

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, Chessington, Surrey	Integrated service for children with disabilities	KT9 2AA
1-2067803639	Bedelsford School, Kingston	school nursing and therapy, excluding speech therapy	KT1 2QZ
1-2067804010	Dysart School, Surbiton	school nursing and therapy, excluding speech therapy	KT6 6HL.

This report describes our judgement of the quality of care provided within this core service by the integrated service for children with disabilities provided by Achieving for Children . 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 the integrated service for children with disabilities provided by Achieving for Children and these are brought together to inform our overall judgement of the integrated service for children with disabilities provided by Achieving for Children.

Summary of findings

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Summary of findings

Overall summary

There are no ratings for this inspection as we do not currently rate small community independent health services.

Although we identified a number of concerns on this inspection, the results of a management review were

released at the end of the inspection, and there was some commonality between the findings of this inspection and that review. The recommendations in the management review, if implemented have the potential to make significant improvements in the service.

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 make arrangements for agreeing the education, health and social care provision.

The focus of the inspection was AfC's Integrated Services for Children with Disabilities (ISCD). This service is registered to provide community nursing services services for children registered with a GP in Kingston upon Thames and for those children and young people attending Bedelsford and Dysart schools.

The ISCD is a multidisciplinary service made up of teams from health and social care based at Moor Lane Centre. The service also works with other AfC teams, external services and the voluntary sector to provide appropriate support for each child and young person under 18. The the service provides specialist school nursing in two special schools and the community health service for Kingston Upon Thames only..

Health referrals for Kingston are made through the Integrated Team Around the Child Referrals Co-ordinator, based at the Moor Lane Centre in Chessington. The community clinical services for children with long term and/or complex health conditions and disabilities are paediatrics, physiotherapy and health occupational therapy, clinical psychology, children with disabilities nursing team and the social communication assessment team (SCAT). The service is for ongoing management of long-term conditions and care for children with multiple or complex needs including autism and severe physical disability, and covers young people from birth to 18 years or older if the young person was still under the care of a paediatric consultant. (In Richmond, the local Clinical

Commissioning Group (CCG) commissions similar health services from Hounslow and Richmond Community Healthcare (HRCH) so Richmond health services were not inspected as part of this inspection).

In both Kingston and Richmond, ISCD provides: social care, short breaks, both domiciliary and in the community, specialist participation and engagement for young people, transition to adulthood and specialist family support including social care and physiotherapy and health occupational therapy for disabled children and their families. Parents reported favourably on the help they had from family support workers.

Children and young people's access to the service is 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.

Children and young people under the age of 18 years make up 21.0% of the population of Kingston upon Thames. 51.9% of school children are from minority ethnic groups. The health and wellbeing of children in Kingston is generally better than the England average.

The level of child poverty is better than the England average with 14% of children aged under 16 years living in poverty (England average 19%). The proportion of children entitled to free school meals in primary schools is 9.6% (the national average is 17%) and in secondary schools is 8.3% (the national average is 14.65%).

The largest minority ethnic groups of children and young people in the area are Asian/Asian British. The proportion of children and young people who speak English as an

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additional language is 33.7% in primary schools (the national average is 18.7%) and in secondary schools it is 28.6% (the national average is 14.3%). The largest ethnic group in the borough is from Korea.

There were 115 children in care at 31 March 2015, which equates to a lower rate than the England average. The rate of children in need was 56 per thousand in Kingston compared to an England average of 64.6 per thousand.

Our inspection team

The team included three CQC inspectors and a variety of specialists: including nurses, a physiotherapist and a school nurse manager.

Why we carried out this inspection

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

How we carried out this inspection

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

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

The inspection team inspected the health related activities at the following three registered locations of the service provider:

Moor Lane Centre

Bedelsford School

Dysart School

Before visiting, we reviewed a range of information we held about the provider and the core service and asked other organisations to share what they knew. We carried out an announced visit on 1- 2 February 2017.

During the visit we spoke with over 20 staff including: paediatricians, school nurses, therapy staff such as physiotherapists and occupational therapists and support staff.

We observed how children were cared for and talked with carers and/or family members as well as representatives of several parent groups. We received nine comment cards from parents and staff. We reviewed care and treatment records. We met with two groups of children and young people who use services who shared their views and experiences of their care and treatment.

What people who use the provider say

We spoke with 10 children and young people during the course of the inspection. All talked positively about the care and treatment they received. They told us staff were kind, caring, compassionate, informative, professional and respectful. They said they were listened to and involved with their care and treatment.

We spoke to about 25 parents and carers. Some parents and carers in Kingston told us they felt very involved as a partner in their child's healthcare, but others had concerns about delays in assessments and in obtaining equipment. A number of parents in both Richmond and Kingston were dissatisfied with the domiciliary care

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aspect of the service which should allow their children to take part in out of school activities with their health needs being met. They mentioned limited availability and inequity in distribution.

Areas for improvement

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

Action the provider **MUST** take to improve

- Ensure level three safeguarding training is in place for all community based staff who are working with children and young people in accordance with the Royal College of Paediatrics and Child Health 2014 Intercollegiate Guidance.
- Ensure child safeguarding supervisors are trained and competent to deliver this role effectively in line with national guidance, and that supervision is evidenced in child's health records.
- Ensure the service has ready oversight at all times of children and families using the service who may be at risk, to provide assurance of effective child safeguarding practice.
- Ensure there is a single, accurate, complete and contemporaneous record in respect of each child, including a record of the care and treatment provided to the child and of decisions taken in relation to the care and treatment provided.

- Ensure that all health professionals have access to a child's complete record and summary chronology of significant events that relate to individual children and young people.
- Draw up a robust recovery plan to address the long ASD assessment waits so the needs of children and young people can be identified promptly and effectively.

Action the provider **COULD** take to improve

- Develop robust oversight of the training and development of staff to ensure compliance and competence of the workforce.
- Proactively recruit a health member to the senior leadership team to ensure the continued strategic development of their health services for children.
- Formalise arrangements to monitor training and supervision of other health providers that AfC commission.
- Develop timely and effective arrangements, that are NICE compliant, to support young people in preparing them for adulthood.

Achieving for Children Community Interest Company

Community health services for children, young people and families

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Summary

- A new incident reporting process had been introduced six months before our visit. Relatively few incidents were reported and incidents were managed on a service specific basis, so for example ISCD did not learn, for example, from incidents in portage or other incidents across AfC.
- Dysart and Bedelsford schools and clinic rooms at the Moor Lane centre were visibly clean and provided suitable environments for caring for children and young people.
- Staffing levels were adequate to meet needs with two exceptions: assessment for ASD and in the domiciliary care short breaks service where there were challenges in recruiting and retaining sessional care staff.
- Risks to children and young people were assessed, monitored and managed on a day-to-day basis.
- We could not be assured that all health and care staff were trained to the appropriate level in child safeguarding in accordance with the Royal College of Paediatrics and Child Health 2014 Intercollegiate Guidance. This requires that all staff with substantial access to children to have received safeguarding training to level three. Furthermore, child safeguarding supervisors were not trained to deliver this role effectively and in line with national guidance, and child safeguarding was not well evidenced in child records. We escalated our concerns regarding this issue at the time of our inspection.
- Children's health records did not meet expected professional standards. Health staff did not all have access to a child's complete record. Other record keeping within the organisation, such as equipment loan records were variable in completeness.

