Oxleas NHS Foundation Trust

RGP

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)
RPGX5	Bluebell House	Short breaks, Respite	SE9 5AD
RPGEG	Erith Health Centre	Bexley Sexual Health Services	DA8 1RQ
RPGDV	Highpoint House	Ferryview Clinic, (Health Visitors) - Health Visitors	SE18 6PZ
RPGDV	Highpoint House	1 Wensley Close (Community paediatrics - Community paediatrics	SE9 5AB
RPGDV	Highpoint House	3 Wensley Close - Audiology & 'looked after' children service & Integrated community children's team	SE9 5AB
RPGDV	Highpoint House	Gallions Reach Health Centre	SE10 9GB
RPGAN	Goldie Leigh Hospital	Goldie Leigh (Children's Occupational therapy and physiotherapy) - Children's Occupational therapy and physiotherapy	SE2 0AY
RPGDV	Highpoint House	Greenwich Square	SE10 9GB
RPGDV	Highpoint House	Kidbrooke Health Centre	SE3 9FA
RPGAG	Memorial Hospital		SE18 3RZ
RPGDV	Highpoint House	Queen Mary's Hospital - Community paediatrics, community children's nursing, occupational therapy, physio, SALT	DA14 6LT

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

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

Summary of findings

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

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Overall summary

Overall services for children, young people and families were rated as 'Requires Improvement'. We found community health services for children, young people and families were 'Requires Improvement' for safe and well led. We found community health services for children, young people and families were 'Good' for effective, caring and responsive.

Our key findings were:

- There were ongoing incidents related to the electronic system, communication issues and record problems. These were being periodically reviewed but had not been resolved.
- There were inconsistent methods of recording messages, which meant the trust could not be assured messages had been responded to in a timely manner. Lapses in communication had been identified as a risk when working with vulnerable families.
- There was no caseload weighting tool to ensure health visitors could deliver an equitable service across the trust. Some caseloads were very high, above the upper limits as set by professional organisations.
- Allocation meetings where staff allocated work were not recorded consistently. This meant there was no process to review staff allocation. There was no robust system regarding allocation of families and their level of need with the capacity of the staff to meet the need.
- Some premises were not suitably equipped for families to ensure their safety and infection prevention and control measures were not consistently in place.
- Data was not robust in relation to health visiting performance and the trust could not be assured it was able to deliver health visiting services to meet people's needs.
- School nursing for 2014/15 achieved 100% uptake in the reception year National Child Measurement Programme and 99.9% in year 6. A new healthy weight programme had been introduced for those children classed as overweight to meet the high rate of obesity.
- The trust delivered care in line with current evidence-based guidance, standards, best practice and legislation. There was good engagement with other providers and across disciplines, we saw some excellent examples of multidisciplinary working.
- Staff told us they felt respected and valued. All staff said they enjoyed their jobs and liked working in their team and for the trust.
- Innovation was promoted by the trust. For example, the use of technology to improve access to health information on sexual health websites for Bexley and Greenwich as well as the electronic application 'app' for new parents.

Summary of findings

Background to the service

Oxleas NHS Foundation Trust provided community health services for babies, children, young people and their families across two London boroughs: Greenwich and Bexley. These services included universal health services, specialist nursing services, community paediatrics, a short break service as well as physiotherapy, occupational therapy and speech and language therapy services. The commissioning of health visiting transferred from NHS England to Public Health within the two local authorities in October 2015. The total population of Bexley and Greenwich is just under half a million. The family nurse partnership service was delivered by another provider. The trust provided sexual health services, in Bexley the community children and young people service provided this to those aged under 25 years of age, in Greenwich it was provided by the adult community services.

In Bexley and Greenwich, children and young people under the age of 20 years made up about a quarter of the population. In Bexley, 36% of school children were from a minority ethnic group, whilst in Greenwich 64% of school children were from a minority ethnic group. The levels of obesity in children were worse in Bexley than the England average and significantly worse in Greenwich than the England average. A higher than average proportion of children (73%) were judged to have achieved a good level of development by the end of foundation stage. The foundation stage assessment is completed in the final term of the academic year in which a child reaches the age of five years. Child poverty in Greenwich was worse than the England average and both Bexley and Greenwich had a family homelessness rate worse than the England average.

We visited the following locations:

- Bluebell House, (Short breaks, Respite service),
- Erith Health Centre (Bexley Sexual Health Services)
- Ferryview Clinic, (Health Visitors)
- 1 Wensley Close (Community paediatrics)
- 3 Wensley Close (Audiology & 'looked after' children service) & (Integrated community children's team)
- Gallions Reach Health Centre
- Goldie Leigh (Children's Occupational therapy and physiotherapy)
- Greenwich Square
- Kidbrooke Health Centre
- Memorial Hospital
- Queen Mary's Hospital (community paediatrics, community children's nursing, occupational therapy, physio, SALT

Our inspection team

Our inspection team was led by:

Chair: Joe Rafferty, CEO Merseycare NHS Trust

Team Leader: Pauline Carpenter, Care Quality Commission

The team inspecting community health services for children, young people and families included CQC inspectors and specialist paediatric nurses.

Why we carried out this inspection

We inspected this provider as part of our comprehensive community health 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 between 26 and 29 April 2016. During our visit we observed how people were being cared for in different locations across Greenwich and Bexley and we talked with 30 people who used services in person or on the telephone. We held focus groups with staff who worked within the service, and spoke with 85 members of staff including, nurses, health visitors, doctors and therapists. We reviewed 22 sets of records and an extensive range of service-related documents including policies, performance reports and complaints files.

What people who use the provider say

During our inspection we heard many positive comments from parents, carers and young people.

Parents told us that staff were helpful and supported them. All felt that staff had the right skills to do their work. Parents felt involved and listened to in the care and treatment of their children. 'They've been a great help' and 'very good communication between services'. One parent whose child used the speech and language therapy service spoke about there being a real emphasis on partnership, 'a team effort between home and school, like a net around us'.

Young people valued seeing staff they knew in places they were familiar with and at times convenient for them. Parents told us that most of the time health visitors were friendly and caring.

Of the 22 people we spoke with, there were four negative comments these included, a delay in seeing paediatricians and being referred to therapy services, not having a timely response to telephone messages left for individual practitioners and not liking the single point of access system. The reasons given for not liking the single point of access system included having to repeat their child's details and history, it being impersonal and not getting directly through to the person in a timely manner.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Consider the use of a weighting tool to ensure health visitors deliver an equitable service across geographical locations.
- Consider how data collection and collation mechanisms can be made robust or health visitor service metrics and breastfeeding data at six to eight weeks postnatally.
- Consider how the statutory guidance for the completion of Initial Health Assessment within 20 days will be achieved.
- Make arrangements to ensure that all child health clinics are suitably equipped for families and children to ensure their safety.

Action the provider COULD take to improve

- Review arrangements of the investigation of serious incidents to ensure timely investigation.
- Review systems used to record telephone messages and ensure action taken.
- Introduce a consistent process for recording allocation meetings that capture what has been allocated to whom and time frames for action.
- Consider arrangements for a professional lead for children with a learning disability.

Summary of findings

- Investigate incidents related to the electronic system, and related communication issues.

Oxleas 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 services for children, young people and families as 'Requires Improvement' for safety because there was limited assurance that people were protected from abuse and avoidable harm because:

- There were periods of understaffing, which did not ensure people's safety was always protected. The use of tools for the systematic planning and monitoring of staffing levels was not well developed in all services.
- Not all Health Visitor clinics were held in a suitable environment.
- The electronic system for patient records presented risks in relation to the timeliness, completeness and accuracy.

However, we also found:

- Safeguarding children was given sufficient priority and staff were proactive and focussed on early identification of potential abuse.
- There were adequate arrangements for the safe storage and administration of medicines.

