St George's University Hospitals NHS Foundation Trust

RJ7

Community health services for children, young people and families

Quality Report

162 St John's Hill
Battersea
London
SW11 1SW
Tel:0208 812 4000
Website:www.stgeorges.nhs.uk/

Date of inspection visit: 21-23 June 2016
Date of publication: 01/11/2016

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)
RJ760	St Johns Therapy Centre		SW11 1SW

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

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

Where applicable, we have reported on each core service provided by St George's University Hospitals NHS Foundation Trust and these are brought together to inform our overall judgement of St George's University Hospitals NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall we rated services for children, young people and families (CYP) as 'Requires Improvement'.

We rated safe as requires improvement because:

- Staff were not consistently given feedback from managers about incidents, and learning from incidents was not disseminated.
- We found a drug cupboard unlocked which contained oral contraception. Staff told us this had happened before and there was no spare key to lock the cupboard at the time.
- Staff were referring to out of date safeguarding policies and safeguarding provision was on the care group risk register due to staff shortages.
- Records were not always available to staff in a timely way due to significant IT issues.
- We found a number of sharps bins that were not stored correctly.
- However, staff had a good awareness of safeguarding concerns and there were good escalation processes in place.
- Staff worked with a number of high risk groups and followed a robust lone working process.

We rated effective as good because:

- Peoples' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. A number of audits monitored compliance against guidelines.
- There were good examples of inter-professional and multi-agency working.
- Staff reported good access to supervision on a regular basis. For example, staff within the family nurse practitioner service had weekly supervision.
- Staff followed Gillick competence and Fraser guidelines to ensure people who used services were appropriately protected. Staff had a good understanding of consent. People using services told us staff asked for consent before carrying out any treatment.
- There were some good examples where technology had helped improve services. However access to information in a timely way was affected by IT issues.
- Access to training for professional development was limited due to financial constraints.

We rated caring as good because:

- Staff across services for children, young people and families were professional, compassionate and caring.
- We observed staff communicating with children, young people and families in polite and courteous ways.
- Patient feedback about staff was very positive. People we spoke with said staff were caring, respectful, understanding and supportive.
- Staff treated children, young people and their families with dignity, respect and in age appropriate ways.
- Those using services received information about their care. They felt involved in their care and treatment.

We rated responsive as good because:

- We found services were responsive to the needs of the local population.
- There was good access to provision across the different locations.
- Staff communicated with children and young people in ways that met their needs and involved them in making decisions about their care. For example, staff used a pictorial exchange communication system for children with communication difficulties.
- There was a good understanding of different cultural needs of patients and access to interpreter services in a range of different languages.
- However, some mothers told us there was no private space to breastfeed in some clinics.
- Some parents told us staff did not provide them with information on how to make a complaint and were unsure of the process.

We rated well led as requires improvement because:

- There was a trust wide strategy in place but staff were unable to tell us the strategy for children and young people's services.
- Issues with the electronic patient records system in the community and been raised a number of times and

there was no action plan to address this. Some staff told us the trust had mentioned providing laptops. At the time of our inspection none had been provided to staff.

- Staff said that executive managers were not visible within community services and community staff felt very separate from the trust.
- Staff said that in their opinion, the acute services were the main focus of the trust and they were forgotten in community services.
- However, there were some good examples of service development, such as the transgender sexual health service, perinatal mental health champions and breast feeding champions.
- Staff felt well supported at a local level and by community services managers.

Summary of findings

Background to the service

St George's University Hospitals NHS Foundation Trust provides health services for babies, children and young people and their families across the London borough of Wandsworth in south west London. The trust serves a population of 1.3 million across the borough. Children and young people aged under 20 years make up 20.7% of the population. Around 74% of schoolchildren are from a minority ethnic group. The level of child poverty is similar to the England average with 18.6% of children aged under 16 years living in poverty. The rate of homelessness is worse than the England average, at 4.8% compared to 1.8%.

Children and young people's services came under two divisions within the trust. The Community Services Division comprises of five care groups, of which the Children and Families group is part. The service includes child safeguarding, a service for homeless, refugees and asylum seekers, a haemoglobinopathy service, an immunisation service, health visiting, school nursing, special schools nursing and child health records. A sexual health service for young people is provided by the integrated sexual health care group. Children's community nursing, continuing care, speech and language therapy, occupational therapy, and physiotherapy is provided by the Trust within a home and community setting. These services sit within the Children's and Women's Diagnostics, Therapeutics and Critical Care Division.

We inspected a selection of the trust's services across Wandsworth. During our inspection, we visited a number of locations, including two schools, and health services at Balham Health Centre, Tooting Health Centre, Brocklebank Health Centre, Stormont Health Centre, Eileen Lecky Clinic, Doddington Health Centre, the Early Years Centre, St Johns Therapy Centre, Queen Mary Hospital and St Georges Hospital. We also accompanied staff on home visits and observed clinics.

We spoke to 41 service users and their family members. We observed care and treatment and looked at ten sets of care records. We also spoke to more than 70 staff members including health visitors, school nurses, continuing care nurses, community nurses, nursery nurses, occupational therapists, physiotherapists, speech and language therapists, family nurse practitioner nurses, service managers, clinical team leaders, administrators and sexual health doctors. In addition, we reviewed national data and performance information about the trust relating to community services for children, young people and families.

Our inspection team

Our inspection team was led by:

Chair: Martin Cooper

Team Leader: Nick Mulholland, Head of Inspection CQC

The team inspecting community health services for children, young people and families included CQC inspectors, experts by experience and specialist nurses including a health visitor, community children's nurse and a school nurse.

Why we carried out this inspection

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

Summary of findings

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?

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 21st and 23rd June 2016. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 4th June 2016.

What people who use the provider say

We spoke with 31 parents and carers and 10 children and young people during the course of the inspection. Everyone we spoke to talked positively about the care and treatment they received. They told us staff were kind, caring, compassionate, informative, professional and respectful. They felt listened to and involved with their care and treatment.

Of the 41 people we spoke to we had some negative comments which included delay in accessing speech and language therapy, limited privacy for breastfeeding in health centres and difficulties in being referred by GPs to the early years centre.

Good practice

- The Family Nurse Partnership (FNP) service demonstrated a very effective evidence based service that was highly valued by the young parents it supported.
- The early years centre ran a group for parent and carers, which they found very helpful in teaching and supporting them to develop strategies to use with their children. We saw good linked working between early years staff and Wandsworth Council.
- We saw good examples of service development, such as the transgender service within sexual health services and the Mothers Like Me Project.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The service should:

- Introduce a consistent process for feeding back information, learning and action points from incidents and complaints to staff within community services.
- Make arrangements to ensure that all children and young people services are equipped with suitable IT systems to support their work.
- Consider how data collection and collation mechanisms can be made robust for data collection of the 6 to 8 week health visiting reviews.
- Consider how the statutory guidance for completion of initial health assessments within 20 days will be achieved.

Summary of findings

- Ensure there are trust targets for the Healthy Child Programme and services are measuring their performance against these targets.

