

North East London NHS Foundation Trust

RAT

Community health services for children, young people and families

Quality Report

North East London Foundation Trust
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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)
	Acorn Centre	Child Development centre, community medical paediatrics, social communication clinic.	RM7 9NH
	Axe Street Child and Family Centre	Child and family clinics, BCG immunisation clinic, Paediatric occupational therapy	IG11 7LZ
	Thames View Health Centre	Health visiting, school nursing.	IG11 0LG
	Harold Wood Clinic	Audiology Clinic	RM3 0FE
	Harold Hill Health Centre	Health visiting	RM3 9SQ
	South Woodford Health Centre	Health visiting	E18 2QS
	Brentwood Community Hospital	Paediatric physiotherapy, Paediatric speech and language therapy.	CM15 8DR
	Grays Health Centre	School nursing, 0-19 health families, health visiting	RM17 5BY
	Wood Street Child and Family Centre	Physiotherapy, childrens community nursing team, LAC team	E17 3LA
	Trinity School	Special needs school nursing	RM10 7SJ
RATDK	Mayflower Community Hospital	LAC team, specialist health visitors	CM12 9SA
	Hainault Health centre	Infant feeding team	IG7 4DF
	The Grove	Specialist services for CYP – early intervention services, autism disorders	RM6 4XH

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.

Summary of findings

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		Good	●
Are services safe?		Good	●
Are services effective?		Good	●
Are services caring?		Good	●
Are services responsive?		Good	●
Are services well-led?		Good	●

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service is good because:

- Following our last inspection in April 2016, we issued one requirement notice requiring the service to take action to remedy breaches to Regulation 17, in relation to good governance and issued 15 actions the provider should take to improve. During this inspection, we found that the service had dealt with or shown improvement for most of the previously reported concerns.
 - Although the trust had addressed the previous inspection's requirement notice through the implementation of electronic diaries, the leadership team recognised some staff were still using paper diaries whilst awaiting agile working equipment. The trust mitigated risks by completing data management audits of these diaries alongside supervision with line managers. However, the trust still had to ensure all staff had access to electronic diaries through the appropriate equipment.
 - The trust had been addressing concerns around heavy caseloads through different methods. These included increasing staff skill mix, using a new caseload allocation tool and performance allocation tool, implementing managerial supervision to discuss caseloads, checking staff wellbeing and negotiated extra funding for staff from commissioners. However, the decommissioning of services, changes to service contracts, changing populations needs and recruitment challenges meant caseloads remained high for some services.
 - The trust had implemented a transition policy in August 2017 but commissioning issues still affected the transition arrangements. Service leads acknowledged there were some gaps and recognised that receiving services had different criteria. Transition was recognised as a national commissioning issue. However, where transition arrangements were in place, the process was effective.
 - The trust had recently developed a 10 year vision and strategy for the service. Senior leads told us the trust medical director engaged with staff and members of the public and patients to develop the strategy.
- However, the document was in its infancy and the trust acknowledged that not all staff would be aware of the document, and more time was required to embed it fully.
- The trust had demonstrated improvements in reducing staff vacancy rates in some services but recruitment of specialist therapy roles remained a challenge for the trust. However, the trust managed vacant staff posts effectively by using bank and agency staff as required.
 - Although the trust had made improvements to waiting times for some services, further work was still required to be compliant with national guidance and maximum waiting times of 18 weeks. Staff recruitment and capacity issues affected wait times, but the trust had conducted data cleansing exercises to ensure only those clients who needed assessment and interventions remained on the waiting list.
 - The trust had cleared the initial backlog of transferring scanned consent forms for immunisations by using additional administration staff. However, on this inspection, there was still a backlog due to lack of appropriate equipment such as scanners. The trust was addressing this at the time of the inspection and had developed an action plan to monitor progress.
 - The community health services for children, young people and families (CYP) service had systems for identifying, reporting, and managing safeguarding risks. The safeguarding team provided good support to staff across CYP services through supervision, training, monitoring of incidents and advice via the duty desk.
 - Staff were encouraged to raise concerns and to report incidents and near misses. The CYP service effectively shared learning from incidents and good practice with staff through regular meetings, newsletters and across localities. Staff told us they valued working for the trust and that service leaders were supportive, accessible and approachable.
 - The CYP service demonstrated effective internal and external multidisciplinary (MDT) working. Clinical

Summary of findings

practitioners worked with other staff as a team around the child. The co-location of services in health centres and partnership working with other service providers facilitated MDT working.

- The trust health centres and children centres we inspected were clean, tidy, and clutter free. Waiting rooms and clinic rooms were child friendly with toys, books and other resources appropriate for different ages.
- Staff supported the patients and families they worked with, and provided patient-centred support in clinics and in homes. The trust actively sought feedback from people using the service and engaged them to improve services.
- People using the trust's community CYP services were treated with dignity and respect. People felt listened to by health professionals, well informed and involved in their treatment and plans of care.
- The service was responsive to the needs of people using it and had adapted to meet the diverse needs of the community it served. Staff, patients and families we spoke with told us they had good access to translation services.

- There was a robust governance framework and reporting structure. Staff had confidence in their immediate line managers and leadership at board level.

However:

- We saw inconsistent compliance with controls and standards for hand hygiene and infection prevention at some of the locations we visited and among staff.
- Compliance targets across localities were not consistent, with some localities performing significantly worse than others in the delivery of certain aspects of the health visiting service.
- The trust managed complaints appropriately, completing relevant investigations and responding within the time scales set in the trust policy. However, we found completion of the online recording system incomplete as risk assessments and lessons learnt sections were blank in some cases.

Summary of findings

Background to the service

North East London Foundation Trust (NELFT) provides an extensive range of integrated community and mental health services for people living in the London boroughs of Barking & Dagenham, Havering, Redbridge and Waltham Forest and community health services for people living in the south west Essex areas of Basildon, Brentwood and Thurrock. The trust employs around 6,000 staff.

The trust managed services for children and young people on a locality basis aligned with the seven boroughs that the trust works with. Within each locality

children and young people (CYP) services were separated into two divisions: targeted services and universal services. The trust's universal provision included health visiting, school nursing and immunisation. Targeted services included child development, community paediatricians, looked after children, children's community nursing, paediatric physiotherapy, occupational therapy, and speech and language therapy.

Since our last inspection in April 2016, some services had been decommissioned such as Family Nurse Partnership (FNP), and health visiting in Essex.

Our inspection team

Our inspection team was led by:

Inspection manager: Max Geraghty, CQC

The inspection team included two Care Quality Commission (CQC) inspectors and a number of

specialists, including two health visitors, a school nurse, paediatrics service senior manager, a safeguarding nurse for children, a speech and language therapist, community paediatric physiotherapist and an Expert by Experience.

Why we carried out this inspection

We inspected this provider as part of our comprehensive inspection programme, and to follow up the progress of the service following our previous inspection in April 2016.

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 patients at nine focus groups.

We inspected a selection of the trust's services across localities. During our inspection we visited the trust's health and children's centres such as the Acorn Centre, Axe Street Child and Family Centre, Thames View Health Centre, Harold Wood Clinic, Harold Hill Health Centre, South Woodford Health Centre, Brentwood Community Hospital, Mayflower Community Hospital, Redbridge Child Development Centre and Wood Street Child and Family Centre.

Summary of findings

We also attended home visits and clinics in local children's centres. We spoke with 45 patients and their family members. We observed care and treatment and looked at 40 care records, ten administration medication charts and 11 looked after children (LAC) records. We also spoke with 106 staff members, including health visitors, community children's nurses, consultant community paediatricians, physiotherapists, other allied health professionals, administrators and senior management staff.

In addition, we reviewed national data and performance information about the trust and read a range of policies, procedures and other documents relating to the operation of the service. We also looked at patient feedback about the service over the past year.

What people who use the provider say

- We spoke with 45 patients and their families during the course of the inspection. Although some patients reported long waiting times, the patients we spoke with talked positively about the care and treatment they received once in the system.
- Patients and their families told us they found staff to be kind, caring, compassionate, informative,

professional and respectful. The following was representative of the feedback received: "very happy with the care", "staff do a wonderful job", "staff have time to talk to you and encourage children" and "good emotional support".

Good practice

- The service demonstrated highly effective internal and external multidisciplinary working, facilitated by co-location of services and partnership working with other service providers.
- The trust had comprehensive safeguarding supervision processes in place for staff. There was very good compliance with the trust's child safeguarding training and comprehensive safeguarding supervision processes in place.
- The CYP 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 patients.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

Action the service **SHOULD** take to improve

- The trust should consider aligning compliance targets across the trust so that there is better uniformity of approach to the delivery of health visiting services.
- The trust should ensure all of the trust locations within all the localities comply with hand hygiene and infection prevention and control standards.
- The trust should ensure that all equipment is calibrated regularly including safety testing of equipment in schools.
- The trust should improve the completion of the online recording system for complaints ensuring risk assessments and the lessons learnt sections were completed.

Summary of findings

- The trust should continue taking steps to reduce the backlog of transferring scanned consent forms for immunisations onto the trust electronic record systems with the provisions of appropriate equipment such as scanners.
- The trust should continue working on reducing waiting times for therapy and diagnostic services such as speech and language therapy, occupational therapy and social communication pathways.
- The trust should continue working with commissioners to develop consistent transition arrangements from paediatric to adult services across services and localities.
- The trust should continue taking steps to reduce caseload allocation for therapy staff to ensure compliance with relevant national guidelines.

North East London NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as **good** because:

- The trust had clear and comprehensive policies, processes and training for child safeguarding. The safeguarding team and the trust board regularly reviewed policies ensuring they were up-to-date. Staff told us they could find policies easily from the trust intranet.
- The trust reviewed mandatory training regularly through management supervision to ensure compliance rates across CYP services were in line with the trust target of 85%.
- The service had robust systems for identifying, reporting, and managing safeguarding risks. The child safeguarding team provided support to staff across CYP services through supervision, training, monitoring of incidents and providing advice via the duty desk.

- The service had good processes to report risks and identify learning from incidents. The service shared learning from incidents in team meetings, through internal emails and across localities.

However:

- The trust had not ensured all services complied with infection prevention and control measures to prevent the spread of infection. During this inspection, we found that some locations were not compliant with hand hygiene standards, for example, the Child and Family Centre on Axe Street.
- The trust did not ensure contractors regularly conducted safety checks on all equipment used across the service. For example, we found checks on most of the portable weighing scales were out of date. We highlighted this during the inspection. The trust told us the external contractors subsequently calibrated the portable scales on 17 October 2017.

Are services safe?

Mandatory training

- CYP staff compliance rates for mandatory and statutory training across the service had improved and generally met the target of 85%. The mandatory and statutory training programme included equality and diversity, health and safety, basic life support (BLS), immediate life support, infection prevention and control, information governance, adult and child safeguarding, fire safety, prevent levels one and two, manual handling and conflict resolution. The trust used a mix of classroom-based and online training modules.
- However, trust data showed some exceptions where staff compliance for mandatory training did not meet the trust target. For example, in Barking and Dagenham the completion of BLS in school nursing special needs was 50%. We raised this with senior managers. Managers told us their report systems for staff on long-term sick leave, maternity leave and new starters distorted figures for compliance rates.
- Staff received regular clinical and managerial supervision which focused on development and learning. On our last inspection, we found the completion of mandatory training, required improvement. On this inspection, the trust had implemented monthly management supervision, which included discussions on mandatory training completion. Senior managers also told us they discussed mandatory training at monthly performance meetings and re-checked and challenged compliance rates where necessary, which had improved completion rates for mandatory training. For example, the mandatory training compliance scorecard for Thurrock health visiting and school nursing team in Grays Health Centre showed that the service achieved the trust target of 85% across all of the modules. Some modules such as safeguarding in children (levels one to three) achieved 100% completion rate.
- Staff told us that they had protected time to complete their mandatory training and they could easily access e-learning which had become easier with the introduction of agile working. Staff told us they used monthly supervision meetings to book classroom training sessions as needed. Staff and managers told us staff

received a reminder email to update mandatory training that is due to expire. Managers received notifications when a staff member's training was due to expire and raised this in supervision with their staff.

- The service required new staff to complete the trust's corporate induction and subsequent local induction. The corporate induction included a meet and greet with the executive team and mandatory training such as fire safety and equality and diversity. The service induction included training on the trust's policies. Staff told us the induction also covered the whistleblowing policy to support staff to raise concerns at supervision. The local induction included a walk around to meet the local team. Staff told us locum staff received the same induction as permanent staff.
- The trust had a policy titled Care of the Deteriorating Patient, which included early identification, and treatment of sepsis using the national sepsis screening tool. We requested compliance data for staff training on sepsis but did not receive it. However, the trust had delivered a sepsis training package to medics at Waltham Forest and Redbridge Psychiatry teams last year and a similar sepsis package on the non-medical prescribing (NMP) day over the summer.

Safeguarding

- The trust had clear and comprehensive policies, processes and training for child safeguarding. The trust had a range of specialist policies, for example, domestic violence, harmful sexual behaviours and mental health and substance misuse. Staff told us they could find policies easily on the trust intranet.
- There was a high rate of staff compliance with the trust's child safeguarding training. Staff understood how to keep children and young people safe from avoidable harm and abuse and to provide them with the care and treatment they needed.
- The trust's safeguarding team was available to support staff. Staff knew where to get advice about safeguarding concerns. The trust operated a safeguarding duty desk for telephone advice during weekday working hours only. Staff told us the safeguarding team was responsive and supportive. Named nurses for both CYP and adults provided advice to staff. These named nurses received level four safeguarding training.

Are services safe?