Detailed findings

Safety performance

- Between April 2015 and March 2016, the service reported 523 incidents in children's services. The main categories were 'records' with lost, missing or misfiled information and 'communication' with breaches of information and communication failure. However, a retrospective analysis identified that inaccurate uploading of information related to 29 of the record incidents. During the same period 169,711 documents were uploaded onto Rio this equates to 0.02 % of records being incorrectly uploaded into the system. Of the 524 incidents 96 (18.32%) were related to third party information errors in communication and reporting of child deaths which were outside of the remit of Oxleas.

Requires improvement

Are services safe?

- Between April 2015 and the end of March 2016 there were two serious incidents requiring investigation both within children's specialist services and were currently being investigated.

Incident reporting, learning and improvement

- The service had identified learning from serious incidents and identified case reviews may not be embedded. In community children and young people's services some learning had been embedded for example in using generic team emails. In a serious case review it had been identified that an individual staff member's email had not been responded to and had caused a lapse in important information being communicated.
- Incidents were reported using an electronic system and staff we spoke with knew how to use the system. Staff told us they were supported by team leaders and managers to use this system to report incidents. Some staff told us they did not get feedback or updates following an individual incident. However, we were advised of a system in which learning is disseminated to staff.
- Incidents were reported in high level meetings such as the trust's patient safety group, a sub group of the trust's quality committee and in staff team meetings.
- Senior staff told us, and minutes from an executive meeting showed, a retrospective analysis of incidents where incidents had taken place. Learning was then shared through professional development meetings, supervision, team meetings, emails and the staff newsletter. Minutes from meetings showed staff discussed incidents and considered learning points from them. Staff spoke of learning from serious incidents and the serious case review and changes in practice. For example, generic team emails were used and out of office reminders with alternative contact details which ensured messages were directed appropriately and picked up in a timely manner. Staff told and we saw in incidents reported recurring themes with the electronic record system. The trust told us that analysis of these themes was ongoing.

Duty of Candour

- Staff demonstrated knowledge of the Duty of Candour in being open and transparent with people, including when things go wrong with their care and treatment. An example was given regarding an immunisation incident, the incident was recorded, the parents of the child were informed of what had happened and what action would be taken to prevent this reoccurring. Learning from this incident resulted in a change in policy, with clarification of disposing of needles post immunisation in an appropriate container and in extra training for staff.

Safeguarding

- Staff were able to recognise safeguarding concerns for children and young people and showed a good knowledge and awareness of the safeguarding processes and their responsibilities in protecting children from harm. All staff we spoke with told us they were able to access safeguarding advice when required**.** The trust's safeguarding children policy dated January 2016 included the revised Working Together 2013 government guidance and the London Child Protection Procedures 2013 and was available on the trust intranet. Child protection cases were managed by health visitors and school nurses qualified as specialist community public health nurses. Children and young people with safeguarding concerns could be identified on the electronic records system, which ensured all staff were kept up to date.
- Guidance ensured staff were aware of risk factors, signs and symptoms of child abuse, self-harm, child sexual exploitation, female genital mutilation and mental health, alcohol, substance misuse and domestic abuse. Staff told us and we observed staff asking parents about whether they intended to have female genital mutilation performed on any daughters or females in the family and that parents would be referred to Children's Social Care if this was the case.
- Staff working with young people who sought sexual health advice used a risk assessment based on national guidance to help health professionals identify young people at risk of child sexual exploitation. This tool was completed for all young people under the age of 16 years and at staff member's discretion for those aged 16-18 years. Safeguarding advisors or the domestic violence specialist health visitor attended initial Multi Agency Risk Assessment Conferences (MARAC) with health visitors and school nurses where information was shared about high risk domestic abuse. Staff were trained in using the Domestic Abuse, Stalking and

Honour (DASH) risk identification checklist. There was also a rota for community health staff cover at the refuge to offer and initiate support for parents and their children.

- 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. Newly qualified staff and/or those new to the trust were supervised within one month of joining. School nurses were seen termly for one to one supervision and health visitors were seen for one to one supervision every three months by the safeguarding children team.
- The trust had indicated on the trust risk register that safeguarding children was not fully embedded across the trust. However in community services we observed processes and work that prioritised the protection of children from harm. The trust's director of nursing was the safeguarding children executive lead. The safeguarding children team consisted of the head of safeguarding, lead named nurse, named nurses and doctors for Bexley and Greenwich, and the safeguarding children nurses based at the Multiagency Safeguarding Hubs (MASH) in Bexley (one nurse) and Greenwich (two nurses). The trust together with a neighbouring authority also had a lead practitioner for safeguarding children in Bexley from adult mental health services. There was a safeguarding children and adult administrator who was managed by the adult safeguarding service. There was also a specialist health visitor aligned to domestic abuse. Senior members of staff attended Local Safeguarding Children Board meetings.
- Health visitors and school nurses were notified by the paediatric liaison health visitor of any emergency department attendances of a child or young person where concerns were raised regarding their safety. The paediatric liaison service provided by the trust at the Queen Elizabeth's hospital would request urgent follow up if needed with health visitors and school nurses.
- In community services all staff had received safeguarding training level 1, level 2 had been completed by 99% of staff who required it, and level 3 by 95% of staff requiring it. The trust target was for 80% of all staff at the trust to have the required safeguarding children training, therefore community services exceeded this target.

Medicines

- Staff ensured medicines requiring refrigeration were stored at suitable temperatures by monitoring and logging fridge temperatures. Systems were in place to check medicines were in date and in stock. In the short break service we observed controlled drug regulations under the Misuse of Drugs Regulations 2001 were adhered to. The sexual health service and the specialist and community children's nurses had regular contact with a pharmacist. The sexual health service told us they worked together and this helped them with the patient group directives (PGD) with the written instructions for the supply and administration of medications for this group of patients.
- Audits had been undertaken within the last ten months, these included reviewing: medication charts in the community children's nursing service, medicine related incidents in specialist children's nursing and the handling of medicines in special schools. Recommendations and actions included how to reduce the likelihood of inaccuracies in transcribing of instructions onto medicines administration charts (MAR). These included: giving an explanation of administration at certain times, checking what was transcribed with labels on medicines' containers, referring to reference documents such as a hospital discharge letter and ensuring the MAR charts were scanned onto the electronic records in a timely and reliable manner. There were plans to re audit annually.
- There was a dedicated immunisation team who administered BCG immunisations and school age immunisations within schools. We saw processes to manage the cold chain for the storage and transportation of vaccines. Vaccines may lose their effectiveness if they become too hot or too cold, and we saw processes to ensure that immunisations were stored at the correct temperature including during transport.
- Nurses delivering immunisations were competent to administer medicines under patient specific directives (PSD) which identified the individual patient in an immunisation clinic. A patient service directive is the traditional written instruction signed by a doctor or non-medical prescriber for medicines to be administered to a named person after the prescriber has assessed the

person on an individual basis. The immunisation team had yearly updates of competencies, for example, treatment of anaphylaxis, a rapid severe potentially life threatening allergic reaction.

- Many health visitors were nurse prescribers, however the prescribing rate had been low, therefore training sessions and support from pharmacists had recently been introduced, together with the development of prescribing champions to encourage prescribing.
- Community children's nurses did not use PSDs or PGDs, each patient was individually prescribed the medication they required. Most children being cared for by the community children's nurses had one paper medication chart at home, which included the weight of the child or baby in order to determine dose and charts that corresponded with the medicines administered. Medical letters, including information about medication for children with complex medical needs were stored on the trust's electronic record system as were care plans which included instructions for managing medicines.