St George's University Hospitals NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- Although staff were encouraged to report incidents, feedback from investigations and action plans were not always shared. This meant staff were not always aware of learning and changes in practice.
- Staff in the community had significant issues accessing the electronic patient record systems in a timely way. Staff reported the system could be down for hours at a time which prevented them accessing patient's notes and completing records.
- We found an unlocked drug cupboard at Stormont Health Centre containing medications for the sexual health service. Staff at the centre told us they had no spare key to be able to lock the cupboard. This incident had not been reported on the electronic system until we highlighted this to the trust.
- A revised safeguarding policy had been developed by the trust but this had not been disseminated to all community staff. We asked a number of staff to show us the policy they used and were shown an out of date policy.
- The children's care group risk register highlighted safeguarding provision as a concern due to insufficient staffing levels.
- We found a number of sharps bins had not been dated or signed. Some had open lids. This could pose a risk to staff and patients if the bin fell over and sharps fell out.

However:

- Across all staff groups we found a good awareness of the duty of candour. Staff understood the importance of being open and transparent with children, young people and their families.

Requires improvement

Are services safe?

- There were effective risk management systems in place, including a robust lone working policy for staff.
- Staff were knowledgeable about their responsibilities regarding safeguarding vulnerable people and there was a good awareness of female genital mutilation and child sexual exploitation.

Safety performance

- The service reported zero never events for the year preceding our inspection. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurring for that incident to be categorised as a never event.

Incident reporting, learning and improvement

- Between May 2015 and April 2016, the service reported no serious incidents (SI's) requiring investigation.
- Staff we spoke with all told us they were encouraged to submit concerns and issues to the trusts incident reporting system. They felt confident to escalate concerns and understood how and when to report incidents appropriately.
- The service reported 21 incidents between May 2015 and April 2016. Of these, one had been classed as severe harm, one as moderate harm, two as low harm and 17 as no harm.
- 52% of all incidents related to consent communication and confidentiality, 14% related to medication, 14% related to access, admission, transfer, discharge (including missing patients).The remaining 20% related to treatment and procedure (10%), implementation of care and ongoing monitoring/review (5%) and medical device and equipment (5%). The moderate harm incident related to treatment and procedure.
- The trust used an online incident reporting system and staff we spoke with could access this system. All CYP staff we spoke to told us they felt able and comfortable to submit incidents to the system. However, some staff reported they were not always able to complete datix forms due to connection issues with the IT system.
- Service managers discussed incidents in divisional meetings and told us feedback was cascaded to community staff. However, around half the staff told us they did not receive feedback from incidents. This meant that staff were not always aware of learning from incidents and changes in practice.

Duty of candour

- There was no formal duty of candour training for staff.
- Senior staff understood their responsibilities under the duty of candour and were able to describe the need to give feedback in an honest and timely way when things had gone wrong.
- Despite the lack of formal duty of candour training, staff working in the community demonstrated a good knowledge of duty of candour about being open and transparent with people, including when things go wrong with their care and treatment.
- Service managers told us the trust's incident reporting section incorporated a section on duty of candour.
- Service managers gave us an example of how they used the duty of candour regarding an immunisation incident where a young person was given a flu immunisation twice. The parent had been informed and possible side effects had been discussed. The service also apologised to the family over the telephone. The trust reported that this was not reported as a serious incident because no significant harm was caused to the child.

Safeguarding

- There was a system in place for highlighting and monitoring children where there were safeguarding concerns. Safeguarding concerns were highlighted by adding alerts to the online system.
- All staff we spoke with told us they underwent safeguarding supervision at least every three months.
- A safeguarding children supervision matrix was used to set the frequency and type of supervision as well as which grade was required to perform the supervision for each job role within the trust.
- Some staff were receiving safeguarding supervision from an independent safeguarding supervisor and some were receiving supervision from their line managers.
- We saw the names and contact details of the safeguarding team displayed in the locations we visited, and staff were able to name who the safeguarding lead was. Staff told us the safeguarding team were very accessible and supportive. They were able to give us examples of when they had needed to speak with the team as well as the advice they received.

Requires improvement

Are services safe?

- Staff demonstrated a good awareness of safeguarding processes and were able to describe to us in detail, actions they would take if they had any safeguarding concerns.
- The safeguarding team had strong links with external agencies and were represented on the Multi-agency safeguarding hub (MASH) team. This ensured appropriate information was shared between agencies. Health visitors told us they had good relationships with social services, which helped facilitate good practice.
- Within sexual health services, staff were aware of action they should take if they had any safeguarding concerns about patients attending.
- Staff working with young people who sought sexual advice used a risk assessment to help identify young people at risk of child sexual exploitation. Within the area covered by the trust, sexual exploitation had been highlighted as a feature within gangs and staff were aware to look for subtle signs of child sexual exploitation
- There were child and adult safeguarding awareness and support posters displayed throughout the trust's health centres. This included posters on child sexual exploitation, female genital mutilation (FGM), domestic violence, radicalisation and domestic violence.
- There was thorough awareness and consideration of FGM amongst the staff we spoke with and staff told us FGM was part of their level three safeguarding training. There was a monthly FGM multiagency meeting, and an awareness day had taken place on the 22nd July 2015. We saw a draft policy for FGM. This covered things such as risk indicators, how to escalate concerns and referral pathways.
- Within the haemoglobinopathy team, a service for children and families with blood disorders, the instance of families consistently missing appointments would be escalated to MASH as neglect.
- The safeguarding committee meeting minutes showed that 84% of staff requiring safeguarding level three training had undertaken it. The trust reported issues with the system registering completion of training so there was not a robust way to capture compliance.
- When we asked staff to show us the safeguarding policy, the policy did not correspond with the policy shared with us during the inspection by the safeguarding lead. The new policy included the revised Working Together 2015 government guidance and the London Child Protection Procedures 2016. This meant there was a risk staff were not working consistently within current multiagency guidelines to safeguard children.
- CYP services had indicated on the children's care group risk register that safeguarding provision was insufficient due to staff sickness and staff reduction as part of the cost improvement plan. However, staff we spoke to during the inspection said they had good access to the safeguarding team and were well-supported.

Medicines

- There were effective policies and procedures in place to manage the storage and administration of medicines at trust sites and external locations.
- Patient Group Directives (PGD) were used by staff to enable them to give children immunisations and vaccinations. The PGDs used had been reviewed regularly and were up to date.
- PDGs were used in sexual health services allowing three trained nurses to give medication and fit contraceptive devices.
- There was a robust process and standard operating procedure in place to manage the immunisation cold chain to ensure vaccination vials were stored and transported at appropriate temperatures. For staff travelling between clinics there were fridges available that plugged into staff members' cars. Fridge temperatures were checked and signed twice a day.
- Some issues had been identified in satellite clinics where fridge temperatures were not being consistently recorded. The trust audited this and found not all fridges were being checked and signed for every day. The trust took actions to address this by moving some fridges to more accessible locations. In addition, staff were reminded to record fridge temperatures.
- Satellite sexual health clinics stocked a small number of drugs and medications. In one health centre, we were able to access an unlocked drug cupboard which contained an oral contraceptive, injections and lidocaine. These medications should be stored securely. Staff at the health centre told us the sexual health service used this cupboard and there was no spare key to lock it at that time. Staff had to call their manager to feed this back. There was no mention of this being

recorded as an incident until they recognised this should be done. Following the inspection the trust provided data to show this incident had been reported on datix.