- There was a strong focus on safeguarding children among practitioners through effective safeguarding supervision processes. This included opportunities to learn from complex cases, to review safeguarding decisions and receive guidance and support from the trust's safeguarding team. Staff told us the trust had an escalation procedure in place for high-risk children.
- Case holding staff for universal services accessed one to one supervision whilst other CYP staff accessed group supervision. Staff identified cases for discussion to bring to these sessions where risks were analysed, decisions validated and peer learning took place. Senior leads told us the trust also used online video link software to facilitate remote supervision.
- The service worked effectively with other agencies to protect children and young people from abuse. The safeguarding team had links with local multiagency safeguarding hub (MASH) teams. Service leads told us MASH practitioners were part of operational teams and the trust safeguarding team provided safeguarding supervision for them. In some localities MASH and looked after children (LAC) were co-located in shared offices with social care teams which facilitated effective information sharing. The trust had PREVENT leads who engaged with local safeguarding children's boards (LSCB). Senior managers attended all nine LSCBs.
- The service had effective systems for following up safeguarding concerns and progress review. The trust's monthly management supervision included safeguarding cases or issues of concern as a specific agenda item. When a CYP risk was identified, staff members used a structured assessment and record keeping model. This allowed risks to be effectively analysed, appropriate action taken and a suitable record made. This helped staff and supervisors to agree actions and to track the progress at subsequent sessions.
- Managers told us about an approach known as 'one plan' that allowed health and other agency practitioners to provide support to families in a co-ordinated way, using a single plan, under the 'early help' processes. This approach was in place in some of the local authority areas served by the trust but was still evolving in other areas and so we were not able to assess the impact of this approach.
- The trust used two different electronic patient record systems across its footprint. The two different systems used system 'flags' to alert staff of children and young people with a child protection plan or for whom there were safeguarding concerns. This allowed staff to be aware of any safeguarding concerns during their contacts.
- Staff received dedicated training in safeguarding to ensure they understood training on how to recognise and report potential abuse. Trust records for August 2017 indicated that completion across the CYP staff groups for safeguarding children levels one, two and three were 93%, 95% and 93% respectively, against a trust target of 85%. Safeguarding adults (enhanced) and safeguarding adults (recognition and referral) completion rates across the CYP staff groups were 85% and 90% respectively.
- The trust had quality markers in place for safeguarding and monitored them using an electronic data dashboard. Managers were able to review indicators for staff completion of disclosure and barring service (DBS) applications, management of allegations, supervision and training provision, female genital mutilation (FGM) cases and safe staffing.
- Staff we spoke with showed thorough awareness and consideration of FGM. We observed routine questioning on FGM by health visitors during clinics and home visits. This was approached in a sensitive and culturally appropriate way. Staff could find the FGM identification protocol on the trust intranet. There was good understanding of child sexual exploitation (CSE) risks, and this was particularly evident among the trust's looked after children (LAC) staff. LAC nurses received specific training in child sexual exploitation awareness. The LAC team had a register of their CSE patients.
- The trust had specialist LAC nurses who operated across localities and named LAC doctors in addition. The LAC team had a close working relationship with child and adolescent mental health services (CAMHS) with a fast track system in place for clients to access CAMHS services.
- The trust had effective formalised processes for staff to receive regular planned supervision on safeguarding matters. This included monthly safeguarding supervision and group supervision sessions to discuss

Are services safe?

events and case studies and reflect on learning on a three monthly basis. Data provided by the trust showed that as of August 2017, the average percentage of staff who received one to one supervision in the last 3 months was 92% trust wide. The average percentage of staff who received group supervision in the last three months was 87% trust wide. The trust also organised an annual away day for safeguarding to give staff time to reflect and talk about support needed.

- The trust encouraged staff to share lessons with their teams and the wider service. CYP staff told us there was good sharing of learning in a supportive environment. For example, the trust had supervision networks that met twice a year in each locality to share learning and there were monthly safeguarding meetings. Meeting agenda items included new safeguarding risks, case discussions, other issues related to safeguarding such as new guidance and lessons learnt. Service leads demonstrated good awareness of safeguarding children on the team's caseloads such as LAC, children in need (CIN), early offer of help (EOH) and those with child protection (CP) plans.
- Managers held regular quality safety meetings to discuss serious case reviews across all services. A named nurse or safeguarding advisor completed the individual management reviews before quality assurance took place prior to sign off. A team of investigators completed root cause analyses (RCA) for internal investigation processes.
- During our inspection, we saw child and adult safeguarding awareness and support posters displayed in some of the trust's health centres and children's centres. This included posters on female genital mutilation (FGM) awareness in Thames View Health Centre and the Expect Respect (an education toolkit for children in fear of domestic violence) poster in the Acorn Centre. The posters included contact details for the trust's safeguarding duty desk and Caldicott Guardian (a senior person responsible for protecting the confidentiality of patient and patient information and enabling appropriate information sharing).

Cleanliness, infection control and hygiene

- The health and children's centres we visited were visibly clean, tidy, well organised and clutter-free. The floors in corridors were clean with no evidence of dust. The toilet

facilities we inspected across sites were clean and tidy. In the 2016 Patient-Led Assessment of the Caring Environment (PLACE) assessment, the trust scored 99.6% for cleanliness. Most of the health centres we visited had easily accessible handwashing gel facilities located at the main entrance and throughout public and clinical areas. For example, we saw a hand sanitiser at the reception desk in Grays Health Centre and Acorn Centre. At Hainault Health Centre, the hand gels had a sign to notify reception staff when empty. The audiology clinic in Havering was also hand hygiene compliant.

- The service generally managed infection prevention and control well. The trust's hand hygiene policy states staff should follow the World Health Organization (WHO) five moments for hand hygiene and six step hand decontamination technique. Staff told us the trust provided staff with alcohol hand gels and had personal protective equipment (PPE). For example, we observed clinics in Wood Street Health Centre and saw staff had aprons and gloves. At Trinity school, in the medical room we saw posters on handwashing technique and PPE equipment such as gloves, dressings and wipes were in date. There was appropriate disposal of clinical waste.
- However, there were some exceptions. For example, on our visit to the Child and Family Centre on Axe Street we did not see any hand hygiene signs and no handwashing facilities except in the consultation rooms, which had sinks. The consultation rooms did not have any cleaning materials or replacement sheets for examination tables or scales. Although scale calibration was in date, we found the scales placed on the floor with no cleaning supplies. We reviewed the March 2017 report for the infection control audit for Axe Street. The reported recorded 81% Hand hygiene compliance. The audit highlighted that hand sanitising gel should be available in all clinical areas/wherever-clinical activity takes place and hand cream should be available in wall mounted or pump-operated dispensers in at least one area. However, we found the action plan incomplete, and evidence of compliance, responsibility and due dates was not included.
- Most of the clinicians and health professionals we observed cleaned their hands, were bare below elbows and followed hand hygiene procedures appropriately while in homes and in clinics before and after contact

Are services safe?

with clients. For example, we observed home visits with health visitors who followed hand hygiene procedures and disinfected equipment such as the weighing scale after use.

- We observed most health visitors and therapists' clean equipment before and after use, using disinfectant wipes. For example, at the child development clinic in Grove Health Centre we saw evidence that staff cleaned the room including toys and surfaces after every use with updated cleaning records on completion.
- We observed a few isolated occasions where some clinical staff did not adhere to the infection prevention and control guidance and did not follow the hand hygiene procedures prior to patient examination. For example, during a home visit, we found the health visitor did not wash their hands or use hand sanitising gel. On another occasion, we observed a home visit where the staff member had not cleaned the weighing scales before or after use. This was despite the child urinating on the scales. Similarly, at South Woodford clinic, we observed staff change the disposable paper between each patient but we did not see any wiping down of changing mats or evidence of using hand gel.
- The trust completed quarterly infection prevention and control audits the CYP services and localities to measure quality of practice in health centres and in the community. For example, the clinical audit report between April and June 2017 for audiology (in Havering, Barking and Dagenham and Brentwood) and integrated targeted services (such as paediatric physiotherapy, occupational therapy) showed 99%, 100% and 100% compliance for hand hygiene, equipment cleaning and PPE respectively.
- The clinical audit report for Waltham Forest, between April and June 2017, showed that school nursing (5-19), community nursing team, CAMHS, child development team, health visiting (0-5), community paediatrics, paediatric occupational therapy and physiotherapy, special schools and looked after children all achieved 100% compliance for hand hygiene, equipment cleaning and PPE. The speech and language therapist team achieved 100% compliance for equipment cleaning and PPE respectively and 98% compliance for hand hygiene.
- We visited 13 trust sites, which included health centres, special schools, community hospital and child and family centres. The centres were modern, bright and welcoming with adequate spaces for patients and their families. For example, the clinical areas in the Acorn Centre and Wood Street Health Centre were child friendly with bright colours, painted murals and children's artwork and staff photos on walls. The locations had no trip hazards, as they were clutter free. Each of the locations we visited had accessible facilities and baby changing facilities. However, at Grove Health Centre, we did not see any clear signage to the entrance despite the premises undergoing building work.
- Children's centres were secure with locked entrance doors. Receptionists controlled entry and exit to the centres and CCTV monitored entrances.
- The equipment we inspected was visibly clean and clinic rooms had sufficient space with which to use it. For example, the gym at the Acorn centre was big, bright, clean, and tidy with lots of space. The gym had a full range of child friendly physiotherapy equipment for assessments such as mats, balls and steps. All of the equipment and toys were visibly clean.
- Fire exits were secure with fire extinguishers at accessible points.
- Most of the centres managed equipment appropriately. For example, at Havering audiology clinic, we saw evidence of up-to-date safety testing of equipment with visible stickers on display. We observed clinics where staff cleaned equipment before and after patient use. All of the clinic environments were child friendly with colourful toys. For example, staff told us the Wood Street Health centre had received funding from charities for the gym, sensory room, soft play and playrooms.
- The trust completed environment audits using the care setting process improvement tool. Completed audit reports for Langthorne Health Centre (July 2017) and Child Development Centre in Thurrock (July 2017) showed that where they failed in a given area, appropriate actions plans were put in place. However, the report did not include any completion dates.
- An external contractor serviced the trust's clinical and electrical equipment on an annual basis. However, we found some equipment had not been safety checked or calibrated within the one year timeframe. On some

Environment and equipment

Are services safe?

home visits, we found the weighing scales calibration was expired, for example in July 2017. We fed this back to the trust. The trust has told us the external contractors had calibrated all portable scales by 17 October 2017.

- Staff told us their partner schools completed the safety testing of equipment. However, at Trinity school we saw evidence of safety testing equipment out of date: for example, weighing scales (2014), sitting scales (2016), kettle and fridge (2015). The clinical fridge that stored medication did not have any safety testing sticker on it. PPE equipment such as gloves, dressings and wipes were in date. We fed back the expired safety testing of the equipment to the trust. The trust has since completed the outstanding safety testing on 16 October 2017.

Assessing and responding to patient risk

- Staff appropriately recorded assessment information, for example in baby record books and in patients' notes. We saw health visitors record the observations of infant development indicators such as height, weight, communication and motor skills. Staff assessed infants for actual and potential risks related to their health and well-being.
- The service had mechanisms to identify patients at risk, such as vulnerable women and children and record details in electronic records. The system provided vulnerability alerts. 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 a child in need (CIN) meeting at Trinity School. The school nurse, social services, paediatrician, school management, parents, key worker, family support worker, senior leads for teaching and learning, attended the meeting. An appropriate risk assessment and medical review of the child was completed. Parents were given the opportunity to voice their opinions and given information to manage their expectations. We observed comprehensive completion of the risk assessment, which included emotional and psychological needs of the child and family members, an action plan and the transition process. The meeting discussion included the voice of the child for example, their hobbies, likes and dislikes. Staff members updated the child's record accordingly.

Staffing

- The trust had improved vacancy rates across CYP services. At our last inspection, service managers confirmed substantive staff vacancy rates averaging 20% across all services, with between 50-67% vacancies in some services and localities. At this inspection, the CYP staff vacancy rates showed an improvement since the last inspection. The current vacancy rate as of August 2017 was 13%, against a trust target of 10%. The trust had secured extra investment with commissioners for specialist roles such as paediatric occupational therapists and physiotherapists; however, senior staff told us recruitment of some specialist therapy staff had been difficult. This concern was not specific to the trust but a national issue.
- The trust managed vacant staff posts with the usage of bank and agency staff. The trust provided data for bank and agency staff used to fill the staffing gaps between October 2016 and September 2017. Although each locality had varied use, the data showed that the trust had gaps in specialist therapy roles such as physiotherapy, occupational therapy and speech and language therapy. The highest use of bank and agency staff was in Redbridge and Havering with 37% and 35% respectively. The community paediatrician service used locums, but some consultant community paediatricians told us they frequently worked longer hours to cover gaps out of good will. Staff told us that they could take back extra hours worked with agreement with their manager. However, it was difficult to do so at times as capacity issues remained.
- The trust provided CYP staff sickness rates between September 2016 and August 2017. The data showed improved rates with the highest sickness rate of 5.36% reported in January 2017 against 3.3% in August 2017, below the trust target of 3.7%.
- However, the CYP staff turnover rates between October 2016 and September 2017 had increased from 14.4% in October 2016 to 24.8% in September 2017, against the trust target of 10%. The quality report for September 2017 stated the turnover remained high for a number of factors, which included service decommissioning and termination of a number of fixed term contract workers across numerous services.

Are services safe?

- The trust continued to identify heavy caseloads and staffing levels as their top risks and was clear that this presented a challenge to the delivery of CYP services. At our last inspection, we found extensive recognition among all the staff and managers we spoke with of heavy caseloads for staff across universal and specialist services. During this inspection, caseloads remained high in some services for a number of reasons. These included decreased staffing levels, growing populations and recruitment challenges for specialist therapy staff.
- The trust had mitigated this with regular allocation meetings with staff and had implemented monthly management supervision, for staff to discuss caseloads and their wellbeing. Staff and managers told us the caseload waiting tool and performance allocation tool helped score the work they had to determine how heavy the caseload was. A performance allocation tool looked at scoring caseloads and the number of contacts needed. Staff told us all mandated health visiting checks were managed in the same way.
- The trust used a new caseload weighting tool on the electronic recording system, which helped support the allocation of caseloads equitably. We saw minutes for Havering performance reports for July 2017. The report included a comprehensive caseload breakdown data for example, information on age group, gender, ethnicity, number of children in child protection and safeguarding cases and looked after children (LAC), primary health condition/disability and referrals to specialist services.
- The trust had also increased the skill mix of the staff to increase capacity. For example, the trust was involved in a national pilot for the nursing associate programme, which involved upskilling health care assistants to perform at a more advanced level. The trust was in the process of training the staff at the time of the inspection. The trust also had a band six leadership programme to support staff to take on the role of caseload management, and carry the generic caseloads. More experienced and established staff received the complex cases.
- The trust provided data on CYP health visitor caseloads between September 2016 and August 2017. As adults and children were registered to health visitor's caseloads, the data was not specific to CYP. The data showed that staff across all localities had heavy caseloads, which were above the Community Practitioners' and Health Visitors' Association (CPHVA) guidelines and the Institute of Health Visiting who advised an optimum ratio of 1:250.
- For August 2017, the average caseload for health visitors ranged between 368 (in Barking and Dagenham) to 835 (Waltham Forest). However, health visitors in Redbridge had the highest average caseload at 1294. The trust was developing a 'skill mix' model for the service in Redbridge and had recruited more staff by the end of September 2017 to support the development of the new model. Therefore, we were unable to assess the impact of the new model on this inspection.
- Service leads told us they used the Institute of Health Visiting (IHV) resilience framework to support staff with changes to staffing. The framework provided leaders and managers of health visitors and the organisations they work within, evidence based information to ensure that the health visiting workforce was resilient whilst remaining compassionate. In Barking and Dagenham, the family nurse partnership (FNP) service was decommissioned in September 2016. Staff told us the FNP cases were allocated into the health visiting caseload after re-assessments. Staff we spoke with reported that the change did not have any impact on the workload and service provided.
- Caseloads for occupational therapists (OT) varied by locality. Havering children's physiotherapy and OT was 63 in August 2017, which was near the guidelines of 50-60. However, Redbridge paediatric OT caseload was 275 in August 2017, above the guidelines. After our inspection, the trust clarified that Redbridge OT service was integrated with Education, Health and Social services. The trust told us the largest proportion of the caseload was within Education as the children remained on the caseload for the termly or half year reviews as identified in their Education Health and Care plans.
- In Thurrock, staff told us they used a clinical activity regulatory system (CARS) which reviewed practitioners' activity daily. Service leads monitored the data monthly at one to one meetings. Practitioners had to submit the data within 24 hours and the average for Thurrock was 85% completed within 24 hours. Where clinicians were not meeting the 24 hours competency, managers supported them informally to review the workload and included a discussion on health and wellbeing.

