guidance.
- There were clinical care pathways in place across the organisation, using NICE and other national guidance. We reviewed 40 including infant feeding, school assessment, autistic spectrum disorder, developmental delay for occupational therapy, constipation and enuresis. A hip surveillance-monitoring pathway embedded into the electronic patient record system, enabled easy access for practitioner reference. Autistic spectrum disorder affects social interaction, communication and behaviour. Enuresis is a repeated inability to control urination. The service had a number of standard operating procedures (SOP's) which included health visiting (review 2018), health assessments for looked after children (review 2018) and statutory reviews for looked after children (review 2018). These provided evidence based guidance on practice. Children (under 18) may be 'Looked After' by Local Authorities under a number of legal arrangements. Statutory guidance states all children in care must have a health assessment completed within 28 days (Initial Health Assessment/IHA) of coming into care and subsequent health assessments every six months for children aged under five years and every 12 months for children/young people aged five to17 years (Review Health Assessment/RHA).
- Health visiting used evidenced based assessment tools for assessing post-natal depression. We saw evidence of the organisation embedding these into the patients electronic care record for staff to complete as required. We saw evidence of staff completing them.
- We saw evidence of staff using the Brazelton newborn test. This is an evidence-based tool for the assessment of newborn babies in relation to behaviour and attachment.
- We attended an antenatal visit with a health visitor and observed an assessment of emotional wellbeing using the Whooley questionnaire. The Whooley questionnaire is an evidence based tool recommended by the National Institute of Clinical excellence (NICE) to identify potential depression.
- Specialist healthcare staff delivered healthcare intervention training for individuals caring for or working with children with disabilities and complex needs. We saw staff delivered training against NICE and other best practice guidance. For example we observed staff delivering epilepsy training using NICE guidelines 137 (January 2012), The Diagnosis and Management of Epilepsies in Adults and Children in Primary and Secondary Care.

Pain relief

- Orthotics staff introduced pain scores to monitor effectiveness of the service, these included smiley faces for younger children and number levels for older children. Orthotics provides artificial devices such as splints and braces.

Nutrition and hydration

- Staff gave parents up to date and relevant advice about breastfeeding, weaning and nutrition and hydration in children and monitored breastfeeding and weaning rates. Staff provided extra visits or put on extra clinics when they could to provide extra nutritional support to parents. Staff determined the extra support by the baby's weight gain and confidence of the mother following the clinic assessment.
- The organisation monitored breastfeeding rates. The average percentage of mothers who had continued breast-feeding at six to eight weeks for the period March 2016 to October 2016 was 48% this was against an organisational target of 48%.
- We saw staff give dietary advice to young people. One young person told us they had found the advice from school nurses helpful. We observed a school nurse assessing a young person's diet and offering advice and support.

Good

Are services effective?

- The service did not have a dietetic children's service. Instead, dependent on the location staff would refer patients to the local hospital paediatric dietician service.

Patient outcomes

- The organisation undertook a multi-agency case audit (July 2016) to demonstrate how they worked together with other agencies and how they used learning to plan and deliver improved outcomes. This included findings, recommendations and action planning. There were four recommendations; we saw evidence of action planning to address these. This included reviewing training materials, audit themes to present to the organisation, sharing key themes with the Essex Safeguarding Children's Board (ESCB) and continued involvement with the multi-agency case audit.
- Documentation showed for the period March 2016 to October 2016 the organisation had achieved an average of 94% of new baby reviews within 14 days, age one year review averaged a 91% completion and an average of 98% of children received the age two to two and a half review. This was set against a completion target of 90%.
- We saw in patient records evidence of staff working with mother and child to develop action plans.
- We saw evidence of a clinical audit work plan (2016 to 2017) for the department of community paediatrics and child health these included audits for initial health assessments for looked after children, pathway for children with attention deficit hyperactivity disorder (ADHD) and a medication audit.
- Information provided by the organisation demonstrated a care plan audit (January 2016 to February 2016) had been undertaken. This included results, reviewed key points resulting from the audit, comparison with other areas and an action plan.
- We saw evidence of a hip surveillance audit for children with cerebral palsy (2016) which resulted in the development of a pathway based on evidence based guidance for practitioners to reference. We saw the organisation had embedded this into the electronic patient record system, which enabled easy access for practitioners to reference.
- The podiatry service audited pain scales pre and post treatment to establish its effectiveness.
- The autism assessment clinic monitored positive diagnosis of children. Staff told us between 70% and 80% of those assessed were diagnosed with autism.
- The physiotherapy service undertook gross motor function measure (GMFM) assessments, which was a standardised approach. GMFM is a clinical tool designed to evaluate change in gross motor function in children with cerebral palsy. Gross motor skills are larger movements a baby or child makes with their arms, legs, feet or his entire body.
- The physiotherapy service used goal attainment scores (GAS) for groups of children with movement and co-ordination difficulties. GAS is a method of scoring patients achievement of individual goals during a course of treatment.
- We saw evidence of the physiotherapy service setting specific, measurable, attainable, relevant and timely (SMART) goals with parents to achieve outcomes of care for their children.

Competent staff

- As of October 2016, 172 out of 190 staff (91%) had received an appraisal against an organisational target of 90%. Staff we spoke with told us they were up-to-date with their appraisals, they told us they were effective and felt supported to access training.
- The safeguarding leads and named nurses within Provide attended relevant and level four safeguarding training in line with Intercollegiate Document (RCPCH, 2014). Data provided by the organisation for October 2016 confirmed 100% compliance. Staff told us the organisation monitored this training through performance development reviews (PDR's).
- New members of staff received induction and preceptorship packages. We spoke with an allied healthcare professional who told us they had received a six-day comprehensive, service induction programme. There was also continued support from senior therapists. Staff told us there was a preceptorship pack, which contained learning objectives to complete.
- Staff reported clinical supervisions through staff personal development reviews (PDR's). Information provided by the organisation demonstrated between November 2015 and November 2016 a total of 128 health visitors and school nurses had accessed clinical supervision. However, a statement provided by the organisation stated the data provided did not include staff transferred in April 2016 to the organisation from another provider, as they would not have been eligible

for a PDR in 2016. Clinical supervision is a formal process of professional support and learning, which enables practitioners to develop knowledge and competence.