However;

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- Management did not have clear oversight of statutory and mandatory training.
- The separate IT systems used in ISCD did not facilitate joint working and underlay some of problems we identified with joint working.

Incident reporting, learning and improvement

- Staff were familiar with the reporting systems for incidents and all staff had access to a paper incident reporting system. Not all staff were able to report incidents electronically. On average five incidents a month were reported to the clinical governance meeting but the minutes generally did not record actions. An annual audit was planned for March 2017 for reporting to the clinical governance group (CGG) but no other analysis of trends was evident. Staff were unsure when asked about trends.
- Staff across the community children and young people services told us the number of incidents reported was low because the types of services they provided meant there was a low risk of incidents occurring.
- Individual services recorded their own incidents and did share learning across other areas of AfC health provision.
- Staff with the appropriate level of seniority, such as the service managers, were responsible for reviewing and investigating any incidents logged on the system to look for potential improvements to the service.
- Staff told us incidents and complaints were discussed at staff meetings, so shared learning could take place. We saw evidence of this in the meeting minutes we reviewed.
- Across the three locations we visited, we saw good practice of reporting incidents and staff were able to explain how they would report and escalate incidents.

Duty of candour

- Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation (being open and honest with families when things go wrong).
- Staff told us that the service had not had any reason to use the duty of candour since its introduction in April 2015. Staff told us the duty was included in safeguarding

training. We were told by the service manager that the incident reporting system prompted staff to consider duty of candour requirements in the event of incidents where something went wrong.

Safeguarding

- 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. Several staff we asked about this were unable to explain what the differences were.
- AfC's safeguarding policy was generic and did not specifically mention children with disabilities, aside from a passing reference to children with communication or learning difficulties having barriers to reporting abuse. This policy approach is not in line with Safeguarding disabled children: practice guidance (2009) which states that disabled children can face an increased risk of abuse or neglect yet are underrepresented in safeguarding systems. The policy did not give information about reporting safeguarding and did not name the safeguarding leads.
- The uptake of dedicated training run by the Local Safeguarding Children's Board (LSCB) was too low. The course was run every year. The annual provision of this training may impact on the accessibility of this to staff. Most health staff in AfC had not been trained specifically in safeguarding for children with disabilities. Of the 27 staff identified on the training matrix, three staff had attended this course in 2014. None were recorded as attending more recently.
- Some sessional bank child care workers took individual children out for the day or stayed in their homes with them while parents were out. They carried out personal care and gave medication as needed. Despite their unsupervised access to vulnerable children they were only trained in safeguarding to level two.
- We saw two different child safeguarding supervision models. AfC policy was for child safeguarding supervision to be part of management supervision. This was insufficient as it prevented detailed analysis of risks and protective factors for individual children, and did not enable the creation of SMART child safeguarding action plans that set out the action required to help

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keep children safe. Furthermore, records of child safeguarding supervision were held separately rather than informing the child's ongoing care, rendering the child's record incomplete.

- In the second model, the lead community nurses told us they had access to quarterly child safeguarding supervision with a named safeguarding nurse in the local acute hospital, therefore distinct from line management and with an appropriately trained professional. Safeguarding supervision was part of the current contract with the local NHS trust. However, nurse records of supervision were not included in the child record so there was no evidence of any resulting individual actions or plans to support the practitioners' ongoing contact with the children
- Child safeguarding supervisors require additional knowledge and expertise above the level three standards (Royal College of Paediatrics and Child Health 2014) to ensure effective development and scrutiny of child safeguarding practice. Supervisors had access to training to support the provision and delivery of supervision to AfC staff. The training database supplied (6/2/17) indicated seven staff had undertaken generic supervision training. After the inspection we were told that the lead physiotherapist responsible for giving supervision to other physiotherapists, had supervision training in 2007 and saw the certificate. There was no bespoke training for child safeguarding supervisors to comply with the guidance above.
- A social care manager told us there were aspirations for health workers to have to have joint supervision with social care. At the time of our inspection we did not see close working between the two services. The electronic ISCD care notes system did not interface with the case management system used in social care. The separate IT systems did not support integrated working.
- Frontline health staff told us if they had a safeguarding concern they would contact the single point of access (SPA) and talk to a social worker, or speak to their supervisor or line manager. Therapists had no direct access to a named nurse, trained to level four, for specialist child safeguarding advice.
- Although managers told us learning from serious case reviews (SCR) was important to service learning and improvement, there was a lack pace in adopting

pertinent recommendations from SCRs. An SCR in Kingston in 2015 that every child should have a lead professional to help co-ordinate their care but this was only due to be in place in June 2017, and then only for children with the most complex needs. The scope of the co-ordinator role had not yet been defined. Other recommendations to use chronologies and monitoring tools such as centile charts were not consistently used in paper or electronic records at the time of the inspection.

- Social workers told us they were planning to introduce the Signs of Safety model, a tool to help practitioners with risk assessment and safety planning working with other disciplines and in partnership with children and families.
- All safeguarding incidents/issues were monitored and reported by the service to AfC Social Care Teams and data was then provided to the Management Board and Clinical Governance Group for action.

Medicines

- There were policies in place to provide staff with guidance on handling and storing medicines.
- The majority of services did not routinely stock any medicines.
- The two schools we visited had a medicines administration procedure for children. Medication administration records that we reviewed were appropriately completed. Although the majority of medicines were stored in the homes of children and young people, those that were the responsibility of AfC staff were safely stored. Fridge temperatures were monitored and discrepancies were dealt with appropriately to ensure that medicines remained effective.
- We found the nursing staff were appropriately trained in the administration of medicines, including medicines given via gastrostomy tube. The nurse demonstrated good practice with regards to the administration, record keeping and disposal of medicine, in line with guidance and legal regulations. Nurses also trained teaching assistants to administer medicines.
- Sessional bank child care workers who cared for individual children requiring medication were given training in administering medication.

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- The two lead nurses were working on a training the trainer model to support the training of staff in centres taking children in AfC's care on activity breaks so their healthcare needs could be met appropriately.

Environment and equipment

- The Moor Lane centre and the schools we visited were well-maintained, free from clutter and provided a suitable environment for treating children and young people. There were suitably adapted toilet facilities in the areas we visited.
- All the environments where children were treated were child/young person friendly.
- The equipment we observed was visibly clean. Children's activity items were age appropriate, clean and well maintained. We saw some bright and colourful areas with lots of space for therapy and for consultation with young people. Staff told us they used sterile disinfectant wipes to clean and decontaminate equipment and toys.
- Equipment servicing was managed by a centralised maintenance team. Equipment we saw had labels showing they had been calibrated or serviced and when they were next due for servicing. All the portable equipment we saw had also been appropriately tested. We also observed a wheelchair clinic, where all wheelchairs were checked and maintained as appropriate. However nurses told us that not all equipment was optimally managed to maximise timely access for children and families. A new staff member would oversee this as part of their role.