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Quality of records

- The CYP service used the trust's electronic record systems (ERS) to input and access patient records. The trust used two ERS: one for London boroughs and a separate system in Essex boroughs. Since the last inspection, the trust had put in place an ERS champion in each locality, for each ERS system to support staff with agile working. Staff told us ERS user groups took place every six weeks. All staff members could attend the user group forum.
- The ERS systems were available to all staff including doctors, health visitors, community nurses and therapists. All professionals recorded patient information from clinics, home visits and therapy sessions in chronological order in the notes section. This included history, consent and referrals. This meant recording errors from illegible writing were virtually eliminated. Staff received prompts to incomplete record sections through the ERS system alerts. Staff told us only one of the ERS was linked to the local GPs system, which facilitated timely information sharing. However, staff worked around this by ensuring communication was sent in a timely manner. For example, staff in the Havering audiology clinic told us staff members sent out GP letters on the same day the child was in clinic.
- The electronic patient record system required password access with a smartcard to ensure security. Staff members had unique accounts to ensure professional accountability. Staff we observed were careful with confidentiality and locked the computer when not in use. We observed practitioners and administrators using the ERS and saw they were adept at using the system.
- The Trust had implemented electronic clinical records in all the CYP services. At our last inspection, we reviewed a sample of paper records in Havering audiology and found inconsistent notes keeping compliance. On this inspection, we found Havering audiology used electronic records except for audiology test results, which were recorded on paper. However, the ERS showed other healthcare interventions where an audiologist had been involved. Staff told us ERS was not compatible to record the audiology results but the team had submitted a business case to request the appropriate software. We reviewed seven audiology records and found all entries were completed comprehensively with signatures, clearly documented patient details and consent records. We saw evidence of timely record completion during our visit. We observed staff store the paper audiology results in locked cabinets. We saw evidence in the notes that staff members sent out GP letters on the same day the child was in clinic.
- At our last inspection, we found sensitive personal information recorded in paper diaries. This breached regulation 17 and resulted in a requirement notice. On this inspection, we found the trust had addressed the requirement notice by implementing electronic diaries and stopped staff ordering any further paper diaries. Staff and the senior team told us about a serious incident subsequent to our inspection in February 2017 where a paper diary with patient information had been left on the roof of a car. The trust had shared the learning through an infographic and circulated key guidance to all staff and managers. The leadership team told us a small number of staff were still using paper diaries whilst awaiting for agile working equipment. However, the trust had completed two audits of these paper diaries to mitigate any risk and found good data management compliance.
- We reviewed the audits and found appropriate guidance for staff using paper diaries for example, anonymising any patient information recorded within paper diaries. The trust mitigated any further data management risks by having line managers review the use of paper diaries and the information contained within, with staff during supervision sessions. Line managers would also need to ensure that patient information was removed from paper diaries at the end of the session / day and destroyed securely after the patient's clinical record was updated with the relevant information. We spoke to staff that still used paper diaries and found they understood the data protection risk and applied the trust policy well.
- We reviewed 40 children's' records and care plans and found notes completed in a logical and comprehensive way. The notes provided detailed description of care plans, observations, allergies, documentation of multidisciplinary (MDT) working, patient history, evidence based practice, risk assessments, action plans and patient progress. Records were consistent with the nursing and midwifery council (NMC) guidelines for record keeping. The ERS flagged patients who were at risk, such as safeguarding concerns. We saw evidence

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that the ERS flagging system worked well as the ERS system recorded vulnerability alerts. The system also provided an alert for patients with learning disabilities or allergies. This meant all staff were aware of a patient's specific needs.

- In the Basildon and Brentwood integrated therapies service and in the child development unit in Redbridge we saw records were of a high quality. Staff members recorded assessments comprehensively showing good clinical and social history in a templated format, enabling future users of the record to be clear about the child's needs.
- We observed health visitors record information in 'My Child's Health Record' red books which parents kept. All content was readable and dated. However, on some occasions the time entry was missing. Before going on home visits, we observed health visitors find information from both the electronic patient record system and the GP system to find the patient's full history. We observed the immunisation clinic where staff members obtained and documented consent by completing the red book appropriately.
- We reviewed 11 LAC records and found the notes comprehensive and fully completed. The notes included documented consent, aims and goals for the patient, voice of child, MDT, health education appointment, personal wellbeing, home environment, growth chart, attendance in accident and emergency, annual vision test, completed care plans, medical history and any referrals. LAC staff told us they worked with social services to escalate concerns such as 'did not attend' (DNA).

Medicines

- The service had effective policies and procedures to manage the storage and administration of medicines at the trust sites and external locations we visited. Staff received training in medicines management and could demonstrate competency around the safe and effective use of medicines.
- We saw evidence where staff members' actioned recent Medicines and Healthcare Products Regulatory Agency (MHRA) medical safety alert regarding anti-epileptic medication. Staff told us all patients who were on the named medicines received medication reviews.
- 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. Nurse prescribers told us that if they did prescribe, they informed the relevant GP appropriately.
- We found prescription pads securely stored in locked cabinets. Community paediatricians told us they took one prescription at a time and documented the serial number in the log. Staff told us community paediatric clinics did not have any medicines on site. The commissioners and trust lead pharmacist monitored the prescribing of paediatricians for safe prescribing and consistency.
- Staff told us that patient information leaflets for some medicines was available in 12 translated languages. We saw evidence of this on the trust's internet page.
- We observed community children's nurses provide evidence-based advice to families and patients on storing medicines at home.
- We visited the immunisation clinic and found the drug fridge locked in the clinical room and temperature monitored. We saw evidence of the fridge log completed daily with no omissions. The trust had a standard operating procedure (SOP) on the safe handling on vaccines. The SOP included guidance on ordering and receiving stock, how to manage excess stock, stock rotation, monitoring fridge temperatures, transfer of vaccines, spillage, incident reporting, disposal of vaccines and what to do if the fridge temperature readings were out of range. The SOP referenced Department of Health (DH) guidance called 'The Green Book Immunisation Against Infectious Disease'. This guidance provided general information on vaccines and immunisation. We saw staff follow this SOP consistently.
- An external provider managed the trust's vaccine supply. A staff member would sign for the delivery and placed the items in the fridge. We observed the clinic staff following Public Health England (PHE) guidance with a Patient specific Directions (PSD) in place and followed the process consistently. The Bacillus Calmette–Guérin (BCG) vaccine was unlicensed and we saw evidence of information leaflets that explained this to families and

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carers. However, the information was only available in English. Clinic staff showed knowledge of the yellow card scheme and told us they could call the trust pharmacist if they had any queries.

- The immunisation staff used an immunisation impact assessment toolkit. 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. We saw a sample of immunisation records and found them to be comprehensive with consent and allergies recorded.
- At our last inspection, we found there was a backlog of consent forms that required uploading onto the electronic system. Staff told us that although the initial backlog was cleared through additional administration staff, there was still a backlog due to equipment. The service reported a backlog of 6634 consent forms, which required uploading onto the ERS from across the four boroughs (Barking and Dagenham, Havering, Redbridge and Waltham Forest). However, service managers told us the team were trialing the use of a portable scanner at Axe Street to upload the consent forms from the clinic as they are received. The support workers planned to focus on the back log at Bernard House twice a week. The service lead had developed an action plan with weekly updates to demonstrate the backlog was being resolved.
- At Trinity school, we found staff monitored the fridge and room temperatures daily and the log had no omissions and temperatures were in range. For children who required emergency medicines, these were stored in a locked cupboard in the school medical room. The keys were stored securely and the nursing staff restocked the medications as needed. We looked at a sample of drugs and found them to be within the expiry dates. Staff recorded date of opening on liquid medicines. We reviewed ten administration medication charts at Trinity School and found all entries thoroughly completed. The medication charts included photo identification, documentation of allergies and were appropriately dated and signed. The service sent consent forms to parents to sign every year. Staff told us they relied on parents to inform them of any medication changes as the neighbouring local hospitals used a different electronic record system.

Safety performance

- There was a good overall safety performance and an embedded culture of safety within the children and young people (CYP) services at NELFT (the trust).
- The trust reported serious incidents to the Strategic Executive Information System (STEIS). The CYP service reported eight serious incidents between September 2016 and August 2017. These included an unexpected death of an infant, a safeguarding incident, pressure ulcers causing moderate harm (4), potential loss of personal identifiable data and actual or alleged abuse.
- The CYP service reported zero never events for the year preceding our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Incident reporting, learning and improvement

- The trust used an online incident reporting system. All staff had access to this system to record incidents. Staff we spoke with said they felt able and comfortable to submit incidents to the system. There was good awareness among CYP staff across all services and localities of processes for incident reporting.
- During our last inspection, we found the 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. This resulted in junior staff not receiving direct feedback on incidents they had reported. On this inspection the trust policy had changed so that all staff could freely report incidents independently of their managers' and senior leads informed us all staff had received training for the online reporting system.
- Staff we spoke with said they could obtain support from the managers and the safeguarding team easily if needed. Staff felt confident to escalate concerns and understood how and when to report incidents appropriately. We spoke with medical, nursing and allied health professionals who told us the trust encouraged them to report incidents.

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- Staff felt encouraged to report incidents and near misses, concerns, identified risks, and told us they received feedback from reported incidents. The CYP service shared learning from incidents and serious case reviews effectively in team briefs, in service-wide emails, newsletters or in individual supervision. Service leads told us they used incidents as case study examples to support learning. Staff told us that team meetings included agenda items on learning from incidents, risk management, incidents reports, and action plans, which we saw, recorded in meeting minutes.
- Staff gave us examples of incidents and lessons learned and actions taken. For example, after the investigation of four serious incidents on pressure ulcers causing moderate harm, service leads told us there was a rolling audit for pressure ulcers, which looked at surface, skin, keep moving, incontinence, nutrition (SSKIN). SSKIN is a five step approach to preventing and treating pressure ulcers. Staff told us school and health were involved in the investigation process for the pressure sores and learning was shared effectively. Staff told us the trust had provided online training on consequences of pressure ulcers as a result.
- Staff completed risk assessments comprehensively. We observed health visitors and community children's nurses conducting risk assessments while on home visits and in clinics. Records we reviewed showed evidence that staff members had logged risk assessments appropriately. Speech and language therapy (SLT) staff told us of an incident where a therapist had given out thickening powder which had expired. The parent complained and staff members applied duty of candour. Therapy staff completed the risk assessment with an action plan in place. As a result, the service now had a process in place to check stock expiry dates. The team shared the learning with the clinical excellence group and now everyone in the trust was doing the same thing.
- The trust had developed effective team working to review incidents and improve processes. Senior leads told us moderate and above incidents were reviewed weekly by an incident review group. Attendees included head of risk assurance, representatives from the incident reporting team, a staff member from serious incidents team, health and safety, safeguarding. The incidents team worked closely with the safeguarding team and met monthly. The trust had a patient and safety group that met monthly and shared learning across the boroughs. Senior leads told us that the average number of reported incidents was between 200 and 300 per week. However, there were no identified themes specifically related to the CYP service. The trust recorded the number of daily incidents live on the intranet and we saw evidence of this.
- 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, during this inspection staff told us of an insulin overdose incident, which had been escalated to the police and the safeguarding team. We reviewed the root cause analysis (RCA) investigation report for this serious incident and found completion to be comprehensive, with thorough investigation with all actions completed. The report was thorough, for example, the trust had completed a 'fishbone analysis' as part of the RCA. A fishbone is a visualisation tool for categorising the potential causes of a problem in order to identify its root causes as part of service evaluation. The case was now subject to a serious case review (SCR) for which the trust was in the process of completing the individual management review (IMR).
- The duty of candour (DoC) is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients or other relevant persons of 'certain notifiable incidents' and provide reasonable support to that person.
- The trust had a policy called Duty of Candour and Being Open. 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. Service leads told us the trust provided assurance to commissioner monthly for DoC and was currently working on getting a template on ERS. All investigating leads received RCA training before undertaking an investigation and DoC formed a part of this training.
- Most staff we spoke with demonstrated awareness of DoC and were able to give examples. We found senior

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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 when concerns were raised they reported them to managers in the spirit of openness. For example,

following a recent mix up in appointment times, the staff member documented the mix up in the patient's notes and apologised to the parent. The staff member offered the parent an appointment when suitable for her.

- Senior staff told us the trust's incident reporting section incorporated a section on DoC responsibilities to record staff had shared information appropriately with patients and their family members.



Are services effective?

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

Summary

We rated effective as **good** because:

- The children, young people and families (CYP) service demonstrated effective internal and external multidisciplinary (MDT) working and practitioners worked with other staff as a team around the child providing person centred care. The co-location of services in health centres facilitated partnership working with other service providers, such as GPs and the local borough.
- CYP practitioners provided competent, thorough and evidence based care and treatment in home visits, clinics, development reviews and therapy sessions. Staff delivered care in line with national guidance. CYP staff demonstrated awareness of how new clinical guidelines were identified and disseminated.
- On this inspection, community paediatricians told us they had adequate time to complete audits to monitor patient outcomes and clinical performance and provided examples.
- The trust had single point access systems for most services.
- The trust applied comprehensive supervision structures for staff, which facilitated reflective practice. There were good learning and development opportunities for staff.
- Community specialist nurses provided individualised care for patients and family members. Children told us staff make things better for them and take time to explain things to them
- School nurses used social media to provide advice on health promotion.