Environment and equipment

- We found all equipment in use was clean, checked and had been regularly serviced. We saw evidence of weighing equipment and audiometers being regularly calibrated and electrical items had Portable Appliance Testing (PAT) dated stickers as well as lists of tested equipment. Staff told us they had enough equipment to deliver safe care and had no problems ordering equipment.
- Parents caring for children with complex health needs told us it was easy to get access to equipment.
- In the short breaks service the equipment was in good condition and the environment and adaptations were designed to meet the needs of children with complex health needs.
- The trust's bases and rooms used by community children's nurses, therapy services and community paediatricians for specialist, second tier services were suitable, welcoming environments for families. There was adequate space, light and toys.
- We visited a total of six health visitor clinics and bases, of the six where child health clinics were held, three were not suitable for parents and young children. Two of these clinics had no or very few toys, with one of these having inadequate baby changing facilities. A third base had reported four incidents over a year, three of which were preventable and attributed to the environment. Two incidents, six months apart involved a child banging their head on the edge of a table. At the later incident a staff member requested a full risk assessment to ensure the room was safe for child health reviews.
- Staff were provided with mobile phones and community children's nurses, community paediatricians and therapists had access to electronic work tablets. We saw these were being rolled out to health visitors and school nurses. Staff told us they were able to access desk top computers at their bases and there was enough office space.

Quality of records

- The majority of staff working across community children's services used a recognised electronic records system that was used trust wide. Access to trust wide data ensured the holistic and effective planning of children's care. However, some therapy assistants and health care assistants were unable to access the system, which resulted in duplication of work.
- The electronic record system used by the majority of staff across community children's services was cited in four out of seventeen items on the risk register for this service. The risk of data being entered late or data being missing was identified as a high risk. Audits of the electronic system highlighted there was not a uniform approach to documenting and some processes for scanning were not adhered to. From the audits individual teams were advised of errors in documenting and there were reminders about the processes for documenting in the staff newsletter. However we saw incidents related to the electronic records were still ongoing.
- Staff were generally positive about the electronic records system but some expressed frustration with recurrent incidents of incorrect or missing patient details. Incidents with the electronic record system had resulted in incorrect and missing patient information and lapses in communication. Many staff told us of ongoing problems with the record system. An analysis of records by the trust six months ago had found some incorrect processes being used and reminders had been sent to staff via newsletters on correct recording processes. We saw in one newsletter from April 2016 a reminder on processes for producing letters. These incidents were ongoing. During and after our inspection the trust informed us there was ongoing analysis of incidents with records.

Requires improvement

Are services safe?

- We looked at 22 sets of records across the community children's services this included personal child health record books held by parents for their children and used by staff working with children. The books held by parents and carers contained appropriate information about the child, recording assessments, development checks, immunisations, and the child's progress with weights plotted on centile charts. They were accurate, complete, legible and signed.
- The 'looked after children' (LAC) nurses and doctors used the trust's electronic records system. An audit of record keeping regarding health assessments for LAC had been completed and the majority met the standards including: key worker, GP, dentist identified, recording of vision, hearing, dental checks, immunisations being up to date, allergies recorded or their absence and a completed health plan with identified issues actioned. The review health assessments and health plans were completed by LAC nurses, the health plans reflected a multi-disciplinary approach to the child or young person's health care.

Cleanliness, infection control and hygiene

- All trust clinical areas and premises we visited appeared visibly clean. Two premises used by the trust's community children's services had been assessed under the Patient Led Assessments of the Care Environment (PLACE) scheme. Queen Mary's Hospital scored 97%, which was about the same as the England average and Goldie Leigh scored 99%, which was better than the England average.
- Compliance for infection prevention and control training in community children's services was 93%. The infection prevention and control policy of January 2016 stated that all staff required this training.
- Staff adhered to practice that would reduce the risk of infection. We observed staff washing their hands, cleaning scales and replacing the paper roll on the scales between seeing babies. Staff adhered to 'bare below the elbows' guidance. Personal protective equipment was available for staff such as aprons and gloves as required. Gloves were available in a range of sizes and stock was adequate.
- Appropriate arrangements were in place for the handling, storage and disposal of clinical waste including sharp items.
- We saw six cleaning schedules of rooms, toys and equipment. On the schedules it was unclear whether staff were cleaning at the dates and times stated which made auditing cleaning impossible.

Mandatory training

- Staff told us the trust placed a high importance on training and they were satisfied with the quality of training courses. Trust wide 95% of staff were up to date with their statutory and mandatory training, in community children's services results showed 96% compliance.
- Trust wide mandatory training included equality and diversity, fire safety, health and safety, infection control, information governance, safeguarding adults and safeguarding children. The level of safeguarding training followed guidance from the Royal College of Paediatrics and Child Health Intercollegiate document.
- Community children's services also received mandatory training in conflict resolution. Paediatricians told us they had good access to training in their job plans.

Assessing and responding to patient risk

- The trust had a system for cascading and monitoring the implementation of central safety alerts in order that staff completed actions in a timely way.
- The trust 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. These included; the universal service, the universal plus, for those requiring a brief period of extra support and the universal partnership plus, for families requiring intensive support involving other professionals.
- Health visitors only provided antenatal assessments to first time parents and those referred by midwives for whom there were concerns. Therefore needs were not always identified early and support needed may be lacking. NHS England's guidance is that all families should expect an antenatal visit one of five 'universal health reviews'.
- Children's electronic records identified which level of service children were receiving and described their

specific needs and risks. Alerts could be added to the system to indicate specific risks such as domestic abuse, which ensured staff were aware of and had speedy access to individual needs and risks.

- Assessments were recorded in a timely way. We saw a range of records across children's services, for example, risk assessments and all were up to date and completed. The trust had policies and pathways for staff to use when certain risks were identified, for example, domestic abuse and child sexual exploitation. Staff knew how to identify when children required more specialised services and referred them appropriately.
- School nurses identified children with a medical condition that required management in the school environment. School nurses worked with the school to produce a medical alert handbook, which contained an individual health plan including advice on how best to support the child/young person's health needs.
- Community children's nurses had handovers twice a week to ensure staff knew what was happening with particular children, which was documented in the diary.
- Health visitor teams held weekly allocation meetings where they planned and allocated work including the Healthy Child Programme work. If additional new birth visits were required they would meet more frequently to accommodate the needs of families. Information came to teams mainly through the electronic system, emails and from colleagues liaising and was recorded and stored in various ways.
- However, allocation meetings were recorded inconsistently across the service, it was not always possible to capture what had been allocated and there was no robust system regarding allocation of families and their level of need with the capacity of the staff to meet the need. A staff newsletter from March 2016 advised staff the electronic monthly team planner was not reliable and to use the electronic referrals page.
- In community children's nursing message books it was possible to see what action had been taken and when in response to the message received.
- Health visiting message books used by staff had no process to capture what had been reviewed and what action, if any had been taken. This meant staff may not be able to respond to family's needs in a timely manner.

Staffing levels and caseload

- The trust had reached its planned trajectory of 66.52 whole time equivalents (WTE) in Greenwich by October 2015 for the recruitment of health visitors in line with the expected increase in workforce through the 'Call to Action; Health Visitor Implementation Plan 2011-15'. In Bexley the number of allocated WTE health visitors had remained at 39.54 from March 2012, at the start of the Call to Action programme, there had not been an agreed trajectory with NHS England for Bexley.
- Across universal community children's services in March 2016 there were 14.7 WTE vacancies in health visiting and school nursing representing a 9% vacancy rate. Vacancies were higher in Bexley however, two school nurses had been recently recruited. At the time of our inspection student health visitor and school nurse training posts were being advertised.
- The trust identified a risk in April 2016 to service delivery in health visiting in Bexley with a 12% vacancy rate. The trust identified the reason for this being long term sickness and maternity leave and geographical realignment had increased caseload by 500 children. At the time of our inspection there was no current mitigation plan in place for the shortfall in health visitors in Bexley. Health visitors did not use a recognised weighting tool, issues related to this could be seen across the trust with caseloads varying from one WTE to 250 children to one WTE to over 600 children. Senior staff told us a weighting tool was being developed which was going to be implemented in Bexley and if affective then Greenwich. The Community Practitioners and Health Visitors Association (CPHVA) recommend caseloads for health visitors should be a maximum of 400 in the least deprived 30% of the population and ideally 250 per WTE or less in the most deprived 20% of the population. Therefore the trust was not meeting this target.
- A few health visitors reported there were not enough staff to manage caseloads with high levels of need. The identified shortfall in health visitors and the lack of caseload weighting meant that the trust could not be assured that there were sufficient staff to meet the needs of children across the health visiting service.
- The school nursing team was responsible for 33 secondary schools, 17 in Greenwich and 16 in Bexley. Greenwich had 14 qualified school nurses, one school nurse was responsible for three behaviour units. Bexley

had 12 qualified school nurses with two due to start. 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 was close to meeting this recommendation across the trust. School nursing teams offered drop in sessions in schools and contributed to school health promotion as well as the scheduled health assessments and child protection as necessary.