- Allied Health Professionals (AHP's) told us they accessed individual and team clinical supervision with their direct supervisor.
- Information provided by the organisation demonstrated additional training staff could access which included new born behavioural observations, perinatal mental health, child sexual exploitation, cystic fibrosis, community child health, autistic diagnosis, practical management of eating and drinking difficulties in children, supporting children on the autistic spectrum with eating disorders, paediatric continence, complex bladders and bowels and neuro-disability from birth to transition.
- We saw evidence of 19 staff who had attended training in August 2016 related to special educational needs and disabilities.
- Information provided by the organisation demonstrated for September 2016 97% of health visitors who delivered the maternal early childhood sustained home visiting (MESCH) programme had received clinical supervision. MESCH is a home visiting programme delivered to pregnant women considered at risk of adverse maternal and/or child outcomes.
- As of September 2016 115 health visitors had completed the MESCH training.
- The organisation based specialist healthcare training such as epilepsy and anaphylaxis on national standards and guidance. Anaphylaxis is an acute allergic reaction which can be life threatening if not treated.
- Evidence provided by the organisation demonstrated a monthly medical staff-training programme from January 2016 to December 2016. Some of the training included adolescent health, neurodisability, complaints feedback and complex case discussions.
- There were child exploitation (CSE) champions in the organisation to support staff and promote awareness. All CSE champions attended Essex Safeguarding Children's Boards (ESCB) CSE Champion's training. CSE is a form of sexual abuse involving the manipulation and/or coercion of young people under the age of 18 years into sexual activity in exchange for things such as money, gifts, accommodation, affection or status.
- Some staff not in direct clinical practice attended an RCN accredited forum to keep up to date with their revalidation. The forum met quarterly and discussed issues of clinical practice. Some staff worked with children's community nurses and undertook visits to keep up to date with clinical practice. Staff said managers were supportive of their revalidation work.

Multi-disciplinary working and coordinated care pathways

- We observed multi-disciplinary (MDT) working well across the service.
- We attended and observed a MDT autism assessment clinic. Which demonstrated occupational therapists (OT), speech and language therapists (SALT) and a consultant paediatrician working together to assess children for autism. Therapists said if a child was waiting too long the OT and SALT worked with the family in the home, with the nursery staff and in schools until the assessment at the clinic was available, or the family were ready to accept an assessment was required.
- Occupational Therapy (OT) and Physiotherapy (PT) staff held joint appointments and made joint home visits for families.
- Information provided by the organisation demonstrated clear co-ordinated pathways for the transferring of information from maternity services to health visiting and health visitor to school nurse.
- Occupational therapy and physiotherapy held joint monthly team meetings.
- Speech and language therapists worked closely with other professionals. Staff told us they had recently worked with a health visitor to support a mother with learning difficulties to support her child. They both saw the mother and the child together to jointly contribute to their care.
- The school nurse service meets with the hospital based epileptic service annually to discuss management of children and up-dates in training. Staff told us this improved communication between the two teams and enhanced the joint care delivered to the child.
- Health visitors and school nurses worked very closely with each other when a vulnerable child or family transferred to the school nurse team at the age of five years.
- School nurses worked across teams to maintain continuity of care for vulnerable families. For example, two siblings attended different schools. School nurses

based in different boroughs covered the schools however, the same school nurse kept the children on her caseload to maintain continuity whilst maintaining links with the school nurse who covered that school.
- The physiotherapy service visited the neonatal unit at the local hospital to offer continuity of care from hospital to the community.
- We saw evidence of care delivery for a child requiring complex care shared with school and included shared care between the child's school and the children's specialist nursing service.
- The children's specialist nursing service worked with special schools, mainstream schools, and the specialist epilepsy nurse from a local acute hospital to complete an epilepsy care plan for emergency medication administration.
- We observed a multi-disciplinary (MDT) meeting for a child who required complex care delivery. There was evidence of effective MDT communication and liaison between social care, family members, teachers and the children's specialist nursing service. An action plan and up-dated care package was agreed and a review meeting date arranged for further re-evaluation.
- There was a Family Operations Hub provided by the local authority, which practitioners could contact to access and share information about vulnerable families and children. Practitioners could also request input from other services providing targeted support for children and their families.
- We saw evidence of a care pathway and referral form for improving access to psychological therapies (IAPT). This NHS programme offers evidence based psychological interventions.
- We reviewed a patient electronic record, which demonstrated evidence of referral to other specialist agencies to support a vulnerable young person.
- We attended a MDT meeting for a pre-school child who staff diagnosed with autism. Their family, and all of the professionals contributing to the care were present, these included the SALT, social worker, special educational needs co-ordinator, the parent and an early support link practitioner. The meeting was to support the child starting school. We saw evidence of an education healthcare plan, which all professionals contributed to which co-ordinated the child's care and logged their journey. This prevented the parent having to tell the child's story repeatedly to different professionals. Staff arranged a plan of care and a follow up meeting. The parent stated in the meeting, 'I feel a lot more comfortable now'.
- Specialist healthcare staff worked with local authority and voluntary sector staff to deliver child specific healthcare intervention training. In addition, the team worked alongside the local authority assessing and reviewing transport requirements for children with complex conditions. A multi-agency panel met monthly to discuss referrals and children's needs. By working with other stakeholders, staff could help to provide the correct treatment and care for children and young people.

Referral, transfer, discharge and transition

- Referrals to specialist services such as community paediatrics, occupational therapy, physiotherapy and speech and language therapy were triaged and prioritised for assessment.
- Referrals could be made from GPs, school nurses, health visitors, specialist nurses, allied health professionals, child and adolescent mental health services, acute paediatricians, education, nurseries and social care services.
- Staff told us there was going to be (January 2017) self-booking for parents wanting to access the physiotherapy service.
- The speech and language service received referrals from all professionals; in addition, they operated a self-referral system. Self-referral means patients, parents or guardians can arrange access for their child.
- There was a multi-agency transition protocol for young people with disabilities and additional needs moving from childhood to adulthood version one (September 2011). This was in partnership with the local authority and three NHS health organisations.
- Staff told us the orthotic service could assess a child and provide a made to measure appliance within three weeks. Orthotics provides artificial devices such as splints and braces.
- Staff said approximately 26 children were seen at the autism assessment clinic per month. Staff always made any on-going referral appointments and plans of care prior to parents leaving the clinic.
- We saw examples of children and adult services working together to improve transition to adult services.