However:

- Compliance targets across localities were not consistent, with some localities performing significantly worse than others in the delivery of certain aspects of the health visiting service such as the percentage of children who received a two year to two and a half year review.

Evidence based care and treatment

- Staff told us they could easily find corporate information on the trust's intranet. Staff showed us how they could find protocols, standard operating procedures, policies and guidance for clinical care and other patient interventions. Staff told us they found the trust intranet easy to use.
- The trust policies were clear and easy to follow. For example, the policy for care plans for children with additional needs covered a wide range of conditions. The policy clearly documented that the care plan must be completed in partnership and who should be involved, what monitoring should take place and covered consent. Referenced guidance and good practice underpinned the policy.
- The trust had a 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. For example, the dysphagia guidelines referred to and included evidence from the Royal College of Speech and Language.
- CYP practitioners provided competent and evidence based care to patients and their families. We observed competent, thorough and evidence based care and treatment by practitioners in home visits, clinics, developmental reviews and therapy sessions. All practitioners conducted full assessments as per guidelines and provided up-to-date and evidence-based advice. For example, we observed staff applying 'Conners Clinical Index', which is a diagnostic tool for assessing attention deficit hyperactivity disorder (ADHD). Therapy staff told us they improved patient outcomes using the Reason, Observation, Comment, Assessment/Analysis, Intervention, Plan (ROCAIP) evidence based model.
- The trust's autism pathway and post diagnostic audits were in line with the NICE Autistic Spectrum Disorder

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(ASD) guidelines. Staff told us that audit outcomes improved the communication following diagnosis and information. The trust also implemented training for autism diagnostic observation schedule (ADOS) assessment for practitioners. ADOS is a semi-structured assessment of communication, social interaction, and play (or imaginative use of materials) for individuals suspected of having autism or other pervasive developmental disorders. We observed an ADOS assessment video with two practitioners, mother and child and saw appropriate care and assessments took place.

- We observed health visitors in clinics where they provided appropriate advice, education, reassurance, and guidance to the mothers. For example, health visitors provided advice on weaning and sleep patterns.
- Staff provided patient centred care and treatment, which extended to supporting the family. We observed a continence assessment at Trinity School and found the consultation embedded the voice of the child principles. We saw staff compliance with NICE guidance for continence. The assessment included discussions on nutrition and allergy, documentation of medical history and a bowel and continence assessment. Both the child and mother were involved in treatment discussions and the staff member used the Department of Health (DH) triangle assessment framework. The framework incorporated child assessment, parent capacity and family environment. The mother received information on social services support and health promotion. The staff member was sensitive to both the child and mother's needs.
- The CYP audiology service in Havering applied British Society of Audiology standard testing protocols and moulding protocols.
- The trust had improved the staff intranet to provide information on new clinical guidance. During our last inspection, we found not all senior staff were clear on implementation and dissemination of new clinical guidelines. On this inspection, we saw evidence on the intranet where staff received information on new guidance. The intranet had a page called 'all things NICE' that staff were directed to for clinical guidance. Staff we spoke with were aware of this intranet page. Service leads told us the trust had a central team who would monitor new NICE guidance. The central

leadership team would then email the integrated service managers who would assign a staff member to review the guidance. New guidance would go through the tiers of governance for approval and for dissemination. Senior leads shared new guidance with staff via emails and team meetings.

- The trust provided the five mandated checks (antenatal, new birth, six to eight weeks, one year and two year) in the health visiting healthy child programme.
- School health included reception screening and national child measurement programme (NCMP), hearing screening, enuresis clinics and drop-in sessions for primary and secondary schools.
- The Infant Feeding team (IFT) was an integrated service delivered within the 0-19 universal health service. The IFT complied with UNICEF guidance for Baby friendly accreditation. The Baby Friendly Initiative, set up by UNICEF and the World Health Organization, is a global programme, which provides a practical and effective way for health services to improve the care provided for all mothers and babies. At our last inspection, the service was on target to complete full accreditation in 2016. On this inspection, the service had achieved full accreditation (level three) which was due for review in June 2018. Achieving stage three of accreditation is the final step in becoming 'Baby Friendly'.
- The Barking and Dagenham health visiting team worked closely with children centres and local authority to co-deliver the Health, Exercise, Nutrition for the Really Young (HENRY) programme. The HENRY programme was a national evidence based programme for duration of eight weeks. The programme covered five themes, which included parenting confidence, physical activity for little ones, what children and families eat, family lifestyle habits and enjoying life as a family.
- The CYP services had a comprehensive audit plan, which included audits on environment and infection prevention and control (IPC), medicines management audit and equipment in clinic rooms and record keeping.
- There were specific clinical audits in individual service lines. For example, paediatricians in the child

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development team completed audits on efficiency of genetic tests in developmental assessments, epilepsy audits and attention deficit hyperactivity disorder (ADHD) audits.

- We reviewed a sample of care plans derived from assessments and found some variability in quality. Some plans were task oriented, as opposed to outcome focused and were insufficiently time-bound to enable progress to be measured effectively. For example, one plan in a patient record in the child development team at Redbridge noted 'continue to be supported by speech and language; continue to be supported by health visitor'. These were not helpful in describing what outcomes the child was expected to have achieved from such support and by when.
- Some plans however were outcome focused and child centred and showed good evidence of co-production. In one case, we looked at in the integrated therapies service in Basildon and Brentwood and saw evidence of the child's voice prominently recorded in a structured care plan. Sections entitled, 'my next step', 'why this is important to me', 'I can do', 'I will be able', 'how I will achieve this', 'X can help me by' demonstrated the child's part in constructing the plan and allowed the practitioner and any other health professionals using the record to fully understand the plan from the child's perspective.
- In one other case in the child development team in Redbridge, we noted one record that contained an exemplar of good practice of an outcome based plan. In this case, a practitioner as part of the information gathering process assessed a child prior to creating an education and health care (EHC) plan. The practitioner's report to the local authority showed a thorough consideration of the child's clinical and social history and the outcome of the practitioner's assessment of the child. The outcome based plan included what activities the child could achieve in one year's time and for how long, what strategies to use to support the child to achieve the goals with the frequency of use, the identity of the person responsible and when to review the plan.

Nutrition and hydration

- Staff provided relevant advice to patients and their families regarding nutrition and hydration. School

nurses and health visitors discussed children's food with both the parents and children. Where necessary, staff members would make referrals to the dietitian, speech and language therapists and infant feeding team.

- During our inspection, we saw that staff gave parents up-to-date and relevant advice about breastfeeding, weaning and nutrition and hydration in children. For example, new birth visits included advice for mothers on breastfeeding. Health visitors checked the baby's weight to check if the baby was thriving and recorded in the red book appropriately.
- In clinics, we observed staff supplement advice with information from Food Standards Agency, NHS choices and other NHS websites. Staff provided parents with the opportunity to ask any questions they had. We observed staff provide leaflets to mothers on breastfeeding cafes as further support. For example, in Redbridge staff organised baby feeding each weekday at different children centres and health centres. The leaflet included breastfeeding contact numbers and the contact number for the healthy eating team in the locality.

Patient outcomes

- Staff completed appropriate assessments in line with national guidance. For example, we observed health visitors completing maternal mood assessments using the 'Whooley' anxiety questions in line with the Edinburgh Postnatal Depression scale. Whooley questions are a screening tool, designed to try to identify two symptoms that may be present in depression. Mothers also received guidance on sleeping arrangements to avoid sudden infant deaths (SID).
- Health visitors used the 'ages and stages questionnaires' (ASQ) during visits and at clinics. These were evidence-based assessment tools used to highlight areas of concern about aspects of a child's development. The questionnaires covered communication and language, fine motor skills, gross motor skills, problem solving and personal-social development. Health visitors told us they used antenatal promotional cards to promote early infant development and early parenting.
- During home visits, we observed health visitors provide evidence based advice to the mother around vitamin D for the baby. The mother received thorough

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information, which included the red book, advice on safety and hygiene, immunisation appointment, emergency contacts, consent for sharing information and checked registration status with the GP.

- The trust provided data for Key Performance Indicators between October 2016 and August 2017 for health visitors by locality. The initial data did not include compliance targets, which we further requested. Although the trust provided compliance targets for some of the indicators, each locality had different compliance targets, which have been included in brackets. For example, the percentage of new birth visits within 14 days by a health visitor between April to June 2017 by locality was: Barking and Dagenham 98% (against 95% target), Waltham Forest 97% (against 90% target), Thurrock 98% (against 90% target), Havering 99% (against 87% target) and Redbridge 95% (against 70% target).
 - However not all indicators met the compliance target. For example, between April and June 2017, the percentage of children who received a two year to two and a half year review was 44% in Waltham Forest (against 47.5% target). In contrast, the reported percentage for the same indicator in Havering was 79% (against 47% target).
 - The trust provided data on infants for whom breastfeeding status was recorded at the six to eight week check. Between April and June 2017, the percentage of infants being totally breastfed at six to eight weeks in Waltham Forest was only 14% and no target had been set. For Thurrock, the reported figure for August 2017 was 53%, against target 40%. However, data was not available for Barking and Dagenham, Havering and Redbridge as from April 2017, the local authority obtained data directly from commissioners.
 - The trust provided data showing the uptake of BCG immunisations by locality. For August 2017, the percentage uptake for Barking and Dagenham, Havering, Redbridge and Waltham Forest was 95%, 92%, 91% and 95% respectively. The trust's compliance target was not included in the data submission.
 - The trust provided data for the school health service by locality. The total percentage of NCMP completed in reception year, between June to August 2017: Barking and Dagenham 99%, Havering 97% and Redbridge 99%.
- The total percentage of NCMP completed in Year six, between June to August 2017: Barking and Dagenham 99% and Thurrock 94%. The trust's compliance target was not included in the data submission.
- Local monitoring data of patient outcomes against national benchmarking data showed the trust performed better than London and England in NCMP completion. The trust provided data for 2015/16, as 2016/17 was not available at the time of our inspection. The figures for 2015/16 showed the trust completion for NCMP in reception was 96% for the trust, in comparison to London (94%) and England (96%). The trust completion of NCMP for Year six was 96% in comparison to London (95%) and England (94%).
 - The trust provided data for the Thurrock School Health Service Prevention Programme (Key stages one to four) at academic year end in August 2017. The percentage of children that reduced consumption of fizzy drinks (from baseline) was 77% and the percentage of children that increased the proportions of fruit and vegetables eaten per day (from baseline) was 81%.
 - At our last inspection, we found some consultants felt workload pressures limited opportunities to audit outcome measures or benchmark against peers and similar services. On this inspection, community paediatricians told us they had adequate time to complete audits to monitor patient outcomes and clinical performance. For example, community paediatricians had completed an audit on the monitoring of antipsychotics drugs in child and adolescent mental health services (CAMHS) using NICE guidelines. The audit findings resulted in increased screening of glycated haemoglobin (HbA1c) test pre-medication in line with NICE guidance. This was because antipsychotic medication can cause an increase in blood glucose levels, which increases the risk of diabetes. HbA1c test is used to diagnose diabetes.
 - Service leads told us the trust was commissioned for activity and output, not outcomes. However, service leads acknowledged this could be improved with better commissioning landscapes.

Competent staff

- The trust had effective induction processes for newly appointed staff to the organisation. All new staff underwent a one-day corporate induction, which

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included sessions on equality and diversity, quality improvement and fire safety. Staff told us they would then receive a local induction and orientation to their service. New starters had a meet and greet day with the chief executive and the human resources (HR) team.

- Newly qualified health visitors told us they received support through preceptorship and mentorships. New staff received named preceptors with a three month training programme which included a competency based framework, one to one support and a sign off.
- The trust offered staff a broad range of training, education and development opportunities to support their roles. The trust arranged external training for services for example parent and child interaction, cleft palate and neuromuscular courses at a child specialist hospital. Service leads told us approximately 80 staff members attended a recent event for therapy staff. We spoke with a number of administrators during the inspection, who felt they had an opportunity to train and develop within their roles for example, some administration staff had applied for college courses. The trust had courses to help administrators with their roles for example, computer software courses, time management and communication and dealing with difficult patients.
- The trust applied robust competency frameworks and comprehensive supervision structures for staff. Staff received monthly clinical supervision and safeguarding supervision. Supervision was in one-to-one sessions and group sessions with peers. Staff groups such as health visitors and school nurses received one to one supervision on a monthly basis. Other staff groups such as therapists had monthly group supervision sessions as well as individual supervision. Staff also received monthly child protection supervision as a group for therapies. CYP staff told us the supervision was thorough and constructive and provided good reflection and learning opportunities.
- Staff told us they received regular one to one meetings with their line managers and said they felt supported. The trust provided leadership training to staff with management responsibilities. This included management training, leadership workshops and quality improvement training. The trust offered staff a rotational programme and apprenticeships to ensure staff were working at the top of their competencies. Senior leads told us the trust had a training initiative for band five staff moving to band six.
- The trust had good provision of emotional support and wellbeing for staff, particularly in child safeguarding cases. The trust provided support to psychological support if necessary for health visitors and community nurses. Staff received debriefing sessions as needed and had support from the partner Macmillan nurses when needed. For example, there were a couple of expected child deaths in July 2017 and staff were supported through peer support and a debriefing session. The trust had identified a specialist practitioner who was keen on developing staff training on mindfulness.
- Some staff told us they received peer support; for example, physiotherapy staff met every three months. Staff we spoke with gave us examples of joint training events. For example, speech and language therapists and school staff had joint training on supporting autism with sensory input.
- Staff told us they had monthly team meetings and the agenda included trust-wide issues, child protection supervision, waiting times, service developments, recruitment updates and mandatory training.
- Since the last inspection, the trust had implemented monthly managerial supervision across localities. This included review of mandatory training compliance, caseload review, any conduct concerns, annual leave requests, compliments received and emotional wellbeing.
- Staff received annual appraisals to review their performance. Data provided by the trust showed that as of August 2017, the appraisal completion rate across CYP services was 88%, against 85% trust target. Appraisals were used to sign off competencies and identify training and development needs. Annual appraisals were linked to the trust values and behaviours.
- Training identified in personal development plans was discussed between staff members and their managers. Where appropriate, staff members could apply for the trust's clinical development programme. For example, the programme included sepsis courses and all trust staff could attend the courses free. The trust provided

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in-house training and resources on conflict resolution and managing difficult conversations. Staff told us about a recent external dysphagia training programme the trust had arranged using continuing professional development (CPD) funding.