Environment and equipment

- We visited a number of the trust's health centres. The centres were bright and welcoming spaces for service users and their families.
- Each of the locations we visited had accessible facilities that were also accessible for those in wheelchairs and those with prams.
- Each location we visited had information boards for service users, information leaflets and posters.
- We found equipment in use had been safety tested.
- The rooms used for health visitors were suitable, welcoming environments for families.
- Each set of scales had a date by which calibration was due to take place. We found a number of scales had not been calibrated by their due date. This meant staff could not be assured that weights were accurate. Staff were aware of this and said that calibration was due to take place soon.
- The school nursing team told us they did not always have dedicated rooms to use in schools. This was an ongoing issue for the team.
- Staff reported a number of issues with IT equipment being old and not updated, meaning there were difficulties accessing the trusts systems. This prevented them accessing and completing patients' notes in a timely way.
- We looked at the resuscitation bag within the sexual health service at Queen Mary Hospital. Staff told us the bag should be checked once per day. However, records indicated this was not done consistently.

Quality of records

- The organisation used an electronic record keeping system. However, some services, such as continuing care, were still using both electronic and paper notes. Staff using the electronic system recorded clinic information, home visits and therapy sessions in the progress notes section of the record.
- The electronic record keeping system required password access to ensure security. Staff members had unique accounts to ensure professional accountability.
- The electronic system flagged service users who were at risk, such as those under a child protection plan.
- We observed health visitors record information in 'My Child's Health Record' red books which parents kept. All content was legible and dated.
- Information governance was part of the mandatory training programme staff were required to complete. Due to the way the trust provided their data we were unable to identify what percentage of CYP services staff had completed this training.
- Staff were generally negative about the electronic system and expressed frustration with the constant issues they faced. Staff told us the system could be down for hours, which limited access to patient information prior to visits. This delayed the recording of time spent with patients. Staff said it posed a significant risk and they have received no feedback from the trust about what would be done to remedy this. Nursing and Midwifery Council (NMC) code states that staff should complete all records at the time or as soon as possible after an event, recording if the notes were written sometime after the event.
- Continuing care and community nurses were using both electronic and paper records. This was time consuming for the team led to a lot of duplication. Records were taken to families' homes if carrying out assessments but if it was a short visit records were completed retrospectively after the visit. This was usually on the same day but could be the following day.
- An audit of record keeping for community children, young people and families' service had been completed in July 2015, which looked at the quality of records within health visiting and school nursing. The audit was conducted following a serious case review which found record keeping was sometimes inadequate. Records were audited and then re-audited to see if there had been any improvements. Whilst improvements were made a number of records were still rated as inadequate when looking across six domains: Rational/ Reason, Environment, Client/Child view/comment, Observation/Assessment, Risk/Analysis, Decide Action (RECORD). Line managers had been asked to address inadequate record keeping with staff and another audit was planned for 2016.

Cleanliness, infection control and hygiene

- Staff had access to personal protective equipment (PPE) and were aware of how to dispose of used equipment safely and in line with infection control guidelines.

Requires improvement

Are services safe?

- Infection control was part of the trust's mandatory training programme. Due to the way the trust provided their data we were unable to identify what percentage of CYP services staff had completed this training.
- We saw that clinics visited were clean and tidy and there were rotas in place with cleaning logs showing the areas were cleaned regularly.
- Staff at the early years centre told us toys were wiped after every use and cleaned properly during half term holidays.
- We observed most staff using hand gel or washing their hands before they interacted with patients. Equipment such as scales were cleaned after use and lined with fresh paper roll. However, in some of the clinical areas we visited we could see no hand gel available.
- We saw most staff in clinic following good hygiene practice. However, we observed some clinical staff not adhering to bare below the elbow guidance, wearing bracelets or long sleeves.
- We saw some sharps bin lids were not closed and a number had not been signed and dated as required.

Mandatory training

- Trust wide mandatory training included equality and diversity, fire safety, health and safety, infection prevention and control, information governance, safeguarding adults and safeguarding children (at the level recommended by the Royal College of Paediatrics and Child Health Intercollegiate document), and conflict resolution. The trust used face-to-face and online training modules. The trusts target for mandatory training is 85% except information governance which was a target of 95%. We asked the trust to break down this for children and young people's community services only but an overall percentage was not provided.
- Service managers we spoke with demonstrated the systems they used locally to monitor their staff attendance at mandatory training to ensure it was completed, or refreshed. Staff told us they got emails to remind them when their training is due.
- Service managers told us that the system, where mandatory training was completed had had some problems. Access in the community was difficult as the computers were not fully migrated onto the main trust server system. Access had improved but this was an ongoing frustration with staff. Some staff have completed training but the system had not registered it as completed.
- CYP staff told us that training was very hospital focused and there were not many questions linked with community services.

Assessing and responding to patient risk

- Children and young people's services used the Healthy Child Programme and the National Child Measurement Programme assessment stages and tools to identify and respond to children, young people between 0 and 19 years and their families who may be at risk of harm or ill health. The Healthy Child Programme was used by health visitors and school nurses to identify and support children, young people and families according to their level of need. The levels of service used depended on need and the risk of harm.
- There were mechanisms in place to identify patients at risk, such as vulnerable women and children. Details were recorded in electronic records, which all clinical staff had access to.
- We saw health visitors record the observations of infant development parameters such as height, weight, communication and motor skills. These were recorded in the baby record book and within patient's notes. Infants were assessed for actual and potential risks related to their health and well-being.
- The trust had policies and pathways for staff to use when certain risks were identified, for example, child sexual exploitation.
- The Haemoglobinopathy service developed care plans for schools which gave guidance on when schools would call an ambulances for a child.
- We saw a range of records across children's services which contained up to date risk assessments, and escalation plans. For example, we saw joint care plans between the haemoglobinopathy team and schools.
- CYP staff told us they would call 999 if they were immediately concerned about a child or young person

Staffing levels and caseload

- At the time of the inspection, there was a designated Looked After Children (LAC) nurse for Wandsworth. The caseload was below 100 and therefore meeting Intercollegiate Guidance 2015.
- Family Nurse Practitioner (FNP) caseload was 100 and the team did weighted allocation so cases that are more complex could be shared amongst the team.

Requires improvement

Are services safe?

- There were 63 whole time equivalent (WTE) health-visiting posts and at the time of the inspection with six vacancies, at the time of the inspection, making the vacancy rate 9.5%.The trust was in the process of interviewing to fill the vacant posts.
- The trust gained an additional four WTE posts because of the Call to Action: Health Visitor Implementation Plan.
- Health visiting managers reported that health visiting staff caseloads were in line with the Lord Laming 2009 recommendation of 300 children per WTE health visitor caseload level of 300 children per health visitor. However, the trust worked with corporate caseloads so it is difficult to provide exact numbers. Corporate caseloads are when caseloads are pooled together and allocated according to the capacity of each health visitor. During the announced inspection, we attended an allocation meeting and caseloads were allocated in this way.
- We observed an allocation meeting for health visiting and the caseload was shared appropriately amongst staff based on the staff's current work and the level of need each family had. Challenging cases and those involving safeguarding were shared equally.
- The sickness rate for community nurses and midwives was 5.23%.
- Therapy service managers told us there were national shortages of therapy staff, which compounded their recruitment of specialist therapists, particular occupational therapists (OT), and specialist speech and language therapists (SLT). A number of steps had been taken already to improve this including a training programme for those in band 6 post who wanted to develop. An OT had been seconded to lead on the development of an OT programme, focussing on paediatrics. Managers told us they are also looking at upskilling some community therapy support staff.
- National guidance from the Royal College of Nursing (RCN) recommends one qualified school nurse for each secondary school and its cluster of primary schools. The trust had not been meeting this target for the previous 12 months due to three vacancies. The school nursing service was responsible for 11 secondary schools and managers told us these had been recruited into for September 2016. Every quarter the school nursing team completed an action plan, which looked at the schools' population needs. Through this needs analysis, which was sent to commissioners, the team had secured funding for an additional band six school nurse.
- School nurses were commissioned to spend 30 hours per week in each secondary school and one day per week in primary schools. One of the biggest challenges for the service had been achieving this target due to staff shortages and issues with accessing RIO to document time spent in schools. We saw the school nurse quarterly report which reported data from between January 2016 and March 2016. The target for school nurses to attend a minimum of one day per week in primary schools and 30 hours per week in each secondary school was 100%. The trust had not reported their percentage achieved in this report.

