CareQuality Commission

North East London NHS Foundation Trust

RAT

Community health services for children, young people and families

Quality Report

Goodmayes Hospital, Barley Lane,
Ilford, Essex, IL3 8XJ
Tel: 0300 555 1200
Website: www.nelft.nhs.uk

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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)
RAT	Goodmayes Hospital	Community health services for children, young people and families	IL3 8XJ

This report describes our judgement of the quality of care provided within this core service by North East London NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by North East London NHS Foundation Trust and these are brought together to inform our overall judgement of North East London NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service: Requires Improvement

We found that services for children and young people at North East London NHS Foundation Trust (NELFT) required improvements to safety, effectiveness and well-led. We rated the service as 'good' for caring and responsiveness.

- The Community health services for children, young people and families (CYP service) had good overall safety performance across services and localities with low levels of serious incidents and good management of incidents generally. However, there were major staffing shortages and recruitment challenges across all staff groups and localities. There was extensive recognition of heavy and unsustainable caseloads for practitioners across all universal and specialist services. There were some data protection risks, including examples of staff using paper diaries to record sensitive personal information. We also found inconsistent compliance with paper record keeping processes in some services.
- Universal and specialist services were based on evidence and good practice and delivered in line with national guidance. There was effective internal and external multidisciplinary working and there were

pockets of excellent service provision. However, there was inconsistent measurement and analysis of patient outcomes across services and localities because of staffing capacity and heavy caseloads.

- Staff across the CYP service were courteous and professional and service users were treated with dignity and in an age appropriate way. We saw staff communicating with service users with empathy and in a polite and caring way. Parents of children using services gave us universally positive feedback about the service.
- There was good access to multiple CYP services, facilitated by the co-location of services in health centres and coordinated appointment bookings. However, there were challenges with long wait times and waiting list breaches for referrals to therapy and diagnostic services such as speech and language therapy, occupational therapy and social communication pathways.
- The staff we met reflected the trust values and were dedicated to providing a good service. There were some highly effective, dynamic and progressive local leaders in some services who worked hard to improve quality and develop services. However this was not consistent across localities. There was no clear or documented vision for the CYP service as a whole and practitioners were not clear about the strategic direction of the CYP service.

Summary of findings

Background to the service

Information about the service

North East London NHS Foundation Trust provides community healthcare services to a diverse population of over 2.5 million people in the London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest in north east London, and the boroughs of Basildon, Brentwood and Thurrock in Essex. The trust employs around 6,000 staff.

Services for children and young people are managed on a locality basis aligned with the seven boroughs that the trust works with. Within each locality children and young people services are separated into two divisions: targeted services and universal services. The trust's universal provision includes health visiting, school nursing, family nurse partnership and immunisation. Targeted services include child development and community paediatricians, looked after children, children's community nursing, paediatric physiotherapy, occupational therapy, and speech and language therapy.

Our inspection team

The inspection team included Care Quality Commission (CQC) inspectors and a number of specialists, including: health visitors, a school nurse, a community paediatric physiotherapist, a speech and language therapist, a pharmacist and a paediatrics service senior manager.

Why we carried out this inspection

We inspected this provider as part of our comprehensive inspection programme.

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before the inspection visit we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from service users at two focus groups.

We inspected a selection of the trust's services across localities. During our inspection we visited the trust's health centres at the Acorn Centre, Axe Street Child and Family Centre, Thames View Health Centre, Harold Wood Clinic, Harold Hill Health Centre, Seven Kings Health Centre, Brentwood Community Hospital, Redbridge Child Development Centre and Wood Street Child and Family Centre. We also attended home visits and clinics in local children's centres. We spoke with more than 30 service users and their family members. We observed care and treatment and looked at 20 care records. We also spoke with more than 50 staff members, including health visitors, community children's nurses, consultant

Summary of findings

community paediatricians, physiotherapists, other allied health professionals, administrators and senior management staff. In addition, we reviewed data and performance information about the trust.

The CQC held a number of focus groups and drop-in sessions where staff from across the trust could speak with inspectors and share their experiences of working at the trust. We also received information from members of the public who contacted us to tell us about their experiences both prior to and during the inspection and looked at patient feedback about the service over the past year.

Good practice

- There was highly effective internal and external multidisciplinary working. This was facilitated by co-location of services and partnership working with other service providers.
- The trust applied comprehensive supervision structures for staff which facilitated reflective practice.
- There was very good compliance with the trust's child safeguarding training and comprehensive safeguarding supervision processes in place.
- The service used a single point of access referral system with a single point of contact, such as a specialist health visitor, to simplify the process for service users.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must ensure that sensitive personal information is kept securely and not recorded in paper diaries.
- The trust should review trust incident reporting processes to ensure all staff can record incidents or concerns independently of senior staff and ensure all staff receive direct feedback from reported incidents.
- The trust should take steps to further reduce the backlog of transferring scanned consent forms for immunisations onto the trust electronic record systems.
- The trust should improve compliance of paper record keeping in the Havering audiology service and all other services that use paper records.
- The trust should take steps to improve completion of mandatory training, particularly in occupational therapy services.
- The trust should take steps to reduce caseload allocation for therapy staff to ensure compliance with relevant national guidelines.
- The trust should take steps to reduce waiting times for therapy and diagnostic services such as speech and language therapy, occupational therapy and social communication pathways.
- The trust should ensure standard operating procedures for referrals are applied consistently across services and localities.
- The trust should improve measurement and analysis of patient outcomes across services and localities.
- The trust should ensure adequate, protected time for community paediatricians in all localities to audit patient outcomes and clinical performance.
- The trust should take steps to develop consistent transition arrangements from paediatric to adult services across services and localities.
- The trust should ensure all relevant community health services for children, young people and families staff are aware of trust processes for the identification and dissemination of new clinical guidelines.
- The trust should take steps to improve reliability of remote connections to the electronic records system so practitioners can access and record patient information contemporaneously.
- The trust should develop a formal documented vision and strategy for the community health services for children, young people and families service as a whole.
- The trust should provide further opportunities for staff interaction to improve shared learning and communication of different practices and priorities across localities.

Summary of findings

- The trust should communicate to staff how community health services for children, young people and families services are represented at trust board level, and the named individual ultimately accountable for community health services for children, young people and families services within the trust.

CareQuality Commission

North East London NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement 🟠

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the CYP service as 'requires improvement' for safety. This was because:

- There were major staffing shortages and recruitment challenges across all staff groups and localities. It was being managed but with consistently high usage of bank and agency staff and this was impacting on continuity for service users.
- There was extensive recognition amongst all staff of heavy and unsustainable caseloads for practitioners. This was across all universal and specialist services.
- Electronic records were completed in full, but we found inconsistent compliance with paper record keeping processes.
- There were some data protection risks, including staff using paper diaries to record sensitive personal information.

However:

- The CYP service had good overall safety performance across services and localities with low levels of serious incidents and good reporting of incidents generally. There was evidence of learning from incidents and sharing of learning, including audits, training and supervision.
- There were comprehensive processes and training for child safeguarding.
- Incidents were reported and investigated appropriately. Learning from incidents was disseminated.
- All of the locations we visited were clean and tidy and staff complied with infection prevention and control processes.
- There were effective risk management systems in place, including a robust lone working process for staff.

Safety performance

- There was a good overall safety performance and an embedded culture of safety within the children and

Are services safe?

young people (CYP) services at NELFT (the trust). The CYP service reported zero never events for the year preceding our inspection. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

• The trust reported serious incidents to the Strategic Executive Information System (STEIS). The CYP service reported four serious incidents in the year preceding our inspection. These related to reports of a backlog of files awaiting dictation by clinician, loss of patient information, an inherited pressure ulcer and an incident affecting a staff member.

• The staff we spoke with universally told us they were encouraged to report concerns to the trust's incident reporting system. They felt confident to escalate concerns and understood how and when to report incidents appropriately.

Incident reporting, learning and improvement

• The trust used an online incident reporting system. All CYP staff could access this system. Doctors, nurses and allied health professionals told us they felt able and comfortable to submit incidents to the system.