- In specialist nursing there were 4.9 WTE vacancies against an establishment of 48.8 in March 2016, this represented a 10% vacancy rate. Each WTE community children's nurse had approximately 30 children on their caseload, there was no acuity tool. This meant no tool was used to assess the dependency and number of patients with the number of appropriately skilled nurses to meet the needs of the patients. The trust could not be assured that there were sufficient staff to meet the needs of the children across the community children's nursing service.
- Staffing levels in the short breaks service reflected the needs of children staying there. The trust identified as a high risk on the risk register for community children and young people the risk to quality of service delivery from the use of or overuse of bank or agency particularly in community paediatrics and the delivery of specified care programmes to children. Staff working in the delivery of these care programmes did not report any concerns with staffing.
- The trust had a lead consultant for community paediatrics who was the designated doctor for safeguarding in Bexley. They also led on particular health specialisms across the trust and there was a speciality doctor who was the medical advisor for looked after children under the care of the borough of Bexley. In Greenwich there was a consultant paediatrician who was the designated doctor for child death, the lead for autism and for training and there was the designated doctor for 'looked after' children under the care of the borough of Greenwich. Difficulty in recruiting community paediatrics was identified as a moderate risk on the risk register and community paediatricians told us there was no designated doctor for child protection in Greenwich. Cover arrangements were in place with a 'consultant of the week' system.
- These were annual agreements which set out what work the paediatrician would do, when and where, the hours they were available to work, the resources needed to achieve the work and the amount of flexibility there was within this.
- At the time of our inspection there were designated Looked-after Children (LAC) nurses for both Bexley and Greenwich with two LAC nurses for Greenwich with a further post advertised, and one LAC nurse for Bexley who is employed by the CCG. LAC nurses completed the statutory review health assessments. At the time of our inspection in Greenwich there were 530 'looked after' children under the age of 19 years of age and in Bexley there were 361 'looked after' children.
- For allied health professionals there were 4.8 WTE vacancies against an establishment of 109.4, this represented a 4.37% vacancy rate. Staffing allocation was in response to capacity and demand, the physiotherapists and occupational therapists did caseload analysis regularly and used a prioritisation tool.
- Overall we found staff worked together to cover each other's shift to ensure anticipated work was covered during staff annual leave and training commitments.

Managing anticipated risks

- The trust had a lone worker policy, which staff were aware of, staff informed colleagues of their schedules, staff were aware of each other's whereabouts and all staff working in the community had a work mobile phone. We saw staff risk assessments in records where staff visited a child's home in order to minimise the risk of injury to staff.
- 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. There was a plan for community children and young people's service, which included a list of prioritised essential services and the actions required. For example priority one following a major incident meant the service had to focus on work with families requiring safeguarding support, new birth visits, families assessed as vulnerable and those with mental health needs. Priority two would cover limited immunisation sessions and clinics and post-natal visits.

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 services for children, young people and families as 'Good' for effective because:

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation and was monitored to ensure consistency of practice
- Patients had good outcomes and received effective care and treatment that meets their needs. There was participation in relevant local and national audits information about effectiveness was shared internally and externally, and was understood by staff and used to improve care and treatment and people's outcomes.
- Staff were qualified and had the skills needed to carry out their roles effectively and in line with best practice and were supported to maintain and further develop their professional skills and experience.
- Staff were supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal.
- However, the outcomes of people's care and treatment was not monitored robustly and some national programmes of care were not delivered in full as set out in national guidance.

Detailed findings

Evidence based care and treatment

- Staff participated in regular professional group meetings to review professional standards and practice to ensure they were in line with standards and evidence based guidance. The trust showed a range of evidence in using nationally recognised tools, procedures and pathways. We saw pathways had been reviewed, for example, maternal mental health pathway and pilots started to improve outcomes for families, children and young people, Examples included a rapid response pilot with the aim to prevent hospital admission and reduce hospital stay.
- Health visiting and school nursing services had standards which set out levels of care, expected contacts and guidelines for assessment, referrals and support. The guidelines were based on national guidance, for example, health promotion topics such as NICE 2008 guidance on maternal and child nutrition, NICE guidance 2009 preventing unintentional injuries in the home among children and young people and in NICE guidelines 2014 for domestic abuse.
- Health visitors and school nurses 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, immunisation and health and development reviews as set out by the Department of Health (DH), however not all elements of this programme were being delivered.
- Health visitors used a family health needs assessment based on the framework of assessment to assess the family's needs. The DH advocates six high impact areas of work 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.
- As part of the Healthy Child Programme, health visitors provided an antenatal visit at 28 weeks of pregnancy to first time parents or pregnant women identified by midwives as needing extra support. Health visitors would also arrange to visit a new birth between 10 and 14 days post natally, organise a 6 to 8 week post-natal review as well as health reviews at one year of age and two to two and a half years of age. Health visitor teams used the 'Ages and Stages Questionnaires' (ASQ's) at the one year and two to two and a half year health reviews. The ASQ's are an evidence based tool used to identify a child's developmental progress and provide support as needed to parents. However, antenatal visits/classes for all pregnant women where contact could be made with health visitors, were not scheduled across the trust as set out in the Healthy Child Programme. This meant the needs and support requirements of mothers and babies were not always identified at an early stage.
- The health visiting service in Greenwich had achieved the UNICEF and World Health Organisation (WHO) final stage 3 Baby Friendly breastfeeding accreditation. This

is an evidence based approach to support breastfeeding by improving standards of care and support. The stage 3 assessment involved assessing that mothers were supported with feeding so they could continue to breastfeed for as long as they wished and that they had been given useful, accurate information. In Bexley the health visitors were due to be assessed in June 2016 for stage 2 accreditation.