Quality of records

- Record keeping did not meet expected professional standards. Health staff did not always have access to a child's complete record.
- At the time of the inspection ISCD were transitioning from paper to electronic records. The interim arrangements were not robust and we saw fragmented records of variable quality. Children who were the subject of safeguarding or looked after were not easily visible in paper or electronic records. This prevented some frontline health staff, in particular specialist school nurses, from having access to a complete health

record to inform the child's ongoing care and planning.

The ISC in their annual improvement plan 2017-2018 set out that IT access for special schools would be operational from the end of February 2017.

- We sampled some records (16) for individual children, for example a community nursing written record, care notes and electronic record, the record held in the special school and the safeguarding supervision record. This revealed a lack of connectivity between records. A parent gave an example of the community nurse and specialist school nurse referring to different care plans in an emergency treatment situation. We also found loose papers in files, including child in need meeting notes and hospital reports which could easily be lost. Files contained documents such as growth charts which had not been completed.
- Not all paper records contained the child's current care plan. This was out of line with the requirements of the 0-25 Code of Practice and the focus on integration of health and education information because of the impact of children's health on their life chances.
- Records were kept in different places, some at Moor Lane and some in schools. They were stored securely.
- Children's health records did not contain either individual service or multidisciplinary team-specific chronology of significant event documents, which could help staff have an oversight of escalating or de-escalating concerns.
- An electronic record system was gradually being introduced. There was no prioritised plan for the transfer of information in paper records to electronic, for example prioritisation of safeguarding information. There was the opportunity to place an alert on children's electronic health records, for example, for children that were looked after or the subject of child safeguarding plans. This useful facility was not being utilised effectively as case records we sampled showed alerts were missing from some records. This reduced the visibility of important information about children in ISCD's care.
- The standard of record keeping around the loan of equipment was variable and not always compliant with AfC policy. We saw cases where relevant details were not recorded – for example a serial number was recorded without naming the equipment, and there was no

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parent signature to confirm receipt. Staff in the same team were working to different standards with regard to recording and obtaining parental signatures regarding equipment loaned to them.

Cleanliness, infection control and hygiene

- Clinical areas at Moor Lane and the schools we visited appeared visibly clean, and we saw staff washing their hands and using hand gel between treating children. Toilet facilities and waiting areas were also clean in all areas we visited. Personal protective equipment, such as gloves and aprons, was available for staff use.
- There were arrangements for the handling, storage and disposal of clinical waste, including sharps in clinic and school environments. Staff used sterile disinfectant wipes to clean and decontaminate equipment as well as other areas of the general environment (e.g. furniture) where patient contact had taken place.
- Staff were aware of current infection prevention and control guidelines. The areas used for seeing Children, young people and families were clean, tidy and well maintained. There were adequate hand washing facilities for staff and patients in the clinic settings.
- Staff carried out routine cleaning of the environment and equipment and completed cleaning checklists. We looked at cleaning checklists across all the locations we visited and saw these were complete and up to date. The IPC policies and procedures included, including guidance related to the cleaning standards. The nurses were the IPC lead in their respective schools, we were not aware of any IPC audits been undertaken by the service.

Mandatory training

- Managers did not have clear oversight of mandatory training. We were told that individual's attendance at mandatory training was held in individual staff files but did not review these.
- The workforce development unit held information about core and mandatory training attendance. The training database showed who had completed training and what was mandatory. This included safeguarding level 3, consent, incident reporting, clinical record keeping, information governance, mental capacity act training and manual handling which had been completed by most permanent staff.

- All community nurses had first aid training, and training in record keeping and incident reporting. However only six of the nine had completed level 3 safeguarding. Only three of the nine nurses had training in infection control, domestic violence and supervision. Domestic violence was high risk in families with children with a disability.
- The therapy assistants had very little mandatory training recorded.
- The training matrix showed physiotherapists had safeguarding and manual handling training, but other training for therapy staff was sparse.
- Staff told us they were responsible for keeping up to date with their own mandatory training. There was a training and development policy for health staff which detailed mandatory training requirements, which were discussed in supervision and annual appraisal.

Assessing and responding to patient risk

- Staff we spoke with were able to demonstrate awareness of key risks to children and young people including safeguarding. We found from viewing children and young people's records that risk assessments were in place to identify specific day to day risks. Risk assessments also contained guidance for staff on mitigating risks, for example in using hoists.
- To mitigate identified risks staff were aware of how to arrange further support for a child, by referral for specialist assessment or provision of additional equipment.
- The local child health profile highlighted factors which made some children in the community more vulnerable. This included the number of children living in poverty with related problems. Staff showed that they were aware of this in their own practice and could help families access other services.

Staffing levels and caseload

- The service did not have enough staff in every area to meet all children's needs in a timely way, particularly relating to ASD assessments. Dysart school considered health resource resilience a concern: nurse staffing was only just sufficient to ensure children were safe and received the right level of care and the school risked closing on a day that specialist nursing was not available.

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- The nursing service covered community nursing and specialist nurses working in two special schools who were employed by AfC. There were 4.2 whole time equivalent (WTE) nursing staff and 1.45 WTE healthcare assistants in post, plus 1WTE agency nurse covering a vacancy. ISCD had recently strengthened the leadership of community nursing with more senior management oversight.
- The community nursing caseload was 34 children. Community nurses carried out about 50 visits a quarter and provided specialist nursing care and equipment at home, support for children and families to manage their healthcare needs and signposting to other support services. Universal health care services such as health visiting were run by another independent health provider, continuing care was provided by the local hospital paediatric outreach team and GPs also provided healthcare. Caseloads were consistent with the previous year.
- About 80 children were on the specialist nurse caseload at each of the two special schools.
- Therapies were staffed by six WTE physiotherapists, five WTE occupational therapists (OT), two WTE therapy assistants and 0.8 WTE clinical psychologist. OT caseloads had increased over the previous year but physiotherapy demands were more stable.
- AfC had delegated commissioning responsibilities for child health services. The paediatricians were an integral part of AfC although the staff were employed by a local acute hospital. The existing community paediatric contract had been extended for a year following problems with commissioning. The service was being recommissioned at the time of the inspection. The paediatric team had a caseload of about 500 children.
- The manager of the service providing breaks for young people said staff shortages were the biggest challenge facing the service. Bank, and, in exceptional circumstances, agency staff provided children with the care they needed when taking part in activities, but

there were occasions where staff sickness prevented the provision of services. Some parents mentioned that the turnover of sessional care staff was high. Demand for short breaks had increased and efforts were being made to provide the same level of service to both boroughs, which had put additional pressure on staffing. Managers told us rolling recruitment took place but demand outstripped supply. Demands on family support were also growing.