• There was good awareness amongst CYP staff across all services and localities of processes for incident reporting. However, trust incident reporting processes required junior staff at band five and below to be accompanied by a band six or above to record an incident or concern on the reporting system. Although this is common practice in some organisations, it resulted in junior staff not receiving direct feedback on incidents they had reported.

• There were effective incident investigation procedures including case reviews, root cause analyses and debriefing meetings, where all involved contributed what they had learned and how their service could have worked better. In some cases the trust appointed internal investigators to review incidents and suggest recommendations for improving processes, for example, incidents involving loss of personal identifiable data resulted in revised information governance training and the introduction of lockable boxes for document storage.

• Incidents reports, risk management and action plans were discussed in weekly team meetings and formally recorded in minutes.

• We found evidence that learning from incidents and serious case reviews was shared effectively. Staff across the CYP service told us they received feedback from reported incidents and were able to provide examples of learning and improvement from incidents. Staff told us that feedback and learning was shared in team meetings we saw this recorded in meeting minutes.

• Community paediatricians held monthly meetings to discuss incident investigations, learning from incidents and audits.

Duty of Candour

• The staff we spoke with were aware of the trust's policy on Duty of Candour (DoC).

• The trust provided formal DoC training for staff but this was not mandatory. This was included in inductions for new staff and as standalone training for existing members of staff.

• We found senior staff within the CYP service understood their responsibilities for DoC, and were able to describe giving feedback in an honest and timely way when things have gone wrong.

• Junior staff were aware of the term duty of candour and when asked were fully able to articulate how they would respond should a mistake happen. They appreciated the need for openness and honesty in the investigation of incidents. Staff told us that when concerns were raised they reported them to managers in the spirit of openness.

• Senior staff told us the trust's incident reporting section incorporated a section on DoC responsibilities to confirm staff had shared information appropriately with service users and their relatives.

Safeguarding

• The trust had clear and comprehensive policies, processes and training for child safeguarding.

• There was good completion of mandatory level three training in child safeguarding across all CYP staff groups. Trust records indicated that 91% of CYP service frontline staff had completed this mandatory safeguarding training against a trust target of 85%. The trust provided tailored level three child safeguarding training in partnership with local authorities.

Are services safe?

- CYP staff could access supplementary training in safeguarding, in additional to mandatory training. This included discrete training in risk management and identifying professional dangerousness in child protection practices.
- There were child and adult safeguarding awareness and support posters displayed throughout the trust's health centres and in partner children's centres. This included posters on child exploitation warning signs, female genital mutilation (FGM), domestic violence and human trafficking. The posters contained contact details for the trust's safeguarding duty desk and Caldicott Guardian (a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing).
- There was thorough awareness and consideration of FGM amongst staff we spoke with. We observed routine questioning on FGM by health visitors during clinics and home visits, which was approached in a sensitive way. There was extensive training in FGM awareness and staff felt confident they could recognise and deal with concerns and understood what questions to ask. Staff accessed the FGM identification protocol on trust the intranet.
- There was very good understanding of child sexual exploitation risks, and this was particularly evident amongst the trust's looked after children (LAC) staff. LAC nurses received specific training in child sexual exploitation awareness. There was a child sexual exploitation lead within the trust.
- Staff told us that the trust's child safeguarding team was very accessible and visible and was available to support them in difficult safeguarding cases. The team helped staff with report writing for safeguarding incidents and attended child protection meetings.
- There were effective formalised processes for staff to receive regular planned supervision on safeguarding matters. This included group supervision sessions to discuss events and case studies and reflect on learning on a three monthly basis. CYP staff told us there was good sharing of learning and in a supportive environment. Safeguarding supervisors received training by the NSPCC.
- Community paediatricians received regular safeguarding supervision and de-briefings in difficult cases.

- We found evidence of shared learning from serious case reviews which was recorded in monthly team leader meetings and cascaded to individual teams.

Medicines

- There were effective policies and procedures in place to manage the storage and administration of medicines at trust sites and external locations.
- Staff received training in medicines management and could demonstrate competency around the safe and effective use of medicines.
- Some health visitors and community children's nurses were independent prescribers. They told us that although they did not prescribe many medicines for children, they received support in this role from the trust's medicines management team.
- Nursery nurses and special school nurses did not administer medication. They trained staff in schools to administer medications and ensured medicines were stored correctly. Schools had their own medications policy, which were reviewed by the trust pharmacist.
- Prescription pads were securely stored in locked cabinets and the serial numbers of prescribed medicines were recorded and sent to the medicines management team for audit.
- Patient Group Directions (PGDs) were used by immunisation staff to enable them to give children vaccinations. The PGDs used had been reviewed regularly and were up to date.
- There was a robust process and standard operating procedure in place to ensure vaccination vials were stored and transported at the appropriate temperature.
- The trust pharmacy team provided support to services and advised them on action needed to maintain appropriate temperatures. The trust was working towards direct delivery of vaccines to schools and health centres to save nurse time in transporting vaccines. Pre-loaded vaccinations were transported to schools.
- Storage of vaccines was compliant with trust policy. Drug fridges were locked and temperature monitored.
- There was an immunisation impact assessment toolkit for staff. This included Gillick competency and Fraser guidelines to help assess whether a child has the maturity to make their own decisions without consent of a parent or guardian and understand the implications of those decisions.

Are services safe?

- We observed community children's nurses provide evidence-based advice to families on storing medicines at home.
- There was a backlog of transferring signed consent for immunisation records onto the trust electronic record systems (ERS). Staff told us this was because of limited administration capacity. Immunisation staff reported that all immunisation results and NHS number had been updated on the ERS.
- There was a tri-monthly nurse prescriber forum for staff across the trust where staff received updates on medication processes and products from pharmacy and university partners.

Environment and equipment

- We visited a number of the trust's health centres. The centres were modern, bright and welcoming with adequate spaces for service users and their families. For example, the clinical areas in the Acorn Centre and Wood Street Child and Family Centre were very friendly child friendly with bright colours, painted murals, children's art work and staff photos on walls.
- Each of the locations we visited had accessible facilities.
- Each of the locations we visited had information boards and stands for service user information leaflets.
- Children's centres were secure with locked entrance doors. Receptionists controlled entry and exit to the centres and entrances were monitored by CCTV.
- Physiotherapists had access to gym and rehabilitation equipment such as treadmills, parallel bars, exercise balls and mats.
- Toys and children's books were available in waiting areas at health and children's centres.
- Clinical and electrical equipment was serviced annually by an external contractor.
- The equipment we checked, such as scales, was calibrated appropriately. There were set days throughout the year for each service to check and calibrate equipment.
- There were first aid boxes and fire extinguishers in each of the locations we visited.
- Therapy equipment in some localities was provided by the local authority. The trust did not directly purchase equipment for children. Some therapists told us they had difficulty in obtaining equipment and some requests had been denied by commissioners. They felt in some cases this had impacted on child development and increased physiological risks.

Quality of records

- The CYP service used the trust's electronic record systems (ERS) to input and access service user records. The trust used two ERS: one for London boroughs and a separate system in Essex boroughs.
- The ERS systems were available to all staff including doctors, health visitors, community nurses and therapists. All professionals in the care of a service user recorded information from clinics, home visits and therapy sessions in chronical order in the notes section. This included history, consent and referrals. This meant recording errors from illegible writing were virtually eliminated. Records were consistent with NMC guidelines for record keeping.
- We observed practitioners and administrators using the ERS and saw they were adept at using the system.
- Local GP practices were able to access service user information on the ERS, which facilitated timely information sharing.
- The ERS required password access to ensure security. Staff members had unique accounts to ensure professional accountability.
- The ERS flagged service users who were at risk, such as safeguarding concerns. The system also provided an alert for patients with learning disabilities or allergies so all staff were aware of a service user's specific needs.
- Staff were alerted to incomplete record sections by ERS system prompts.
- We accessed the ERS with the assistance of administrators and healthcare practitioners. We reviewed 20 patient records and found electronic records were completed in a logical and comprehensive way. The notes provided a detailed description of care plans, observations, attendances, action plans and service user progress. Care plans included all identified care needs.
- We reviewed a sample of paper records in the Havering audiology service and found inconsistent note keeping compliance. In some records all entries were signed, filed chronologically, clearly documented patient details and records of consent. But in others we found incomplete sections, missing pages, illegible entries, missing signatures and printed names and consent not recorded.