- Service leads told us the majority of school nurses had completed training and qualifications to become specialist community public health nurses (SCPHN). This public health training helped school nurses support children and young people in making healthy lifestyle choices to reach their full potential and enjoy life. As school nurses worked across education and health they provided a link between school, home and the community to improve the health and wellbeing of children and young people. Staff that had not completed the SCPNN training were encouraged to attend courses, although senior leads told us it was a competitive process.
- The trust encouraged all nursing staff to complete the revalidation requirements set by the Nursing and Midwifery Council (NMC), to improve protection of children and young people who use the service. Staff felt supported with their revalidation and felt it provided an opportunity for self-reflection on individual practice. Staff told us the trust organised revalidation workshops and support was readily available on the intranet. Practitioners felt supported and had access to the medical director if needed. Clinicians told us the revalidation process was very smooth and the yearly appraisals were geared towards meeting revalidation requirements. Trust doctors took part in the General Medical Council (GMC) revalidation initiative for all UK licensed doctors to demonstrate they were competent and fit to practice.
- The trust provided a copy of the medical appraisal and revalidation annual report, which went to the July 2017 Board meeting. The report stated that during the appraisal year 2016/17, eight doctors required validation, four doctors were recommended for renewal of their license, five doctors deferred (although one revalidated in the same year), six doctors were referred to the GMC Fitness to Practise procedures. Of the six, three were closed without further action, two cases were longstanding and one case was under investigation. The report stated “The 2016/17

revalidation round has very low numbers as most doctors has gone through a revalidation process in the first three years following the implementation of revalidation in 2012.”

Multi-disciplinary working and coordinated care pathways

- The CYP service demonstrated effective internal and external multidisciplinary (MDT) working. Clinical practitioners worked with other staff as a team around the child. The co-location of services in health centres and partnership working with other service providers facilitated MDT working. Staff told us this allowed much closer joint working and improved access for patients, particularly those with complex needs or those with challenging behaviours.
- The Acorn Centre was a multi-disciplinary centre with many services on site including occupational therapy, physiotherapy, speech and language therapy, CAMHS, links to looked after children’s (LAC) nursing, specialist schools and community paediatricians. All the services used the same electronic recording system, which facilitated timely information sharing. Senior leads told us they were implementing breakfast clubs to facilitate locality integration and planned to include further joint staff training. The breakfast club would take place every three months.
- At Grove Health Centre, the child development team and CAMHS shared pathways and had joint single point of access. MDT meetings included all professionals and paediatricians and included discussions on pathways. Similarly, the Child and Family Centre on Axe Street provided many services, which included occupational therapy, physiotherapy, speech and language therapy, CAMHS and immunisations.
- We visited a specialist school and the school staff said the links with school nursing worked well. The specialist school had an integrated team consisting of school nurses, dieticians, paediatricians, dentist and therapists. This ensured a comprehensive approach to treatment. For example, at Trinity school, there was effective MDT working between speech and language therapists and physiotherapists. Staff told us the speech and language therapists were based on the school site.



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- Coordinated appointments with schools were arranged where the paediatricians and allied health professionals would go to the school. Staff told us that vulnerable children in schools had joint appointments with allied health professionals, district nurses and paediatricians.
- Staff told us there was an increased presence of health staff on the Education, Health and Care (EHC) plans panels. EHC plans were for children and young people aged up to 25 who needed more support than was available through special educational needs support. EHC plans identified educational, health and social needs and set out the additional support to meet those needs but arrangements could differ in different local authorities. Senior leads told us the service had strong links with education.
- The 0-19 Healthy Family School Nursing team was an integrated health visiting and school nurse function. The operational leads for this service met regularly and worked together to ensure the standard operating procedures (SOPs) were standardised taking into account the different commissioning arrangements. Nursery nurses had health visitors on site for advice if needed.
- Health Visitors shared many locations with GP practices allowing closer collaborative working. For example, health visitors attended joint GP meetings to discuss any concerns regarding patients or vulnerable families and newly registered children. Health visitors told us they worked with other agencies such as children centres, nurseries and midwives.
- During clinics, we observed clinicians sharing information received from the other MDT services, such as occupational therapy, with the patients, providing a holistic approach to patient care.
- 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.
- The trust had clinical networks in place, which allowed therapists in the same field to share good practice. For example, just before our inspection, a shared children event had taken place and included shared learning from incidents and good practice. The trust's education forum and community of practice (COP) also helped share learning.
- The trust had set up clinical excellence groups within health visiting services. The groups were working on a joint conference with the occupational therapy team called 'inspired to achieve'. The aim was to help achieve consistency and help colleagues network across the trust sharing evidence based practice. Staff told us peer support and joint training sessions had helped with staff retention.
- Each locality had an integrated children's services manager or equivalent who met monthly in order to integrate all the localities as one trust. Services leads told us they felt "really proud of multidisciplinary working with joint goal setting which had a positive impact on the child". Each locality had a link GP within the clinical commissioning groups (CCGs). Senior leads told us they attended GP conferences to promote learning.
- 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, for example, the Integrated Targeted Children's Services MDT meeting in Barking and Dagenham for August 2017. The agenda included discussion of new referrals, high risk children, looked after children (LAC), those in need of internal referral or shared intervention, children who have not attended for three appointments, attendance rates, pre-discharge planning, agreed actions and action updates from previous meeting.
- Staff and service leads told us cross-locality working had improved. A conference had been organised for November 2017 where representatives from each locality would attend. Speech and language therapists told us they were trying to set up cross-locality working and practice groups and said they had good support from managers to accomplish this.

Health promotion

- School nurses delivered the healthy schools programme, which included providing resources and information on nutrition, obesity and mental health.

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Staff told us the early year program included the use of puppets for health promotion. School nursing in Thurrock helped Year 8 students around smoking through peer pressure. Trinity school displayed flu vaccine posters to encourage uptake in pupils and staff.

- The School health national child measurement programme (NCMP) for Year six included measurements of children's height and weight to assess overweight and obesity levels. School nurses at Grays Health Centre told us they ran bedwetting clinics. The nurses gave advice on what to drink, how much to drink and healthy eating. Staff told us there was a mobile application on the smart phone for bedwetting.
- We observed home visits with health visitors where there was good coverage of health promotion communicated to mothers. For example, health visitors gave advice on exercises such as postnatal pelvic floor exercises. Staff told us health improvement advisors provided monthly breastfeeding workshops. Staff in the Hainault Health Centre advertised local infant feeding cafes for mothers.
- Health improvement specialists and practitioners provided health promotion and early intervention for example: hand hygiene and targeted approach to health lifestyle using Personal, Social, Health and Economic education. Health improvement staff received requests from schools and allocation took place at fortnightly team meetings.
- Community specialist nurses such as respiratory nurses worked to empower patients and their families to live with long-term conditions and completed thorough care plans. We observed a community home visit with a specialist respiratory nurse. Feedback from the mother and children was extremely positive. The mother said, "Although the staff member may not be the same each time, effective handovers took place so she didn't have to repeat herself". The mother felt community nursing specialist nurses understood the family and was able to support their needs. The children told us the nurse made things better for them and explained the plans to them. We observed appropriate advice and information provided during the visit, including support on how to use a peak flow meter. The specialist nurse completed the asthma plan for the patient to share with the school.
- The trust's school nurses had produced a '10 minute live shake up broadcast' to provide online, accessible advice

to school students on exercise and fitness, and this was shared on social media platforms. It received positive feedback from Public Health England. School nurses told us they planned to do monthly videos on various subjects to support health promotion initiatives.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The trust had a policy for consent to examination or treatment. Staff we spoke with were aware of the trust policy and told us they could easily find the policy on the intranet.
- School nurses were knowledgeable about Fraser guidelines and Gillick competencies to help assess whether a young person of a certain age had the maturity to make their own decisions without consent of a parent or guardian and understand the implications of those decisions. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment. Gillick competence is concerned with determining a child's capacity to consent. Practitioners showed awareness of situations where these principles would be applied.
- We observed practitioners request consent for information sharing and consent to treatment during clinics and home visits. If parents wanted to request information from the records, the trust policy stated that request must be made in writing.
- Staff clearly recorded consent in the patient notes on the electronic record system for example the LAC records we reviewed all had documented consent. However, we found some isolated instances where consent was not recorded. Some staff told us they took patient attendance as implied consent for the assessment or intervention.
- Patients and their family members told us that in most cases, 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. For example, health visitors told us about a case where the principles of "voice of the child" was applied in practice where the child wanted independence but had protective parents. The health visitor specialist supported the family with the child's medical condition

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and the nursery nurses focussed on what was important to the child, such as likes, dislikes, thoughts and feelings. The child named the care plan, which helped, put the child at the centre of care.

- We observed homes visits where the health visitors introduced themselves, explained their role, sought consent appropriately and documented the electronic record appropriately.
- The trust provided the statutory and mandatory training matrix, which showed all clinical staff received training

in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of mandatory training. The trust delivered the training either through e-learning or through a classroom session. Records showed varied compliance across the localities. For example, staff in Havering and Thurrock across all services had met the trust target of 85%. However, in Redbridge, all services met the trust target except paediatric occupational therapy and the school health service which reported 75% and 60% respectively.

Are services caring?

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

Summary

We rated caring as **good** because:

- Most of the patients and families we spoke with said they were happy with the care and treatment received and would recommend the service to others.
- Children, young people and their carers told us that staff treated them with compassion, dignity and respect. We saw staff communicating with patient and families with empathy and in a polite and caring way.
- During our inspection, we observed children, young people and their families receive treatment with kindness and compassion. Staff supported patients and families they worked with, and provided patient-centred support in clinics and in homes.
- Patients and their families felt listened to and involved with their care and treatment.
- The children and young people (CYP) service encouraged patients and their families to provide feedback on the care and service they received.
- Parents told us that although they do not see the same staff in clinics, this did not cause any problems as effective handovers took place so parents did not have to repeat themselves.

Compassionate care

- Patients told us they would recommend children, young people and families (CYP) services to their families and friends. Most patients we spoke with said they were very happy with the care and treatment they had received. They told us staff treated them with dignity and respect. The following was representative of the feedback received: “does not feel rushed”, “staff do a wonderful job”, “treated with dignity and respect”, “the support is brilliant”, “good emotional support” and “staff were professional, organised and gave clear and concise information”.
- The specialist community children’s nursing team displayed a compliments poster for the public to view. The compliments were received between June and September 2017. Comments included “thank you for looking after us, you’re wonderful”, “thanks for the

support you give not only to me but my family”, “community nurses were kind, caring and patient and put my child at ease”, “information was explained clearly and helped me understand a lot” and “thank you so much for your fantastic service”.

- Parent feedback from children and families using services in Axe Street was generally positive. One mother told us staff members had offered her emotional support. Other parents also said “although the physiotherapist changed regularly, the general support provided by staff was good as effective handovers took place”. Patients and family members were pleased overall with the service as staff were helpful and welcoming, the location was accessible and their child was happy.
- Patients and family members feedback on the audiology service was staff were brilliant and the environment was calm and relaxed. Comments also included “the service was quick and efficient” and “it was always easy to get through on the phone”.
- Health visitors created a friendly and child-focused atmosphere during activities and assessments such as weighing and height measurement. We observed health visiting staff introduce themselves and demonstrated supportive care to mothers they visited, and provided person-centred support in both clinics and in homes. We observed good interactions between health visitors and babies. For example, health visitors praised children and babies when they cooperated with activities and assessments such as weighing and height measurement. Mothers’ felt listened to and said the “health visiting staff were incredibly caring and supportive”.
- We observed positive rapport between the practitioner and the child. We also observed school nurses at a drop in session where age appropriate explanation was provided. The staff member listened, showed concern, and was caring and aware of the emotional needs of the children.
- Staff clearly explained what was going to happen during an appointment and gave parents the opportunity to ask questions and raise concerns. Parents we spoke

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with said clinicians and therapy staff engaged with the patient during consultations. Staff took the time to explain the findings of assessments to the parents. We observed speech and language therapists provide very clear and informative advice on exercises and other tips at home. The staff member handed out feedback forms to parents and family members. Parents were “very pleased” with the session the outcomes.

- The trust’s overall score for privacy, dignity and wellbeing in the 2016 PLACE score was 82%. This had decreased from 2015 PLACE score which was 86%.
- Each of the locations we visited had information boards for patients, information leaflets and posters such as family support for health care, emotional support, childcare placements and signposting to free local courses. Toys and children’s books were available in waiting areas at health and children’s centres. We observed welcoming staff speak with patients and family members and found they spoke clearly and politely.
- All the staff we spoke with showed passion for their roles and dedication to making sure that the children and young people they cared for received the best care possible. Senior leads told us the trust used the ‘voice of the child’, and friends and family test results for understanding patient experience.
- The Friends and Family Test (FFT) was launched in April 2013. It asks people who use services whether they would recommend the services they have used; giving the opportunity to feed back on their experiences of care and treatment.
- The trust provided the friends and family test data for children community services between September 2016 and August 2017. The trust divided the data into three services, health visiting, school nursing and specialist paediatric services. The percentage of patients who were extremely likely to recommend health visiting, school nursing and specialist paediatric services for the trust was 64%, 46% and 65% respectively. Service leads discussed friends and family test results with staff in team meetings.
- The trust also provided patient experience data for children community services between September 2016 and August 2017 and divided the data into three services: health visiting, school nursing and specialist

paediatric services. From the 3080 responses, the percentage of patients who found it easy to get care, treatment and support from health visiting, school nursing and specialist paediatric services was 98%, 100% and 90% respectively. When asked if patients felt involved in their care as much as they would have liked, the percentage of patients who said yes for health visiting, school nursing and specialist paediatric services was 93%, 91% and 92% respectively.

- Each location we visited had locality specific FTT. For example, Grays Health Centre displayed the results as “your views count” for July 2017. From 833 responses, 94% would recommend the service.

Emotional support

- CYP practitioners across universal and specialist services could refer patients 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.
- Staff provided emotional support to the patients and their families. We observed health visitors sensitively discuss mothers’ feelings and emotional wellbeing during home visits. We observed health visitors create a safe atmosphere allowing mothers to talk openly about difficult matters. However, staff offering emotional support to parents was inconsistent as some parents told us staff did not offer them emotional support.
- We saw evidence of emotional health leaflets for the public. For example, at the Acorn centre, we saw a Samaritans leaflet, which included telephone numbers for ChildLine, parent surgery (free advice service for parents and carers), Young Minds (CYP wellbeing and mental health) and Harmless (a self-harm support organisation). The leaflet included a free telephone number, mobile number to send a text and email address for the Samaritans.
- Staff told us they had good access to the emotional wellbeing service. School nurses provided emotional support to children and families through drop in sessions. School nurses told us they had access to counsellors in secondary school and sometimes in primary school. One parent voluntarily told us she felt well supported, especially at the nursery school.