- Staff sickness levels were low, 2% or below. There were currently two bank registered paediatric nurses, one physiotherapist and one occupational therapist. We were told there was budgetary contingency for additional or locum staff to be recruited in case of additional need or gaps in staffing levels.
- The schools employed some therapists directly as well as having support from ISCD staff. Teaching assistants were trained by ISCD staff to meet some of children's healthcare needs in the classroom, for example gastrostomy tube management.

Managing anticipated risks

- Clinical staff undertook environmental risk assessments to ensure clinicians were working in a safe working environment.
- All staff we spoke with were aware of the process for escalating risks and concerns to their line managers. Key risks, such as staffing and capacity issues, were discussed during routine meetings within each team.
- Staff were aware of AfC's recently introduced lone worker policy, which outlined the process for managing staff safety where lone and remote working took place. A lone working risk assessment included instructions for staff on how to maintain their safety when carrying out visits. Following the inspection, the provider told us that was also a telephone contact system for lone workers.

Major incident awareness and training

- There were fire instructions for staff to follow in the event of a fire. Not all staff had fire training. There were lead fire warden in both schools we inspected.

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

- There was a plan to review compliance with National Institute for Clinical Excellence (NICE) guidelines. While standard nursing care and therapies appeared to be provided in line national clinical guidance, this was not the case for Social Communications Assessment NICE quality standard [QS 51] which says the diagnostic assessment should be started within threemonths of their referral. Transition from children to adult healthcare was not compliant with NICE guideline [NG43].
- Staff had access to policies, procedures and pathways, although some were due for review.
- Therapy services measured individual outcomes for children they cared for by using goal attainment scaling (GAS). However, the use of outcomes based interventions was less evident in the other services we reviewed.
- Our observation of practice, review of records and discussion with staff confirmed there was multidisciplinary input into children's care.
- Staff were aware of their responsibilities for obtaining consent and we saw consent documented in children's records, from the parent or child or both as appropriate.
- Children and young people had comprehensive assessments of their needs and were cared for by a multidisciplinary team of dedicated and skilled staff.

However;

- There was no location specific performance dashboard. The performance monitoring of ISCD was at the provider level, and individual locations were responsible for monitoring their own activities and outcomes.
- Very limited work had been done on transition to adult health services, which was contrary the Code of Practice for children and young people with special educational and needs and disabilities under the 0-25 SEND Code of Practice: a guide for health professionals. September 2014 (and NICE guidance.)

Evidence based care and treatment

- Day to day care and treatment was evidence-based and the policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE). Community lead nurses told us they had access to a hospital evidence base and access to specialists at several hospitals.
- Autistic Spectrum Disorder assessments were not compliant with NICE because of the very long waiting time for assessments. As a consequence of a commissioning decision children and families were not provided with any post diagnostic follow up after identification with ASD, which conflicts with NICE guidance. This limited the opportunity to explore the impact of diagnosis on the child and their carers and to assess their needs further. Managers told us they were considering whether to add the review to the pathway.
- Pathways for transition from paediatric to adult health services were not NICE compliant. It was developed locally by the provider. Few pathways had yet been developed. Staff were aware of the delay.
- After reviewing evidence of success, a constraint induced movement therapy (CIMT) pathway for improving manual ability in children with hemiplegia had recently been introduced. Hemiplegia is lifelong condition resulting in varying degrees of weakness, stiffness and lack of control in the affected side of the body.
- Staff told us a Policy Development Group was reviewing policies and developing others to reflect current guidelines. Some policies had recently been reviewed (Safeguarding January 2017) and some had recently been written, for example a local Lone Working policy for ISCD. A policy on Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and on physical intervention were in development. We looked at some policies and procedures and these reflected national guidelines.
- We saw from the Management Review that AfC intended to review all its policies to ensure they were inclusive of

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the needs of children and young people with disabilities. ISCD's health-specific policies and operating procedures would be added to the policy framework to ensure there would be a single set of policies covering all aspects of service delivery.

- The management review also identified that multidisciplinary approaches to learning from best practice are less well developed. We saw that there was an intent to give all professional teams within the ISCD to access to the Research in Practice online service so they could use evidence-based practice to develop their own practice and improve the service they provide to children with disabilities and their families, and to ensure staff routinely sought out best practice.
- Children and young people with severe disability, long-term conditions or complex needs had personalised care plans, which were up to date and set out clear goals for them.
- Assessment tools and pathways followed recognisable and approved guidelines. Clinical pathways were used to ensure appropriate and timely care for patients in accordance with nationally recognised standards.

Pain relief

- There was guidance in care plans about pain management for children where it was appropriate. We saw staff follow the pain management care plan and administer liquid analgesia to a child for pain control.
- Clinical staff told us there was no specific paediatric medication prescribing training provided by the service provider for staff to attend.

Nutrition and hydration

- Nursing staff had training on enteral feeding, and in schools, teaching assistants also provided support on this.
- Sessional child care workers on the short breaks service were trained with regard to what the individual children they worked with could eat, and the support they needed with eating and drinking.

Technology and telemedicine

- Care records were in the process of being digitised.
- Telemedicine was not used to monitor children's health and no telephone clinics were run.

Patient outcomes

- Each professional group was responsible for monitoring their own activities and outcomes for children. Managers were not therefore able to benchmark outcomes against other providers to compare the impact of the service on children and young people in line with good practice.
- No staff mentioned individual healthcare plans to specify the level of support required to meet the medical needs of children and young people with medical conditions and how this linked with any education plans. The Supporting pupils at school with medical conditions 2014 guidance was not referenced on the local offer website.
- The physiotherapy and occupational therapy staff measured patient outcomes using nationally recognised tools. Data showed improved functional outcomes and reduced pain. However, the use of outcomes based interventions was less evident in the other services we reviewed.
- The health care service carried out a number of clinical audits, for example monthly case note audits, hip surveillance audit, orthotics demand and had audited the care pathway needs in preparation for the introduction of the electronic case notes system. We reviewed the audit report of case notes to senior managers and found it did not show trend analysis month on month, and potentially gave false assurance in the light of our concerns about the quality of records.

Competent staff

- We were told by the service manager that newly appointed staff received an induction, which included a corporate induction and mandatory training. However the training matrix did not record that most staff had received an induction.
- Clinical staff told us they routinely received clinical supervision, this included safeguarding supervision as well. We saw a supervision schedule for physiotherapists and occupational therapists showing monthly supervision. Team meetings were used to provide peer group supervision and case study discussion.
- We reviewed some management supervision records, for which safeguarding was a standing agenda item, but

Are services effective?

found the safeguarding information recorded were limited. There was no evidence of any resulting individual actions or SMART plans to support the practitioners' ongoing contact with the children.

