Berkshire Healthcare NHS Foundation Trust

RWX

Community health services for children, young people and families

Quality Report

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Date of inspection visit: 7 - 11 December 2015
Date of publication: 30/03/2016

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWXX6	Manor Green Respite Unit	Manor Green Respite Unit	SL6 3EQ
RWXKK	Ryesh Green Bunglow Childrens' Centre	Ryesh Green Bunglow Childrens' Centre>	RG7 1ER
RWXX3	St Mark's Hospital	St Mark's Hospital	SL6 6DU
RWX85	Upton Hospital	Upton Hospital	SL1 2BJ
RWXX1	Wokingham Community Hospital	Wokingham Community Hospital	RG41 2RE

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall, we rated this core service as good. We found each of the five domains of safe, effective, caring, responsive and well led were good. People we spoke with were complimentary about the services they received and the attitude and competency of staff.

Our key findings are:

- Overall, premises and equipment were clean, safe and suitable, although the Skimped Hill sexual health clinic in Bracknell was not secure, in a good state of repair or kept clean.
- Staff reported incidents and there was a good approach for sharing and learning from incidents. This included incidents or concerns related to safeguarding children and young people.
- Staff managed medicines safely. However, in Skimped Hill sexual health clinic systems were not in place to ensure medicines were stored at safe temperatures.
- There was an integrated IT system for services, which promoted safe storage and exchange of records. This was not accessible to sexual health services which meant they had to operate 'workarounds' to log information safely. Staff created good records in all services.
- Staff used technology to promote their services with young people, for example using social media and texting reminders for appointments.
- People using services spoke highly of the attitude of staff. They said they were friendly, kind and good listeners. They showed empathy, were skilled in gaining children's trust and involving them in care programmes. Staff also took people's emotional wellbeing and family circumstances into account when discussing and planning their care.
- There was good multi-disciplinary working within the service. This was supported by the integration of therapy services and a locality based structure. Where there were issues in delivering a responsive service for looked after children, staff were working with partners in social care to improve processes. Staff were optimistic that that joint working with the children and adolescent mental health service (CAMHS) would improve in 2016 with the integration of CAMHS with children's community health services.
- Leadership and management were effective and staff felt supported. Staff were complimentary about the visibility of senior management and the chief executive in particular. Staff were involved in service development, however services were commissioned by a large number of organisations with changing priorities and budgets, and this had caused a lot of service changes. Staff in sexual health services were unsure of their service direction and strategy, due to forthcoming commissioning changes.
- Staff had good access to training and professional development and applied evidence based practices. They used nationally recognised assessment tools and care pathways, to deliver good patient outcomes. Care and services were focused on the needs of individual children and young people. Staff met with people in locations that were best for the children, as far as possible, and prepared person-centred care and treatment plans.
- Systems were in place to review clinical practices regularly and staff said the trust had a good culture of encouraging improvements in care delivery. Risk registers were mostly up to date and managed effectively and governance arrangements meant staff managed service performance, quality and safety consistently. All staff showed a passion to provide an improving service to children and young people.
- The services had received only a few complaints; however, guidance on how to make a complaint was not readily available. Staff managed informal complaints locally and ensured there was learning from complaints as appropriate. Information leaflets were only available in English, which meant they were not accessible to all members of the local population.
- Staff monitored the timeliness of assessments, referrals and interventions. Waiting times were mostly within the target timescales. Actions were being progressed in areas that had difficulty achieving agreed waiting times.

Summary of findings

Background to the service

This inspection reviewed services provided to babies, children, young people and families in their homes, community settings or schools. These services included universal health services, specialist nursing services, children and young people integrated therapies (CYPIT) and community paediatrics. It also included sexual health services, which were provided by the trust's adult community services.

The trust provides services for children and families across six Local Authorities: Bracknell Forest, Royal Borough of Windsor and Maidenhead, Reading, Slough, West Berkshire & Wokingham. They provide sexual health services in the three local authorities in the east of Berkshire only, with services in West Berkshire covered by a different health trust. From August 2015 a different provider delivered the newborn hearing programme.