- The school nurses delivered the National Child Measurement Programme (NCMP) as set out by Public Health England and the DH. The National Child Measurement Programme NCMP consisted of measuring the weight and height of children in reception class (age 4 to 5 years) and year 6 (age 10 to 11 years) to assess overweight and obesity levels. This provided staff with an opportunity to engage with children and families about healthy lifestyles and programmes. School nurses also provided a regular drop in for students in the school and contributed to the delivery of Personal, Social, Health & Economic Education (PSHEE) curriculum in schools. There was a stand-alone trust wide immunisation service offering school based immunisations, the childhood BCGs and the childhood flu immunisation programme.
- Care plan audits across individual services and community services showed all services apart from health visiting were ensuring that the majority of care records had care plans. In the report dated 2015 provided by the trust there were no plans on how they were dealing with this, however in directorate minutes of April 2016 there was a reported improvement to 80% of compliance in care plans. On the community risk register, a lack of evidence of involvement of people using the service in their care plans and not having their care plans reviewed every six months was identified as a moderate risk. Audits of assessments in care plans however showed services had sought children's and carer's views which reflected the child's individual needs. Half or less of those receiving a health visiting service had a care plan on the system, across services it was mixed for having a goal or expected outcome in care plans, having review dates, and evidence of care plans having been reviewed. This meant the service could not be assured that goals in treatment or care were being achieved and that some outcome measures were being captured.
- We observed integrated working across therapy services and standardised assessment tools used with a variety of examples of evidence based practice being delivered. For example, physiotherapists used Goal Attainment Scores (GAS) to score how a child's individual goals were achieved in the course of intervention and the Gross Motor Function Measure (GMFM) to measure change in physical movement over time in children with cerebral palsy. Occupational therapists used the Movement Assessment Battery to assess if a delay or impairment in the physical movement was having a detrimental impact on activities at home and outside the home.
- The trust had various accredited programmes. These included the ICAN (children's communication charity) Early Talk programme awarded in December 2016 for the speech and language therapy service supporting children in nurseries, the MOVE (Movement Opportunities Via Education) programme awarded to the physiotherapists and the haemoglobin disorders review in September 2015 for the service working with those with haemoglobin disorders. We saw protocols informed by NICE guidance for example the Attention Deficit Hyperactivity Disorder (ADHD) pathways, using age appropriate referral criteria, a recognised screening tool and having behaviour management as the first line of management. The trust did not have play therapists, staff told that therapy assistants were skilled in distraction therapies.
- The sexual health service met the objectives of the National Chlamydia Screening Programme. We saw how the service was ensuring young people had access to sexual health services and normalised regular chlamydia screening among young adults. Sexual health services followed guidance and service standards from the Faculty of Sexual and Reproductive Healthcare and other professional bodies. An example of this was the management and follow up of a woman or young person requesting emergency contraception.
- There were systems in place to ensure the health needs of 'looked after' children were addressed and met. The LAC team used the 'Strengths and Difficulties Questionnaires' (SQDS) as a screening tool to identify any concerns around the emotional health of a child/ young person. If the child or young person scored above a certain score, they could be referred to the LAC Child and Adolescent Mental Health Service teams (CAMHS).

Good

Are services effective?

Pain relief

- The children's community nursing team and the short breaks service included pain as part of their nursing assessment and was detailed in care plans. They used tools appropriate to the child's age to assess pain. This ranged from a numerical sliding scale of 1-10 for older children, to face scales with happy to sad faces. Staff observed face, legs, activity, cry and consolability (FLACC) for babies or children with nonverbal communication.
- However, staff told us there had not been an audit on pain assessments for many years, therefore staff could not be assured they were effectively meeting the pain needs of children.

Nutrition and hydration

- Staff supported breastfeeding one to one with parents and were able to signpost families to regular breastfeeding support groups in local facilities. Information about initiation of breastfeeding and rates of those breastfeeding at six to eight weeks was requested from the trust but the trust reported problems in producing this data. Information from the NHS England showed in the first quarter of 2015/16 the initiation of breastfeeding in Greenwich was 82% which was better than the England average of 74%. In Bexley the figures did not meet validation criteria. There was no validated information in NHS England data for breastfeeding rates in Bexley and Greenwich at six to eight weeks postnatally. Parents were supported at post-natal groups with issues such as baby led weaning, Health visiting teams also advised parents not to introduce solid foods until six months of age, in line with national guidance.
- School nurses offered advice on healthy eating through school drop in sessions and the NCMP delivered in schools. Other members of the community services supported children with complex health needs to support their nutritional and hydration needs. At the short breaks service, children received special individualised meals or specialised feeding suitable for their individual complex needs. The fluid and nutritional intake of children was closely monitored to ensure their nutritional and hydration needs were met.

Technology and telemedicine

- Overall we saw that the trust was utilising information technologies in the delivery of its services.
- Community children's nurses, community paediatricians and therapists had been issued with electronic work tablets and we saw these were being rolled out to health visitors and school nurses. Staff were able to access the network and the trust intranet and we were shown staff accessing trust policies in the community. A few staff spoke about brief lapses in connectivity. Most staff were able to access the electronic record system and we observed community children's nurses accessing children's individual care plans in the child's home. Staff told us that IT training and support from the trust was very good.
- The trust had just developed an electronic application 'app' for new parents to download with content from the trust tailored to the services available in Greenwich and Bexley. Sections included feeding and nutrition, immunisation, child development information and local services.
- The sexual health services for Greenwich and Bexley both had websites with information about accessing services, contraceptives and free home testing for sexually transmitted infections.
- School nurses had a link on their electronic tablets where they were able to capture the views of the young people using the service with young people clicking on smiley faces to depict their satisfaction with the service.

Patient outcomes

- The trust's children and young people's management dashboard measured the following Healthy Child Programme performance indicators against a target: the percentage of new birth visits carried out to babies within 14 days, one year checks completed by 14 months of age and the number of children who received a school entry health screen by the end of year one. Information from Public Health England on health visitor service delivery metrics reported the local authorities now responsible had not made any submission in quarter one or two of 2015/16. The trust told us there were ongoing problems with getting the dataset correct. Senior staff told us there was no robust process to capture antenatal contacts.

Good

Are services effective?

- Trust data showed the percentage of new birth visits completed within 14 days was 93% better than the England average being 87% but below the trust target of 95%.
- Trust data around the six to eight week review showed 16% had been achieved, significantly worse than the England average of 82%.
- From trust data the 12 month review completed by the time the child was 14 months was 91%, worse than the trust target was 95% but better than the England average of 82%.
- Trust data for children who received a two to two and a half year review by the time they were 30 months was 68% compared to the England average of 74% for this completed health review. However we did not consider this a serious issue as overall only 5% of teams were below target.
- In school nursing for 2014/15 the trust had achieved 100% in the reception year National Child Measurement Programme and 99.9% in year 6. The trust had achieved 99.7% in the number of children who received a school entry health screen by the end of year one. The trust achieved 51.5% uptake of the annual flu immunisation within the national target of 40-60% uptake.
- In the sexual health service in Greenwich the chlamydia detection rate was better than the England average; however in Bexley it was worse than the England average. The syphilis and gonorrhoea diagnosis rates for Greenwich were slightly worse than the England average but better than the England average in Bexley. The HIV diagnosed prevalence rate for both Greenwich and Bexley was slightly lower and so slightly better than the England average.
- Revised NICE guidance around diabetic care came out in August 2015 relevant changes were being addressed but 75% of those requiring a blood ketone meter were waiting for them and not all of those who now required five capillary blood glucose tests a day had had them increased from four tests a day. The trust told us they were unable to get hold of the monitors as there was an increased demand nationally following the change in NICE guidance.
- Statutory guidance states that initial health assessments for 'looked after' children are supposed to be completed within 20 working days of placement. Information provided by the trust following our inspection indicated 14% of children coming into the care of Greenwich and 62% of those coming into the care of Bexley were seen within 28 days of coming into care. The main challenges identified by the trust were changes in social care practitioners who may be unaware of the local process and in receiving the necessary paperwork in a timely way from colleagues within Children's Social Care. Changes in practitioners resulted in reiterating processes, it was important to ensure they were present for the assessment regarding consent and the child's history. Also with sibling groups becoming 'looked after' it was harder to logistically arrange the initial assessments. All 'looked after' children had received their regular review health assessments. The service was addressing this issue through dialogue with newly recruited social workers social work colleagues.

Competent staff

- The majority of staff we spoke with had good access to training and were encouraged and given opportunities to develop. Some staff supporting health visitors reported they had been unable to access relevant sessions.
- Staff commented that induction training and role specific training was good. Newly qualified health visitors spoke positively of the preceptorship programme and the regular learning sessions and support available. Staff spoke positively about supervision stating upcoming supervision dates were booked in their calendars.
- Staff told us they received management supervision and clinical supervision, for those holding a clinical caseload this was every six weeks. CAMHS provided supervision every three months for school nurses as well as training around early attachment in parenting for health visitors. Information provided by the trust showed that 86% of staff across the services had received regular clinical supervision.
- Immunisation staff received yearly immunisation updates and competencies were regularly assessed.
- Staff commented that their appraisals were useful, two way discussions with their manager. The average appraisal rate across community children and young people services was 95%, rates varied from 81% to 100%. In the NHS Staff Survey 2015, 91% of staff said they had been appraised in the last twelve months; this was the same as the England average.