- Nurses and therapy staff providing community children's services were competent and knowledgeable when we spoke with them. We saw there was an annual training needs analysis and, for example, additional training was planned for managers to cover skills gaps that had been identified.
- An external provider offered training for AfC staff in speech and language.
- Therapists told us they had access to training to support their professional development. CPD lunchtime sessions were available, but no information was available on attendance.
- Staff said they were encouraged to access additional and specialist training as part of their professional development. They told us managers were supportive of study leave.
- A parent reported a lack of confidence that all sessional workers were sufficiently trained in the use of equipment such as hoists. We were not assured that all sessional workers had effective training.

Multidisciplinary working and coordinated care pathways

- Achieving for Children (AfC) held a weekly meeting, Integrated Team Around the Child (ITAC) meeting at Moor Lane Centre where the health referrals were discussed and allocated. This meeting included professionals from other providers, for example the organisation providing speech and language therapy.
- There were monthly (health-led) multidisciplinary Team (MDT) meetings. A separate multidisciplinary meeting co-ordinated the care management for children with the most complex needs. Practitioners reported inconsistent attendance at the meeting by all teams. We noted the intent to make attendance at MDT meetings contractual which would improve their value.
- There were no clear MDT overview for individual child, even though the management review commissioned by the service recommended a "Team Around the Child" (TAC) approach to reviewing the care plans of children.

- There was no management level overview of how many children used a combination of health services. More than one parent reported that medical professionals did not communicate with one another and were not present at Moor Lane case reviews.
- Nurses said the service worked closely with the Paediatric Outreach Nursing Team (PONT) from the local acute hospital, and some children moved between the two services. They worked with the local school nursing team run by another provider, with whom they had regular meetings (three to four times a year).
- The quarterly Joint Health Service Managers meeting at Moor Lane, focused on early years, which involved other local health provider providing health visiting. Some parents reported insufficient early years support, given the recognised importance of early intervention. They said that parents who could not afford to seek help more quickly by paying for support risked missing out.
- The SCAT team consists of professionals from ISCD and external providers to include; speech and language therapy, clinical psychologist, educational psychologist, and developmental paediatricians. The team undertake assessments for autism spectrum disorder in children age 0 to five years of age and older children with significant learning difficulty.
- The Moor Lane centre is a hub for a range of services for children and young people external to ISCD such as the child and adolescent health service, educational psychology and the educational service for sensory impairment (ESSI). Co-location of services whether external to or part of ISCD did not always contribute to effective joint working. Services for continence, wheelchairs, continuing care and palliative care were provided by other external organisations. Although the local offer website signposted parents to all these organisations, we would have welcomed more assurance of seamless services to families through close working between the various providers.
- There was potential for confusion for families because some services commissioned by the CCG were only for families with a Kingston GP, whereas other such as the portage service (a structured home based system to support a child's early learning and development) was for children in both boroughs.

Are services effective?

- Bedelsford School held daily health briefings with nurses and therapists. Confidential information sharing books linked nursing and care and each child was assigned a key worker through the day. Other information sharing was conducted through email and telephone calls. There were half termly meetings between therapy, nursing staff and school staff. There were also six monthly, multi-professional meetings to which community nurses were invited. The head teacher said that day to day communication between health professionals was sometimes difficult because the different hours services worked.

Referral, transfer, discharge and transition

- There were aspirations to improve transitioning between hospital and ISCD community services through joint handovers but this arrangement was underdeveloped and did not happen routinely. We observed a joint handover that showed the benefits of this approach; the nurse sensitively completed a holistic assessment of the complex needs of a child at the point of transitioning into their service. The nurse fully engaged the parent in co-producing the care and plans of their child.
- Operational managers reported that there were few clear pathways to support and prepare young people moving from paediatric to adult health services other than a pathway for young people with learning disabilities. Staff told us a number of young people under the care of the disabled team transferred to the local college for 16 -25 year olds with high needs.
- Staff acknowledged delays in the implementation of the Preparation for Adulthood SEN team. This meant that children were not being transferred from the ISCD team, family support and social work teams, increasing their caseloads. This was on the risk register. We saw that some older children already attended joint clinics with adult services, such as a joint splinting clinic, and we were told there was effective transition for ASD patients who transferred into the Community Neuro Rehabilitation Team run by another local provider.
- We were not able to review EHCPs because paper and electronic health records did not make it easy to identify

which children had them. As a consequence we had limited opportunity to review more broadly the quality of ISCD health professionals' contribution to EHC assessments, plans and transition arrangements.

Access to information

- Staff within the service reported they had good access to information and had hard copies of policies and procedures and electronic copies off the intranet.
- We saw a number of leaflets for families. Some information was aimed at parents and carers were not easy to read, for example the information on how to access the Aiming High grant for short breaks. However we saw very clear information in leaflets for young people. We were told that more leaflets were in development, for example on gastrostomy, blood tests and orthotics for young people.
- The guide to services, the 'local offer' was mainly internet based and so may not have reached some parents were not accustomed to use the internet as an information source. It contained a lot of information and allowed people to create personalised accounts to filter relevant information on the website in a variety of formats, such as video and cartoons. There was very clear information for children and young people using a variety of formats such as video and cartoon but some of the information for parents was complex, and some of the downloadable documents were not easy to read. For example information about personal budgets. We were told a separate brokerage service helped parents with the process.
- The Special Educational Needs and Disabilities Information Advice and Support Service (SENDIASS), a confidential and impartial support and advice service for parents, carers, children and young people (up to 25 years) on issues related to Special Educational Needs and disability was based in the same building at Moor Lane.
- Children and young people at Bedelsford and Dysart schools had home school books where nursing and therapy staff could record information for parents, and parents could leave messages for health staff.

Are services effective?

Consent

- The community children's nursing team told us consent to share information and consent to provide care and treatment to children and young people was recorded and reviewed annually.
- Parents were involved in giving consent to examination and treatment of their child until children could consent themselves. Staff were aware of Gillick competence. This is a decision whether a child or young person aged 16 years or younger, is able to consent to their own medical treatment, without the need for parental permission or knowledge and would respect the rights of a child/young person deemed to be competent to make a decision about their care or treatment.
- We observed how community nurses explained procedures to children in a way they could understand. We attended home visits where we observed examples of staff asking for permission before providing care and treatment.
- For care staff supporting children at home or taking them on outings an agreement was drawn up, following a home visit by the carer. Parents were asked to give written consent.

Are services caring?

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

Summary

- Children and young people and their families were supported and treated with dignity and respect, their privacy and confidentiality were respected at all times.
- Parents spoke highly of the care children and young people received and told us they felt involved in their children's care. We observed examples of compassion and kindness by staff. Staff spent time with children, young people and their families in their homes and in clinic environments to make sure they understood their care and treatment.
- Staff were passionate about the care they delivered and this was reflected in the positive comments made by patients and their relatives.
- Children, young people and their families encouraged to be involved in making decisions about their care. Staff spent time talking to children, young people and parents, often using specialist communication techniques.
- Staff responded compassionately when children and young people needed help and supported them to meet their basic personal needs.
- Throughout our inspection we found the approach staff used was consistently appropriate and demonstrated consideration and compassion for the child or young person. Staff interacted with children, young people and their relatives in a respectful and considerate manner.
- We spoke with three parents regarding the care their children received and they told us that children were seen as individuals foremost, and their physical, emotional and social needs were recognised and responded to.
- Parents told us staff demonstrated an effective approach to calm children who were distressed and provided clear explanations of the care being provided. They said staff ensured children understood the importance of taking their medication and staff were sensitive and supportive of their child's needs.