Commissioning arrangements are complex. The commissioning of health visiting and family nurse partnership moved from the NHS England to Public Health within the six local authorities in October 2015. There are seven CCGs commissioning services in this area. The total population of Berkshire is just under one million.

Overall, the demographic for this area show child health indicators were above the English average. There were very few indicators significantly worse than the England average and these were predominantly found in the Slough local authority. Slough and Reading both had poorer results than average for; numbers of 16-18 year olds not in education, employment or training; obese children and infant mortality. This data contrasts with better or significantly better than average profiles in the other four local authorities.

The trust is organised into six localities mapped to the local authority boundaries, overseen by locality directors and clinical directors. Some county-wide or regional services for children and families were hosted by specific localities due to the specialist nature of the service.

Our inspection team

Our inspection team was led by:

Chair: Dr C I Okocha, Medical Director and Responsible Officer, Oxleas NHS Foundation Trust;

Head of Inspection: Natasha Sloman, Head of Inspection for Mental Health, Learning Disabilities

and Substance Misuse, Care Quality Commission

Team Leader: Lisa Cook, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists including health visitors, school nurses, a sexual health nurse, therapists and specialist community nurses.

Why we carried out this inspection

We inspected this core service as part of our ongoing programme of comprehensive inspections of NHS trusts.

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?

Summary of findings

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 8,9,10 December 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with people who use services. We observed how staff cared for people and provided treatment, talked with carers and/or family members and reviewed care or treatment records of people who use services.

For this core service with visited and spoke with staff at 17 locations, including children centres, clinics schools, respite centres, GP surgeries and hospitals. We invited staff to attend different focus groups, for school nurses, health visitors, therapists, and administration. We spoke with service leads and clinical leads. We observed care in sexual health clinics and in a variety of health visitor, school nurse and therapy settings, including on home visits. We attended staff meetings and multidisciplinary meetings. We reviewed 41 sets of care records and an extensive range of service documents. These included performance or activity reports, service plans, minutes of meetings, care pathways and audit reports. We spoke with 147 staff across the service including health visitors, school nurses, administration assistants, community nursery nurses, therapists and therapy assistants, nurses from the services for looked after children, leads for children's safeguarding, paediatricians and sexual health nurses and health advisors. We also spoke with staff in management roles.

We spoke with, or observed care and treatment for 28 parents, children, young people or their carers.

What people who use the provider say

Relatives of children who received CYPIT services said they were very pleased with the service, 'It's been great' and 'staff always respond to my emails', I am respected and listened to' and 'I fully understand the importance of completing the 'homework' strategies'. One parent commented they had found the health visiting and speech and language therapy services had been excellent. The negative comments related to waiting for therapy services and the community paediatrician and to failing to fully describe the role of parents in the Care Aims approach.

People were positive about the health visiting service and the transition of care to the CYPIT team. One mother said they felt respected and listened to, saying 'they are a wonderful team' and they 'could not have dreamed such a valuable service could be available'. They said the service was professional yet treated the family as part of the team. Another commented on the impact the speech and language services had on their child's communication. We also received feedback with comments such as 'fantastic', 'couldn't fault it', and 'I have seen so much improvement [in my child's behaviour].'

Good practice

The respite unit at Ryeish Green provided an outstanding service for children with complex needs. The service was child-centred, well organised and staff understood the needs of individual children. Staff maintained an excellent standard of records.

The school nurses supporting young people in mainstream secondary and special schools demonstrated a high level of competency and compassion. We observed a drop-in session where the nurse showed an exceptional understanding of young people's emotional needs.