Good

Are services effective?

- Transition planning for young people receiving care from community paediatric services started when the young person was 14 years. There was a transition-planning document in the patient's electronic record, which recorded when this started and documented the transition planning.
- Community diabetic service offered two transition and two handover clinics per year, which started at aged 16 years, however, extra appointments were available if required. All clinics were nurse led. In addition, there was a consultant led appointment at the handover point.
- The transition clinics handed the young person over to adult services at 18 years, however, staff assessed patients on an individual basis and some young people remained with the clinic until 19 years. Staff told us of a young person aged 17 years with special educational needs who had delayed transition to adult services until aged 19 years to allow for an increased level of independence planning achieving self-injecting of a medication.
- We attended a diabetic transition clinic where we observed a young person and a family member planning transition to college. The nurse reviewed the current level of care and jointly planned the next steps with the family member and the young person.
- The organisation provided evidence of a policy for the management of children and young people who fail to attend appointments (review October 2016).
- We saw evidence of a health visiting to school nursing service transfer template completed when a child transfers from one service to another. This meant there was a consistent approach when children transferred between services and staff could track them through the system.

Access to information

- The organisation used an electronic patient record system, which meant staff could access patient records flexibly. Staff worked remotely when conducting visits and clinics in the community using a laptop. They could work on or off line depending on the connectivity of the area. A majority of staff we spoke with chose not to work remotely, they told us they preferred to write on pre-printed forms and then re-enter this information on return to their office base. They told us they did not like typing whilst conducting a consultation with a client.
- A majority of GPs jointly accesses electronic patient records. This promoted joined up working and effective communication between professionals. In addition, consultants wrote to GPs after appointments outlining the outcome of the appointment and future treatment. Parents we spoke with confirmed they also received copies of letters.
- All professionals within the service had access to their caseloads through a secure electronic patient record system.
- We reviewed the personal child health record or 'red book' being used; staff gave it to parents before discharging them from the midwife. The red book holds medical information about a child from birth to four years of age and recorded child, family and birth details, immunisation records, screening, routine reviews and growth charts.
- We observed allied professionals sharing assessment reports with parents. A physiotherapist assessed a young child at home, discussed the outcome of the visit with the parent and explained they would send the report to them.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff understood and could explain both Gillick competency and Fraser guidelines. Gillick competency and Fraser guidelines refer to a legal case, which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16 year olds without parental consent.
- The organisation provided evidence of a consent to examination or treatment policy (review 2018). This included the concept of Fraser and Gillick competence.
- School nursing staff worked within Fraser and Gillick guidelines to make decisions about whether young people had the maturity, capacity and competence to give consent themselves.
- We saw records showing parents had signed consent forms for health assessments. Staff kept records of consent on the organisation's electronic record system.
- During home visits, we saw staff asking parents and young people for consent before staff examined or shared information with them.
- We observed staff gaining consent from parents, caregivers, children and young people. We observed staff recording the outcome of this within the patient's electronic record.

Good

Are services effective?

- We observed all practitioners obtain consent to share information with other professionals. For example, following physiotherapy assessment staff obtained consent to share information with the GP and the health visitor caring for the child.
- We observed staff re-confirming consent with the parents during an assessment. For example, during an assessment a young child would not walk or crawl and cried when staff supported them to do so. The therapist spoke with the parent to re-confirm consent and involved the parent in the decision-making.

Outstanding ☆

Are services caring?

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

Summary

We rated this service as outstanding for caring because:

- Feedback from people who used the service and those close to them were continually positive.
- During our inspection, we gave people the opportunity to comment on the care they had received by completing CQC comment cards. Out of the 103 cards received, all were positive about the staff within children's specialist and public health services.
- There was a strong, visible person-centred culture. We were particularly impressed with the person-centred care delivery we observed. Staff treated children, young people and their families with dignity, respect and maintained confidentiality. We observed a multi-disciplinary autism assessment clinic where staff gave feedback sensitively highlighting the positives and the negatives of the child's diagnosis and behaviour. We observed a member of staff giving time to a parent who was upset, showing empathy and appreciation regarding the child's diagnosis. The member of staff was sensitive to the parent's feelings and emotions at the time.
- People think that staff go the extra mile. Comments included included 'I don't know how I would have coped without them', ' happy, healthy child, amazing service, great support' and 'health visitor really wonderful', 'always available, keeps in contact, fabulous, always supports me with everything', 'doctors are a fantastic support'.
- Staff demonstrated sensitivity in the care of an adolescent receiving therapy services. The staff member was sensitive to the anxiety it had caused the teenager in asking for help.
- Staff delivered information in ways children; young people and their families understood and enabled them to make informed choices.
- We observed staff to be caring, compassionate and supportive in all observed situations. Staff knew not to overload parents with too much information. We observed one member of staff offering to call the parent when they returned home to give them the opportunity to ask any further questions.
- People's emotional and social needs were highly valued by staff and were embedded within their care and treatment. We were particularly impressed when observing staff recognising and supporting children, parents and carers emotional needs. Staff offered care and support when needed.