Understanding and involvement of patients and those close to them

Detailed findings

Compassionate care

- We observed compassionate care delivered by staff across community services. Staff were seen to be responsive, considerate and empathetic towards children, young people and their families, and other people. Staff demonstrated a good understanding of children and young people's emotional wellbeing. We observed gentle and responsive care to meet child's needs.
- Children and young people's social and emotional needs were valued by staff and embedded in the care and treatment community staff provided. There was a visible child-centred culture. For example, we observed a physiotherapist talking to a parent about their child's progress.
- Many of the patients and parents we spoke with were complimentary about staff attitude and engagement. They told us the staff kept them up to date and informed about the care and treatment their child received. The comments received included, "I feel listened to and understand the reasons for the appointment" and "staff explained what they were doing".
- All the parents and carers we spoke with told us they felt involved in the child's care. We saw that staff spent time ensuring they, and the children as far as possible, understood their care and treatment.
- The clinical staff ensured parents and guardians were invited to relevant appointments at schools or the Moor Lane Centre to make sure they were involved in the care of their child.

Are services caring?

- We spoke to two carers of looked after children who told us the service was good and the young person they cared for had given consent to ensure that they were kept informed about the care.
- Staff told us a priority was to improve the understanding of children and young people about the safe use of equipment, medication and other tools and this should be reflected in all care and treatment plans.
- We saw staff skilfully using a wide range, and often highly specialist, communication techniques to understand and respond to children and young people's views, wishes and feelings.
- We saw two examples where the voice of the child was captured well. In one sampled record the All About Me section of their EHCP was child centred and evidenced the voice of the child well by saying "I have a hearing

difficulty and need the following approach". The lack of easy identification of which children had an EHCP limited our opportunity to test the voice of the child further.

Emotional support

- Parents we spoke with at clinics and at home told us they and their child were given emotional support by clinical staff.
- Staff we spoke with were aware of the emotional aspects of care for patients living with long term conditions and provided specialist support where this was needed.
- Joint development sessions had been implemented and delivered with parents to promote the experience of families receiving services and to ensure the emotional and social needs of the family were recognised and understood earlier.

Are services responsive to people's needs?

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

Summary

- ISCD services were mainly planned and delivered in a way that met the needs of the local population and staff respected the equality and diversity of patients and their families.
- The ISCD service used standardised care pathways, which gave continuity of care to a family even if they moved within the borough.
- Waiting times were variable. They were much longer than recommended national guidelines for assessments for children who might be on the autistic spectrum.
- There was a weak system for ensuring all managers had an overview of all complaints and that relevant staff learned from these.
- Staff had access to translators and a translation service.
- We saw evidence of staff been responsive to meeting the needs of patients including those with complex medical needs, those with severe disability and those with Autism.
- Health occupational therapists did not issue large health-related equipment. Families had to apply to the CCG. A parent told us they had been on a waiting list for two years for home support equipment which limited what their child could do at home.
- There was a four week waiting list for orthotics equipment to meet children's assessed needs. The demand for the service had doubled in the past year and the service had noted the increase.
- Some parents said the frequency of physiotherapy offered by ISCD was only every four to six weeks which meant they had to supplement their child's physiotherapy by making private arrangements.
- In view of the pressures on demand for health and therapy services we noted the intent to re-baseline demand for health and therapy services based on a clear assessment of need; and to negotiate with commissioners for additional funding where the need for additional health and therapy provision was evidenced.

Detailed findings

Planning and delivering services which meet people's needs

- The waiting list for assessment of children for autism was too long at 67 weeks. Post-diagnostic support was not commissioned. A proposal had recently been agreed to reduce the waiting list over a two year period but the pace of implementation was slow, and the plan did not show milestones to measure progress.
- Staff told us small items of support equipment were readily available; however, funding applications had to be made for larger items such as suction machines, which was time consuming and could lead to delays. Some parents mentioned that the process for obtaining regularly used equipment such as catheters and swabs was haphazard. As a result, they had to collect items from Moor Lane themselves rather than having it delivered.
- Since April 2011 has been a legal requirement to provide short breaks for disabled children with a care package enabling them to participate in out of school activities. A short break is any out- of-school activity that a child does that provides a positive experience for them and a break for the parent. The activities included holiday clubs, after school clubs, individual activities such as horse-riding or swimming, overnight stays away and holidays. There were different levels of service, and different residential opportunities between the two boroughs. A number of the parents were unhappy about the availability of short breaks and considered AfC had not taken sufficient account of families' views and needs in planning provision given that consultation was a fundamental part of the SEND reforms.
- AfC accepted that the commissioning process for short breaks in 2015 and 2016 had not been timely, had not involved parents, carers and young people sufficiently and recognised some potential providers had not tendered because of short timescales. The process for 2018 was being managed by an experienced commissioning manager.

Are services responsive to people's needs?

- There was dissatisfaction from some parents about the high threshold for access to short breaks. About 90% of those whom a social worker assessed as needing the service were accepted but many other children on the Register of disabled children did not have the opportunity for out of school activities in which their health and care needs could be met. We noted the recommendation in the management review that managers must ensure the consistent application of eligibility criteria and the provision of support through case sampling and other established quality assurance activities which would help ensure equity.
- Parents told us the application process for Aiming high grants for which any child meeting the criteria in the Equalities Act for disability services was eligible, was too difficult for many parents to complete. We noted the proposal for a single panel to make co-ordinated decisions about the allocation of short-break care support, and the introduction of a single appeals panel.
- The introduction of Parent Carer Needs Assessments had also caused concern among parents. AfC was reviewing complaints that the process had not been applied consistently and had not led to the provision of appropriate and timely support.
- Although all children and young people had 'all about me' booklets, health passports were not yet being used. Nurses said there was a plan to develop these and we saw a model passport.
- Staff provided some parent education about caring for children with specific disabilities. We observed a session for parents of fussy eaters to help them understand their child's anxiety about unfamiliar foods and how to introduce change.
- Information leaflets about services were available. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Patients that could not speak English were identified when referred to the services. Staff had access to an interpreter service if needed. Staff had a good understanding of the ethnic diversity and levels of deprivation within the local population.
- Staff told us how they accommodated religious and cultural diversity of patients and how it had informed individual care plans of these patients.
- Equality and diversity awareness training was available. Although not all staff had completed this many staff could demonstrate an understanding of the issues.