Managing anticipated risks and Major Incident Awareness and Training

- The CYP service adhered to the trusts lone working policy, which staff could access on the trust intranet. There was a good awareness of lone working arrangements amongst the staff we spoke with. The homeless team had ordered some lone working devices due to potential risks.
- There was a major incident plan in place for the trust. The trust had a business continuity plan which set out the triggers and levels of response to certain major incidents. The triggers included staffing crises and adverse weather conditions which could impact on service delivery. We looked at two different business continuity plans. One covered therapies and the second covered other children's services including health visiting, school nursing, Family Nurse Practitioner (FNP), the haemoglobinopathy service, safeguarding and immunisation. Both plans included details on what essential services should be prioritised in the event of a crisis. Services were rated on a scale of one to five, with five being the most critical service and level one being a service that could be deferred for a week.
- Some of the staff we spoke with did not know what a major incident plan was. Staff did not know if there had ever been a major incident trial exercise.

Good

Are services effective?

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

Summary

We rated effective as good because:

- Universal and specialist services were based on evidence-based guidance, standards, best practice and legislation. There was a good provision of evidence-based advice to those using CYP services.
- Staff were supported to deliver effective care and treatment, including regular supervision with their managers.
- There was participation in relevant local audits and participation in national peer reviews. A breastfeeding lead was appointed to support community services in working towards level one in the UNICEF baby friendly award.
- There was effective internal and external multi-disciplinary working which was facilitated by good communication and some co-location of services, such as the early years centre. There was good inter-agency partnership working with local authorities and safeguarding partners.
- Staff had a good understanding of how to obtain consent. Gillick competence and Fraser guidelines were followed to ensure that people who used the services were appropriately protected.

However:

- Access to information was limited at times due to difficulties with IT and the electronic patient records system in the community.
- Some staff could not access some training due to budget constraints in the service.

Evidence based care and treatment

- Staff accessed policies and corporate information on the trust's intranet. There were protocols, policies and guidance for clinical care and other patient interventions available. Staff told us the trust intranet was easy to access and navigate.
- We reviewed a sample of trust policies for CYP services and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE), Royal College guidelines and other nationally or internationally recognised guidelines.
- We reviewed a number of minutes from governance meetings and saw evidence that NICE guidance was discussed, such as guidance on attachment and adoption. NICE guidance was an agenda item at the monthly managers meetings.
- Health visiting and school nursing services were guided by the Healthy Child Programme with its emphasis on the early identification of need and the support of families to improve health and wellbeing and reduce health inequalities. The Healthy Child Programme has a schedule of screening, immunisations and health and development reviews set out by the Department of Health (DH).
- Health visitors used a family needs assessment, the DH advocates six high impact areas of working including; the transition to parenthood, maternal mental health, breastfeeding, healthy weight, managing minor illness and accident prevention and healthy two year olds and school readiness. We observed health visitors teams using the Ages and Stages Questionnaire (ASQ) at reviews, this is an evidence-based tool used to identify a child's developmental progress and provide support as needed to parents.
- There were policies and standard operating procedures to ensure that looked after children and children with long term and complex needs had their needs met in appropriate ways.
- The organisation had a family nurse practitioner (FNP) team. FNP is a voluntary home visiting programme for young people and first time mothers. It is underpinned by internationally recognised evidence based practice. We observed FNP nurses conduct assessments of children and parent in their own environment, feedback was given in an accessible language and progress recorded. The FNP service was able to provide us with

evidence of how they followed the nationally recognised approaches and techniques. This included meeting targets and achieving key milestones with participants of the project.

- Some staff told us they had access to a journal club where they could discuss learning and academic research.
- We observed competent, thorough and evidence based care and treatment by CYP practitioners in home visits, clinics, developmental reviews and therapy sessions. All practitioners conducted full assessments as per guidelines and provided up to date and evidence-based advice. For example, in one year reviews we saw parents being advised about national Department of Health (DH) and World Health Organisation (WHO) guidance around breastfeeding with parents being encouraged to breast feed for at least 12 months.
- The CYP services had a comprehensive audit plan which included audits on fridge temperature, record keeping, domestic violence, DNA in the haemoglobinopathy service, safeguarding documentation, hand hygiene, case note and care plan audit in therapies. The CYP services had also conducted a number of audits assessing compliance with national guidance including adherence to Autism Spectrum Disorder (ASD), Attention Deficit and Hyperactivity Disorder (ADHD), and spasticity in children and young people guidelines. Each audit identified areas where the service could improve and put an action plan in place to address this. Re-audits had been conducted in a number of areas to assess improvements. For example, the ADHD audit was conducted in September 2012 and a re-audit was conducted in 2014. The service had found improvements across the service, particular in the recording of growth and blood pressure and highlighted further actions to address to improve compliance with NICE guidance.
- The school nurses delivered the National Child Measurement Programme (NCMP) as set out by Public Health England and the DH. The NCMP consisted of children's height and weight being measured to assess overweight and obesity levels. However, there had been some issues accessing the NMCP database to record height and weight due to IT difficulties.

Pain relief

- The haemoglobinopathy team used pain assessment tools that were appropriate to the child's age. This ranged from a numerical scale of one to ten for older children and face scales for young children.
- We observed a home visit where a child was worried about pain. The nurse used some distraction techniques such as talking about the child's favourite food whilst taking blood from the child. We also observed an immunisation nurse singing a nursery rhyme to a baby when giving an injection to distract the baby from the pain.

Nutrition and hydration

- During our inspection we saw that staff gave parents up to date and relevant advice about breastfeeding, weaning and nutrition and hydration in children.
- School nurses offered healthy eating advice and offered a referral to weight management programmes for young people who were assessed as overweight.
- Children in Wandsworth had rates of obesity of 7.8% in children aged 4 -5 which is lower than the England average of 9.1%. Children aged 10-11 had obesity rates of 20.5% which is higher than the England average of 19.1%.
- Community services had applied for stage one accreditation from the Unicef UK Baby Friendly Initiative and was due to be assessed in October 2016. There are a number of levels in Unicef ranging from intent registered, certificate of commitment, stage one accreditation, stage two accreditation and stage three full accreditation. Stage one means the service has created policies and procedures to support the implementation of the standards and these have been externally assessed by Unicef and found to be adequate. A breastfeeding lead had been appointed four months prior to the inspection to take a lead on achieving this award.
- The early years centre ran a multidisciplinary feeding clinic which was created to help children that find it challenging to eat. The group involved a range of professionals including a clinical psychologist, dietician, OT and SLT. The group helped parents develop strategies to improve feeding.

Good

Are services effective?