Compassionate care

- We saw evidence of a customer service report (April 2016) carried out by the children's community nursing service which involved a questionnaire for both children and parents to respond to either in picture or written form. This included a question about 'Do you feel you and/or your child were treated sensitively with kindness and consideration for your or their needs'? Thirty-four people responded to this question and 33 (97.06%) people gave a positive response.
- We reviewed the NHS Friends and Family Test results in the children and young people's service for the period June 2015 to June 2016. The Friends and Family Test (FFT) is a single question survey, which asks patients whether they would recommend the NHS service they received to friends and family who need similar treatment or care. Data from the organisation showed the average FFT score for this period was 98.1%.
- We observed a multi-disciplinary autism assessment clinic where staff gave feedback sensitively highlighting the positives and the negatives of the child's diagnosis and behaviour. We observed a member of staff giving time to a parent who was upset, showing empathy and appreciation regarding the child's diagnosis. The member of staff was sensitive to the parent's feelings and emotions at the time.
- Staff knew not to overload parents with too much information. We observed one member of staff offering to call the parent when they returned home to give them the opportunity to ask any further questions.
- We observed rewards given to children for participation and achievement, these included age appropriate stickers which the children visibly enjoyed receiving.
- We observed staff playing on the floor with children and interacting at their level. For example, we saw a therapist playing with a child on the floor whilst

undertaking an assessment, the child remained happy and engaged. The therapist was using language the child understood. We observed staff reassuring children in clinics using praise and encouragement.

- We attended a child developmental check and observed the health visitor offering advice and support to a parent who was experiencing threatening behaviour from their partner. The health visitor was respectful and caring in her approach, allowing time for the parent to talk.
- We spoke with parents, children and carers about the different services they received from the organisation. Without exception spoke with was positive about the staff, services and the care they received. Some of the comments included 'I don't know how I would have coped without them', ' happy, healthy child, amazing service, great support' and 'health visitor really wonderful', 'always available, keeps in contact, fabulous, always supports me with everything', 'doctors are a fantastic support'.
- During our inspection, we gave people the opportunity to comment on the care they had received by completing CQC comment cards. Out of the seven venues where these were placed we received 103 completed cards, of these, 90 were positive comments included 'very friendly and helpful staff', 'staff are very caring and listened really carefully' and 'staff are there when you need support'. The 13 negative comments related to environmental, availability issues such as a room being too warm, a cancelled baby-weighing clinic, and difficulty accessing a class. There were no negative comments about staff.
- We saw a speech and language therapist play calmly with the child whilst other professionals conducted a discussion around the child's condition. We observed the therapist to be incredibly sensitive to both the parents and child's needs. The child did not appear distressed and was engaged in play.

Understanding and involvement of patients and those close to them

- Of the visits and multi-disciplinary meetings we attended, we saw evidence of involvement of parents, carers and family by all members of staff.
- We witnessed staff demonstrating person centred care in relation to a child with severe life limiting disabilities. Therapy staff worked hard to set attainable goals for the parents to reach whilst respecting their distress at the child's condition. Staff considered parent's emotional wellbeing as well as the child's needs. They tailored appointments and care to in line with their needs.
- All staff demonstrated both the emotional and social needs of the family were highly valued and embedded in their care and treatment. The praise and reinforcement given to families highlighted the supportive relationships developed between therapy staff and families.
- Staff demonstrated sensitivity in the care of an adolescent receiving therapy services. The staff member was sensitive to the anxiety it had caused the teenager in asking for help.
- All assessments we observed involved the parents, staff gave explanations before they carried out treatment. They explained about the next steps were and provided appropriate literature.
- We observed an assessment for a child with suspected autism. The team encouraged the parents to contribute to the assessment. We saw conversations with the parents aiming to establish their concerns and involve them in the decision process. The therapist explained to the parents the need to address parent priorities and the team around the child.
- We observed an assessment by a speech and language therapist, who involved the parents throughout. The therapist explained the process of assessment and the possible outcomes. We observed positive, respectful interactions between the therapist and the parent. The parent told us they felt they knew the right things to do and their 'mind was at rest'.
- We observed practitioners involve the parents in their child's care. For example, during a physiotherapy assessment the physiotherapist involved the parent to help measure the child's hips. The physiotherapist maintained rapport with the parents whilst assessing the child and gave explanations throughout the examination.
- We saw examples where staff explained to parents the process of sharing assessment reports with them for their children. One parent told us they found this reassuring to see the assessment in writing and felt involved with the care.
- We attended an MDT meeting discussing an autism diagnosis. The family and all professionals contributing

to the care were present. We saw evidence of a health care plan, which the family had contributed to which included photographs, family celebrations and a daily diary of events.

- All parents, children and carers we spoke with said staff involved them in care and treatment. They felt informed and said staff gave them opportunities to ask questions and clarify any information they had been given. This showed that parents were fully involved in their childs care.

Emotional support

- We observed a member of staff interact with a young child who was very anxious and not willing to undertake the assessment. The staff member spoke with the child in terms they could understand and was empathetic towards the emotional stress the child was displaying. The child visibly relaxed and began to take part in the assessment and was fully co-operating by the end of the session.
- We observed a practitioner explain to parents about an approved local charity who offered support for children who have autism. The practitioner then made contact on behalf of the parent.
- During a visit, we observed a health visitor support a parent who required emotional support. We saw staff listened to the patient empathetically, acknowledged anxiety and supported the parent with continuous intervention. The parent told us they had begun to socialise more with friends because of the care they had received.
- We observed a school nurse undertake a home visit for an initial assessment for a young person who was not engaging with services. The school nurse demonstrated empathy, conducted the assessment at the pace of the young person, kept calm and maintained respect toward the young person when behaviour was challenging.
- We attended a new birth visit where we observed a health visitor providing emotional support and encouragement to a mum who required assistance breast-feeding her baby.
- We attended a child developmental check and observed the health visitor offering emotional support to a parent who was experiencing threatening behaviour from their partner. The health visitor was sympathetic and re-assuring offering support and guidance to the parent.
- We observed an antenatal visit with a health visitor who explored and assessed emotional health challenges of a parent. The health visitor offered support and guidance respectfully and sensitively and explained how the health visiting team could offer continued support.
- All parents and carers we spoke with said staff gave them time, did not rush them and provided ongoing advice and support. Parents we spoke with staff provided them with information on support groups and activities where they could meet peers and receive emotional support.
- We reviewed the care record of a parent who had experienced emotional challenges following the birth of their baby. Interventions by the health visiting team over a number of years demonstrated support, guidance and expert care which resulted in a positive outcome for the parent and her baby.
- Staff provided children and young people with calming and coping strategies in the event they become angry or upset at home. We observed sessions where staff discussed emotions in detail and encouraged children to think about what to do if they felt angry.