Are services caring?

- The trust worked in partnership with independent organisations and charities to provide emotional and practical support to patients such as counselling and family activities. The CYP services in Essex boroughs worked with local charities including SNAP (Special Needs and Parents) and the Sycamore Trust, which helped local families with children and young people with special needs or disabilities. SNAP offered different parent training which included large specialist talks for parents and professionals. The charity had produced a leaflet, which included their services, and we saw the leaflet displayed in some of the children's centres we visited.
- Sycamore Trust had set up an autism hub in Havering to support families and individuals affected by autism, putting them in control of the delivery and accessibility of local services and opportunities. The hub worked in partnership with local hospitals, GP surgeries, dentists and other health service providers to achieve better health outcomes focused on resilience, support networks and coping strategies. The leaflet included different services such as family support, parent support groups, befriender project, autism ambassadors, signposting and advice and youth clubs.
- A charity called Open door in Thurrock provided cognitive behavioural therapy (CBT), a mental health programme and a self-esteem programme. Staff told us this service had supported children and families experiencing domestic violence.

Understanding and involvement of patients and those close to them

- Staff across the different services worked together in partnership with the patients and their families. Practitioners demonstrated a patient-centred approach and encouraged family members to take an active role in their child's healthcare. Parents' feedback included "positive experience, we were always aware of next step". This included adapting the style and approach to meet the needs of the individual children and involving their relatives appropriately.
- We observed therapists and clinicians involve the child in assessments to ensure that everyone took part

equally. Practitioners explained the Education, Health and Care (EHC) plan to parents in jargon free language. The clinics we observed were child-led and involved the child for the whole session.

- Health centres we visited displayed information leaflets and the reception staff were welcoming and polite. These included advice and guidance on victim support, financial support and breast-feeding. We found age appropriate books, games and toys across most of the health and community centres we visited.
- We witnessed age appropriate instructions with clear explanations, encouragement and feedback given in all CYP staff interactions with children. One mother told us the "staff member was professional, honest and good at listening. She even researched information to support advice given".
- The trust worked with local independent community groups. For example, Havering and Barking and Dagenham had a local support and action group called 'add+up' which helped unite parents who had children with attention deficit disorders. The group taught parents/carers new skills to manage ADHD in their everyday lives to help reduce the risk of family breakdowns. The children would learn how to manage their ADHD and were encouraged to remain in education to achieve their true potential.
- Staff showed good cultural understanding of their local population. For example, therapy staff in the child development centre had supported a child undergoing assessment for social communication disorder and noticed the identified ethnic minority group did not discuss the disorder freely. Therapy staff noticed the father was showing signs of social communication difficulties and supported the father by referring him to his GP. The father was now accessing mental health support. The overall outcome for the family had been positive, staff told us the mother, and father's relationship had improved since the father had accessed appropriate support. This created a better environment for the child to manage his recent diagnosis with family support.

Are services responsive to people's needs?

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

Summary

We rated responsive as **good** because:

- The trust planned and delivered services in line with local needs and in partnership with local commissioners.
- The trust had worked to make services as accessible as possible facilitated by co-location of multiple services in health centres. This included flexibility in the timings of appointments, where the clinics took place and how the service was organised.
- Waiting rooms and clinic rooms were child friendly with toys, books and other resources appropriate for different ages. Staff communicated with children and young people in an age appropriate way and involved them as decision makers in their care.
- The trust had redeveloped the referrals standard operating procedure to make the process more streamlined for patients.
- The trust followed up patients who did not attend their appointments to ensure they were safe and well.
- Staff had a good understanding of the different cultural needs and backgrounds of patients.
- Staff and families we spoke with told us there was good access to translation and advocacy services.
- The trust offered good provision of services and support for vulnerable client groups.

However:

- The trust had improved the waiting times and referral to treatment times for some services but still faced challenges from commissioning, staffing capacity and recruitment of specialist therapy staff.
- Although the trust responded to complaints within the trust time scales, we found completion of the online recording system incomplete as risk assessments and lessons learnt sections were blank.

- Although some services managed the arrangements for transition from paediatric to adult services well in some services, service leads acknowledged there were a gap and admitted that receiving services had different criteria.

Planning and delivering services which meet people's needs

- 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 leads told us they had regular communications and, for the most part, constructive working relationships with commissioning bodies. All of the staff we spoke with recognised the different population demographics, socio-economics and healthcare needs of the diverse communities in the local area.
- Service leads were concerned about their ability to provide services to rapidly growing and changing populations. However, where the trust had felt services were not safe to run, discussions had taken place about giving notice to the commissioners.
- Local authorities and commissioners had decommissioned a number of CYP services in the year before our inspection. Although this had created some uncertainty for staff, the staff we spoke with said they felt the trust and service leads had kept them informed accordingly. For example, the Thurrock Health Visitors meeting minutes for September 2017 included an agenda item on tendering and staffing updates for Brighter Future and Healthy Family Service.
- Patients and their families also noticed the changes to commissioning arrangements, which meant they did not see the same staff member at each visit. However, parents told us that "this didn't matter too much as effective handovers took place between staff beforehand, with no need to repeat myself".
- The trust had a robust policy for interpreting and translation for use when English was not the first language to help patients and families make informed decisions. The policy included legislation, national



Are services responsive to people's needs?

guidance and referred to the NHS constitution. The policy gave clear guidance on consent and safeguarding and details expectations of the service. The trust had an interpreter service and telephone translation service and staff in the CYP service used the services appropriately. Staff told us they recorded translation requirements for patients in the electronic records systems.

- The trust's partner interpreting service provided translation for 36 different languages. Staff and patients reported good links to interpreter services. However, we observed a session where the quality of interpretation was poor as there were missed opportunities to translate. The trust was in the process of rolling out devices to staff to facilitate the use of an immediate online translation tool.
- The Havering audiology clinic displayed a wide variety of leaflets, mostly from the National Society of Deaf People, which were available in different languages. The trust had a leaflet on compliments, comments, concerns and complaints available in different languages. These included Turkish, Albanian, Portuguese, Bengali, Farsi, Polish, French, Tamil, Arabic and Russian. We saw this leaflet at most of the locations we visited.
- Staff at Grove Health Centre told us that they ensured two staff members were available to give feedback to parents after a confirmed diagnosis of an autism disorder. The rationale for this was to enable staff to support the family as well as acknowledge the child who was present. This also increased peer support among staff. Staff requested translation services where needed especially for feedback sessions where parents received the diagnosis.
- The locations we visited had age appropriate spaces and environment for children, which included toys for them to play with and children's drawings on display. The service displayed patient information boards in reception areas of health centres, which provided information about local children's centres, baby groups and other activities and free courses available in the local area.
- Staff in some services ran different sessions in a number of locations and on different days of the week with a mixture of both morning and afternoon sessions to optimise attendance. For example antenatal breastfeeding workshops were available in six health centres across Redbridge.
- We observed home visits with health visitors where mothers were signposted to services and given supporting information leaflets. The trust's breastfeeding leaflet included telephone numbers for the national breastfeeding helpline, national childbirth trust and breastfeeding line and Bengali/Sylheti breastfeeding helpline.
- The trust offered a wide range of services to support patients and their families. For example, local residents in Barking, Dagenham, and Havering were offered free English classes to help with employment through a registered charity called Lifeline. The classes not only helped individuals with learning English and making friends but also helped with job applications. However, as this service was advertised in English, access would have been limited to those who had English as their first language.
- Service leads told us that although it was not possible to produce material in all the languages, patients and their families could request translation of leaflets into the required language. However, we did not see any signage saying this service was available either.
- Staff told us they adopted a targeted approach to parental involvement for CYP patients. They told us being honest and open was a key focus when dealing with parents and they said this had resulted in much improved relationships. However, some staff reported difficulties managing the expectations of some parents which contributed to increased workloads.
- Health visiting and school nursing teams applied a duty system from Monday to Friday 9-5pm to enable timely access to other services. Staff had a duty folder with relevant contact details for the different teams. The duty folder included contact details antenatal pathway, prevent escalation process, guidance on concerns with patient/carers, information for other health centres, safeguarding contact details, brief intervention for smoking, domestic abuse forms, accident and emergency forms, responsibilities for duty health visitor and weekly duty rota.



Are services responsive to people's needs?

- The nursery nurses offered a range of interventions to support parents and children, which included toilet training, sleep, eating, education preparation, behaviour management, early support process and observation with children undergoing investigation for autism.

Meeting the needs of people in vulnerable circumstances

- Staff directed patients to relevant support groups. Health visitors' directed patients to local support groups, charity groups and religious groups for example, funding and social services support. Health visitors used antenatal and postnatal guides to target young teenage mums, looked after children and other vulnerable groups.
- The trust provided a number of resources for autism support, which included parenting groups, support and home visits, play and development support and multidisciplinary coffee mornings.
- We observed therapists using pictorial timetables and care plans for children living with a learning disability. We found therapists used appropriate language and body gestures to help communication with patients, for example clapping to say "well done".
- The service offered appointment times to suit the needs of individuals. We observed several interactions between staff and patients and their families to demonstrate flexibility with appointments. Staff told us if patients were running very late and missed the appointment every effort would be made to reschedule another appointment where possible.
- The trust used an appointment reminder system through text messages to inform patients and their families of their appointment details. For example, the support worker at the immunisation clinic sent text messages the day before or on the morning for appointment reminders in addition to postal appointment letters. This had resulted in fewer missed appointments and patients and their families fed back that the system worked well. Practitioners told us continually missed appointments were referred to health visitors and schools to identify actions and whether a safeguarding referral was needed.
- The trust used a single point of access referral system to simplify access to child development and paediatric therapy services such as physiotherapy, autism and social communication assessment and speech and language therapy. Patients could access these systems through a single point of contact, such as a specialist health visitor. Staff told us clinical leads triaged referrals. Paediatric therapy practitioners told us that the single point of access had rationalised referrals from stakeholders.
- At the last inspection, we found inconsistent compliance with the trust's referrals standard operating procedures (SOP). The trust's community of practice (COP) for CYP had reviewed the SOP and implemented a revised version across all localities in the summer of 2017. The trust completed an audit to check compliance and the trust found the SOP was fully embedded which meant patients were not referred too frequently or unnecessarily.
- Staff told us that once a referral was received, a MDT referral meeting took place. Various health care professionals attended for example, speech and language therapists, occupational therapists, physiotherapists, child and adolescent mental health services (CAMHS) and paediatricians.
- Staff gave us examples of where the service was finding new ways of working. For example, the north locality project was a pilot extended support scheme, which aimed to work with five to six families that do not meet the referral threshold, for one year. Staff told us this had improved joint working and information sharing. The service included PREVENT escalation, intervening earlier from health, social care and the local authority.
- The trust had a vulnerable children initiative in place since May 2017 aimed at children who do not meet the threshold for referral to social services. This could include children who were on a child protection plan or looked after children (LAC). The trust had received good feedback from parents on this initiative. We saw evidence that local social services had provided positive feedback on joint working with the trust. The trust's CAMHS transformation project funded the initiative, which improved joint working with CAMHS. The initiative improved parent resilience and helped improve communication with children and schools.
- Each locality had a youth offending team, which consisted of a clinical psychologist and a specialised

Are services responsive to people's needs?

nurse. The team received referrals from youth offending services and the team provided support around mental health, physical health and health promotion until patients needed transition to adult services. Although young people accessed the service on a voluntary basis, consent was obtained and the young person received an appointment within a month of referral. There was no set limit on visits and contacts as the service was led by the young person's needs. Practitioners sought feedback at each session using a questionnaire.

- During our review of records, we saw comprehensive care plans for patients with appropriate referrals made. Staff we spoke with told us patients would not be discharged until the outcome was received. Service leads told us there was a local and national strategy for children with disabilities to be within young people services until the age of 25 years and be offered services based on their needs. The trust had a clinical interface group in place to review the most vulnerable, high-risk patients with complex needs.
- Although the trust had produced a transition policy, some local commissioning arrangements still impacted on effective transition arrangements. Senior staff told us transition was a national commissioning matter and not within the trust's control but service leads acknowledged there was a gap and admitted that receiving services had different criteria. At the last inspection, we found inconsistent transition arrangements from paediatric to adult services across services and localities. The trust had since implemented a transition policy in August 2017 and had appointed a transition lead. The policy was robust and based on relevant child and adult guidance and legislation and referred to Fraser guidelines and the Mental Capacity Act. The policy clearly outlined the expectations on children's and adult practitioners to work jointly to ensure transition was seamless.
- However, not all services had transition arrangements in place because of commissioning arrangements. Therefore, it was not always clear where the child would be transferring to. For example, service leads advised us that therapies services were only commissioned for children and young people up to the age of 16, or up to 19 for those who had an education and health care plan. Generally, young people with a learning difficulty would be transitioned into the adult learning disability service.

However, this offer might be different across the different local authorities. Therefore, it was not clear which service young people would go to if they required specialist therapeutic intervention such as speech and language or occupational therapy up to the age of 25 as required by the Children and Families Act 2014.

- Where the trust had transition arrangements in place, for example the learning disabilities team for adults, transition arrangements were effective. Staff told us there were good transition arrangements for patients with epilepsy. Transition included multi-agency team meetings with all the necessary health professionals who would also visit the patient's school. This involved working with specialist education needs and disability (SEND) staff from primary to secondary school. The community nurses continued to provide support for the families. Both parents and patients would also be involved.
- The trust told us there was no pathway for children in special schools to transition to adult services. The trust offered early support to children with special needs with joint working with education and health to support transition into school. Currently, when children were leaving special schools, aged 16-19 they were transferred back to the care of the GP by the school nurse. The school nurses wrote to the GP and copied in the parents to advise them that care was transferring to them. School nurses reviewed children with more complex health needs in school clinics before they left school, to ensure referrals were made to adult services. The school nurse referred children with a learning disability to adult learning disability team if appropriate, but the adult team did not accept referrals until 18 years and above so this was not always appropriate. The trust told us there was no capacity to see all the children who were leaving for a transition medical. There were a few children for example who had life limiting conditions, who were referred back to a child development centre (CDC) when they left school if there was still a clinical need and transfer to adult services were still ongoing.
- The trust told us children community nursing team would refer the transitioning child to district nurses and carry out a joint home visit to transfer care to them.