Technology and telemedicine

- The early years centre used video techniques to help train parents. Video feedback was used as part of the 'Lets Communicate' programme. Home visits incorporated video feedback sessions linked with play and interaction between parents and their child. Parents responded positively to these sessions.
- If mothers were struggling to get their baby to breastfeed then some staff would seek consent and film or take pictures of positioning on the mothers own phone. Mothers could then refer to this when feeding to ensure they had the most comfortable position.
- Therapies used a text reminder service for families who persistently did not attend therapy sessions to give them an extra reminder. At the time of the inspection we did not see evidence of audits to assess whether this had a positive impact on DNA rates.
- The haemoglobinopathy service participated in the West Midlands Quality Review Service (WMQRS) peer review . The report highlighted that the service used a text reminder service and personalised telephone calls a week before appointments. This had resulted in a 30% reduction in DNA rates within the service.
- Families using the Attention Deficit and Hyperactivity Disorder ADHD service could email any questions to a specific email box and staff responded within 24 hours, this was set up to improve access to staff. The ADHD service was, at the time of our inspection, developing a website which would have key information for families and a section for frequently asked questions.
- Practitioners across universal and therapy services reported significant issues with the IT system. This had an impact on electronic recording of patient notes, patient facing time and access to patient records. Staff told us there had been discussions about laptops being bought for staff, but this has not happened. We observed a number of home visits where patients' notes were hand written. Staff told us they added the information to the electronic record systems when they got back to base. Staff reported this was a longstanding issue and the trust had given no feedback on what would be done to improve this.

Patient outcomes

- We observed integrated working across therapy services and standardised assessment tools being used. For example, physiotherapists used goal attainment scales (GAS) and risk assessment measures including pain, strength, balance and endurance.
- Physiotherapists used the Movement, Assessment Battery for Children (ABC), Goal Orientated Assessment of Life skills and Bayley scale assessment tools to identify motor function impairment
- We observed staff discussing mother's moods and recommending mood assessments on visits by health visitors in line with NICE guidance on maternal mental health.
- Health visitors and service managers told us they were achieving their targets for the Health Child Programme. The trust reported at the moment there are no national comparatives as the dataset has only recently been agreed. We asked the trust to for their trust wide targets for the healthy child programme but these were not provided.
- Trust data showed the percentage of new birth visits completed within 14 days for the past 12 months averaged at 91%.
- The trust reported data issues for the 6 to 8 week check which have arisen from several sources and multi-agency cooperation to resolve. The 6 to 8 week check is the GP's responsibility and across the year, these were completed between a low of 69.5% (October 2015 to December 2015) and a high of 78.5% (Jan 2016 to March 2016) of cases.
- The trust reported declines over the past 12 months in the number of children receiving their 12 month check within 12 months. Between April 2015 and June 2015 this was achieved in 77.3% of cases compared to January 2016 and March 2016 where it was achieved in 66.3% of cases. By 18 months of ages over 75% of children have had their 12 month review.
- Trust data showed the percentage of 2.5 year checks completed for the past 12 months averaged at 48%.
- Health visitors used the 'ages and stages questionnaires' evidence-based assessment tool during visits and clinics to highlight any areas of concern about a child's development across five different areas: communication and language, fine motor skills, gross motor skills, problem solving and personal-social development.

Good

Are services effective?

- We saw evidence that patients' needs were thoroughly assessed before care and treatment started and there was evidence of care planning. This meant children and young people received the care and treatment they needed.
- The haemoglobinopathy service participated in a haemoglobinopathy peer review in May 2015. This reviewed the services compliance with Quality Standards for Health Services for People with Haemoglobin Disorders. The peer review was developed by the UK Forum on Haemoglobinopathy Disorders and West Midland Quality Review Service (WMQRS), to improve clinical outcomes for patients. The review covered all services within the trust.
- Statutory guidance states that initial health assessments for 'looked after' children are to be completed within 20 days of placement. Between January 2016 and March 2016 the trust achieved this in 71% of cases against a local target of 100%.
- The immunisation rates for measles, mumps and rubella (MMR), diphtheria, tetanus, polio, pertussis and Hib were lower than the England average.
- The England average for diphtheria, tetanus, polio, pertussis and Hib immunisation rates was 95.7%, and the trust achieved 93.3%.
- The England average for MMR immunisation rates was 92.3%, and the trust achieved 87.1%.

Competent staff

- Staff and managers told us that most staff had had an annual appraisal. Trust data showed that for the Children and Family Services within the Children and Women's Diagnostic, Therapeutic and Critical Care Division 85% of additional clinical services staff, 87.5% of administrative and clerical staff and 83% of nursing and midwifery registered staff had completed their appraisals. This was against a trust target of 85%.
- Staff told us they received regular 1:1 meetings with their line managers and said they were well supported. Staff had access to both managerial and clinical supervision.
- FNP nurses had weekly supervision with their manager to discuss case management, safeguarding, emotional reflections and educational needs. The FNP nurses told us they were supported and valued.
- There was a comprehensive full week training programme for FNP practitioners, based on an evidence-based programme.
- Student nurses told us they were well supported by their supervisors and they were given opportunities to develop competencies within their roles.
- The trust participated in the GMC revalidation initiative for all UK licensed doctors to demonstrate they were competent and fit to practice. Staff told us they were supported by the trust in this process.
- All new staff to the organisation underwent a corporate induction. However community staff reported the trust induction was very acute focused and there was not much mention of community or paediatrics. Staff told us the induction was one day and they would then receive induction and orientation to their service.
- The majority of staff we spoke with told us they had difficulties accessing training for professional development due to funding issues because of budget constraints in the division.
- Some staff reported access to training that was important for their job role was difficult to access due to funding. For example, one nursery nurse could not access sleep training which was important for their role.
- We spoke to a number of administrators during the inspection, who felt they had little opportunity to train and develop within their roles.

Multi-disciplinary working and coordinated care pathways

- There was an emphasis on multi-disciplinary (MDT) and multi-agency working within the organisation and there was effective internal and external MDT working and practitioners worked with other staff as a team around the child.
- The early years centre shared a space with the local authority and a family charity. Staff told us this enabled much closer joint working and improved access for service users. For example, speech and language therapy (SLT) staff could link in with the portage which is a home visiting scheme for children with additional needs. SLT and portage could joint targets for children and parents, working towards small achievable goals. The SLT and occupational therapy(OT) team could also visit the nursery, which was onsite to provide additional support for staff.
- Staff told us they had good working relationships with GP's, school staff, social services and the police. This

meant information was shared readily across agency working and ensured that when there were concerns about vulnerable children, these were shared and responded to appropriately.
- Staff had a good awareness of the services that were available to children in the area.
- We visited a specialist school in the borough and the school staff said links with school nursing were very good. The specialist school had an integrated team consisting of school nurses, OT, SLT and physiotherapy. This ensured a comprehensive approach to treatment.
- School nurses had very good links with their local schools, we observed this when we observed staff at a drop in clinic at a secondary school.
- The haemoglobinopathy team worked very closely with the acute hospital to ensure effective sharing of patient information. There were regular MDT meetings and Team Around the Child (TAC) meetings to share information. The team also did some education sessions for teachers so they could learn how to manage the conditions.
- The FNP team worked closely with a number of other services such as GP's, midwives, perinatal mental health and local authority social services. We saw positive feedback from the perinatal mental health service regarding the FNP service. The FNP team also linked with the local gang team due to there being a number of gangs in the local area. The team also worked with the multi-agency risk assessment conference (MARAC), which is a police led forum for local safeguarding awareness.
- Continuing care and community nursing worked with other hospitals such as Great Ormond Street Hospital (GOSH) to provide training to parents to support discharge. Continuing care also had regular MDT meetings, which included the local authority and the family. We looked at an Education, Health and Care (EHC) plan that was put in place for young people with more complex needs. The plan was developed during TAC meeting, which set a number of goals with the family. Staff said the plan did take time but the goals were relevant and families had ownership over them.
- The ADHD service work closely with Child and Adolescent Mental Health Services (CAMHS), and have developed a joint pathway for referral.