Are services safe?

- All paper records were stored securely in locked filing cabinets. Paper records were stored in an orderly fashion and were well maintained. Old paper records for child protection cases and vulnerable families were kept in locked cabinets.
- We observed health visitors record information in 'My Child's Health Record' red books which parents kept. All content was legible and dated. Health visitors explained that information in the red book was recorded in duplicate and notes were uploaded to the ERS and shared with other health care providers such as GPs.
- Health visitors and community children's nurses used paper diaries to record appointment details. We found that some health visitors were recording sensitive personal information in paper diaries such as name, address and reason for visit. Paper diaries could be easily misplaced, lost or stolen, which presented a data protection risk and contravened the trust's data protection policy. The policy was clear that personal sensitive data must be kept securely. However, there was no provision within the policy for use of, or recording sensitive personal information in paper diaries.
- Information governance was part of the mandatory training programme staff were required to complete. The trust target was 85% of staff having completed the training. Across all CYP service lines, 94% of staff had completed training.

Cleanliness, infection control and hygiene

- All of the locations we visited were visibly clean. The children's and health centres we visited were clean, tidy, well organised and clutter-free. All floors in corridors were clean. There was no evidence of dust. Infection prevention and control was generally well managed.
- In the 2015 Patient-Led Assessment of the Caring Environment (PLACE) assessment, the trust scored 99% for cleanliness. The national average is 98%.
- We observed clinicians and health professionals cleaning their hands and following hand hygiene procedures appropriately, before and after contact with service users. For example, community children's nurses cleaned their hands and used protective gloves and wipes when changing dressings and administering medication. There was appropriate disposal of clinical waste.
- The trust's health centres had easily accessible handwashing gel facilities located at the main entrance

and throughout public and clinical areas. We did not see handwashing gel facilities in local authority managed children's centres, but health visitors and other staff using these centres had dispensers of cleaning gel which we saw them use in between all contacts with service users.

- We observed health visitors and therapists clean equipment before and after it was used. For example, we saw health visitors use disinfectant wipes on scales and mats.
- The equipment we reviewed was visibly clean, for example gym equipment in therapy rooms. However, equipment was not labelled as clean and ready for use across all clinical areas.
- Equipment had protective single use covers where needed, for example the audiology service used disposable otoscope tips and head phone covers.
- The toilet facilities we inspected across sites were clean and tidy.

Mandatory training

- The trust target for staff completion of mandatory and statutory training was 85%. At the time of our inspection, aggregate compliance with mandatory training for all CYP lines was 85% across all staff groups.
- The mandatory and statutory training programme covered equality and diversity, health and safety, basic life support, infection control, information governance, adult and child safeguarding, fire safety, manual handling and conflict resolution. The trust used a mix of practical and online training modules.
- Newly appointed staff were required to complete a corporate induction and subsequent local induction.
- CYP staff reported accessible and useful online training modules. However, some staff told us booking onto sessions for some practical mandatory training modules could be difficult because of limited availability, for example, domestic abuse awareness training.

Assessing and responding to patient risk

- We saw health visitors record the observations of infant development parameters such as height, weight, communication and motor skills. These were recorded in the baby record book and on the ERS. Infants were assessed for actual and potential risks related to their health and well-being and we saw evidence of these in notes.

Are services safe?

- CYP staff told us they would call a doctor if they were immediately concerned about a child or young person's health or welfare.
- We observed health visitor and community children's nurses conducting risk assessments while on home visits and in clinics.
- The trust placed health visitors in local acute hospitals during weekends to support triage and identification of CYP needs. Senior leaders told us this resulted in fewer admissions to the emergency department and reduced waiting times.

Staffing levels and caseload

- We found high levels of vacancies across all universal and specialist services. Service managers confirmed substantive staff vacancy rates averaging 20% across all services, with up to 50-67% vacancies in some services and localities. This was particularly prevalent in health visiting teams in Barking and Dagenham and Waltham Forest, and therapies in Redbridge. The staff shortages were managed, but with consistent and sustained high usage of bank and agency staff to cover shift and service gaps, including some very long term locum staff. The staff we spoke with felt that the high level of vacancies did not impact on the safety of care as the service was funded to fill gaps with temporary staff. However, trust data highlighted that low staffing levels had resulted in waiting time breaches in some services such as speech and language therapy.
- Staffing challenges were recorded on the CYP service risk register and trust senior leader and commissioners were aware of capacity challenges.
- There was extensive recognition amongst all the staff and managers we spoke with of heavy caseloads for staff across universal and specialist services. Staff across disciplines and localities told us consistently they regularly worked extended hours and took work home. They perceived the caseload allocation and high volume of service users as unsustainable over the long term. For example, in some localities health visitors held large universal caseloads of up to 600 service users. Guidelines by the Community Practitioners' and Health Visitors' Association (CPHVA) advise an optimum ratio of 1:250 and the Institute of Health Visiting also advises this ratio. In Barking and Dagenham there were 0.33 therapists per 10,000 children, which meant that physiotherapists had caseloads of 78 patients each, above recommended guidelines of 40-50. Similarly, occupational therapists had caseloads of 100-150 service users, above guidelines of 50-60. Therapy staff told us about their frustrations of not having enough staff and its impact on continuity of provision for service users. To manage limited capacity, therapy teams across localities had prioritised or reduced the frequency and amount of practitioner input for each service user. Some therapy practitioners told us they were anxious their heavy caseloads meant they were not always providing the required interventions and this could mean they might miss something in the care of a service user.
- Community paediatricians told us they frequently employed locum doctors to cover rota gaps, but they were not always able to secure regular known doctors. They felt this had a negative impact on continuity of care.
- The Royal College of Paediatrics and Child Health conducted an extended visit to the trust in 2014/15 and 2016 and identified clinical capacity as a concern, with inadequate medical and administrative staff. Community paediatricians told us that workforce gaps had resulted in increased wait times for some pathways, particularly for autism and social communication services.
- Senior leaders told us they had previously tried to cross-cover staff by flexing staff between localities, for example temporarily transferring SALT practitioners from Brentwood to Thurrock, but such arrangements had not been sustainable.
- There were a number of concurrent recruitment practices across localities. For example, in Waltham Forest, local recruitment campaigns had been successful in attracting new health visitor and therapy staff. There was also monthly trust-wide recruitment of different staff groups with continuous advertising on the NHS recruitment website. However, therapy service managers told us there were national shortages of therapy staff, which further compounded their recruitment of permanent and temporary staff.
- Trust staff in London boroughs received London Weighting, which staff in Essex boroughs did not receive. Service managers told us this had impacted on recruitment in some services and localities.

Managing anticipated risks and major incident awareness and training

- The CYP service adhered to the trust's lone working policy, which staff could access on the trust intranet.

Are services safe?

There was good awareness of lone working arrangements amongst the staff we spoke with. Health visitors, Family Nurse Partnership (FNP) nurses and children's community nurses conducting home visits used a text messaging service to inform other staff of their location. Visit details were also recorded in staff diaries on the electronic record system. There was a buddy system and shared diary access to ensure that staff were aware of their colleagues' whereabouts. A duty staff member ensured that all staff had responded to text messages on a daily basis.

- A number of staff told us they experienced violent and threatening behaviours from service users and this was recorded on service risk registers. CYP staff told us the trust was supportive in cases where staff had received threats of violence and liaised appropriately with police and social services.

- There was a major incident plan, policy and protocols for the trust and CYP service. The staff we spoke with were aware of the major incident plan and where to access emergency information such as emergency contact telephone numbers.

- The trust provided alerts to staff on major incidents on the trust intranet pages. This included alerts for traffic and road works, adverse weather and infection outbreaks.