Access to the right care at the right time

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- Patients had good access to multiple CYP services across the trust. The co-location of services such as therapies in one location, as well as shared premises with general practices, facilitated good access for patients (see multi-disciplinary working and coordinated care pathways section for more detail). The service displayed posters throughout CYP premises to signpost patients to other services. Staff told us there was effective communication between departments within the organisation.
- CYP services followed the trust's 'did not attend' (DNA) policy. Staff told us letters were sent out to parents and if they did not respond, then the child was discharged. If the child was vulnerable or there were safeguarding concerns, and they did not attend a community paediatric clinic, staff members would then contact the GP, health visitor, social worker to make them aware. However, staff told us that where parents did not attend and still wanted another appointment, the service remained flexible and would always try to slot them into a clinic. We observed a member of staff being sensitive to the needs of patients and family members whilst offering a physiotherapy appointment.
- Community paediatricians told us that if a patient did not attend a clinic, the doctor would try to call them and send a text message. Additional appointments would be offered where contact was made. However, if no contact was made, the doctor would inform the crisis team and social services.
- The physiotherapy team had a 48-hour cancellation policy. Where a patient did not attend, the staff member would make contact within the hour. If contact was made, appointments would be rescheduled. However, if there was no contact, a written letter would be sent. After three DNAs, the patient would be discharged. Staff told us DNA rates were low due to appointment reminders by text message.
- The service managed DNAs through electronic reminders for patients in addition to an appointment letters. The trust provided DNA data for CYP services. The DNA rate for the CYP service had increased for July 2017 and August 2017 at 9.13% and 9.67% respectively. However, prior to that, DNA data for June 2017 was 7.73%. The trust's compliance target was not included and the data provided was not broken down by services.
- Clinic appointments ran on time with minimal waiting time for patients and their families. During our inspection, we observed children and families did not wait long for their appointments. Most of the parents told us clinic appointments ran efficiently with no cancellations from the service. However, where appointments were cancelled, alternative appointments were booked promptly.
- Trust administrators worked closely with practitioners to ensure that multiple sessions were combined in one appointment to reduce the impact of multiple visits on patients and their families. Although the trust health centres we visited were well located for local public transport with accessibility across localities, administrators alerted patients to factors such as limited parking or public transport in appointment letters to ensure they attend on time. However, some parents told us parking was an issue and found it frustrating at some centres, for example Wood Street Health Centre.
- 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. School nurses worked across a number of schools and had drop-in sessions for parents in primary schools every term to maximise opportunities with parents.
- The trust provided waiting times data by core service in a 'Clock Stop Report'. The data was representative of the CYP service across all services. The percentage of CYP patients seen within 18 weeks was 93%. The percentage of CYP patients seen within 19 to 37 weeks and 38 to 56 weeks was 6.5% and 0.5% respectively.
- The trust continued to face the challenges of breached waiting times due to recruitment difficulty of specialist therapy posts. At the last inspection, we found evidence of long waiting lists and waiting list breaches in paediatric therapies across localities, 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. During this inspection, service leads told us that although commissioners had granted further investment, recruitment for some posts remained a challenge. For example, funding had been approved for additional occupational therapy posts but there was a

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national shortage, which has affected recruitment. Therefore, on this inspection, we found that waiting times remained high for some services. Staffing levels affected waiting times for example physiotherapists told us that patients had to wait between 8 to 12 months. Service leads told us the trust monitored waiting times, waiting lists, and said all patients on the waiting lists received clinical harm reviews to maintain safety.

- The trust also provided data on the first treatment to follow up. The percentage of CYP patients who received their follow up appointment within 18 weeks of the first appointment was 84%. The percentage of CYP patients who received their follow up appointment within 19 to 37 weeks and 38 to 56 weeks of the first appointment was 14% and 2% respectively.
- Some parents told us they had noticed changes to some services, which they perceived was a result of changes to funding arrangements. For example, the autism clinic used to be a drop-in clinic but now was appointment only. However, patients and their family members told us services had improved communication. For example, previously parents told us they did not always receive appointment letters in a timely way. However, they felt that the system of text messaging reminders for appointments worked well for them.
- Parents we spoke with said they always received appointment letters and the service rescheduled any cancelled appointments promptly, offering flexibility where possible. However, some parents told us it was difficult to get a physiotherapy appointment and they felt they waited “months and months” but the service was “much better now”. Although parents commented on the long waiting times, they also said, “Once they were in the system, the care received was supportive, caring and amazing.”
- There was recognition that staffing and resource allocation differed between localities because of commissioning arrangements. However, CYP staff worked through the challenges adapting new ways of working to manage waiting times. For example, therapy staff told us they completed data cleansing to check with parents if the referral for physio or OT was still required.
- Although, the trust had shown some improvement in waiting times for some services, further work was still required to be compliant with national guidance with maximum waiting times of 18 weeks. At the last inspection, community paediatricians and therapists reported long waiting lists for the autism and social communication pathway. The referral pathway for autism began with a referral into the service, an assessment by a paediatrician followed by an Autism Diagnostic Observation Schedule (ADOS) assessment. On this inspection, staff told us the trust had implemented a quality improvement programme. This was an initiative to manage waiting lists for services such as community paediatrics and autism diagnosis. Staff told us the waiting times had improved. For example, the waiting time for autism diagnosis was previously 24 months and now was 8-12 months. The service had also made sustainable changes to tackle waiting times and facilitated improvements. For example, staff reported increased speech and language therapy sessions from two per month to eight per month.
- The physiotherapy department within Brentwood hospital had a MDT triage system in place with single point of access, which included speech and language, occupational therapy, physiotherapy and paediatrics. The MDT meetings took place weekly and on occasions, used skype meetings to facilitate attendance.
- The audiology service provided a daily drop-in clinic for patients with hearing aids and after school appointments. The clinic provided same day service for battery replacement, new moulds and replacement hearing aids. We observed that patients did not wait too long to be seen. Parents told us appointments could be changed to suit the patient needs. Staff told us the Harold wood clinic would see children within four to six weeks from referral.
- Parents we spoke with commented on the waiting times. For example, at Wood Street Health Centre, one parent said, “six months wait was far too long and upsetting”.
- Service leads told us that although staffing levels affected waiting times: they were confident that staffing levels did not affect the quality of care.

Learning from complaints and concerns

- The trust provided feedback forms and submission boxes in health and community centres where CYP

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services were delivered. The locations we visited displayed leaflets on the trust complaints process and guidance on complaints, concerns and compliments. Most of the families we spoke with told us they had received information on how to make a complaint. However, they told us they had no concerns or complaints about the service but felt the waiting times were long.

- Between 1 September 2016 and 31 August 2017, the trust received 19 complaints related to children and young people services. Of these, 16 were closed and three remained open. One of these was fully upheld, five were partially upheld and 10 were not upheld. No complaints were referred to the Ombudsmen. Service leads told us there were no particular themes from recent complaints and most complaints were about staff attitude, communication and clinical care involving the diagnostic assessment.
- The Trust recorded 393 compliments from CYP patients in same 12 month period. The service recorded compliments by location on the online reporting system. We reviewed 12 compliments for the Acorn

Centre in the last six months and comments included: "I am grateful for all you have done for me", "as a first time mum I really appreciate knowing someone cares enough to help us after being passed around so much" and "we really appreciate you being here". On some occasions, children submitted drawings as part of their compliments with comments such as "I miss you".

- We reviewed two CYP service complaints on the online reporting system, from two different localities and found risk assessments and lessons learnt were not completed. We fed this back to the senior managers, including the complaints manager, during the inspection. However, the two reviewed records showed comprehensive responses, compliance to the trust timelines and application of duty of candour in both cases.
- Service leads told us that learning from complaints and incidents was shared using the community of practice (COP) structure and 'our sharing learning strategy'. Service leads presented cases at COP meetings for learning and in team meetings.

Are services well-led?

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

Summary

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

- The trust had robust governance structures and systems for the review of performance and risk management information.
 - The service had a strategy that reflected the needs of people using the service and the changes happening in local health and social care services. This reflected current best practice in providing services for children, young people and families.
 - The service consulted and worked in partnership with the local community, other commissioners and stakeholders to improve services and health outcomes.
 - The trust had published the vision and strategy for the entire CYP service in July 2017 having engaged with both the staff and the public.
 - The trust managed risks effectively. For example, staff had a good awareness of lone working arrangements.
 - Despite some areas of high workload and commissioning challenges, there was good morale among CYP staff and practitioners across all services.
 - Staff demonstrated innovative working using technology.
 - Staff told us that service leads were supportive, accessible and approachable and they articulated how they would escalate any concerns beyond their immediate line manager.
 - The staff we met reflected the trust values and vision. Staff valued working for the trust and told us that the trust involved staff in different ways; for example, during the development of the trust vision and strategy.
- leadership team as supportive and encouraging. Staff described service leads as compassionate and knowledgeable. Practitioners told us their managers listened to needs of the service and provided support.
- The trust's leadership team for the CYP service acknowledged that with the different commissioning arrangements and individual localities each locality had localised working practices to deliver services based on their local populations' needs. However, the trust had embedded robust governance and safeguarding structures to facilitate a cooperative and consistent approach. Opportunities for staff interaction or shared learning across localities were in place and supported by service leads.
 - The trust adopted a 'communities of practice' (COP) model to provide trust wide multidisciplinary strategic leadership to CYP services. The COP included a clinical lead, operational lead and nursing lead. The COPs coordinated development of corporate strategies, developed new pathways and led on audit and evaluation. Staff told us the COP met every eight weeks across the organisation and helped integration of localities into the trust ensuring consistency with processes such as standard operating procedures (SOPs). Senior leads in the CYP COP told us there was no single lead for CYP as a whole as the COP was based on a partnership model.
 - At the last inspection, we found clarity was needed around the representation of CYP services at trust Board level. The trust had recently appointed a non-executive director (NED) on the Board with responsibility for CYP services. The NED told us there was representation of the CYP voice at Board; for example, the trust invited a patient to each board meeting to share their experience and give their opinion of possible improvements.
 - The trust leadership team explained their services were not organised through service lines but through locality. Therefore, staff would have an awareness of how to

Leadership of this service

- The trust had an established and stable leadership team in the CYP service. Allied health professionals such as health visitors, community nurses and therapists told us service leads were visible, accessible and receptive to staff feedback and evaluation. Staff viewed the CYP

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escalate any concerns to their line manager, and the next line of management, their named nurses and professional leads but would be unlikely to know their assigned NED.

- Staff we spoke with told us they felt confident to raise any concerns and demonstrated awareness of the management line in order to do this. Staff told us they knew the names of their immediate team lead, operational lead and assistant director. Staff could access the organisation chart to identify other senior team leaders.
- The trust organised leadership listening events for staff. We saw posters advertising these events in some of the locations we visited. Practitioners told us about the drop in surgery for staff members to raise and discuss any issues or concerns with senior management. Staff told us they felt listened to by managers but also understood the financial restrictions on the service, which limited what managers could do.
- Managers supported staff in their roles. Staff with management responsibilities had access to leadership and management training funded by the trust. Operational staff such as health visitors, school nurses, therapists and community nurses told us they felt well supported by service managers. Staff told us that since our last inspection the visibility of senior management had increased. For example, the non-executive chair visited some of the locality teams. Staff also told us about the breakfast with the chief executive, which took place every month in different localities. For example, there was one in Thurrock a few weeks prior to our inspection.
- Several staff told us: “my manager is fantastic”, “I admire my manager”, “we have a good supportive team”, and “we are like family”. Staff told us that one to one meetings had increased and were more regular. Senior management rescheduled any cancelled one to ones promptly. Administrative staff told us they felt well supported. Staff told us team meetings were not cancelled and said “there is always someone you can go to”.
- Staff received regular information from the senior team through staff engagement meetings and team meetings. Staff told us they received the trust newsletter weekly, which included information on what was happening

across the trust, training information, positive stories within the trust and nominations for staff awards. Staff told us that the director of the CYP service was accessible and visible and attended team meetings to notify staff of any changes or when requested to attend.

- The trust involved staff during the tendering of services. Several staff told us managers kept them informed of any updates. Service managers supported staff to manage their anxieties and concerns. For example, staff at South Woodford Health Centre told us about a staff away day arranged to discuss new ways of working and transition. Staff also told us the links to the trust’s human resources team had improved and they had direct contact details for their named human resources partner.

Vision and strategy

- Staff we spoke with understood the trust’s values. Most of the staff, including practitioners that we spoke with could tell us about the trust’s values. All of the staff were committed to delivering excellent care in line with the trust’s strategy. Staff told us about their passion for providing high quality care for their patients during our conversations with them, which we further observed in clinics and home visits.
- Staff demonstrated effective patient-centred, internal and external multi-disciplinary team (MDT) working and they were “proud of the integration”. Staff provided examples of integrated working such as allied health professionals and paediatricians working more cohesively and linking in with school nursing.
- The staff we spoke with were aware of local challenges and continually worked on engaging with hard to reach groups. For example, on many occasions, we observed staff provide holistic care for patients and extend this care to other siblings in a family.
- Some of the locations we visited displayed the trust’s visions and values on the public notice board, for example, we saw the information displayed at Grove Health Centre. The display also included key quality outcomes, aims and benefits of the targeted service, team purpose and team feedback.
- The trust had produced a Best Care Clinical Strategy Summary in July 2017. At our last inspection, the trust did not have a formal documented vision and strategy for community health service for CYP as a whole. On this

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inspection, the trust had developed a 10 year vision and strategy for the service. Senior leads told us the medical director who engaged with staff and members of the public and patients, led on the document. The trust had recently cascaded the document through various channels such as the intranet, the three tiers of governance, in the weekly newsletter and at team meetings. However, the document was in its infancy and the trust acknowledged that not all staff would be aware of the document, as more time would be required to embed it fully. However, the trust had started to develop the implementation approach for the Best Care strategy and had recognised that staff and services will need support to take these principles and understand what they might mean for their services and how to make changes. Service leads told us the trust had incorporated use of technology into the trust's vision and strategy.

- Although corporately the CYP service was one trust, the leadership team acknowledged that the CYP services presented as separate entities and individual localities rather than one trust. Different commissioning arrangements had resulted in localised working practices to meet the needs of the local population. However, the trust had embedded robust foundations across the localities, which included governance and safeguarding structures to ensure there was consistency across the trust. Staff and service leads told us the CYP community of practice (COP) worked on developing standard operating procedures and care pathways to standardise the services and delivery.

Culture

- The service had an inclusive and constructive working culture. We found highly dedicated and passionate staff who were committed to providing a good service for children and young people, often working in challenging circumstances. However, some staff felt that there were fewer opportunities to be proactive due to commissioning challenges and changes to roles.
- Practitioners across services were very positive, knowledgeable and passionate about their work. The staff we met understood their local challenges and demonstrated a desire to improve services for the

benefit of patients. Team working was positive as staff supported each other through effective communication and ensured allocation was equitable to alleviate pressure on colleagues.