Referral, transfer, discharge and transition

- SLT therapists explained that patients could be referred to them in a number of ways including via self-referral, GP, health visitors and the nursery.
- The haemoglobinopathy staff told us they worked closely with St Georges Hospital who notified them when a patient was discharged. They then followed this up in the community.
- The sickle cell team had a health transition plan for adolescents transitioning to adult services, called the adolescent passport document. Young people completed a self-assessment, which helped the team identify the needs and readiness of the young person to transfer to adult services. Assessments were conducted on three occasions, at 12-13, 14-15 and 16-17 years old, and covered knowledge of condition, treatment concordance, self-efficacy, personal responsibility and self-advocacy, and emotional readiness and transition.
- The ADHD service had a joint referral pathway with CAMHS up to the age of 18 years old. The transition service was under development and patients were at the time of our inspection referred to the Maudsley Hospital adult ADHD service.
- We observed a sexual health clinic where staff were referring young people to their school nursing team.
- LAC nurses completed transition passports to give to young people when they left the service. This recorded key information that young people might need to know, such as GP details, immunisations and medical history.
- The homeless team carried out outreach in order to access those who might not normally engage with services.
- School nurses were notified when young people had presented at accident and emergency. This allowed them to do follow-up work with the families.

Access to information

- Staff across the service used the electronic records system which aimed to support integrated working. Staff told us access to the system was very slow and sometimes the system would be out of use for hours at a time, which they found challenging and frustrating. One staff member said 'the system does not really reflect what work we are doing because we cannot access it to ensure it is completed effectively'.

Good

Are services effective?

- We reviewed a number of patient records and found they were completed appropriately. However, some services were still using paper notes as well as the online system which resulted in duplication, staff found this time consuming.
- The intranet was available to all staff and contained links to guidelines, policies, procedures and standing operating procedures. Staff could access this for guidance easily.

Consent

- Service users told us health visitors, community nurses and therapists explained the purpose and evidence for different clinical assessments and interventions and confirmed consent before proceeding with any action. Observation of practice within services showed staff asked for peoples consent before any interventions of care.
- Staff within sexual health services described to us how they obtained consent from young people attending the service. They were also able to give examples of when they had held multidisciplinary team meetings to discuss the needs of vulnerable adults who attend the service.
- School nursing and sexual health staff worked within Fraser guidelines and Gillick competency to make decisions about whether young people had the maturity, capacity and competence to give consent themselves.
- School nursing teams asked parents to opt out of participation in the NCMP if they did not want their child to be measured and weighed.
- Staff were aware of the trusts consent policy, but some staff could not recall if they had any training on consent.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Staff we spoke with were very passionate about their roles and very dedicated to making sure the people they cared for were provided with the best care possible.
- Children, young people and their carers told us they were treated with compassion, dignity and respect. They were involved in discussions about care and treatment and provided with information in a number of formats to help them better understand it.
- During our inspection we observed children, young people and their families being treated with kindness and compassion. Staff were professional and communicating effectively and in a polite and respectful way.

However:

- Some mothers reported clinics to be very busy and there was a lack of space to breastfeed in private.

Compassionate care

- During the inspection we visited a range of services, clinics and schools. We joined staff on home visits and spoke to some people on the telephone. We spoke to 41 people who used the services.
- The majority of service users we spoke with were very happy with the care and treatment provided by the trust. Direct comments from service users included children and their parents. The following was representative of the feedback: “Staff are very professional”, “The staff are fantastic”, “The therapists are very compassionate and understanding of my needs”, “I get good information from my health visitor”, “The staff answer all my questions”, “The staff are very respectful”, “The staff here are second to none”, “This place is amazing”
- All staff we spoke with were very passionate about their roles and were dedicated to making sure that the people they cared for were provided with the best care possible.
- We observed the way children and parents were treated in homes, schools and clinics. Staff were kind, compassionate, patient and informative. We observed staff helping parents with their prams and interacting with babies.
- Staff clearly explained what was going to happen during appointments and gave service users opportunities to ask any questions.
- We spoke to two looked after children on the phone and they told us they had always been treated with kindness and respect. One young person told us the service helped guide them to make important decisions about sexual health.
- FNP practitioners give new mothers a congratulations card and photo frame as a gift when the baby is born, a card for the babies first birthday and will be giving the baby a graduation present when it turns two years old and leaves the service.

Understanding and involvement of patients and those close to them

- We spoke to a group of parents attending the “Lets Communicate” group, they were all very positive about the group and the staff who ran the group. Parents told us it had allowed them to meet other parents going through similar things which had been very helpful.
- FNP nurses provided information sheets to clients and talked through information, for example, advice on contraception, mood/post-natal depression and breastfeeding.

Emotional support

- We observed visits with health visitors, community nursing, therapies, FNP and the homeless team and observed staff supporting the emotional needs of people using the services. FNP and health visitors asked new mothers about their mental health and well-being, and mood assessments were conducted to identify if additional support was required. The service was developing good links with the perinatal mental health service, and was developing perinatal mental health champions in services.

Good

Are services caring?

- Parents told us they thought services provided good emotional support, and would sign post them baby groups to meet other mothers.
- We observed a call between a health visitor and a mother who said she was feeling low. The health visitor arranged a visit to check how the mother was doing.
- The ADHD service advertised a behavioural support drop in group for parents and carers.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- Services were planned and delivered in line with local needs, for example sexual health clinics for young people were held after school.
- We saw examples of services designed to meet the needs of particular groups of patients. For example, the family nurse practitioner service was a specifically designed programme for women under the age of 20, having their first baby.
- Staff communicated with children and young people in age appropriate ways and involved them as decisions were made about their care.
- There was a good understanding of different cultural needs and backgrounds of service users. An interpreter service was available over the phone and face to face and was accessed regularly.
- Services were flexible to work with vulnerable people. For example, the early years centre would run one to one sessions for parents who lived with a learning disability and could not attend the group sessions.
- Service users were able to self-refer to some services, such as speech and language therapy.

However:

- Health centres were not very child friendly and there was a lack of toys and books for children to access.
- Parents were not provided with information on how to make complaint.

Planning and delivering services which meet people's needs

- Senior clinicians in the community team reported a constructive working relationship with local Clinical Commissioning Groups (CCGs) and the local authority
- Occupational therapists and physiotherapists offered a broad spectrum of services including services to children in nursery, schools, special schools, home based interventions including the provision of equipment and assessment of children's home environment
- A parent told us the health visiting service was amazing and they had no concerns or complaints. The staff had organised home visits because the parent had three children and was too tired to come out to clinics.
- A child told us they were very happy with the service they had received. The child liked having home visits for blood tests as it meant they didn't need to get the bus and could carry on playing with toys. A child using the LAC service told us the staff would go to appointments with them which they found very helpful.
- There was good support for parents of children with ASD and social communication challenges. The trust provided access to "Lets Communicate" parent group to help build skills. The trust also signposted parents to independent support groups and resources. The early years centre had a large library of toys and books, which parents could rent out for free to use at home.
- The FNP service is a specifically designed programme for women having their first baby aged 20 and under. The FNP service worked with mothers from pregnancy and visited them weekly for four weeks and every two weeks until birth. After birth, they did a weekly visit for 6 weeks and then fortnightly visits until the baby was 22 months ago. There was then a monthly visit until 'graduation' when the child reached two years old. FNP encourages dads or partners to join in during the home visit if the mother would like them to, we observed a home visit where a mother and father were involved.
- FNP nurses facilitated meetings with clients in local places such as coffee shops if they weren't happy to meet in the home. Staff could cover the cost of this with petty cash.
- Parents could access breastfeeding peer support from mothers who were accredited by the breastfeeding network for advice and support around breastfeeding.
- Patient information boards in reception areas of health centres provided information about local children's centres, baby groups and other activities available in the local area.
- Information leaflets were available in health centres including information on breastfeeding.