Meeting the needs of people in vulnerable circumstances

Equality and diversity

- We found the service had a positive approach to equality and diversity; staff were committed and proactive in relation to providing an inclusive workplace.
- A range of staff patient groups contributed to the organisations equality, diversity and inclusion agenda, which included learning disability patient groups, young people with disability who had transitioned to adult services and parents' groups.
- Staff could provide accessible plans for children and young people available and some information for adults was available in accessible format.
- Most staff we spoke with had a good understanding of the population using the service and were able to explain with confidence the needs of the people they cared for. However we saw limited efforts to engage hard to reach parents who might not use the internet or who did not speak English.
- Although we were told that vulnerable children such as 'looked after children' were identified when referred to the service, we found health staff did not know how many children they cared for who had SEND; were on child protection plans (4); or were looked after children; or who had ECHPs (34).
- Support for children with long term conditions was shared with other agencies to ensure a multidisciplinary approach to care based on individual needs. We spoke with the parents of two children with long term conditions, who told us that all condition specific referrals had been made by the school to other services, such as occupational therapy and physiotherapy.
- Nursing staff said they would like to provide support for families after a new diagnosis but this was not commissioned.
- Families contributed a payment towards short breaks but AfC was able to subsidise low income families.

Are services responsive to people's needs?

Access to the right care at the right time

- ISCD's healthcare services were available during normal working or school hours. There was no emergency service.
- There were waiting lists for some services. The most concerning waiting list was for those waiting for diagnosis of ASD. The longest wait at the time of the inspection was 67 weeks, far exceeding the NICE guideline of three months. AfC had approved funding in late 2016 for a recovery plan to reduce the waiting list to three months over two years. They planned to raise the assessment rate from eight to 12 a month. We requested, but did not receive a detailed plan to define the trajectory, which we were told would include training staff in specialist assessments and recruiting more staff. Implementation was slow in the light of need. A number of parents we spoke with told us they had paid for private diagnosis because of the waiting time.
- We were told waiting lists for health occupational therapy were within the 18 week target. Almost all children referred to physiotherapy were seen within 18 weeks.
- The short breaks service offered a paid service to extend the length of a normal short break activity for working parents from 8.15am to 5.45pm for children over eight. This enabled children to continue to receive relevant care and support over a long period. Some parents said the services did not always offer continuity either of staff or activity.
- Waiting times for clinical psychology were four weeks
- Some parents used personal budgets to access a care package enabling their child to enjoy a short break. No staff mentioned personal health budgets during the inspection, although these should be an option for children with long term needs who could benefit from one.
- During our inspection we observed that children and families did not wait long before being seen in clinics at Moor Lane Centre. Parents told us when appointments were running late the staff kept them informed.
- All professional groups had aspirations for their service but no structured plans for achieving this in a climate of tight funding and a recruitment freeze.

Learning from complaints and concerns

- There was complaints policy. Information on how to make a complaint was displayed in all the locations we visited; this included a telephone number and email address. There was also an accessible version.
- Families could raise concerns in schools or at the centre. Families and carers told us they were able to raise any concerns and make complaints freely. A complaints escalation document was published on the Local Offer website. We saw that the clinical governance group reviewed complaints at a high level.
- Complaints were managed formally and rather defensively. There seemed to be little opportunity for informal resolution. Staff were informed about the outcome of complaints and incidents within their area of practice, but not all staff were aware of themes of complaints. This restricted opportunities for improvement through learning from complaints.
- The complaints record keeping shown to us was confusing. Prior to the inspection, AfC reported they had one complaint in the last 12 months; however a database received later showed three complaints, but did not include the complaint mentioned in the first return. When we reviewed a complaints file there appeared to be other complaints, albeit not a large number, and we saw other complaints referenced in clinical governance minutes. Some of the records on the complaints file were poor photocopies so we could not read the full complaint.
- The most significant complaint from a parent group had been upheld, and had led to an extensive management review of ISCD. An action plan was to be drawn up to improve the areas of identified weakness which included: poor engagement with families; skills and competencies within the ISCD workforce; a lack of quality assurance mechanisms and the effectiveness of parent/carer needs assessments.
- Informal complaints were not captured. A few parents mentioned concerns they had raised but we did not see these in the complaints file. For example complaints about lack of clarity in ISCD communications with parents or that a package of care was changed without parent's knowledge or input. Managers told us there were plans for more timely reviews of packages with more parent involvement.

Are services responsive to people's needs?

- We saw a spreadsheet recording compliments from families about aspects of the service. A number of parents who completed comment cards were also complementary about individual staff, particularly the responsiveness of school nurses.

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

- Senior staff identified with AfC but frontline staff identified with ISCD or individual schools more than with the parent organisation Achieving for Children.
- A lack of health expertise at senior management level in AfC meant that some requirements had been overlooked.
- Not all risks we identified were on the risk register.
- Managers did not have sufficient quality assurance measures in place.
- ISCD managers did not routinely communicate with staff on wider service developments and priorities. However staff reported communication was good at local level. We met some committed and enthusiastic teams who were working hard to develop and improve their services.
- Arrangements for involvement of young people in shaping the service were far more developed than arrangements for involving parents.
- If implemented the recommendations of the recent management review had the potential to lead to a stronger, more effective and responsive service.
- The head of service and head of health and therapies in ISCD directorate were both interim posts at the time of the inspection. They attended ISCD management board meetings. There had also been a number of recent changes to operational management.
- Working together to safeguard children (2015) sets out that providers of NHS care should identify named safeguarding professionals to promote good professional practice, expertise and training pertinent to health in the organisation. After the the inspection, the provider showed us they had secured training and supervision for ISCD staff by contracting with an NHS provider.
- We saw committed leadership and management both at operational level and among senior staff. 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.

Detailed findings

Leadership of this service

- The senior leadership team at AfC did not have a professional with health expertise senior leaders brought this to our attention and reported their intent to recruit into a post to address this. This was a clear gap in a complex commissioner / provider structure in which the Council and the CCG integrated their respective health related functions relating to children and young people with disabilities, developmental and complex health needs, those subject to child protection investigations, those supervised by the Youth Offending team and looked after children.

Service vision and strategy

- The vision of AfC was to provide children and their families with the support and services they need to live happy, healthy and successful lives. Staff were aware of the AfC vision but their focus was on the health and therapy services provided by ISCD. ISCD was a service provided by AfC, whose main expertise was in the provision of early help, social care and education services for children and young people.
- Whilst the service had made efforts to promote integration across and within services through co-location and joint meetings, further integration was required including systems integration.

Governance, risk management and quality measurement

- Although AFC aimed to deliver integrated education, health and social care services in line with the SEND reforms introduced by the Children and Families Act

Are services well-led?

2014. However we found ISCD to be somewhat isolated from the wider services provided within AfC even where those services were co-located at Moor Lane. However, AfC had recently restructured its children's social care senior management to support an integrated social care service across Kingston and Richmond with a cluster model of service. Moor Lane was becoming one of the clusters bringing together schools and children's centres supported by a team of multi-agency workers including mental health workers, family support works, educational psychologists and education welfare officers.