Good

Are services effective?

- Paediatricians told us they had been revalidated, which was evidenced in figures sent by the trust. Revalidation is a process by which all licensed doctors are required to regularly show they are up to date and fit to practice in their chosen field.
- For staff in the 'looked after' children service across the trust competency levels were in line with intercollegiate guidelines from March 2015. Managers and staff in specialist roles described having been supported and encouraged by the trust to undertake and complete post graduate courses.
- Staff spoke about new guidance and how to incorporate them into practice through team meetings and practice forums. Practice forums offered clinical expertise and opportunities to gain further skills or update on areas. An example of this was the health visitor practice forum where prescribing updates were provided with a few becoming prescribing champions to encourage and support colleagues. Staff could also propose possible areas of further work to support families and children, young people.

Multi-disciplinary working and coordinated care pathways

- There was good engagement with other providers and across disciplines. We saw some excellent examples of multidisciplinary working. For example, safeguarding nurses worked from the Multiagency Agency Safeguarding Hubs (MASH) in Bexley and Greenwich, LAC nurses worked regularly from social care bases with social workers and sat on the Children at risk of Sexual Exploitation and Missing multiagency panel and senior staff worked in partnership with the local safeguarding children boards. Speech therapists conducted joint visits with dieticians and community children's nurses.
- Each discipline gave us examples where colleagues from a number of different providers working together with agreed pathways of care and support. We observed a number of multidisciplinary meetings, these ranged from the Attention Deficit Hyperactivity Disorder (ADHD) team to a 'Team Around the Child' meeting. The ADHD team integrated neurodevelopmental staff with staff from CAMHS, we observed the triage process, the initial assessment and saw evidence of follow up processes having been carefully developed with plans for outreach and a parents group as per NICE guidance. The 'Team Around the Child' meeting was held in a junior school with representatives from social care, education and health working together we observed it worked to support the parents and the child with an agreed plan of action.
- In Greenwich there are currently 9 teams and all but one (Ferry view) are directly aligned to a Children's centre reach area. In Bexley there are 9 bases, all but 2 are now corporate working.
- Health visitors attended monthly GP meetings. Health visitors received information from a monthly midwives meeting about pregnant women for whom there were concerns and who would need additional support
- Health visitors and school nurses liaised as appropriate with the specialist health visitor in domestic abuse and attended Multi Agency Risk Assessment Conferences (MARAC). Health visitors were able to liaise with the perinatal mental health service if they had serious concerns about the mental health of a mother.
- School nurses had very good links with their local schools, we saw evidence of this when we observed staff at a drop in clinic at a secondary school. School nurses reported attending regular meetings with pastoral teams at schools. One school nurse in Bexley had been seconded two days a week with CAMHS in a pilot as a link between schools and the CAMHS service.

Referral, transfer, discharge and transition

- There were clear referral protocols and criteria across the community children and young people services to access services. Referrals to specialist and therapy services were triaged and prioritised. When children were discharged from treatment or care, staff were notified.
- When babies were born and were resident in the area or registered with a GP the child health information system allocated these to the relevant health visiting team. The trust had protocols for health visitors and school nurses for when children moved who were new to the area and a policy for those children who did not attend appointments or whose parents could not be contacted. There was a pathway for when children transferred from the health visiting service to the school nursing service and for when children moved out of the area.
- The trust was in the process of developing a transition pathway showing the processes and professionals to be involved in a patient moving from children's services to adult services. Staff told us they used the nationally recognised 'ten pillars required for a therapeutic

transition' including the process being led by the young person, being actively managed, phasing the changes and engaging other professionals. Some services attended multidisciplinary meetings on transition to adult services but others did not. In the sickle cell and thalassaemia service consultants meet to discuss both young people and adults. For the young people receiving treatment for their diabetes, the trust was meeting the best practice tariff of transition at 19 years of age, young people aged 17/18 years attended shared clinics with the adult diabetes team. This meant there was not a consistent approach to transition and young adults may not receive a seamless service.

- When children were discharged from treatment or care, staff were notified. This meant that staff were kept informed of children and young people's needs and were able to offer support appropriately.

Access to information

- Staff across the trust used a recognised electronic records system which supported integrated working. Some staff were able to electronically send letters to GP's and documents straight into a patient's GP record with alerts for action if required. There was no shared system with GP's although a system was being piloted in Greenwich. Most staff told us they received information via email or it came via the trust's electronic record system. For example, emergency department attendance forms from an acute provider were scanned into the trust's electronic system.
- The intranet was available to all staff and contained links to current guidelines, policies and procedures. This meant that staff could access guidance easily.
- The child health information system allocated new births to the relevant health visiting team. GP surgeries informed the child health information system of children and young people registering with the surgery and these were allocated to the relevant health visiting or school nursing team depending on the child's age. The child health system received reports from the national spine on demographic information against which they looked to see if children had transferred out of the area.
- There had been incidents of lapses in communication or inaccurate information in the electronic records with incorrect information being sent to families. The electronic monthly team planner used by staff to allocate work had had episodes of being unreliable and this was used to monitor that standards were being followed by staff. This meant that on occasion staff did not have access to accurate information to fulfil their role.

Consent

- Local authorities obtained parental consent for initial health assessments of 'looked after' children. School nurses and the sexual health service used the Fraser guidelines to make decisions about whether young people had the maturity, capacity and competence to give consent themselves in relation to contraception. In specialist services we observed that consent was gained prior to assessments and signed by the parents. Children gave verbal and nonverbal consent and used technology to express their wishes. Written or signed consent from young people aged between 16 and 19 years who were assessed as competent was not sought by therapy services. Young people of this age are presumed to have capacity to consent so should be asked for consent.
- School nursing teams asked parents to opt out of participation in the national child measurement programme if they did not want their child to be measured or weighed. Observations of practice within the services showed staff asked for people's consent before any interventions of care.

Good

Are services caring?

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

Summary

We rated services for children, young people and families as 'Good' for caring because:

- People were treated with kindness, dignity and respect during all interactions with staff and relationships with staff were positive.
- People felt supported and said staff cared about them.
- Children and young people understood their care, treatment and condition and worked with staff to plan their care and shared decision-making about care and treatment.
- Staff responded compassionately and anticipated people's needs.

Detailed findings

Compassionate care

- During the inspection we visited a range of services, clinics and schools; we joined staff on home visits and telephoned people who use the service. We spoke with 22 people who used services.
- In all areas we visited staff provided treatment and care in a kind and compassionate way and treated people with respect. All parents, carers and young people we spoke with were positive about how staff had treated them. A parent using the health visiting service said "Just so good with my children, make my children feel good, pleased to see us every time we come."
- School nurses treated young people with compassion and understanding. They ensured people had the time to talk openly and staff listened carefully. Staff ensured the individual needs of each young person was recognised and responded to. We saw in school and sexual health services that staff ensured the privacy of young people. An example of this was when teenage boys and girls were separately immunised during immunisation sessions. Across services we saw staff respected confidentiality.
- We observed staff working with children with complex needs, encouraging them and giving them the time they needed. Parents told us the physiotherapist had "been a great help, child loves coming here."
- The trust's patient experience survey for community children and young people's services undertaken between September 2014 and December 2015 exceeded the target of 90% in all areas. The results were good and ranged from 94% to 100% and were good. These included: having enough information about care and treatment, being involved in decisions about care and treatment and being treated with dignity and respect. Staff and parents told us that the views of children and young people were sought in an age appropriate way whether through smiley faces or writing a sentence about what went well.
- There had been 2,754 responses over this period and in the Friends and Family Test (FFT), the percentage who would recommend the service was on average 95%.

