Achieving for Children Community Interest Company

1-1864199043

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-2067367106	Moor Lane Centre	Moor Lane Centre	KT9 2AA

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

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

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

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Overall summary

The care delivered by the service was evidence based and reflected national and best practice guidance. This meant that Children and Young Persons (CYP) were receiving care that was deemed safe, well-led and appropriate to their needs.

The Care Quality Commission (CQC) undertook an unannounced focused inspection of AfC on 26 September 2018. Focused inspections do not usually look at all five key questions; they focus on the areas indicated by the information that triggers the focused inspection. Although they are smaller in scale, focused inspections broadly follow the same process as a comprehensive inspection. We carried out the focused follow up inspection to ensure the provider had taken action to comply with the regulations in the safe and well-led domains in community children's and young person's service.

The purpose of this was to follow up on the actions the provider had told us they had taken in relation to Regulation 13(2) Requirement notice served with the comprehensive report in February 2017.

CQC will not be providing a rating for this inspection. The reason for not providing a rating is because this was a focused / follow up inspection carried out to assess whether the provider had made improvement to services within the required time frame. During the focussed / follow up inspection we only reviewed the safeguarding in the safe domain and leadership / governance in the well-led domain of the community CYP core service.

At the inspection in February 2017 we found:

- There were serious weaknesses in safeguarding processes in relation to health staff: managers and some frontline heath staff did not have an overview of children in ISCD known to children's social care.
- Child safeguarding supervisors were not trained to deliver this role in line with national guidance.
- Safeguarding supervision was not evidenced in child health records and we were not assured all staff, particularly those delivering sessional care staff had been trained in child safeguarding to level 3
- The pace of implementing learning from serious case reviews was slow.
- Child health records were fragmented and stored in various locations which meant health staff did not have access to a child's complete record; the quality of record keeping was variable and did not always achieve expected professional standards.
- In some services such as short breaks, the consultation and involvement of parents had been less timely and effective.

At this inspection we found:

- The service has better oversight of staff training including child safeguarding training. In August 2018 a training needs analysis was undertaken that sets out core training and additional training requirements for health and therapies staff. It is too soon to evaluate the impact of this.
- Data about health staff child safeguarding training indicates there are gaps in level three training. One out of 31 staff required their three yearly safeguarding training updates.
- The advanced care record has a dedicated child safeguarding tab but this was not consistently used to record child safeguarding information.
- The standard of record keeping was variable in the advanced care notes sampled. There were gaps in recording the family composition in the demographics part of the record and the name and relationship of adults accompanying children to appointments were partially recorded.
- In case records we could see evidence of good information sharing which aids more effective joint working to meet children's needs.

Summary of findings

Background to the service

Achieving for Children (AfC) has been delivering children's services on behalf of the Royal Borough of Kingston and the London Borough of Richmond since 1 April 2014. They are a community interest company (CIC) owned jointly by the councils.

From September 2014, councils took on responsibility for jointly commissioning services for all children and young people with special educational needs or disabilities, both with and without education, health and care plans (EHCPs). Local authorities, NHS England and their partner Clinical Commissioning Groups (CCGs) must plan for agreeing the education, health and social care provision.

Children's care services are accessed through the single point of access (SPA). SPA referrals are followed by an assessment by an ISCD social worker who will consider a child's eligibility for services and make referrals to the team best suited to support the child and their family.

AfC hold the computer-based Register for Children and Young People with Disabilities for Richmond and Kingston, which contains information on those who receive or may one day need to use the services from health, social services, education or voluntary organisations. All local authorities are required by the Children Act 1989 to hold a register. AfC encouraged families to register although registration was voluntary.

Our inspection team

The team that inspected the service comprised two CQC inspectors, one inspector with experience in children services inspection. The inspection team was overseen by Helen Rawlings, Head of Hospital Inspection.

Why we carried out this inspection

This was a focused inspection to check on the compliance of the requirement notice issued during the last inspection and implementation of the action plan submitted to demonstrate compliance of the requirement notice.

Before our inspection, we reviewed a range of information we held, including the external report, data from the provider, and the provider's action plan and performance data.

Are services safe?

By safe, we mean that people are protected from abuse

Safeguarding

- Staff understood how to protect patients from abuse, and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff told us they immediately escalated concerns to senior staff. Any incident deemed to be a safeguarding issue was reported to the local Adult Safeguarding team. Through our engagement with the provider, we saw

staff made appropriate referrals to the local Adult Safeguarding team, and worked co-operatively with them to protect patients from abuse. Senior managers maintained oversight of safeguarding across the service.