Good

Are services responsive to people's needs?

- Obesity in four to five year olds was better than the England average, at 7.9% compared to 9.1%, and 10 to 11 year olds was worse than the England average at 20.5% compared to 19.1%.
- Any child identified as obese from the NCMP would be contacted by school nursing, and referred to a weight management programme if this was agreed.
- School nurses were working with schools to address obesity and were calling parents between 5pm and 7pm to improve contact opportunities.
- The level of child poverty in Wandsworth was similar to the England average with 18.6% of children aged under 16 living in poverty. The rate of family homelessness is worse than the England average, at 4.8% compared to 1.8%. The trust had a homeless, refugee and asylum seeker service as part of CYP services.
- The service provided support for families with children under the age of five in local authority homeless hostels and other supported accommodation.
- The trust ran regular child health clinics across Wandsworth including breastfeeding, healthy toddler checks, baby clinics, family planning, breast feeding café, weaning and baby message.
- The trust found a number of accident and emergency attendances were due to minor accidents in the home. As a result the trust developed the Wandsworth Safety Equipment Scheme for Children, which provided free safety equipment for the home of families with children aged 0-5, who were on income support, higher tax credit, under FNP or had a child with special needs. Equipment included stair gates, corner cushions, socket covers, bath mats and other various items.
- The sexual health service, The Point, ran clinics for young people aged 25 and under. The Point ran clinics that covered early evenings between Mondays and Friday for young people aged 25 and under.. Staff told us the clinics were in the evenings so young people could access the services after school or college. The service also has a Saturday morning clinic with hopes of making it more accessible for young people.
- The sexual health service had developed a transgender service to meet local population needs.
- The early years centre was a child friendly environment. It had a large play and development area, including a sensory wall, sensory room, safe space and ball pit for children to access when using the therapy service. The service also had a toy library with a large number of toys available for parents to borrow.
- Some service managers told us waiting times had increased due to vacancies and it was challenging to bring these back down.

Equality and diversity

- Staff reported good access to interpreter services, which offered a wide range of languages. Interpreters were available for face-to-face meetings, home visits and over the telephone. We saw posters about access to interpreting services displayed throughout the locations we visited. We observed a health visitor developmental review where a parent was offered access to an interpreter as their first language was not English. We saw evidence of an interpreter being booked for a home visit.
- Staff were aware of various cultural needs of the people they supported and were able to respond appropriately.
- We saw some evidence of patient information leaflets in different community languages to ensure service users had access to written information.
- Staff attended equality and diversity training as part of their mandatory training.
- Buildings we visited were accessible and adhered to the requirements of the Disability Discrimination Act 1995.
- Parents told us the staff respected diversity and the differences of every child when delivering group interventions.

Meeting the needs of people in vulnerable circumstances

- The CYP service worked in partnership with other local organisations to support the needs of people in vulnerable circumstances. For example, the homeless team worked with local refugees and supported housing. Staff also tried to engage with homeless young people, so their health could be monitored and support offered.
- The trust provided a number of resources for autism support including parenting groups, support and home visits, play and development support, multidisciplinary feeding groups and access to a toy library.
- The early years centre provided individual support for parents who were living with a learning disability themselves and couldn't attend the group sessions for parents.
- We saw therapists were using pictorial timetables and care plans for children living with a learning disability. We found therapists used appropriate language and

body gestures to assist communication with service users, for example clapping to say well done. Therapists implemented a pictorial exchange communication system (PECS) which supported children to say what they wanted by showing pictures during sessions.
- The sexual health service developed ACORN, a service for those living with a learning disability.
- The LAC service made their feedback forms more children and learning disability friendly by using smiley faces as a rating scale.
- Continuing care and community nurses conducted joint visits to families with more complex cases, this ensured they were providing suitable packages of care that met the families' individual needs.
- We saw posters, which offered breastfeeding in private rooms if required, however some mothers told us they could not access private space to breastfeed.
- We visited five health centres, and we found that they had no or very few toys or children's books available in waiting areas for children to play with.

Access to the right care at the right time

- There was effective communication between departments within the organisation. This meant referrals could be made easily.
- The haemoglobinopathy team contacted families as soon as they have been referred to the service, to ensure families could start being educated as soon as possible about the condition. There had been an issue with discharge summaries from the hospital not being uploaded in time for the service to respond. This was due to the hospital and community team being on different systems. In addition, the laboratory which tested blood for haemoglobin disorders now covered other boroughs as well as Wandsworth. This resulted in new staff and new equipment and improved results being received in a timely way.
- During our inspection we observed children and families did not wait long before being seen in clinics. Parents told us when appointments were running late the staff kept them well informed.
- Some services already used a Single Point of Access, such as the ADHD service.
- Data provided by the trust for community services indicated that between April 2015 and March 2016, 91% of community paediatric patients were seen within the 18 week referral to treatment time. The trust did not provide the data for therapies.
- There were examples of multi-agency and MDT working to make sure patients could access all of the services they needed. For example, for those with complex needs there were comprehensive care packages put in place.
- School nurses offered regular drop in sessions for pupils to attend and discuss concerns. We observed a banner advertising the school nurse service in the school we visited.
- Some parents found referral to speech and language therapy (SLT) more difficult than they would have liked. They thought referrals from GP's were difficult to obtain.

Learning from complaints and concerns

- Guidance on how to make a complaint to Patient Advice and Liaison Service (PALS) was on display in clinical areas.
- ADHD staff told us the main concerns raised by parents was being unable to get hold of staff. An email account had been created to improve access.
- Staff reported CYP services did not get many complaints. However, we were unable to identify the complaints specifically related to community children's services from the data provided by the trust.
- The majority of parents told us they had no concerns or complaints about the CYP services. However, parents told us they had been given no information about how to make a complaint from staff.

Requires improvement

Are services well-led?

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

Summary

We rated well-led as requires improvement because:

- There was a documented ten year strategy for the trust but most staff did not know what this was.
- Although the acute trust merged with community services in 2010, there was still a sense of "us and them". Staff reported they did not feel part of the trust and were forgotten. They felt the focus of the organisation tended to be on the acute services and community services tended to get lost.
- Most staff felt supported at a local level however there was some concerns about the disconnect between frontline staff and the executive managers.
- Staff said they were unable to access training for professional development due to the trust's financial difficulties. Financial constraints also impacted on the trusts tender bid for the immunisation service in other boroughs.
- Community services were experiencing significant IT issues with the electronic records system and had received no feedback on what actions were being taken to address this.

However:

- At a local level staff felt very well supported and had access to supervision on a regular basis.
- Staff we met reflected the trusts values and vision.
- There were effective processes for involving service users and the development of services and resources.