Understanding and involvement of patients and those close to them

- We observed positive interaction between therapy staff, children and carers. Staff provided clear explanations and goals. Carers understood their role in continuing with exercises in between therapy sessions. One parent told us "Been a great help, teaching me how to stretch him properly."
- Carers told us they felt fully involved in the care and treatment of their child and appreciated being treated as equals. They commented on the good multidisciplinary working: "Very good communication between all services," and "Blown away, been amazing, no wait, been seamless transferring from Greenwich to Bexley."
- 'Looked after' children were involved in agreeing their health plans and these were written appropriately for their age. Parents and young people were fully involved in multiagency meetings and were encouraged to plan and schedule support they believed would be beneficial.
- Staff in the sexual health service explained different options to people and listened to their views.

Good

Are services caring?

Emotional support

- We observed clients being supported emotionally. At the antenatal contact, health visitors asked patients to think about support they may need to look after their mental health and wellbeing. They were also given a sheet with some questions to reflect on. A maternal mood review was offered postnatally to assess emotional wellbeing with a pathway with guidelines and actions**.** We observed a school nurse showing a high level of understanding of a young person's emotional needs at a school drop in.
- Nationally 10 to 15% of all postnatal women will suffer from mild to moderate depression with the majority being supported by their GP and health visitor. For those who required more intensive support the trust provided a perinatal mental health service. Parents had access to post-natal groups in local venues that offered social interaction and parenting information and support for parents with young babies.
- Looked after children were able to access dedicated psychological support.
- We observed staff supporting children and young people to explore their emotional wellbeing, as well as discuss family history and any anxieties. This enabled children and young people to trust staff and build good relationships. Many staff were able to access or had received training and support from CAMHS in supporting parenting, and in promoting the emotional wellbeing of children and young people.

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 services for children, young people and families as 'Good' for responsive because:

- People's needs were met through the way services are organised and delivered.
- Care and treatment was coordinated with other services and other providers.
- Reasonable adjustments were made and action taken to remove barriers when people found it hard to use or access services.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Complaints and concerns were always taken seriously, responded to in a timely way and listened to and improvements were made to the quality of care as a result of complaints and concerns.

Detailed findings

Planning and delivering services which meet people's needs

- Child health information showed the health and wellbeing of children in Greenwich and Bexley was mixed. Obesity in four to five year olds and 10 to 11 year olds was worse than the England average. In Greenwich 24.9% of children aged 10-11 years were classed as obese. In response to this a new healthy weight programme had been developed and information about the programme was sent to parents when their child was identified from the National Child Measurement Programme as obese. Parents were then signposted to the school nurse for a referral to be made. GPs were asked how they wanted the service to be delivered, as were staff in focus groups who replied to questions from the commissioners of services. In Bexley, a similar healthy weight programme had been commissioned and started in January 2016. This demonstrated services were being developed to meet people's needs.
- Health visitors told us it was challenging to meet the needs of the many families with complex needs. The level of children under 16 years of age living in poverty in Greenwich was 26.8% which was worse than the England average of 19.2%. In Bexley, the health visiting caseload had increased by 500 children due to geographical realignment. In Bexley there was a 12% shortfall in staff with staff vacancies, leave and sickness. The number of health visitors in Greenwich had increased through the national 'Call to Action: Health Visitor Implementation Plan' however there was no increase in Bexley. The trust was delivering part of the national Healthy Child Programme. No service delivery data had been submitted to NHS England and no breastfeeding data on six to eight weeks post-natal breastfeeding rates were available. The trust advised us that there had been problems with data sets and some processes for collecting data were not robust. This meant the trust could not be assured it was able to deliver health visiting services to meet people's needs.
- The sexual health service in Bexley was planned to be accessible to young people with opening hours altered in response to need. The opening hours ranged from starting at 3.30 pm to closing at 7.30pm, some ran for two hours, others for four hours. Outreach also took part in some schools in Bexley and Greenwich.
- A Rapid Response team was piloted from July 2015 to December 2015 as a dedicated admission avoidance and early discharge team with the primary professionals being community children's nurses and physiotherapists. During this period 514 patients were seen which resulted in 409 hospital admissions being avoided.
- Regular child health clinics were held across the region for parents to access advice and monitor the growth and development of their young children. Parents were also signposted to post-natal baby groups which covered topics such as baby weaning, accident prevention, early play, and minor ailments. We observed health visitors discussing accident prevention and managing minor illness with parents. Parents we spoke with told us this information was useful and we saw that parents were signposted for example to weaning sessions.
- The trust was piloting the use of the internet to enable one member of staff to physically with the patient check and administer intravenous medication in conjunction with another member of staff visually over the internet. These children had two MAR charts one in their home

and one at the nurse's base. Staff told us this 'face time' was used was to avoid the need for a patient to attending a clinical environment and only occurred when two trained staff were not available.

Equality and diversity

- Most clinical areas we visited were accessible to people with disabilities. We did not see plans to alter other areas to make them wheelchair friendly.
- The area covered by the trust included a very diverse population. Staff were able to access language interpreters through a telephone system and we observed this working well. On some pages of the trust website there was a translation icon. This meant that people who had English as an additional language were able to access information in the language of their choice. Staff provided leaflets and information on websites, we did not see any literature available in other languages.
- Staff received equality and diversity training as part of their mandatory training with 95% of community staff having completed their equality and diversity training.
- Staff showed respect for the personal, cultural, social and religious needs of children and young people. Some parents had been concerned about the Human Papilloma Virus cervical cancer vaccine, a staff member advised parents on the evidence for its introduction.
- The sickle cell and thalassaemia nurse was addressing barriers to access and was educating GPs and teaching staff. The nurse had set up a patient experience group for adolescents to meet up and share their feelings and experiences in relation to their blood condition. The nurse was going into schools and talking to health professionals one to one and advising on support for children and young people with these blood conditions.

Meeting the needs of people in vulnerable circumstances

- Staff developed detailed individualised care plans for children with long term conditions or complex needs and risk assessments which specified nursing care and/or support required. For those with nursing needs, a paper copy was kept in the child's home. Health visitors completed clear and concise electronic records which were up to date showed family history, issues and agencies involved with the child.
- We saw evidence that families, children and young people's needs were thoroughly assessed before care and support started and there was evidence of care planning in the initial assessments. Occupational therapists and physiotherapists set goals collaboratively with children and families and measured outcomes. This meant children and young people received the care and support they needed.
- The LAC nurses undertook the review health assessments identified health needs and took action on these. National data showed the immunisation rate for 'looked after children' in Greenwich was lower, worse than the England average for this group of children and young people, but in Bexley it was around the England average.
- Staff told us that they prioritised work with people in vulnerable circumstances and would see people at times and places convenient for the young people and parents or carers. All families, including those with No Recourse to Public Funds were offered the full Healthy Child Programme and additional advice and support according to their individual needs. Staff were aware of particular difficulties and knew where to refer families to meet children's needs.
- We observed some staff working within specialist services using Makaton, a communication system using signs and symbols to communicate. By using this communication tool staff were able to communicate with children who otherwise would be unable to communicate.
- There was no practitioner leading for children with a learning disability in the trust, we were told there were plans to address this.

Access to the right care at the right time

- The community children's nurses worked a seven day week from 9am to 5pm, the rapid response work was continuing and this was reducing the amount of children being admitted and enabling earlier discharge from hospital.
- During our inspection we observed children did not wait long before being seen in child health clinics. Child health clinics ran throughout the week in various locations so that parents and carers could access them. Some carers and parents told us when they rang the health visitor base it would not be answered and then there was a delay in being responded to. We saw this had been recorded in team meetings, the trust told us they were planning to introduce a Single Point of Access

system for health visiting. This was where people using the service rang one number where they were then signposted or had a message taken rather than ringing an individual practitioner directly.