- There was a single point of access for all safeguarding referrals in the Richmond and Kingston area. The risk register identified that school practitioners followed school safeguarding and child protection procedures rather than AFC procedures.
- Most staff in AfC had been trained in safeguarding children with disabilities. There was an improved uptake of dedicated LSCB training course to safeguard disabled children.
- Healthcare staff told us if they had a safeguarding concern they would contact the single point of access (SPA) and talk to a specialist child safeguarding advisor, social worker, their supervisor or line manager for advice and guidance.
- There was lack of formalised agreement to secure the input of named safeguarding professionals. Safeguarding named nurse at local NHS Foundation Trust provided safeguarding supervision to frontline special school nurses and the children's community nurse. We acknowledge this practice is in place but in the absence of an underpinning agreement some fragility remains. Reporting of this practice from the named nurse to the chief nurse at Achieving for Children is not well established to help monitor the impact. The action to address this was RAG rated green in May 2018.
- An account of the group supervision was shared with inspectors but this lacked analysis and there was an absence of SMART actions and plans to direct child safeguarding practice. We examined three children's electronic records that were identified as having been the subject of safeguarding supervision but could not find evidence of this. Consequently, any resultant actions or plans arising from the professional discussion were not seen in the child's records which does not inform their ongoing care. Whilst the chief nurse expects and advised staff to record these important professional discussions there has been no audit or monitoring to check that this good practice standard is embedded.
- Group child safeguarding supervision was offered to the special school nurses and children's community nurse each term. Whilst best practice may be providing this on a one to one basis we could see the benefit of combining the special school nurse and children's community nurse team in this arrangement given their close work with these children. The provider told us following the inspection that supervision was combined.
- The frontline staff were very proud of the model of safeguarding supervision used by the organisation. Supervision can be defined as an activity that brings skilled supervisors and practitioners together in order to reflect upon their practice.
- The service has better oversight of staff training to include child safeguarding training. In August 2018 a training needs analysis was undertaken that sets out core training and additional training requirements for health and therapies staff. It is too soon to evaluate the impact of this.
- The service provided a range of information on safeguarding process including how to raise a safeguarding concern. Examples included an information on recognising signs of bruising on children who are not independently mobile.
- Data about health staff child safeguarding training indicates there are gaps in level three training, one out of 31 staff require their three yearly updates. The data is presented in a way that hinders the identification of staff groups that require/have completed specialist competencies as per national guidance. The staff groups listed should access level three training and not start at level two before accessing level three.
- Child safeguarding supervisors require additional knowledge, expertise and bespoke training above the level three standards (Royal College of Paediatrics and Child Health 2014) to ensure effective development and scrutiny of child safeguarding practice. Supervisors and senior staff had access to training to support the provision and delivery of safeguarding supervision to AfC staff. The training database supplied indicated staff had undertaken this additional safeguarding training to comply with the guidance above.
- Good progress has been made since the last inspection about the use of alerts and flags in the advanced care notes. Alerts and flags are highly visible to staff when they open a child's electronic record. This increases the visibility of children with additional needs and/or vulnerabilities so staff can consider this to inform their ongoing care. In one record we could

see that an alert had been updated swiftly to reflect the changing circumstances of the child in that a looked after children flag had been removed. There are good arrangements in place whereby business support staff update alerts and flags which improves their accuracy to reflect changing risks to children.