Service vision and strategy

- We asked staff if they were aware of the trust's values and the majority of staff could tell us what these were.
- We found clear strategic visions were in place within the trust. Senior staff reported the strategy was the same for community and acute services, but each directorate within CYP had its own objectives. For example, services were developing a buying matrix for special needs schools which would help calculate what funding each child would get for care and treatment.
- We asked staff if they were aware of the organisations strategy for children's services. Most staff were unaware of whether there was an organisation strategy for the future, and told us they had been provided with no information from the trust.

Governance, risk management and quality measurement

- Staff understood their role and function within the CYP service and how their performance enabled the organisation to reach its objectives.
- We spoke with the management team of CYP services who 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.
- We saw there was a comprehensive clinical audit programme with a range of audits undertaken by a variety of teams.
- The trust had a risk register in place and CYP services had their own care group risk register which was discussed in meetings.
- There were processes in place to feedback information to staff via a trust bulletin, emails and staff meetings. Staff told us this information was usually very acute focused and there was little information about community services.
- Service managers told us information about complaints and incidents should be cascaded to staff via team meetings. However, some staff told us they received no feedback from incident reporting and could not identify any learning from incidents.
- Staff told us the head of children's services position had been vacant which left a gap in management. We were told on the inspection that this post had now been filled.
- Staff were aware of how to access policies and procedures on the trust intranet. However, a number of policies needed revising and some staff were using policies that were out of date. For example, some staff showed us they were using an outdated safeguarding policy. Service managers told us there was a plan in place to address this from a corporate perspective.

Requires improvement

Are services well-led?

- Staff told us there had been challenges monitoring quality due to issues with getting information from the electronic records system. There were IT issues across all CYP services. The trust told us there was a IT plan supported by a risk reduction matrix in place to aid community IT stabilisation.

Leadership of this service

- The CEO attended the launch of the FNP service.
- FNP staff were very positive about their manager and said: "This is the best team I have ever worked" and "My manager is very supportive and can access them anytime I want".
- Operational staff such as health visitors, school nurses, therapists and community nurses told us they were well supported by service managers. Staff said the general manager, therapies manager and safeguarding lead were present and supportive within the community.
- Staff in the homeless team said they were well supported by their manager and received good supervision.
- Therapies staff told us: "My manager is fantastic", "My manager is very supportive", "We get good supervision", "We have peer review group supervision" "We have a good supportive team". Administrative staff told us they also felt well supported.
- Sexual health staff told us they had been kept informed of the tendering and staff were helping manage their anxieties.
- On the inspection we were told the head of children's services post had been vacant, staff said they lacked support from this level.
- Most staff, in all the localities we visited, said there was a disconnect between the trust's executive board and staff in the front line.
- The majority of staff told us senior leaders were not very visible or accessible to staff in the community. Staff said things like "I have never seen the directors in the community", "They never visit our services", "They focus on acute services more, so we do not see them", "we get support from community managers but higher up than the general manager we don't see". However, we were advised by the Trust that the Divisional chair, Divisional Director of Operations and Divisional Director of Nursing and Governance for the community services division ran monthly community services roadshows in rotating community sites which all staff were able to access.
- A general view amongst staff we spoke with was that "community services felt very separate from the trust". Staff commented things like: "It's very much us and them", "Community services are like a side order", "I don't feel part of the trust", "I don't really know who the trust is", "I think the trust could celebrate community children's services more", "The trust is very acute focused and community gets forgotten", "It feels very separate", "The trust talk about how acute services are developing but community are rarely acknowledged".

Culture within this service

- We found an inclusive and constructive working culture within CYP services. No staff we spoke with mentioned bulling or harassment within services.
- Health visitors, community nurses, school nurses, FNP and sexual health staff reported approachable and supportive colleagues.
- We found highly dedicated and passionate staff who were committed to providing a good services for children and young people.
- We found staff worked collaboratively to focus on the needs of the children and young people, for example community nursing and continuing care worked together for young people with complex needs.
- Student therapists said they were well supported and given good opportunities to learn and develop.
- The organisation had a lone worker policy in place and was in the process of ordering lone working devices for staff who worked in higher risk areas, such as the homeless team.
- Staff felt encouraged to report incidents and near misses, concerns and identified risks.
- Staff told us they were respected and valued within the community services division, however they did not feel valued by the trust.
- Sexual health services were going out for tender in September which was causing anxieties within the sexual health team.

Public engagement

- The organisation took part in the friends and family test. A nation-wide initiative to help organisations assess the quality of their services by asking people who used the service whether they would recommend the service. For

Requires improvement

Are services well-led?

Children and Family Services the trust achieved 100% in May 2016 compared to a recommended England average of 95%. Between July 2015 and May 2016 the lowest score achieved was 93% in April 2016.

- Two clinical areas, Queen Mary and the Child Development Centre had a coin system for children to give feedback. Children were given a gold coin to post in either a smiley or sad face box depending on their experience. We observed two children using this, posting their coin in the smiley face box.
- We saw examples of parents being involved in the development of leaflets. For example, parents had been asked for feedback on the ADHD service information leaflet and changes had been made as a result of this.
- School nursing in Wandsworth collected feedback for children and young people via the school nursing patient survey. The service developed an action plan based on the feedback in order to make improvements to the service. For example, 78% children said they understood everything they were told, so the service has asked staff to ensure information was explained and accompanied by written information.

Staff engagement

- Staff had taken part in the national NHS staff survey, however the results were not specifically available for CYP services.
- Staff acknowledged communication within community services was good. They said they were listened to by their managers and well supported.
- Staff told us, and we saw that there was frequent communication with them via emails and bulletins, and that managers would keep them up to date with what was going on. However, they said this information was very acute focused.
- CYP staff did not feel engaged with the organisation as a whole. Staff told us they would like more acknowledgement from the trust for the things they were doing well.
- Staff were aware of the trusts financial difficulties.

Innovation, improvement and sustainability

- CYP services had recently won the tender for school nursing immunisations.
- Staff told us about the health visitors award, where health visitors could be nominated for good work. Community nurses said a new award scheme for them was just about to start.
- A breast feeding lead for community services was appointed to help services work towards are Unicef baby friendly. To improve awareness and support working towards Unicef breastfeeding champions were being appointed in different localities, the breast feeding lead was working with My Time Active, a commissioned public health service, with the hope of building in the baby friendly standards to the Health Wandsworth Award.
- The respiratory team were given money to develop an asthma team who would work across both acute and community services. This service aimed to educate and provide teaching to families and work towards admission avoidance.
- Pupils within the Paddock school ran the “Paddock Café”. Pupils grew their own vegetables and cooked the food. The OT and school nurses linked with the café by assessing behaviour, communication and strategies to manage behaviours.
- We saw a business plan for the development of a more cost effective speech and language assessment service, aiming to offer earlier intervention for children with suspected ASD.
- A senior practitioner from reproductive sexual health was involved in the Mothers Like Me Project. An 18 month project (launched in January 2014) supporting birth mothers of adopted babies and children in long term care placements helping to identify factors that contributed to this outcome and strategies and support that would help prevent it happening in future. This was a joint venture between Health and Children’s Specialist Services and funded by the Adoption Reform Grant with the aim of promoting the women’s health and well-being through both individual and group support to help prevent repeated loss of their children. The project won Winners of the Positive Practice Award.
- Services had won funding to deliver first aid to parents at children’s centres to help reduce accident and emergency attendances for things that could be dealt with in the home.