Good

Are services responsive to people's needs?

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

Summary

We rated this service as good for responsive because:

- The organisation planned children and young people services to meet the needs of the local population.
- Services were flexible and took into account the differing needs of children and young people.
- Children and young people could access the right care at the right time.
- Complaint systems were accessible and there was evidence learning from complaints took place.
- Services were consistently meeting waiting time targets for access to therapy services.

Planning and delivering services which meet people's needs

- The service evaluated the Essex countywide joint strategic needs assessment (JSNA) (November 2013) to help inform service delivery and planning. JSNA identifies current and future health and wellbeing needs in light of existing services, and informs future service planning taking into account evidence of effectiveness.
- We saw local authority health and demographic profiling for three areas of Essex, which included Maldon (March 2016), Braintree (September 2014) and Chelmsford (September 2014). Demographic and health profiling is a process which assesses a defined population for characteristics such as age, gender, income level, occupation, birth rate, tooth decay and childhood illness.
- The school nurses completed health needs assessments for their local area. They worked with schools and the local authority to devise a plan for each school to determine what services and support for children was required.
- We attended a school health needs assessment. This was an assessment with a school to identify needs in relation to the school population and the geographical area in which they were located. We saw evidence of the action planning (November 2016) as a result of an assessment, which included public health outcomes, emotional wellbeing, leadership, demographics and personal, social, and health education provision (PSHE). Demographics are statistical data relating to the population and particular groups within it.
- Staff worked with other providers, including children's centres and voluntary organisations, to provide support and services to parents and families. Clinics and support groups were set up and based out in local communities to meet the needs of local people.
- The school nursing and health visiting teams worked within allocated boundaries. This process aligned school nurses and health visitors to work in line with the local County Council to inform action planning.
- The organisation's Children's Public Health Service, commissioned by the local authority delivered the Healthy Schools Programme.
- Health visitors and school nurses work corporately within their teams, which meant there was a shared approach to the workload, however, a named school nurse or health visitor would be accountable for decisions and actions made on any given case.
- We attended a children's diabetic transition planning meeting where staff assessed clinics and caseloads to plan transition services for January 2017 to January 2018.
- Speech and language therapists (SALT) met monthly to plan and manage caseloads. Therapists moved according to increased numbers within different clinics and areas to meet the needs of the population.
- Not all of the bases we visited were for clinical use. Some were office spaces used for the clinical teams, and their managers.
- The organisation had a specialist healthcare team based at the local authority who delivered training across the county to carers and professionals involved in caring after children with complex needs. Five clinical commissioning groups (CCGs) commissioned the service alongside the local authority education and social care departments. This enabled professionals and carers to deliver child specific care across the county. Training included healthcare intervention, artificial feeding and administration of particular medicines.

Good

Are services responsive to people's needs?

- We observed information leaflets and contact numbers given to parents. Staff used them appropriately and did not overload parents with information.
- We saw examples of 16 types of leaflets for parents, carers, schools and children, some of which included anger management for children, relaxation for parents, activities to help listening and attention skills, sleep and autism spectrum disorder. We saw evidence of a transition leaflet explaining the journey from childhood to adulthood for parents and their caregivers.
- Toys were age appropriate to encourage the child to enjoy time with the physiotherapists and occupational therapist. Staff thought carefully about how they played.
- Furniture such as tables and chairs were a child friendly size.

Equality and diversity

- The organisation had an equal opportunities and valuing diversity employment policy and procedure (review November 2016), which included the Equality Act 2010 as well as organisational and individual responsibilities.
- All the staff we spoke to was knowledgeable of the policy and understood the concept of equality and diversity.
- Staff demonstrated a good understanding of the cultural diversity of the local community and provided sensitive and respectful care in line with equality and diversity outcomes.
- The organisation designed services with the needs of vulnerable people in mind. For example, staff accessed interpreters for people whose first language was not English, or for those who had a sensory disability.
- Information provided demonstrated between April 2016 and November 2016 the organisation delivered a total of 66 face to face interpreting bookings for languages such as Polish, Bengali, Bulgarian, Turkish and Cantonese. There were five telephone-interpreting bookings for languages such as Mandarin, Portuguese and Farsi. There were 22 British Sign Language and one braille booking. The service required translation services for 13 bookings for languages such as Polish, Urdu and Turkish.
- Buildings we inspected were easily accessible and adhered to the requirements of the Disability Discrimination Act 1995 and the Equality Act 2010.

Meeting the needs of people in vulnerable circumstances

- Staff were knowledgeable about their caseloads and especially if they had any vulnerable children on them.
- Staff worked closely with young people and built up close working relationships with them. Staff were very dedicated to supporting looked after children, and children with child protection care plans. We observed a school nurse providing support and information during an initial assessment undertaken for a looked after child.
- Health visitors and school nurses work jointly from the same base in four areas of Mid Essex. Staff said they worked well together, there was improved communication and information was staff shared more effectively.
- The health visiting and school nurse service had a mobile phone and text service, as parents and young people could not always respond to 'landline' calls. This meant parents and families could access the service by text message. A health visitor gave an example of a young mum texting her to access information, this was then transcribed on to the patients electronic record.
- Health visitors delivered the maternal early childhood sustained home visiting (MESCH) programme. MESCH is a home visiting programme delivered to pregnant women considered at risk of adverse maternal and/or child outcomes.
- We observed a therapist use sign language to communicate with a child. The child appeared calm and engaged. Staff worked hard to communicate at the child's level to reduce stress levels and to optimise the therapy the child received.
- Staff were flexible when undertaking autism assessments. Staff assessed children in nursery or within an appropriate environment when attending the clinic if unfamiliar surroundings were too stressful for the child. Staff saw parents alone to discuss the diagnosis if the parents felt this was more appropriate.
- We saw staff giving detailed feedback to parents giving time for the parents to discuss the needs of the child and plan the next stages. The staff described the service as being 'wrapped around the family and the child to support them all'.
- We observed the school nurse using a variety of visual aids with children to assess their wishes and feelings to support their emotional wellbeing.