- The reason why alerts and flags are placed in records to account for children's changing risks is not always evident in records. Records of children flagged as children in need, contained limited information as to why this had been applied. The lack of consistency in recording this in multi-agency plans or in the same place in the advanced care notes, hindered this further. In one record an alert had been appropriately removed but we could not easily locate information to explain why risks to the child had changed and had to search through summaries of records to find this. Whilst the information was recorded in the record this was reliant on searching for it which for busy practitioners would be time consuming. The use of chronologies of significant events in records can aid the tracking and identification of changing risks to children.
- Action plans from Serious Case Reviews (SCR) were monitored at the bi-monthly Multi Agency Safeguarding Group. The Performance, Quality and Innovation Board (PQI), were aware of all SCRs within the area served by provider and monitored the progress of action plans.
- The number of safeguarding referrals and amount of safeguarding work individual practitioners were taking on was monitored closely. Each practitioner was required to submit figures each month. This allowed trends to be identified and ensures that potential underreporting or excess workloads were considered by managers.
- Staff were aware of their role in identifying and raising a concern for those who may have been subjected to female genital mutilation (FGM). This meant that staff had the knowledge necessary to safeguard children and young people in vulnerable circumstances. There were no recorded cases of FGM identified to date at the service.
- The standard of record keeping was variable in the advanced care notes sampled. There were gaps in recording the family composition in the demographics part of the record and the name and the relationship of adults accompanying children to appointments was partially recorded. This hinders a think family approach and limits professional curiosity around whether the attending adult can give consent or the appropriateness of the adult child relationship. In two records we noticed a delay of a day in recording entries. Whilst an explanation was given in one case this was not evident in the other.
- The advanced care record has a dedicated child safeguarding tab but this was not consistently used to record child safeguarding information. In one record we could see entries made by the health visitor regarding a child subject to a child protection plan. In another case record of child subject to a child protection plan the child safeguarding tab was not used yet occupational therapy staff had attended child protection meetings and had shared information with the social worker. There are benefits to having a shared record however, more may need to be done to standardise record keeping between different services and providers.
- In case records we could see evidence of good information sharing which aids more effective joint working to meet children's needs. In one case the special school nurse liaised with respite staff, school staff and parents and carers to convey important information about a child's wellbeing and the care required. In another, the Speech and Language Team (SaLT) provided through Your Healthcare worked with parents to co-produce a response to challenge the local authority about the provision a child needed that had been omitted from the education, health and care plan (EHCP). Reports from the multi-disciplinary team are shared appropriately with key staff such as GPs, social workers and special school nurses which provides them with up to date information about children's needs.

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.

This key question was not inspected

Are services caring?

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

This key question was not inspected.

Are services responsive to people's needs?

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

This key question was not inspected.

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.

Governance, risk management and quality measurement

- Staff were positive about the structure of the organisation. Staff and managers said the structure of the organisation meant they were only "a few steps from the board". Staff said this meant it was easy to escalate issues or risks.
- The service had processes in place to escalate and discuss risk. Children's services escalated concerns to the Board through the integrated care managers (ICM). The ICMs disseminated information back to team managers.
- The clinical governance group was responsible for providing clinical governance assurance relating to the delivery of the annual priorities and action plan. It was responsible for identifying any gaps or areas of clinical risk, maintaining and monitoring a risk register, and making recommendations to the senior leadership team (SLT) to address these issues.
- Achieving for Children had effective systems of accountability and processes to support the delivery of its strategy, including the delivery of good quality, sustainable children services.
- There was a set agenda for the monthly clinical governance meetings with standing items, which included review of incidents, risks and performance monitoring. The notes of the clinical governance indicated there was a system which enabled the escalation of information upwards and the cascading of information from the management team to front-line staff.
- Staff told us clinical governance was discussed at consultant paediatrician's meetings at the local acute hospital where audits and clinical effectiveness were discussed and clinical care pathways agreed and implemented across the children, young people and families service.

Leadership of this service

- We saw committed leadership and management at operational level and staff told us they were well supported by their managers. Information from management meetings was cascaded to staff via regular email messages and at team meetings. Team leads we spoke with appeared knowledgeable about children, young people and their families' needs, as well as the needs of their staff.
- Since our last inspection Achieving for Children had strengthened the senior leadership of health services they provided and had recruited a chief nurse. The role whilst strategic in its intent involved some operational delivery and management due to vacancies in the service.
- Senior managers understood the challenges to quality and sustainability and could identify actions needed to address them.
- The chief nurse was visible to frontline staff through regular meetings and to senior leaders of achieving for children by attending the clinical governance group and the recently started SEND & ISCD Performance, Quality and Innovation Board (May 2018). Minutes of these meetings demonstrated that the chief nurse was engaged in strategic decisions and discussions regarding the delivery of services to children.
- Staff said leaders were visible and approachable. All the staff we spoke with told us if they had concerns they would feel comfortable to raise them with senior leaders.
- Minutes from meetings the chief nurse had with community nurses, special school nurses and healthcare assistants revealed that safeguarding training and supervision had been discussed within other agenda items. This approach is discrete in nature and could be strengthened by adding safeguarding in its own right to the standard items discussed. This would prompt ongoing professional discussion and oversight of safeguarding children practice between frontline staff and managers.