- CYP staff cited recent examples where business continuity plans had been implemented, including as recent IT and telephone network outage.

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 the CYP service as 'requires improvement' for effectiveness. This was because:

- There was inconsistent measurement and analysis of patient outcomes across services and localities. Some services and localities had very clear patient outcome measures but other services had limited evidence of measuring and monitoring patient outcomes.
- Staffing capacity and heavy caseloads restricted opportunities for community paediatricians in some localities to effectively measure and audit patient outcomes or benchmark their clinical performance.
- There was inconsistent application of referral processes across localities.
- Arrangements for transition from paediatric to adult services were well managed in some services and localities, particularly in diabetes and epilepsy services, but less developed in others.
- CYP staff were not clear how new clinical guidelines were identified and disseminated.

However:

- Universal and specialist services were based on evidence and good practice and delivered in line with national guidance. There was good provision of evidence-based advice and guidance to service users.
- There was highly effective internal and external multidisciplinary working. This was facilitated by co-location of services and partnership working with other service providers.
- There were pockets of excellent service provision including the Infant Feeding Team and Change for Life. There was clear evidence of positive outcomes in promoting breast feeding and reducing levels of childhood obesity respectively.
- The trust had single point access systems for some services.
- There were good learning and development opportunities for staff.
- The trust applied comprehensive supervision structures for staff which facilitated reflective practice.

Evidence based care and treatment

- Staff accessed policies and corporate information on the trust's intranet. There were protocols, policies and guidance for clinical care and other patient interventions on the intranet. The trust intranet was easy to navigate and find relevant policies, such as nurse prescribing protocols and sharps policy.
- There was a trust policy on the implementation of national regulations and guidance. We reviewed a sample of trust policies for CYP services and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) and Royal College of Paediatrics and Child Health guidelines.
- Implementation of new clinical guidelines and regulations was managed and disseminated to the CYP service by a central team within the trust, however not all senior staff were clear about this. Some staff did not know there was a central team and they told us they identified new guidelines within their teams.
- Consultant paediatricians told us that services conducted local audits and benchmarking exercises to ensure compliance of existing local protocols and policies with new guidelines.
- Consultant paediatricians in the child development team were involved in local audits and regional research projects, including contributions to national asthma audits, London-wide sleep in autism study and research into correlation between vitamin intake and Down's syndrome.
- Consultant paediatricians were engaged in public health academic research and were represented at academic round table meetings investigating the interface between primary and secondary care.
- Consultant audiologists and community paediatricians participated in regional consultant networks such as the North East London Community Paediatrics Group and the Great Ormond Street Hospital network to maintain links with other clinicians. They also participated in local peer review with acute paediatricians including presentation of audits.

Are services effective?

- There was a trust-wide programme of clinical audit, but consultant paediatricians felt clinical audits of the CYP service were weighted toward audit of community psychiatry services.
- There were specific clinical audits in individual service lines. For example, paediatricians in the child development team completed audits on efficiency of genetic tests in developmental assessments, the infant feeding team audited breast feeding outcomes against other local areas and similar demographic areas, and initial health assessment compliance in the looked after children team.
- We observed competent, thorough and evidence based care and treatment by CYP practitioners in home visits, clinics, development reviews and therapy sessions. All of the practitioners we observed were encouraging and reassuring, conducted full assessments as per guidelines and provided up to date and evidence-based advice.
- We observed health visitors in their clinics. They gave appropriate advice and education and provided reassurance and guidance to the service user. For example, on weaning and sleep patterns.
- The family nurse partnership service (FNP) used nationally recognised approaches and techniques as prescribed in the FNP model. We observed FNP nurses conduct assessments of children and parents in their own environment. Objectives were set for each FNP visit as per visit guidelines, which included 'ages and stages questionnaires' and activities. Feedback was given in accessible language and progress recorded.
- The maternal early child sustained home visiting service (MECSH) used an evidence-based approach of high frequency home visiting to improve parent-child attachment.
- The school nursing team used puppets for scenario and role play in primary schools to facilitate discussion of bullying, healthy eating and sexual health.
- The CYP audiology service in Havering applied British Society of Audiology standard testing protocols and moulding protocols.
- The Infant Feeding team (IFT) complied with Unicef guidance for baby friendly accreditation and was on target to complete full accreditation in 2016. The service conducted quarterly audits for accreditation purposes. The service manager for IFT developed London-wide

guidance on increasing breastfeeding prevalence and was leading development of a strategy to align policies and provision across boroughs to create service parity for all users.
- The Change for Life team in Thurrock delivered evidence-based interventions on healthy eating and physical activity, including the 'Little Dudes' and 'Fresh' programmes for children and their families. These included cooking lessons and food tasting, group physical activities such as swimming, and discussions with parents and carers about healthy foods. The team had developed a character and narrative for the narrative to link each session.

Technology and telemedicine

- Practitioners across universal and therapy services had access to laptops, secure mobile internet connections and mobile phones to support remote and mobile working. We saw practitioners using laptops to complete forms with service users and record notes contemporaneously during clinics and home visits. CYP staff told us that remote working systems helped them to make better use of their time, but they also found they were working longer hours because remote connections enabled them to complete work at home during the evenings.
- Some practitioners told us that remote connections to the ERS were not always reliable and notes could not always be recorded contemporaneously because of this. Service leaders were aware of this.
- Senior leaders within the service recognised the need for remote working champions and further training to help staff understand the time saving benefits of this technology.

Patient outcomes

- The CYP service assessed patient outcomes using nationally recognised outcome measures, but staff capacity and caseload pressures resulted in variability in the recording and analysis of patient outcomes across service and locations.
- Paediatric therapies measured outcomes using standardised assessments and goal attainment scales such as disabilities of the arm, shoulder and hand (DASH) questionnaires and risk measures including

Are services effective?

pain, strength, balance and endurance. They used a comprehensive range of physiotherapy methods including soft play activity, rebound therapy and mechanical horse therapy.

- Health visitors used the 'ages and stages questionnaires' assessment tool during home visits and clinics, to highlight any areas of concern about a child's development across five different areas. These were communication and language, fine motor skills, gross motor skills, problem-solving and personal-social development.

- The CYP diabetes service in Essex boroughs used East of England Diabetic Group local outcome measures, which included peer review by a team of consultant paediatricians, dieticians and nurses to review performance against set criteria.

- Consultant community paediatricians and speech and language therapists in some boroughs told us of high workload, long waiting lists and limited capacity. The trust allocated protected time within consultants' job plans for clinical review activities, however, some consultants felt workload pressures limited opportunities to audit outcome measures or benchmark against peers and similar services. Consultant community paediatricians told us they did not benchmark the clinical performance or outcomes of individual clinicians because accurate evidence-based comparison was restricted by the wide variation of service provision and demographics across trust localities.

Competent staff

- There were effective induction processes for newly appointed staff. Staff completed a four day trust induction which included completion of some mandatory training modules. Local induction included orientation tours of local workplace and allocation of a mentor. Newly recruited health visitors told us they were well supported and happy working at the trust.

- The CYP service completed annual appraisals across all services and locations. The trust was not able to provide appraisal completion information by core service. Appraisals were used to sign off competencies and identify training and development needs. Annual appraisals were linked to the trust values and behaviours.

- The trust participated in the General Medical Council revalidation initiative for all UK licensed doctors to demonstrate they were competent and fit to practice. At the time of our inspection 91% of eligible doctors in the trust had completed revalidation.

- The trust supported professional development of medical staff. Consultant community paediatricians had annual reviews of their job plans as part of their appraisal. Job plans included two and half weekly allocations (10 out of 40 hours) for professional development and supporting professional activities. However, all of the consultant community paediatricians we spoke with said they worked beyond their allocated hours to complete their non-clinical responsibilities.

- The trust applied robust competency frameworks and comprehensive supervision structures for staff. This included planned supervision sessions, with separate arrangements for clinical and management supervision (weekly) and safeguarding supervision (quarterly). Supervision was in one-to-one sessions and group sessions with peers. Some staff also received psychological supervision. CYP staff told us the supervision was thorough and constructive and provided good reflection and learning opportunities.