- The cluster system was not fully in place but there was potential for this to be a valuable resource for the service for disabled children. This would be strengthened if, as recommended in the management review an operating framework was developed for the cluster model which promotes integrated working between early help, social care and ISCD.
- The Section 75 agreement (a commissioning agreement under the National Health Act 2006 between an NHS body and a local authority) set out health roles and services. The lack of definition about aspects of health provision hindered understanding of the offer to children, young people, parents and carers and made it difficult to set performance measures of impact and quality in services such as the disabled children's nursing team. Reports to commissioners were at the monthly Management Board and a quarterly strategic children's commissioning board.
- Frontline staff understood their role and function within the children and young person's service, and came together in MDT meetings.
- We spoke with the management team of children, young people and families considered felt governance and risk management procedures were fully embedded and robust. We saw evidence that risk, patient experiences, complaints and quality reports were discussed in clinical governance meetings.
- The AfC Board of Directors and the senior leadership team oversaw clinical governance.
- 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 SLT to address these issues.
- There was a set agenda for the monthly clinical governance meetings with standing items, including the review of incidents, key risks and monitoring of performance. 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 paediatricians 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.
- The key risks on the risk register were the recommissioning of the community paediatric and orthotics contract, the recruitment freeze and its impact on morale and organisational capacity and the relationship with the main group representing families. The risk register identified clinical governance as a weakness, and we saw evidence of this e.g. in lack of standard operating procedures for school nurses, such as for storage and use of oxygen. Clinical governance had been identified as an area for development and the membership of the group was being reviewed.
- We did not identify any specific child as 'at risk'. The key weakness was around governance of child safeguarding practice including poor standards of record keeping about safeguarding information and child safeguarding supervision. ISCD management did not have dynamic oversight of children known to ISCD who had social services involvement. We requested a list of looked after children, those subject to child protection plans, children in need, receiving early help, family support and those with education, health and care plans that open to ISCD but staff could not easily identify these children.
- Clinical staff in schools told us they did not know which children were known to social services because neither children's paper records nor electronic records consistently contained this information. This contravened the provider's policy that "it is important

Are services well-led?

that staff know which children are subject to child protection...or have involvement with social care". Whilst managers reported that staff made safeguarding referrals to children's social care they did not monitor this or capture the outcomes of referrals. Lack of no audit of child safeguarding was as a risk.

- The quality of patient notes, and the fact that case notes were held by different professionals so there was not a clear and up to date overview of children's health needs was also a risk.
- We spoke with the management team of children, young people and families who considered governance and risk management procedures were and robust.
- Operational managers reported confidence in the safeguarding practice of frontline health staff but they could not provide evidence of this through spot checks, monitoring or audit. It was not therefore clear how good practice was recognised and weak practice was strengthened, developed and improved to ensure children were effectively safeguarded.
- A contract with the local NHS Trust included a formal requirement for the Trust to provide relevant training and supervision to the community nursing team in the ISCD from a suitably qualified senior paediatric nurse.
- Clinical staff were unaware of a service level risk register and therefore, we were unable to corroborate whether risks to the delivery of high quality care were identified, analysed and actions put into place at service level.
- An ISCD management board was responsible for monitoring quality, contracts, complaints and compliments. They also reviewed safeguarding relevant to the service.
- The nursing team had weekly and monthly meetings to review incidents, performance issues and planning amongst other topics.

Culture within this service

- Services across the service were holistic and child focused. Staff within ISCD generally worked well together and were committed to improving child health outcomes.
- Staff we spoke to were positive, friendly, helpful and approachable. We were told that morale with the

community nursing and therapies teams was good. Staff across the service reported an open culture and said that they felt supported by colleagues. They identified with ISCD but less closely with Achieving for Children.

- Some staff mentioned that ISCD was introducing a patient outcomes model during 2017. This would involve a culture change in the service.
- Staff we spoke to had an understanding of the changing NHS, social care provision, commissioning and the current uncertainties around tendering for services.
- We spoke with managers who told us that they were proud of the staff working in children and young people's services and confirmed their commitment to the organisation.

Public engagement

- There were effective arrangements for seeking the views of children and young people, including an active young person's participation group. Young people talked positively about how their involvement has increased their confidence. Young people were involved in training AfC staff and recruitment, including of workers recruited to short breaks where they played a part in decision making with managers about selecting the most appropriate candidate. Some young people had become champions for the SEND reforms, including some who had moved into adult services. Involvement of young people in the ISCD management board meeting was at an early stage of development and there was more to do to develop links at a strategic level. There was also work to do to seek the views of a broader range of children.
- There were no comparable arrangements for engaging parents in service planning. Some small surveys of parents had been undertaken on specific issues but rates of response were often low. We did not see evidence of efforts to seek the views of harder to reach parents. AfC did not directly invite any parent groups to contribute to the inspection, although CQC subsequently sought the view of groups named by AfC, and received comments from both the groups and some individual parents. We also contacted some parents who identified themselves to ISCD as willing to talk to CQC.

Are services well-led?

- SEND Family Voices was the recognised local parent forum and received government funding for this from the parent participation grant administered by Contact a Family. This group was active in bringing parents together for a range of activities and to discuss points of common interest.
- Concerns raised by this group had led to a management review of the service led by the Deputy Chief Executive. This had identified a number of areas where change would improve the service.
- Family fun days and other events were held at Moor Lane to bring together parents, children and carers.
- Nursing staff turnover was 20% and turnover in the home and community support service was 25%. Nursing vacancies were 30%, which was higher than the provider target.
- An ISCD Service away day had been held for staff for team building and information sharing.
- The 2015 Staff Survey evidenced that the workforce felt valued, supported and that training and career development opportunities were available. 81% of respondents to the survey reported that they would recommend Achieving for Children as a good place to work.

Staff engagement

- We found evidence of bi-monthly staff meetings for clinical staff. We reviewed the minutes of these meetings but they were not always well attended. Staff who did attend told us they felt confident to suggest new ideas that they wanted to try and managers listened.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Personal care

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 13 2 – systems and processes

The provider did not have robust systems and processes in place to ensure children were protected from abuse

Children who use services and others were not protected against the risks associated with unsafe care from untrained staff because not all staff who worked with children and young people had completed level three safeguarding in accordance with the Royal College of Paediatrics and Child Health 2014 Intercollegiate Guidance.

The service did not have adequate systems to ensure they had oversight of all children within its care who were known to children's social care.

Regulated activity

Personal care

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider did not maintain an single accurate, complete and contemporaneous record in respect of each child, including a record of the care and treatment provided to the child and of decisions taken in relation to the care and treatment provided.

Not all health staff had access to a child's complete record or a current summary chronology of the child's main life events.

There was poor management of waiting lists which had been allowed to become much longer than recommended in NICE guidance.

There was no benchmarking with similar services.

This section is primarily information for the provider

Requirement notices

There was a lack of overall management oversight of children and families at risk.

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.