Good

Are services responsive to people's needs?

- The organisation provided a support role for families who were experiencing challenges and required additional support with complex care issues. Staff provided information and guidance for families and young people about a range of support services if required.
- Staff at Moulsham Grange clinic used specialist-motorised wheelchairs for children with mobility difficulties. Staff used the wheelchairs to support the development of motor functions and movement. We did not see them in use but staff explained their use and said they used them regularly. Staff said children should be offered opportunities for movement when other children were developing and learning to walk.
- There was a sensory room at Moulsham Grange clinic, which provided a stimulating environment for children with additional needs. Parents could reserve a time slot for their child to use at the families convenience. Parking was directly outside of the clinic to enable easy access to the external ramped entrance.
- The delivery of child specific healthcare intervention training meant children and young people could access clubs, activities and go to school with their peers. Staff trained people working at schools, clubs and services to ensure there were fewer barriers for children wanting to access activities. One member of staff said, "Training is not a barrier to access".
- Staff gave examples of when they had gone the extra mile to ensure they meet the needs of children. One example was a member of staff listening to feedback about a child and using their judgement to conduct further observations. They responded quickly to diagnose epilepsy, which in turn explained other behaviours. Because the member of staff listened to feedback and individually sought an answer to the child's symptoms, the child's health and education improved.

Access to the right care at the right time

- Staff delivered services in the home, mainstream school, nursery and special schools, community clinics and children's centres.
- School nurses offered a range of services for children and young people, which were accessed through 'drop-in' clinics, by appointment, at home visits and in school. Staff told us they accommodated a majority of visits out of school hours to minimise disruption for the children during the school day.
- School nurses provided basic sexual health information and offered the C-card service; however, they would signpost the young person to another provider for specialist assessment. The school nurse would offer the service by drop-in clinic or would facilitate an appointment if required. The C-card entitles young people aged between 13 to 24 years of age free condoms.
- The organisation offered a specialist continence service for children and young people experiencing continence problems. They offered specialist intervention when basic advice and guidance provided by the school nurse had been unsuccessful.
- The organisation held podiatry clinics in many locations three to four times a week. Staff described offering parents a choice of location.
- Podiatry staff offered appointments at three and six month intervals. Patients and parents received reminder letters for follow up appointments. Two sets of parents told us they could get appointments the following week. They described only waiting three weeks from referral by the GP to attending the initial appointment.
- All therapy services booked their own follow up appointments.
- Staff who organised the multi-disciplinary (MDT) autism assessment clinics highlighted parents who could attend at short notice. This meant in the event of a cancellation a parent could attend an appointment earlier, preventing wasted appointments and meaning children accessed services promptly.
- We saw evidence of a physiotherapy prioritisation tool, which assessed children, and young people's treatment frequency depending on their symptoms or needs. It scored the patient from nought to 25. A patient who scored 25 meant patients might require weekly input and a score of four or less would indicate discharging the patient from physiotherapy care.
- Information provided by the organisation demonstrated between November 2015 and October 2016 the organisation achieved their referral to treatment time (RTT) of 18 weeks for children's community nursing, continence and enuresis, occupational therapy, physiotherapy, speech and language and community paediatric services. The average waiting times for these services for the same period was between six to nine weeks. Parents we spoke with confirmed their children had been waiting less than 18 weeks and were happy with the amount of time taken to get an appointment.

Good

Are services responsive to people's needs?

- Information provided by the organisation demonstrated between November 2015 and October 2016 the average of patients who did not attend (DNA) appointments for the same services was between 0.16% and 8.36%. The three highest DNA rates exceeding the organisations threshold for attendance was paediatric continence service (8.36% with an organisational threshold of 3.0%), children's diabetes service (6.52% with an organisational threshold of 3.0%) and paediatric audiology service (6.03% with an organisational threshold of 1.0%).
- The organisation had a missed appointments procedure for children and young people (review October 2016). It is recognised for some children and young people there could be a high clinical risk if they do not attend (DNA) for a health appointment. Research suggests missed appointments are a feature in Serious Case Reviews where children have died or suffered abuse or neglect.
- We saw evidence of a missed appointments audit (June 2016) undertaken by the safeguarding team. Results demonstrated teams were consistent and adhered to the missed appointment procedure within the organisation. There were recommendations from the audit, for example to share the results within the organisation, to present the findings to the strategic safeguarding forum and to implement a missed appointment template into the patient's electronic patient record.
- The organisation utilised spare appointment slots as much as possible. Staff contacted parents and carers to fill vacant slots if they appeared. Some parents and carers we spoke with said staff contacted them to see if they wanted an appointment due to someone else cancelling. Patients we spoke with felt this was positive and responsive by the organisation.
- The children's diabetic service offered clinics to school aged children after the school day. This meant a child did not have to miss any of their school day.
- We observed referrals made to other services. For example, a therapist conducted an initial assessment with a child and made a referral for a hearing test.
- Community paediatricians accessed specialist mental health and psychology support from the local children's mental health service where clinical issues relating to specific children and young people where staff discussed by telephone, letter or face-to-face meetings. Staff said if a child required a clinical psychology assessment, they would make separate referral, which could delay the diagnosis of a patient.
- We observed a consultant and a nurse undertake an assessment for a child with behavioural and sleeping difficulties. Staff suggested a follow up appointment to the family who voiced concern at the length of time before a re-assessment. The appointment was brought forward and a package of care was discussed with supporting information and resources given to the family.
- There was a clear pathway available for staff to access for children who were accessing home schooling.