- There was good provision of emotional support and wellbeing for staff, particularly in child safeguarding cases and end of life care for children. Health visitors and community nurses received regular debriefing around the care of dying children for staff to express their emotions and seek emotional support at a difficult time.

- Staff at the trust were able to access a broad range of formal and informal training and development opportunities to support their work. This included undergraduate degree programmes, secondments, advanced practitioner training, annual away days, special interest groups, conference attendance and shadowing opportunities. CYP staff highlighted variable access to funding for training but told us that the trust was supportive in providing time for training.

- The trust provided in-house training and resources on conflict resolution and managing difficult conversations.

- There was a local development group for newly qualified health visitors and school nurses led by practice development teachers.

Are services effective?

- The FNP services provided training to health visitors in the FNP model to help build awareness and skills in supporting this group of service users.
- The trust provided leadership training to staff with management responsibilities. This included management training, leadership workshops and quality improvement training.
- Consultant community paediatricians were peer appraised by clinicians in the North East London Consultant Group.

Multi-disciplinary working and coordinated care pathways

- There was effective internal and external multidisciplinary (MDT) working and practitioners worked with other staff across services. There were many examples of multidisciplinary working across the CYP service. The audiology service had good liaison with hearing impairment teachers. Community children's nurses worked closely with local children's hospices. Nursery nurses adopted an integrated approach with specialist health visitors, nurseries and schools to support health promotion with parents and teachers. However, there was some variation in the structures, frequency and formalisation of MDT links across localities and services.
- MDT working was facilitated by co-location of universal and specialist services in health centres and partnership working with other service providers. For example: the Acorn Centre in Havering, Grovelands in Redbridge and Wood Street Health Centre in Waltham Forest were multi-disciplinary centres with many services on site. Staff told us this enabled much closer joint working and improved access for service users, particularly those with complex needs or those with challenging behaviours.
- In some of the trust's health centres, local authority and mental health services were co-located in the same building, which facilitated links between practitioners. In some centres, this included special educational needs teams, psychologists, safeguarding advisors, early years advisors and social services. CYP staff told us that open plan offices and co-location with other services enabled better communication and sharing of information, both formally and informally.
- Each locality held weekly MDT meetings for child and adolescent mental health, local authority, education, therapies and community paediatricians to improve

outcomes for vulnerable children through partnership working. We reviewed agendas of these meetings which demonstrated discussion of new referrals, high risk children, attendance rates, pre-discharge planning, agreed actions and action updates. It was not clear during our inspection if this model was shared or adopted by other localities within the trust.
- Paediatric therapy practitioners attended multi-disciplinary clinical excellence groups for service users with special and complex needs.
- Consultant community paediatricians reported good formal and informal links with paediatric psychiatrists and acute paediatricians in local hospitals. Community paediatricians attended joint teaching sessions with their acute peers.
- There was a trust-wide network for specialist health visitors which met on a monthly basis for peer review and support.
- The FNP service held monthly cross-borough meetings for FNP practitioners to share learning and benchmark.
- Staff in the looked after children's service held weekly meetings with designated doctors for looked after children. They also linked with CYP advocacy services at external organisations such as Barnardo's and the Children in Care Council.
- Paediatric physiotherapy teams held joint training days and conducted joint working projects across boroughs, for example to develop a trust-wide spasticity pathway.
- There was extensive evidence of MDT training across disciplines. For example, staff in the infant feeding team developed a training package on breast feeding for health visitors. Dieticians, paediatricians, nursery nurses and continence nurses provided training to school staff in meeting needs of service users including continence assessments, feeding and use of specialist equipment. Special school nurses provided training to carers in special schools on anaphylaxis, epilepsy, oxygen saturation, gastronomy and stoma care.

Referral, transfer, discharge and transition

- Paediatric therapies staff explained that most referral pathways started with referral by GPs, hospital-based paediatricians or health visitors.
- Specialist health visitors coordinated and advised service users and their families on available services and support provided by the trust.
- The trust used a single point of access referral system in each locality to simplify access to child development

Are services effective?

and paediatric therapy services such as physiotherapy, autism and social communication assessment and speech and language therapy. Service users could access these systems through a single point of contact, such as a specialist health visitor. Referrals were triaged by clinical leads. Paediatric therapy practitioners told us that the single point of access had rationalised referrals from stakeholders.

- In Waltham Forest there was a weekly multidisciplinary referral panel with representation by the local authority to ensure children with multiple needs were referred to appropriate services for health, social and educational needs.
- At the time of our inspection the system was being expanded to encompass more localities and service. Some services, such as education, health and care (special educational needs provision) did not have a single point of access.
- Service managers across specialist services reported some delays with referrals (see access to the right care at the right time section for more detail). They also reported some unnecessary referrals. Operational managers in Redbridge told us some practitioners had prioritised referrals based on their own judgement rather than firm application of criteria for referral. Standard operating procedures were not in all cases applied systematically to ensure service users were not referred too frequently or unnecessarily.
- There was a trust policy on clinical handover of care with protocols to ensure the transition of care from paediatric to adult services. There were some effective arrangements in place for service user transition from paediatric to adult services, but this varied between services and localities. There were effective transition pathways for service users with diabetes and epilepsy in Essex boroughs, with good links to adult service provision within the trust and local acute hospital services. Transition plans included joint meetings between paediatric and adult service leads, joint transition clinics, school visits and expert mentors for support. Community children's nurses supported transition for service users with complex needs and visited families to start the transition process, home equipment checks and ensuring families had named contact details for adult services. The trust notified GPs of service users' discharge from paediatric services and shared updated care plans. CYP staff told us that full transition to adult services usually took 18-24 months.

- In Thurrock, the epilepsy service had developed a transition support pack with support from a national epilepsy charity and was setting up a young people's epilepsy support group.
- The trust had introduced some evening appointments for transition clinics in response to service user feedback that day time appointments were disruptive to school age children.
- There was no transitional care pathway for therapies in Waltham Forest at the time of our inspection and looked after children practitioners identified some challenges in ensuring children leaving care were adequately supported.

Access to information

- The trust used two separate electronic record systems (ERS): RiO for London boroughs and SystmOne in Essex boroughs.
- CYP staff in universal and specialist services could access service user information and records in their respective localities, but could only access information recorded on one ERS. For example, staff in Waltham Forest using RiO could access Redbridge or Havering information, but could not access SystmOne and vice versa. The CYP staff we spoke with told us that two separate systems created some barriers to effective and timely sharing of service user information.
- We observed health professionals using the ERS and saw they were comfortable and adept at using the system. However, some staff in London boroughs told us there were problems with slow access to their system, which the trust was aware of.
- The trust used a verbal handover system to share information between London and Essex localities as necessary. For example, in cases where a service user relocated to a different borough.

Consent

- In most cases, service users told us that health visitors, community nurses and therapists had explained the purpose and evidence for different clinical assessments and interventions and confirmed their consent before proceeding with any actions.
- We found some instances where consent was not recorded on paper or electronic records. Some staff told us that they took service user attendance as implied consent for the assessment or intervention.

Are services effective?

- The CYP service used a paper consent form for children and/or their parents to sign. Consent approval was then recorded on service user records on the ERS.
- The staff we spoke with were aware of the trust policy for consent to examination or treatment.
- There was discrete mandatory training for all staff in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) which was online-based learning. Records showed 58% of staff had completed this training at the time of our inspection. Senior CYP leaders told us that the training content had been revised following feedback from CYP staff that the training was too focused on adult provision.

- CYP practitioners told us they had limited experience of applying MCA/DoLS processes because DoLS applies to those aged 18 years and above, and MCA to those aged 16 and above. Special school nurses told us that they had supported service user families during transition to adult services which required consideration of liberty safeguards and assessments.
- The CYP service applied 'do not resuscitate' orders for some children using end of life care services. We observed staff discussing end of life care and arrangements in home environment and plans to transfer to hospital. The CYP service ensured that there was a named nurse for continuity of care in end of life care.