- Data provided by the trust for community services indicated the specialist services were, in the main, meeting their referral to treatment times of being seen within 18 weeks.
- The ADHD team told us the waiting time for assessment had reduced from eight months to four months since September 2015. Community paediatricians told us clinics were occasionally postponed if several child protection medical assessments were required.
- Some services already used the Single Point of Access. A few parents told us that they did not like this system, reasons given included having to repeat their child's details and history, it being impersonal and not getting directly through to the person in a timely manner.
- Community paediatricians told us they no longer had secretaries, or allocated administrative support to co-ordinate their work, letters, liaise with colleagues and talk with people who used the service. They told us this adversely impacted on several aspects of their work, one being the ability to talk with those who used the service in a timely manner.

Learning from complaints and concerns

- Guidance on how to make a complaint was on display in clinical areas where families, carers, children and young people were seen and treated. People we spoke with did not know how to make a complaint but said they would talk to a member of staff if they wanted to complain.
- Between January 2015 and December 2015 the service received 20 complaints with three upheld and 13 partially upheld. Of the three upheld; one was a breach of confidentiality, therefore further staff training had been organised. One was around a waiting time and availability of an interpreter, a new appointment had been booked. The other was about the assessment process and support for staff, this had been discussed with the relevant person.
- We found the service acted on learning from complaints and feedback. Key learning points identified in the complaints received were to remind teams in supervision to maintain direct communication with clients, to develop a clear communication pathway for stores and to review equipment provision to schools. Staff told us there was a clear pathway for stores and in the staff newsletter we saw a reminder about direct communication with clients.
- We saw examples of 'You said we did', one was about a child health clinic being very busy, this clinic was then extended by half an hour. In the short breaks service the children asked for internet access during their stay, which has since been set up.

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

Overall, we rated services for children, young people and families as 'Requires Improvement' for well-led because:

- Although the trust was aware of recurrent incidents with the electronic system these incidents were ongoing.
- The trust was not managing the risk of high health visiting caseloads. There was no mitigation plan in place for the shortfall of health visitors or recognised weighting tool.
- The information used in performance management and delivering quality care was not consistently accurate and reliable and the sustainable delivery of quality care was put at risk by the financial challenge

However we also found;

- Governance structures and arrangements were clearly set out and understood.
- The service proactively engages and involves staff and patients and ensures they are heard and their contribution acted upon.
- The leadership actively shapes the culture through engagement with staff and are visible and supportive.

Detailed findings

Service vision and strategy

- Some staff knew the trust's vision, others felt it was related to team working. The vision of the trust was 'We aim to improve lives by providing the best quality health and social care for our patients and carers'. Some staff had a small booklet produced in February 2016 which included the trust values, the priorities of the trust, how to raise concerns and information about the organisation and management structures.
- The community service had a separate vision or strategy. The annual plan was focused on work streams, tenders and cost savings, rather than a cohesive plan.
- Staff were positive about working for the organisation and told us they were involved in the development of new pathways and procedures.

Governance, risk management and quality measurement

- The trust provided evidence of the 17 risks identified in the community children and young people's service. Although risks had been identified and learning from serious incidents had been incorporated into practice, some of the identified moderate and high risks were ongoing. These ongoing risks indicated concerns about financial stability, inaccurate data, staffing which were highlighted by the trust as possibly impacting on care provision.
- The trust told us there had been problems with data. Minutes of directorate meetings and quality board meetings also relayed concerns about data quality, however there were plans to set up a data governance leadership group. This meant the service could not be assured of how services were performing.
- There was no health visitor caseload weighting to ensure staff had the capacity to meet people's needs. The trust told us it was in the process of developing a caseload weighting tool for health visiting.
- The electronic record system used for client documentation, work planning and communication had recurrent incidents. The trust had been reviewing issues with electronic records, we saw that individual teams were reminded about processes and reminders in newsletters but incidents kept on reoccurring.
- Staff were clear about their roles and who they were accountable to and senior staff were accessible to teams.

Leadership of this service

- Staff told us the service and trust leaders were visible and approachable. Staff gave us examples of when their manager had been supportive and staff felt their managers had the right skills to lead them.
- Board visits had taken place in the service and board members had asked staff and children what they would like to happen in the service. An example was of a physiotherapist having issues with storage and a shed was being provided.

Requires improvement

Are services well-led?

- Staff told us they had been kept informed of the tendering process and had been offered counselling. Managers and those in professional advisor roles had undertaken post graduate study supported by the trust. Most managers felt well supported.

Culture within this service

- Staff told us they felt respected and valued. All staff said they enjoyed their jobs and liked working in their team and for the trust. Staff were enthusiastic and some felt that their career aspirations could be met at the trust. They understood the uncertainty of the tender process but felt supported.
- Staff worked collaboratively to focus on the needs of the child or young person.
- We were given examples of action being taken when behaviour and values were not in line with trust standards. Staff told us there was an open culture and they were encouraged to raise concerns, report incidents and near misses.
- According to the national NHS survey of 2015, 18% of trust staff had experienced harassment, bullying or abuse from staff in the last 12 months. During our inspection no staff spoke of bullying and all spoke of the trust being a positive place to work. In information provided by the trust we saw two incidents reported out of over 500 incidents in a year reported in the community children and young people services where staff had behaved inappropriately to each other, for example shouting at each other.
- Students told us they were made to feel very welcome and had regular 'check ins'.

Public engagement

- The trust's used a patient experience survey for community children and young people's services. Between September 2014 and December 2015 it exceeded the target of 90% in all areas as well as the FFT with an average score of 95%. However, some parents we spoke with had not been asked for feedback on the service.
- We saw examples of children and young people being involved in the development of services. For example, young people had been involved in setting questions for commissioners on the services they would like developed. A worker in CAMHS was setting up an Oxleas youth form which once fully established would be linked into the Patient Experience Group.

Staff engagement

- Some staff told us they were frustrated by the electronic record system but there was good support available and also by the amount of emails they received which they described as being "overloaded" with**.**
- Some staff felt some areas of practice were business led rather than clinically led, for example, removing administrative staff and introducing the Single Point of Access. Staff told us some people who used the service found it frustrating and would prefer to email staff.
- Staff felt engaged with the trust and thought they were kept informed of developments. A monthly newsletter 'Quality Street' was available and staff found this useful. It reported the top three incidents with brief learning points, which would also be discussed in team meetings.
- Staff we spoke with felt they could make suggestions to improve care and share good practice within their service, this was facilitated through professional forums and their teams. In Bexley all staff in the specialist services were involved in planning the new child development centre (CDC) we saw a report including feedback from staff workshops**.**
- Many services were either currently undergoing a tendering process or it was upcoming. Greenwich universal and specialist services, including the LAC service were undergoing a tendering process as was Bexley's universal service. Staff told us they were fully involved and supported through this process**.**

Innovation, improvement and sustainability

- Innovation was promoted by the trust. Areas of innovation within the service included the use of technology to improve access to health information for example in the sexual health websites for Bexley and Greenwich and the electronic application 'app' for new parents. The majority of staff used electronic tablets in their work to access the electronic records and the trust's intranet. A rapid response service had been introduced to reduce hospital admissions and to increase early discharge. The trust was piloting the use of 'face time' which enabled effective use of resources as one member of staff physically checked a patient and administered intravenous medication whilst another

member of staff observed over the internet. However there was no risk assessment or pathway in place. There was a tendering plan for extending therapy services up to the age of 25 years.

- In documents provided by the trust we saw there were financial pressures to make cost savings. There were savings related to tenders and work streams. In Bexley universal services a significant cost saving formed part of the tender. This service had been identified on the risk register for the shortfall of staff and during our inspection had very high caseloads. When we asked about the considerable proposed cost savings in mobile working there was no explanation as to how this would be achieved in community children and young people's services. In Bexley sexual health service one option proposed in cost savings was for young people to be signposted to GP surgeries rather than a sexual health service for contraceptive and sexual health services. This would have an adverse effect on young people having easy access to sexual health services.