Learning from complaints and concerns

- The organisation had a complaints and compliments policy (review 2018). Staff knew about the policy and where to access it.
- The customer care team co-ordinated all of the organisations complaints. The team directed these to the senior leads of the business units. Staff said the senior manager contacted complainants directly to resolve the complaint locally. For example, a complaint related to physiotherapy not given directly to the child, which was the expectation of the parents. The physiotherapist gave advice and support to the parents to undertake these exercises at home. Following a conversation with the parent, this complaint was resolved.
- We reviewed three complaint case studies provided by the organisation. We saw managers investigated complaints appropriately and identified complaint outcomes. We saw complaint investigators made recommendations or identified actions after completion of the investigations.
- We saw evidence of an action plan, which had resulted from a complaint about the delay in parents receiving their child's blood results from the children's community nursing service. We saw a plan of how the service would communicate these results within 24hours of taking the sample.
- Staff told us they did not always receive feedback from complaints. We reviewed team meeting minutes, which demonstrated an inconsistency with feedback and shared learning.
- Most parents and carers we spoke with said they knew how to complain or raise issues and concerns. All

Good

Are services responsive to people's needs?

parents and carers we spoke with said they comfortable raising their concerns with staff. One parents said, "Staff are friendly and let you be open and honest". Two parents said they had complained to the organisation and the were happy how the organisation had responded to their complaints.

Good

Are services well-led?

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

Summary

We rated this service as good for well led because:

- Leaders were visible and promoted a positive environment where staff felt supported, could escalate concerns and make decisions.
- The organisation had a clear vision and strategy. Staff knew about the strategy and could identify with the organisational vision and values.
- The organisation had processes and systems to manage, monitor and review quality and risks
- There was a positive organisation culture. Staff liked working for the organisation and we saw the organisation had processes and policies in place to keep staff safe. Staff in turn demonstrated children and young people were at the heart of everything they did.
- We saw evidence of staff and public engagement and changes made in response to staff and public feedback.

Detailed findings

Service vision and strategy

- The organisation's vision was 'to provide a range of outstanding services that care, nurture and empower individuals and communities to live better lives. Staff said they identified with the organisation vision and values. All staff said they reflected the organisations values in their work. The majority of staff said they believed in the chief executives model and the ideals of a community interest company.
- The organisation had a clinical strategy (2016 to 2019) which included clinical strategic objectives linked to the organisation vision. For example, involving care and compassion, innovation, competence, nurture and empower. There were priorities for 2016 to 2017 some of which included patient experience, developing new ways of remote working, to ensure Provide had a competent workforce, to establish a practice development forum and pathway to include a mentoring programme.
- There was an operational services strategy (2016 to 2017) with priorities outlined for children's specialist services some of which included personal health budgets for children's continence products, review community paediatric services to consider non-medical roles and implementation of a single point of access for referrals.
- At the time of our inspection, services for children and young people were in transition due to them moving to another provider. This affected the strategy for most services. However, managers had a clear plan regarding transfer of services and all staff we spoke with knew about it.

Governance, risk management and quality measurement

- There was a clear management structure within children's services. The assistant director managed the service supported by locality managers based geographically. Each team had team leaders who supported and managed front line staff. All staff knew the structure and knew their roles and responsibilities within the structure. There was clear accountability through the structure and staff knew their accountabilities.
- Staff were positive about the structure of the organisation as a whole. Staff and managers said the structure of the organisation meant they were only "a few steps from the board". Staff said this meant it was easy to escalate issues or risks.
- The organisation had processes in place to manage and discuss quality and risk. Within children and young people's services, the assistant director met with locality managers every two weeks. In turn, locality managers met with their team leaders and local teams. This meant there was a structure and process for staff to pass information through the structure.
- There were clinical representatives who represented the children's and young people's service at the executive board. This enabled the board to receive updates on risk and performance and ensure senior managers were accountable for service delivery. We reviewed a risk report managers presented to the board dated July 2016 as part of ongoing discussions regarding risk.
- Staff reviewed and managed risk locally and strategically. Local teams reviewed and managed local

risks to their own services and environment. For example, staff on maternity leave or environmental risks. We saw from team meeting minutes staff discuss key risks relevant to their services. Strategically, the organisation had quality and safety meetings where managers discussed risks on the corporate risk register.

- Key risks on the risk register included staffing capacity issues in which affected contacting and recording in parent's records as well as the child for domestic abuse alerts. Data from the organisation showed a new risk relating to negative staff morale and other because of the transfer of services to another provider. The majority of staff could identify the key risks to the service and talked about these affecting children, young people and their families.
- However, a senior manager within the service could not explain what the main risks to the service were or demonstrate key actions taken to address them. For example, the assistant director could not tell us about key actions to ensure the recording of domestic abuse or to improve staff morale.
- The organisation produced monthly performance and quality scorecards for the service. The associate director for the service reviewed these, communicated the results to the team managers who disseminated the information to the teams.
- We reviewed the quality and safety monthly meeting minutes for February 2016, March 2016, April 2016 and May 2016, risks and incidents were a standing item on the agenda.
- We reviewed manager meeting minutes from the children's public health service (November 2016) there was standard items on the agenda, which included incidents, risks and complaints.
- We reviewed team leader meeting minutes from the specialist children's service (September 2016, October 2016 and November 2016) all had standard agenda items of clinical quality and safety, patient experience, finance, information technology solutions, business unit updates and performance.
- Information provided by the organisation demonstrated there had not been any external reviews for the children and young people's service between 2014 and 2016.
- We saw evidence of nine risk assessments for the children's service from August 2015 to September 2016. These included environmental, specialist staff vacancies, parents contacting staff by mobile phone and training in special schools.
- Specialist healthcare teams sat on multi-agency panels to review referrals and activity regarding child specific healthcare interventions for children and young people. We reviewed minutes of these meetings and saw staff identified and reviewed actions regularly. Staff recorded all discussions about the child on the electronic patient record system.