Are services caring?

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

Summary

We rated the CYP service as 'good' for caring. This was because:

- Staff across the CYP service were courteous and professional. We saw staff communicating with service users with empathy and in a polite and caring way.
- Service users told us that health visitors and therapists had a caring approach. Parents of children using services gave us universally positive feedback and highlighted the encouragement and support of health visitors in clinics and home visits.
- Service users were treated with dignity and in an age appropriate way.
- CYP staff continued to engage with service users after discharge and maintained contact with families after the death of a child.

However:

- Service users reported positively about care and valued the service provided, but felt care would be improved by greater consistency and continuity of staffing.

Compassionate care

- The majority of service users we spoke with were very happy with the care and treatment provided by the trust. Direct comments from service users including children and their parents, which were representative of this feedback included: "the support is brilliant", "there is no one like her", 'it's had a big impact on our lives. Our health visitor has advised us and without her we wouldn't be where we are now".
- Service users of the diabetes service in Thurrock told us staff helped them with support and managing their care. They saw some staff as positive role models who understood their condition.
- Service users consistently told us they would recommend the service to their families and friends.
- The trust's performance in Friends and Family Test (FFT) results was consistently good across CYP services and locations. The trust provided aggregate FFT data for all community services for the three months prior to our

inspection. 97% of service users would recommend the trust, similar to the England average of 95%. The trust also used monthly in-house evaluation called 'five by five' to seek service user feedback.
- The trust's overall score for privacy, dignity and wellbeing in the 2015 PLACE score was 86%. This figure is similar to the national average of 86%.
- We witnessed positive interactions between staff and service users, which were very caring and responsive. Health visitors praised children and babies when they cooperated with activities and assessments such as weighing and height measurement.
- Staff clearly explained what was going to happen during an appointment and parents were given opportunities to raise concerns or issues.
- Parents told us that health visitors and community children's nurses were reassuring and able to answer their questions.
- Community children's nurses provided flexible support for families during end of life care, for example nurses attended family homes to offer support and care overnight even though this was not part of their service specification.
- CYP staff told us they continued to engage with service users after discharge and maintained contact with families after the death of a child. During our inspection, community children's nurses attended the funeral of child they had cared for with long term health conditions.
- Community children's nurses supported service users in their interactions with schools and acute hospital providers, for example by advocating in meetings with clinicians, and attending meetings with schools to provide clinical input.
- All of the staff we met embodied the principles of patient centred care. Health visitors and therapists told us they want to do the best for the children and their families and will signpost them to the right support if they cannot provide it.
- We observed health visitors and special school nurses on home visits. Their interactions with children and family members were sensitive, respectful and confident at all times. They listened and showed concern and were caring and aware of the emotional needs of

Are services caring?

children. They involved children and their parents in decision making, including development of care plans. They asked parents to review care plans to check it was agreed and accepted and for the parents to sign. They offered to attend appointments with parents to provide support and guidance.

- Reception staff at the trust's health centres were welcoming and friendly. At the Acorn Centre in Havering we observed receptionists helping a service user book an appointment and arrange a prescription.
- We attended a FNP child development check to a service user in a hostel. The service user told us they had a good relationship with the FNP nurse and felt well supported. However the service user told us she had had three nurses in two years and would have preferred more continuity. Health visiting service users also told us that staffing continuity was limited.

Understanding and involvement of patients and those close to them

- We observed health visitors, community nurses and therapists working in partnership with parents and families.
- Staff across universal and specialist services provided informal training and advice to parents, for example, health visitors using a knitted breast to demonstrate breast feeding techniques to new mothers.
- Information leaflets were available in health centres including advice and guidance on victim support, financial support, infectious diseases and breast feeding.
- We found age appropriate books, games and toys across all of the health and community centres we visited.
- The FNP service facilitated monthly group sessions for service users to meet, socialise and seek support and guidance from local authority staff on job access, housing and welfare. FNP nurses told us the emphasis of the sessions was on building a peer support network but with aspects of health promotion and 'back to work' support. This local initiative went beyond the standard FNP model.
- The trust worked with local independent community groups for such as Positive Parents Havering which was a support network for parents and carers of children with special educational needs and disabilities.

- The trust's communication educator had created a 'parents in partnership' programme, with educational activities and opportunities for parent-child interaction.
- We observed staff in the Infant Feeding Team provide telephone advice. The practitioner was encouraging and friendly and provided suitable evidence-based guidance about skin-skin contact, expressing milk and skin care.
- We witnessed age appropriate instructions with clear explanations, encouragement and feedback given in all CYP staff interactions with children.
- The Change for Life team in Thurrock had developed healthy living programmes called 'Little Dudes' and 'Fresh' for children of different age groups. The team had developed resources using positive and affirmative terminology and removed reference to words such as 'obesity' to reduce stigma and be sensitive to children who may feel self-conscious and vulnerable.

Emotional support

- CYP practitioners across universal and specialist service could refer service users to the trust's psychology and emotional and wellbeing service. Practitioners across services and localities told us listening, managing expectations and emotional support for families of children with disabilities was a core part of their role. Some of the staff we met had counselling skills qualifications.
- Community children's nurses told us they liaised with local authorities to refer service users to local counselling providers and other support.
- The trust's community children's nurses provided post-bereavement visits to families to support and comfort those who had lost a child.
- We observed health visitors sensitively discuss mothers' feelings and emotional wellbeing during home visits.
- The trust worked in partnership with independent organisations and charities to provide emotional and practical support to service users such as counselling and family activities. The CYP services in Essex boroughs worked with local charities including SNAP (Support for Siblings and Parents) and the Sycamore Trust which helped local families with children and young people with special needs or disabilities and provided an online directory of advice and resources such as equipment and funding.

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 the CYP service as 'good' for its responsiveness to service users' needs. This was because:

- Service users could access a range of CYP services in a number of locations. This was facilitated by the co-location of multiple services in health centres and coordinated appointment bookings.
- Clinics and therapy sessions were held in child friendly environments.
- Staff communicated with children and young people in an age appropriate way and involved them as decision makers in their care.
- There was good access to translation services, with good provision of patient literature in community languages and different formats.
- There was good understanding of the different cultural needs and backgrounds of service users.
- There was good signposting to targeted support for service users and their families.
- The trust provided out of hours telephone support to provide advice and guidance.

However:

- There were challenges with long wait times and waiting list breaches for referrals to therapy and diagnostic services such as SALT, occupational therapy and social communication pathways.
- The review, retendering and decommissioning of services was impacting on continuity of service provision across localities.

Planning and delivering services which meet people's needs

- All of the staff we spoke with recognised the different population demographics and healthcare needs within and across the localities that the trust worked with, including the diversity and specific needs of different groups within these populations. Practitioners highlighted challenges of socio-economic and cultural diversity, transient populations and inward migration.

The local population also had many families in temporary accommodation, increasing birth rates, and high levels of reported safeguarding concerns, including child sexual exploitation.

- The trust worked collaboratively with commissioners and other NHS trusts in East London and Essex to plan and meet the needs of local populations. Senior practitioners and service managers told us they had regular communications and, for the most part, constructive working relationships with commissioning bodies. However, senior leaders reported variation in access and relationships, with some commissioners seen as more supportive of children and young people services than others.
- Service leaders were concerned about their ability to provide services to rapidly growing and changing populations and felt that these changes were not acknowledged by commissioners with adequate investment to maintain and develop suitable provision.
- There was recognition that staffing and resource allocation differed between localities because of commissioning arrangements. CYP staff felt that service provision was not entirely equitable as some services were only delivered in one locality and not in another. They felt that this presented risks to continuity of service should a user relocate to a different area.
- Most practitioners delivered services for one locality only and had limited interaction with their opposite number staff in the other localities, despite working for the same trust. The senior staff we spoke with explained that the trust was working to improve integration and standardise practices across localities to ensure equitable provision. However we found many examples of silo working and limited exchange of learning and shared practices across localities. Many of the CYP staff we met told us they felt very much connected to and based within one locality, and commented on different practices in neighbouring localities. For example, new baby visits were not standardised across the trust, with health visitors in one locality conducting 20 minute visits and health visitors in another locality conducting 1.5 hour in depth visits. However, senior staff recognised different practices were a result of different commissioning arrangements across localities.