- Staff we spoke with said the working culture was open and honest which enhanced communication. Senior leads recognised that staff valued honesty from leaders. Senior leads acknowledged the challenges around workload and capacity remained as extra staffing resources were not always possible. However, senior leads said the priority was to look after the staff with regular engagement, supervision and the trust's freedom to speak up guardians. Staff with personal circumstances received support through referral to occupational health.
- Staff told us they felt cared for, respected and listened to by their peers. Health visitors, school nurses, community nurses and therapists reported approachable and supportive colleagues. Staff told us they received counselling and debriefs when needed. Staff we spoke with valued peer support and joint training sessions. Staff said they were able to ask questions and received responses quickly from service leads.
- Staff told us the trust was an enjoyable and rewarding workplace. Staff highlighted the supportive environment and appreciated the training provisions. Several staff travelled long distances to commute to work and had continued to do so for several years.
- Senior leads referred to the staff as their "biggest asset". Senior leads of the service felt proud of their teams and told us staff were committed, respectful to patients and colleagues and made a positive difference to their local communities. Staff and senior leads were proud of the high retention of staff. Staff felt communication with their managers and team was effective. Staff were aware of the trust's award system and felt valued at a local level by their peers and managers.
- The trust had different diversity network groups in place for staff such as the Black and Minority Ethnic (BME) network, disabilities network and the lesbian, gay, bisexual, and transgender (LGBT) network. The trust offered LGBT awareness training, which although not mandatory, was readily available. Although the trust did not mandate unconscious bias training as part of the recruitment process, the trust's clinical development

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programme included an ‘understanding unconscious bias’ workshop. However, staff we spoke with did not mention this to us, which may suggest staff were not aware. BME staff we spoke with said they had received opportunities for career progression but they were aware of less BME representation at senior levels within the trust.

- The trust had improved processes for staff to share learning and good practice effectively across localities with their colleagues. At the last inspection, we found there were limited opportunities for shared learning of different practices across localities. On this inspection, staff told us that communication around sharing learning had improved. For example, the medical director met monthly with clinicians across the localities to share learning and best practice. Each locality had an integrated children’s services manager or equivalent who met regularly to facilitate cross-locality shared learning.

Governance

- The trust had governance structures across the CYP services and localities and staff felt they were effective. The trust had established patient safety and performance governance arrangements which were ordered into three tiers of reporting, each meeting monthly. The tiers included trust board, quality and safety committee and locality performance and quality safety groups (LPQSG) and departmental performance and quality safety groups (DPQSG).
- 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.
- Each CYP 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 LPQSG, which then reported up to the trust board.
- We reviewed minutes for the quality board report for September 2017. The agenda included discussions on staffing trust-wide (including vacancy, turnover,

sickness), financial performance, risk registers, quality dashboard and exceptions, equality impact and actions required. The dashboards were ‘live’ and allowed for direct scrutiny of present performance.

- The trust had forums and meetings for CYP staff to monitor quality, review performance information and to hold service managers and leaders to account. We reviewed minutes for monthly performance reports. For example, the Havering monthly performance report for July 2017 included discussion on key performance indicators for school nursing and health visiting, caseloads, do not attends (DNA), referrals received, discharges and staffing capacity.

Management of risk, issues and performance

- The trust had a major incident plan, policy and protocols in place for the CYP service. The staff we spoke with demonstrated awareness of the trust’s major incident plan and told us they could find emergency contact telephone numbers easily.
- 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. We reviewed the July 2017 monthly safeguarding summary report for shared learning and operational action for Barking and Dagenham, Redbridge and Thurrock. The minutes included a headline message on terror threat with advice to stay vigilant and provided the anti-terrorism hotline number to staff.
- CYP staff cited recent examples where business continuity plans had been implemented. For example, staff told us about the cyber-attack in July 2017. Service leads told us business continuity plans were in place. We reviewed the minutes for September 2017 quality board report where an update regarding the cyber-attacks had been included. The trust had plans, which involved using the leading next generation antivirus solutions, after a trial use. The trust had selected an external company to help them with their cyber security essential accreditation planned for October 2017. This accreditation would allow the trust to inform staff about fake emails and increase cyber awareness. Staff told us they could access the business continuity plan readily on the intranet and found it easy to follow using the flowchart.

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- The trust had fully embedded agile working since the last inspection. Staff told us they used a buddy system and kept in touch with colleagues using a mobile messaging application. We reviewed the agile working policy and found it thorough covering equipment and technology. Staff told us they used the alert system on the electronic recording system to highlight any safety issues and notified the duty desk. Some localities had a code word in place for staff to use.
- Senior leads told us they reviewed risks weekly, allowing actions to be completed on a local level.
- The trust still reported staffing levels as a risk on the risk register for all of the services in each locality. At the last inspection, across all services, workforce vacancies, staffing levels and heavy caseloads were reported as risks, with vacancies in paediatric therapies. On this inspection, identified risks on the register included insufficient capacity either due to increasing demands or staffing levels, heavy caseloads and vacancy gaps in paediatric therapies such as speech and language affecting waiting times. The trust managed staffing and capacity risks by increasing skill mix, using the caseload waiting tool and routinely employing locum and agency staff but the recruitment challenges remained in some services. Other identified risks included retendering and decommissioning of services and changes to Child Health functions. The CYP service rated risks according to impact and likelihood and serious risks were addressed with an action plan and a named lead.
- Staff told us new services where contracts had changed recently, such as health visiting and school nursing in Thurrock, had been added to the risk register. Service leads reviewed new services monthly at the Data Performance Quality Safety Group (DPQSG) meetings.
- The CYP service adhered to the trust's lone working policy, which staff could find on the trust intranet. The policy was based on NHS Protect, Health, and the Safety Executive guidance. The policy stated there were health and safety advisors available for staff and managers. Staff we spoke with demonstrated good awareness of the lone working arrangements. Staff told us they used a code word, which differed, in each locality. Health visitors and children's community nurses conducting home visits used text messaging through phone applications, to inform other staff of their location. Staff recorded visit details in their electronic diaries. The

service had a buddy system in place 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 daily.

- The trust provided information to staff via a trust bulletin, emails and staff meetings. Service managers cascaded information about complaints and incidents to staff via team meetings. We saw the minutes for August 2017 Waltham forest monthly children's integrated services meeting. The agenda included discussion on safeguarding, performance dashboard for mandatory training and supervision, quality and patient safety (which included complaints, compliments, risk register, serious incidents, high risk reporting, patient feedback and service development).

Information Management

- The trust had fully embedded the agile working policy, which included guidance on laptops and other equipment. The trust supplied staff with encrypted phones and laptops to ensure security in line with the trust's data management policy. The service had a dedicated IT team, which staff said were responsive and efficient. Staff told us the agile working team attended staff away days to support and speak to staff about any concerns. Staff we spoke with told us they called the duty desk when they had a home visit or if they were going home post visit. Staff told us the trust intranet was better than before.
- Practitioners across universal and therapy services had laptops, secure mobile internet connections and mobile phones to support remote and mobile working. We saw practitioners using laptops to complete forms with patients and record notes simultaneously during clinics and home visits. Practitioners were responsible for updating the shared drive documenting children with child protection plans, looked after children and children in need. Staff told us they could find the shared drive easily. The shared drive held information on specific service pathways and care plans. Staff did not mention any delays with test results.
- At our last inspection, service leads within the service recognised the need for remote working champions and further training to help staff understand the time saving benefits of this technology. During this inspection, staff told us that the trust had agile working champions in place.

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- The trust used two electronic record systems (ERS) to input and access patients records. Since the last inspection, the trust had put in place a champion in each locality for each ERS system, which supported staff with agile working. Staff were encouraged to attend the ERS user group forum, which took place every six weeks. Patient notes were available electronically which meant they were easy to access with no issues with legibility.
- Regular updates to templates on the electronic recording system took place to facilitate agile working. Staff told us the trust involved them in the development of templates or forms for the ERS systems.
- Some staff felt positive about agile working as it improved their work life balance and reduced travel time. Although most staff told us agile working was good for record keeping, some staff felt that agile working made it difficult to connect with the patient.
- Although staff told us flexible working was effective as it helped them to make better use of their time, staff also told us that some equipment such as old laptops required updating.
- At our last inspection, some practitioners told us that remote connections to the ERS were not always reliable and contemporaneous recording of notes was not always possible. However, on this inspection, most staff told us the connectivity had improved. The trust addressed the remote connectivity issues by using different network providers in different localities, based on the strongest signal. Staff told us connectivity on home visits was facilitated using 4G sim cards in the laptops and we saw evidence of this working well.
- Although staff said that some of the equipment was old, staff we spoke with told us IT support was effective and responsive. Staff told us the current model of trust phones took time to send text messages on. Some staff would send a text from their personal smartphone and then to the work phone before sending the message to the patient. Some staff told us that smart phones would be useful to show patients and families the relevant mobile applications during consultations. Staff members received requests from families and carers to have information via emails.
- Further to staff feedback, the trust had recently piloted the use of smartphones to work out which phone was fit for purpose and to support the use of smartphones

replacing the paper dairies. However, staff awareness of this pilot varied and so the details of the pilot were not clear. Some therapy staff told us they did not have a trust phone and used their personal phones.

Engagement

- The CYP service obtained feedback from patients. The service carried out 'five by five' telephone surveys where a member from each team called five patients and asked five questions each month to discuss their experience of the service. This allowed the clinical teams to respond to any concerns at source. The trust provided summary data from five by five reports on a quarterly basis to the commissioner. Staff told us the trust made service improvements further to feedback for example, the implementation of the duty desk for health visiting and school nursing services.
- Similarly, staff at Hainault Health Centre also gave us an example of how the service made improvements further to patient feedback. Patients had commented on the empty reception desk since the implementation of agile working. The service now had a clinical assistant based on reception who was able to direct patients to their clinics. Staff told us that some health centres had family community days.
- The service used social media to get information to the public and this had proved popular. For example, the health visiting team had a Facebook page, which received the most 'likes' across the trust. School nurses had a Facebook and Twitter page.
- Senior leads told us the trust invited patients and their families to attend the trust board meeting to share their experience of the service and suggest improvements. Service leads told us that patient representatives and young people took part in interview panels. Staff told us about the production of a CYP leaflet on health care assessments included young people in the development process.
- The Acorn Centre had a parent forum in place. Parents had provided feedback on the language used in Education Health and Care (EHC) plans. Parents found the language too complicated and could not determine the responsibilities of all the stakeholders. EHC plans involved health, education and local authority. Service leads had discussed this feedback with the borough and planned to work on a flowchart with the integrated

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team explaining the process and stakeholder responsibilities. The service leads planned to present the draft flowchart to the parent forum to check understanding of the language and clarity of process before implementing.

- Staff at Grove Health Centre held a parent engagement group, which had been in place since March 2017 and membership was increasing. Further to parent feedback, staff told us the service was implementing a new questionnaire as part of the pre-assessments forms. The questionnaire would allow the parents to submit three key questions ahead of the appointment to maximise the use and value of the available time.
- Service leads told us patient's family members had provided feedback on the Ages and Stages letters to request the information in different languages. The service was currently working on translating the covering letter as a result.
- Further to the Francis Inquiry report, the trust published 'you said we did' reports every quarter on the trust website to demonstrate areas where they had responded to feedback to improve services. Service leads provided an example of change to the service further to a patient complaint. For example, if staff members could not make contact with a patient or their family by phone, a written letter followed up communication.
- The trust had completed the NHS staff survey and provided data for the staff survey from September 2015 to September 2016. However, the trust told us the results excluded teams with 11 staff or less and could include data for decommissioned services. However from the staff survey 2016 report, the trust was developing locality based action plans through active staff engagement. Each locality would choose the areas they wished to concentrate on, in addition to the three worst scored areas chosen by the trust. These three areas included 92% of staff reported feeling under pressure from self to come back to work when feeling unwell, 25% of staff reported that they felt there are enough staff available to meet patient needs and 26% of staff agreed that there are enough staff in this organisation to do their job properly. Each locality had

different review dates for the locality plan. The aim of the locality plans was to collate and combine the topics to form an overall trust wide action plan, designed by the staff and delivered in partnership.

- Staff acknowledged communication within community services was good. Staff told us they felt listened to by their managers and well supported. For example, staff at South Woodford Health Centre gave us an example where staff reported concerns for their health and wellbeing. This resulted in the development of a business case which secured funding for staff to access fitness sessions. Senior leads told us stress management training was planned to help staff improve their wellbeing.
- Staff told us they received frequent and effective communication via emails and bulletins, and that managers kept them updated accordingly. Staff told us they had opportunities to provide input into the development of standard operating procedures as there were working groups specifically tasked with this.

Learning, continuous improvement and innovation

- Staff felt encouraged by their line managers to put forward new ideas and make improvements. For example in Barking and Dagenham, staff members completed a piece of work on the costings of health visiting leaflets compared to printing of paper leaflets. As a result, the team had implemented a dedicated social media page to improve public access to information.
- Staff demonstrated innovation using technology. For example, in Havering, the physiotherapy team had filmed their consultations to provide all the exercises for parents from start to finish.
- In Thurrock, staff told us they were using technology more innovatively to improve service uptake and provision. For example, health visitors and school nurses planned to start remote consultations using internet video links. Staff used technology to provide 'e-drop in sessions' so that patients could access services remotely and minimise any disruption to the children's education. The staff made it clear to young people that this was not an emergency service.
- The school nursing service was piloting a new texting system called 'Chat health' to provide confidential and anonymous health advice. The pupils could text the

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school nurses about their concerns and would receive a response within 24 hours. Staff told us they were planning to introduce this service by October 2017 and promote the service using social media and adverts in schools.

- The service was organising a 'Healthy Halloween' event to include oral hygiene, smoking cessation and provision of food for attendees.
- The trust had a new programme called 'Assist' for secondary school students. The programme discussed the dangers of smoking and smoking cessation.
- We saw examples of innovative models of multi-agency working for example, joint commissioning to support

vulnerable families across many agencies. The service developed pathways through experience and measured using individual led outcomes. Similarly, speech and language team were commissioned to work in youth offending teams.

- Staff told us about their plan to integrate early intervention services for autism disorders with CAMHS with implementation of a joint single point of access.
- The trust's medical Education team won first prize in January 2017 at the National Association of Clinical Tutors (NACT) UK for the team's work on sepsis training.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

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.