Leadership of this service

- Leaders were knowledgeable and had the capacity and capability to manage effectively. Leaders ensured they had time to listen and support staff. Leaders were effective because they understood the challenges to delivering good quality care. Leaders encouraged staff to think of solutions and actions to addressing barriers to good care. Leaders we spoke with gave examples of actions taken to improve services provided.
- Managers encouraged supportive relationships. Staff told us how they liaised and communicated with other teams and how they supported each other. The teams held locality meetings to enable all grades of staff to meet and discuss local and organisational information. Staff felt connected to the organisation despite working at different bases because of pro-active communication by managers. Managers
- Leaders spoke positively about staff they managed. Leaders were supportive and visible to staff and we observed positive interactions between staff and managers. Staff said managers were supportive and visible including middle and senior managers. Staff said leaders were approachable and in turn leaders made themselves available to staff. Managers said they had good access to the board and the chief executive. Staff said senior managers had visited them at their locality bases.
- Leaders empowered staff to make decisions and encouraged autonomy. Staff said leaders supported them in decision-making. Staff said the chief executive showed interest in them and asked questions about what they were doing.
- Staff said since the announcement of the transfer of services to another provider the chief executive had been to visit them and reassure them. Staff said the response from the majority of managers had been positive with leaders providing re-assurance.

Good

Are services well-led?

- Some staff said since the announcement of the transfer of some children's services to another provider, they had not seen the assistant director. A small number of staff said a senior leader was not supportive and did not listen to staff.
- The organisation provided a 360-degree appraisal process for teams within the organisation. A 360-degree appraisal is a type of employee or team performance review in which peers of all levels rate the team or employee's performance anonymously. We saw the results of the community paediatric team 360-degree feedback (October 2016).

Culture within this service

- The organisation had policies and procedures designed to keep staff safe. For example, the organisation had a lone worker policy (review March 2018). Staff knew about this and could explain their responsibilities when working alone in the community. We saw evidence of alerts within a patient's electronic care record alerting staff to safety issues such as two staff undertaking a visit or an aggressive dog at a property.
- Staff said the organisation had a supportive culture. We saw there was a positive regard for staff welfare and individual working requirements. We saw examples of where staff had been supported with their long-term medical conditions or disability by making reasonable adjustments. Staff said this type of approach helped them to feel valued.
- The service had a patient focussed culture. All staff we spoke with said putting children first was important in delivering their roles and in their decision-making. Staff said improving the lives of children and young people was the reason they did their jobs. Staff were proud of services they delivered and one member of staff said, "We give a gold standard service that I am proud to be part of".
- There was a culture of collaboration and partnership working. We saw many examples of staff working alongside each other and stakeholders to provide care and treatment to children and young people. Staff said working with other organisations helped to provide better service and they had strong relationships with stakeholders.
- Morale was mostly good throughout the service. The majority of staff we spoke to were happy in their jobs and liked working for the organisation. There was some uncertainty regarding the transfer of services to another provider but most staff we spoke with were positive or optimistic. Staff in areas which had undergone some service changes (the removal or additional or services at their location) were less positive.
- Staff respected and supported each other. Every location we visited staff talked about working positively as a team and we observed good relationships and positive interactions between staff.
- The organisation had an open and honest culture and staff said managers supported and encouraged them to speak up if they had concerns.

Public engagement

- We saw evidence of a customer service report (April 2016) carried out by the children's community nursing service which involved a questionnaire for both children and parents to respond to either in picture or written form. This included questions about the service, their community nurse, how involved the patient or parent felt in the decisions about care, if the care was co-ordinated and if an accurate exchange of information was given by the service. Out of 53 respondents the results were positive overall some negative comments included were related to appointment times, being given sufficient time for their appointment and the timing of follow up appointments.
- We saw evidence of a customer service report (July 2016) carried out by the children's occupational therapy service which involved a questionnaire for both children and parents to respond. Out of 38 respondents, the results were positive overall. One negative comment included equipment being swifter with an additional suggestion of loaning equipment to trial.
- The children and young people's service used an electronic application on a hand held device to obtain patient views and opinions of the service. We saw evidence of this in use with the parent following a multi-disciplinary meeting of a vulnerable child. Children, young people or those close to them could feed back opinions to the organisation through a social media page.
- We saw a 'you said we did' poster at Moulsham Grange clinic. We saw examples of where staff responded to comments and complaints left by parents. For example, staff put up signs to highlight refreshments available for visitors. This was in response to parent and carer comments regarding the availability of refreshments.

Good

Are services well-led?

- We observed staff using the Friends and Family Test (FFT) questionnaires. Receptionists guided parents, carers and children to a tablet device or paper questionnaires before they left clinics.

Staff engagement

- The majority of staff we spoke with said they felt listened to and they could influence how the organisation worked. Because the organisation was a community interest company, this meant staff were shareholders in the organisation with voting powers. This helped the organisation to be employee led on key decisions. This was one of the reasons staff enjoyed working at the organisation.
- Staff said managers communicated and listened to them. Managers engaged staff through emails, bulletins, posters, team meetings and staff forums. The majority of staff we spoke with said they knew what was going on across the organisation. The organisation distributed team briefs to staff containing key messages. Managers conducted team meetings based on the structure of the team brief. Staff said they received feedback from managers when staff escalated issues to them.
- Staff said they felt listened to when it came to service planning and staff held joint meetings and 'away days' to discuss future service provision. Staff said they could make small changes in how they delivered services including changing roles and caseloads to ensure their services worked better.
- We saw evidence of a consultation process (August 2016) undertaken by an external provider to obtain the views of patients, parents and professionals within children's services about a future model of the delivery of care within the service.
- There was a dedicated page on the intranet for staff to access for the most up-to-date information related to the new takeover by an external provider.

Innovation, improvement and sustainability

- We saw evidence of a physiotherapy prioritisation tool for caseload and capacity management. Staff used it within individual caseloads with a view to the organisation implementing it across the teams. Staff told us they had made an application for a research funding with the National Institute for Health research.
- We saw evidence of two staff nominated for organisational leadership awards and a health visiting team being highly recommended for an external award for work undertaken in celebrating diversity.
- Some staff had won awards for their work with other organisations and with service users. For example, two health visitors had won NHS leadership awards for setting up new parenting groups on insolation and post-natal depression. Another group had won an award for its work with first responders.
- Occupational therapists said commissioners had reduced their budget, which caused challenges to service delivery. Managers asked them to sit down and work out how to streamline their service. They put ideas forward, which had minimum impact on the patients and the service. The organisation listened to and used the suggestions.