Are services responsive to people's needs?

- A number of CYP services had been decommissioned by local authorities and commissioners in the year before our inspection, including school nursing in Basildon and Brentwood. This had created some uncertainty for staff and service users. At the time of our inspection, the family nurse partnership in Barking and Dagenham was in the process of being decommissioned and many staff were concerned about the impact this will have on continuity for a vulnerable group of service users. Staff felt that commissioners had not provided proper guidelines for the transfer of vulnerable clients into mainstream services. Health visiting and school nursing were also being retendered or redesigned by commissioners in other localities, with risks to staffing and continued provision of these services.
- Community paediatricians contributed to local authority joint strategic needs assessments of the health and wellbeing of their local communities.

Equality and diversity

- The CYP service used translation services appropriately. This included direct and telephone translation services in clinics and therapy sessions. Translation needs were recorded in the trust electronic records systems. The trust's partner interpreting service provided translation for 36 different languages.
- Large posters advertising translation services in different languages were immediately present on entering the trust's health centres.
- The trust provided a comprehensive range of patient information leaflets in different community languages to ensure that service users had access to appropriate written information. Some service literature contained pictorial demonstrations to remove language barriers.
- Staff members in the immunisation service worked with partner interpreting services to develop service user information in 14 languages.
- We found evidence of good cultural competence and diversity awareness amongst CYP staff. For example, practitioners in the Infant Feeding team were aware of different cultural norms around baby feeding and they tailored guidance and support accordingly.

Meeting the needs of people in vulnerable circumstances

- We found that therapists used appropriate language and body gestures to assist communication with service users with learning disabilities.

- There were dedicated learning disabilities nurses working in special needs schools in some localities. Their role included providing daily medication, support for children with epilepsy, tube feeding, managing challenging behaviours, safeguarding and staff training.
- Specialist health visitors and specialist school nurses supported children with learning and communication disabilities such as autism. They reported good links and collaboration with community paediatricians and MDT input including therapies and community children's nurses.
- CYP staff told us that specialist services assign one nurse to service users with autism to provide greater continuity and stability for this group of service users.
- The trust worked with charity organisations to support vulnerable service users. This included organisations such as Young Epilepsy which provided emotional support, residential and schooling support.

Access to the right care at the right time

- Service users had good access to multiple CYP services, facilitated by the co-location of services within one location (see multi-disciplinary working and coordinated care pathways section for more detail).
- The trust used a text message reminder system to inform service users of their next appointment details. This was supplementary to postal appointment letters. This had resulted in fewer missed appointments. Practitioners told us that continued missed appointments were referred to health visitors and schools to identify actions and whether a safeguarding referral is needed.
- Trust administrators worked closely with practitioners to ensure that multiple sessions were combined in one appointment to reduce the impact of multiple visits on service users and their families. Administrators also alerted service users to factors such as limited parking or public transport in appointment letters to ensure they could make arrangements to attend on time.
- The trust provided telephone advice lines for health visiting and specialist services so that service users could access advice directly without making an appointment. Duty health visitors, community children's nurses and diabetes nurses were available for telephone advice and support during out of hours to help prevent hospital admissions.
- There was evidence of long waiting lists and waiting list breaches in paediatric therapies across localities,

Are services responsive to people's needs?

particularly in occupational therapy, speech and language therapy and dietetics. Senior managers told us this was due to reported staffing pressures and lack of commissioned resources. In Barking and Dagenham, trust records showed there were 148 service users waiting 18-81 weeks for referral to occupational therapy.

- Community paediatricians and therapists reported long waiting lists for the autism and social communication pathway. This had caused some anxiety amongst parents and subsequent complaints about delays in assessment. Clinicians used the Autism Diagnostic Observation Schedule (ADOS): a semi-structured assessment of communication, social interaction, and play to diagnose children with autism. Community paediatricians told us that assessment wait times were case led and prioritised based on need. Parents we spoke with felt that the process was very slow with long gaps between assessments and no interim interventions. They felt there were periods when they did not know what was happening. The child development team in Havering provided a rapid diagnosis clinic for autism spectrum disorder, but during our inspection staff told us that there remained 200 children waiting more than one year for the ADOS pathway in Havering. Royal College of Paediatrics and Child Health service review reports identified a need for the commissioning of additional paediatric capacity.

- Service users reported long wait times for referral to behavioural therapies, and told us they received limited interim support and limited liaison between the child development team and schools to ensure children were receiving adequate educational support.

- SALT practitioners told us that local authorities provided schools with resources to screen children to reduce referral numbers. This had resulted in a reduction in the number of referrals to the service.

- Community paediatricians, dieticians, continence and feeding and swallowing teams all held clinics at special schools so children did not miss out on learning or have to be taken out of school for appointments.

- Community paediatricians worked in partnership with local schools to hold developmental delay and behavioural difficulties clinics in schools.

- Outreach staff in the special school nursing team conducted home visits to ensure those children not in a school setting were able to access educational activities.

- The audiology service provided a walk-in clinic for service users with hearing aids. The clinic provided same day service for battery replacement, new moulds and replacement hearing aids.

- The infant feeding team met its local target of 68% for breast feeding take up and 95% of new born babies checked within 6-8 weeks of birth. The team worked with local GP practices to deliver its programme.

- School nurses worked across a number of schools and parents told us it would be helpful to have a timetable of when school nurses were based in which schools as they were not sure when nurses were available.

Learning from complaints and concerns

- The trust provided feedback forms and submission boxes in health and community centres where CYP services were delivered. Leaflets on the trust complaints process and guidance on independent complaints was also displayed.

- Trust data from 2015 demonstrated that the CYP service received 12 formal complaints in that period. Three of these were fully upheld and six were partially upheld. No complaints were referred to the Ombudsmen. Four of the 12 complaints received related to sexual and reproductive health services in Thurrock.

- The Trust recorded 682 compliments from CYP service users in 2015.

- Senior managers told us there were no particular themes from recent complaints and most complaints were about waiting times for referrals.

- Community paediatricians told us that local demographics of diverse and transient communities resulted in CYP services receiving comparatively few complaints from service users. They perceived that senior managers saw the lack of complaints as evidence that services were coping, despite increased demand and complex caseloads.

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 the service as 'requires improvement' for well-led. This was because:

- There was no clear, documented vision for the CYP service as a whole and practitioners were not clear about the strategic direction of the CYP service.
- Staff were not clear how CYP services were represented at trust board level, and were not clear who was ultimately accountable for CYP services within the trust.
- There were some highly effective, dynamic and progressive local leaders in some services demonstrating evidence of quality improvement and service development. However this was not consistent across localities.
- The CYP service presented as very separate entities and as individual localities rather than one unified trust. This resulted in localised working practices. There were limited opportunities for staff interaction or shared learning across localities.
- There was, for the most part, good morale amongst CYP practitioners, despite high workloads. Staff felt valued and listened to. However, there was low morale amongst community paediatricians.

However:

- Staff told us that local service leaders were supportive, accessible and approachable.
- The staff we met reflected the trust values and were dedicated to providing a good service.
- There was effective dissemination of governance and performance information.

Service vision and strategy

- The CYP community of practice told us there was a vision and strategy for CYP services a whole which aligned with the trust's overarching strategy. However, at the time of our inspection this was not documented or approved. Practitioners across services and localities were not aware of a vision and they were not clear about the strategic direction of the CYP service.

- There were some highly effective, dynamic and progressive local leaders in some services demonstrating evidence of quality improvement and strategic service development. However this was not consistent across localities and there was no evidence of a coordinated strategic overview to drive services forward or review current models of delivery as a whole across the trust. CYP staff told us each locality adopted different service configurations and this resulted in a lack of standardisation in terms of service access, delivery and evaluation.
- The CYP community of practice told us local commissioning bodies had developed a five year plan for local CYP services based on principles of treating people as close to home as possible, greater integration of education, social care, mental and physical health, single point of access, multi-skilling staff, public health programmes and targeted interventions. The five year plan was led and created by commissioning partners in consultation with the trust.

Governance, risk management and quality measurement

- Clinical governance structures were in place across CYP services and localities and staff felt they were effective. There were forums and meetings for staff to monitor quality, review performance information and to hold service managers and leaders to account.
- Each service held regular planned governance and team meetings. Monthly governance meetings were held to review performance against key performance indicators, incidents, risks, complaints and staffing matters. Monthly departmental performance and quality safety groups fed into monthly locality performance and quality safety groups, which then reported up to the trust board.
- Assistant directors for children's services attended monthly quality and safety group meetings with set agendas to discuss performance data, finances, serious case reviews, new guidance, and operational reports from each service.
- Across all services workforce vacancies, staff attrition and heavy caseloads were reported as risks, with high

Are services well-led?

levels of vacancies in health visiting and paediatric therapies. The trust was managing staffing and capacity risks by routinely employing locum and agency staff, but there remained gaps in staffing in some services. Staffing concerns had been reported in local risk registers for a number of months and this was identified as one of the main on-going risks for the CYP service as a whole. Other identified risks included waiting times for referrals (which was a result of staffing challenges), retendering and decommissioning of services, changing demographic profiles and increasing need, and violence towards staff. The CYP service rated risks according to impact and likelihood and serious risks were addressed with an action plan and a named lead.

Leadership of this service

- There was lack of clarity around the representation of children and young people services at trust board level. It was also not clear who was ultimately responsible for leading CYP services as a whole across the trust. CYP staff including practitioners, managers and leadership were not able to clearly explain how CYP services were represented at the trust board.
- Trust governance documentation highlighted that integrated care directors were responsible for locality based management of CYP services, supported by assistant directors for children's services. It was not clear if there was a director level position within the trust with ultimate accountability for CYP services.
- The trust adopted a 'communities of practice' model to provide multidisciplinary strategic leadership to CYP services across, but separate to all localities. The community of practice comprised a clinical lead, operational lead and nursing lead to coordinate corporate strategies, develop new pathways and lead audit and evaluation. Senior leaders in the CYP community of practice told us there was no single lead for CYP as a whole as the community of practice was based on a partnership model.
- Consultant community paediatricians reported to associate medical directors (AMDs) for each locality. Across localities consultants reported variable exposure to AMDs and perceived different agendas between AMDs, who were mostly paediatric psychiatrists, and consultants in community paediatrics. Some of the

consultant community paediatricians we spoke with told us about a disconnect between AMDs and the consultant body and felt they did not fully appreciate the challenges of paediatric community health services.

- All of the practitioners we met told us assistant directors provided clear local leadership and direction to their teams. The assistant directors for children's services presented detailed knowledge of the challenges in their localities. Assistant directors reported good informal links across localities and some planned opportunities for them to meet and discuss local challenges. They recognised the variation in service delivery we observed across localities and highlighted that further work was required to improve standardisation of service access, delivery and evaluation.
- Operational staff such as health visitors, community nurses and therapists told us senior leaders were visible, accessible and receptive to staff feedback and evaluation. The CYP executive team was viewed by staff as supportive and as strong champions for children's services. Service managers were seen as considerate and collegial.
- Staff with management responsibilities had access to leadership and management training, which was funded by the trust.

Culture within this service

- We found, for the most part, an inclusive and constructive working culture within the CYP service. We found highly dedicated staff, often working in challenging circumstances.
- There were some reported problems with staff morale, particularly amongst community paediatricians.
- Many of the staff we spoke with told us they felt more connected to their team and locality than to the wider trust. The trust was seen as a large organisation and some staff felt this impacted on joined up communication across seven localities, with subsequent disparity of service provision and ways of working. Some staff told us they did not have much understanding of what was happening at trust level.
- There were some opportunities for CYP staff to meet with their colleagues in other localities, for example, away days and training sessions. More senior staff had greater opportunities for cross-locality contact, with regular planned meetings for operational and service

Are services well-led?

leads. Senior leaders recognised that the scale of the organisation created challenges, but were seeking to improve opportunities for cross-locality working, communication and sharing of information.

- Some staff reported experiences of racist behaviours and abuse from service users and felt that the trust supported staff from black and minority ethnic (BME) backgrounds with the challenge of dealing with their experiences of racist behaviours. However, there was a sense from these staff that while they believed there was much good will for supporting BME staff, there was insufficient skill and knowledge in how to effectively deal with some of the problems they faced.
- Health visitors, community nurses and therapists reported approachable and supportive colleagues. They told us that they felt cared for, respected and listened to.
- Senior staff were proud of their teams and the support provided by staff to each other across services and locations.
- There were some very long standing and knowledgeable operational staff working in CYP services. Practitioners told us they valued the support provided by administrative staff in effective day-to-day management of appointments and planning services.
- Most of the staff we met recommended the trust as a place to work, and many staff had returned to work at the trust or commuted long distances. They highlighted the supportive environment as a reason for this.
- Staff were aware of the trust's award system and most felt valued at a local level by their peers and managers.
- The trust clearly displayed posters of its values in public areas at health centres for service users to review.

Public and Staff engagement

- The trust provided a number of communications in the form of regular newsletters and all staff emails which highlighted local news, organisational achievements, changes and policy updates. CYP staff told us that communication by the trust had improved, and all staff were aware of initiatives such as staff breakfast with the trust CEO.
- The trust had a staff evaluation survey called 'you said, we did'. Staff said there were actions and changes as a result of their feedback. Staff feedback resulted in the development of new work streams to improve partnership working called 'working well together'.

- A number of CYP services had been decommissioned by local authorities and commissioners in the year before our inspection, including school nursing in Basildon and Brentwood. This had created some uncertainty for staff and service users, however CYP staff impacted by decommissioning felt that the trust was supportive in helping them, particularly with health and wellbeing services and interview training.
- Some staff told us that the trust managed change well and they felt part of decision making processes, with focus groups and workshops to contribute to changes. However, this feedback was not universal.
- There was a quarterly 'meet and greet' session for new staff joining the Thurrock CYP team to meet senior managers for afternoon tea. However, it was not clear if similar sessions were provided in other localities.
- The CYP service used parent feedback as part of its audit and evaluation of service provision.
- The Change for Life team in Thurrock worked with shopping centres in the local community to promote healthy eating and healthy weight campaigns. They also worked with 52 local primary and secondary schools to reduce consumption of sugary drinks.
- The infant feeding team worked with local shops to develop a breast feeding welcome scheme. The trust provided posters, window stickers and a staff policy for retailers to use. The team was aiming to work with big chain stores to expand the programme.

Innovation, improvement and sustainability

- The operational lead for Thurrock created a game called 'KPIopoly' to help staff understand how local commissioning arrangements worked and the impact of commissioning on the way they work. This had helped staff understand things such as target setting and service evaluation, and had helped improve their knowledge of the local healthcare economy and funding environment.
- The trust's 'innovation cave' provided opportunities for staff to present new ideas and solutions for improving healthcare delivery.
- In Havering, nursery nurses piloted nursery nurse led child health clinics to increase capacity and reduce health visitor workload. The nursery nurse clinics were rolled out across the borough following positive evaluation by parents and 100% satisfaction rate.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care	**Regulation 17 HSCA (RA) Regulations 2014 Good governance** Sensitive patient information was not kept secure at all times. The system of using paper diaries to record sensitive information did not support the confidentiality of people using the service and contravened the Data Protection Act 1998. Health visitors and community children's nurses used paper diaries to record appointment details. Some health visitors recorded sensitive personal information in paper diaries such as name, address and reason for visit. This presented a data protection risk and contravened the trust's data protection policy. The policy was clear that personal sensitive data must be kept securely. However, there was no provision within the policy for use of, or recording sensitive personal information in paper diaries. This was a breach of regulation 17(2)(d).