The Children and Young People's Integrated Therapy team (CYPIT) had developed a useful, on-line tool-kit to help parents and carers take an active role in care and treatment programmes. People using the service said this had been a helpful.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The assessment records for looked after children should be completed by the staff who undertake the assessments, to minimise risk of misinterpreting assessment findings.
- The health team for looked after children should work with CCG and Local Authorities to ensure services for looked after children are planned effectively.
- Records for children with complex needs should include detailed instructions on how to prepare food of safe consistency, to minimise the risk of aspiration or choking
- Guidance documents, including guidance on how to make a complaint, should be available in different languages and formats, appropriate to the local population.
- Sexual health services should have electronic records system that links effectively with records created by other services.
- Staffing levels, for example of health visitors, occupational therapists, sexual health managers and looked after children staff, should be reviewed to ensure they meet the needs of the service.

Berkshire Healthcare NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as good.

Staff understood how to report incidents and incidents were investigated and used as opportunities for learning. Staff were aware of the Duty of Candour and the requirement to be honest and open with people about incidents. They also knew how to identify abuse and respond to concerns relating to safeguarding adults and children.

Most services had safe staffing levels. There were vacancies in some areas, such as looked after children service, occupational therapy (within the integrated therapy service) and sexual health services, and recruitment was ongoing. School nurses carried high caseloads, which had affected the responsiveness of the service. The service was staffed in line with the service specification and staff prioritised their activity based on patients' needs.

The majority of services for children, young people and families were delivered in premises which were safe and suitable. Staff carried out routine maintenance and checked equipment was clean. However, the clinics used for sexual health services were not consistently safe. For example, the Skimped Hill, Bracknell clinic was not in a good state of repair or kept clean.

Sexual health clinics and the school nurse service staff managed medicines safely in line with trust polices. Electronic monitoring of medicine fridge temperatures meant risks of medicines being stored outside safe ranges were mitigated.

Records were stored safely and staff completed accurate records of assessments, interventions and care plans. Most

Good

Are services safe?

services used an electronic records system, which flagged key concerns about children and young people. Sexual health services used a different electronic records system and created a combination of paper and electronic records. This introduced an additional risk that staff might not transfer information accurately. Records for looked after children were detailed and comprehensive. Staff carrying out health assessments did not always create their own records which was against a Code of Professional Standards set by the Nursing and Midwifery Council.

Staff were up to date with mandatory training, in areas such as infection prevention and control, safeguarding and health and safety. Staff also had access to business continuity plans in the locations we visited.

Safety performance

- Between December 2014 and November 2015 the service reported 443 incidents for children's services. The main categories were 'procedures not carried out' and 'confidentiality issues'.
- There was one serious incident reported requiring further investigation in children's services in the year to August 2015. This incident occurred in the health visiting service. The service carried out a full investigation involving children's social services.
- Incidents were reported in high-level meetings, such as executive, locality and clinical governance meetings, but not routinely in all team meetings. Trends, such as in the level of low or no harm incidents, were not monitored and reported.

Incident reporting, learning and improvement

- Staff reported incidents electronically using a specific recognised system. All staff said the reporting system was straightforward to use and they were encouraged to report incidents. They were confident there was an effective reporting culture. They referred to incidents that had taken place in their own teams or in other teams, and outlined any learning and changes in practice. For example, a therapist described a confidentiality breach, where staff had sent a letter to the wrong client. As a result, administration procedures were improved such that staff had to generate their own letters directly, from the electronic records system letters, to minimise errors.
- Staff said they received feedback from incidents they had reported, with emails providing them with an update and assurance that the incidents had been logged. Incidents were also shared on the trust's intranet and via the 'team brief', which enabled staff to find out about incidents in areas outside their own teams.
- Staff demonstrated a knowledge of the Duty of Candour, to be open and transparent with people including when things go wrong with their care and treatment.
- Incidents were monitored, discussed and considered for themes and learning. Staff regularly discussed incidents at the monthly locality patient safety and quality meetings. Minutes of these meetings, as well as from team meetings, showed staff discussed incidents and considered any learning points.
- We observed evidence of learning and group discussion from a serious case review at a clinical overview meeting, during the inspection.
- The school nurses outlined a change in practice that had resulted from an incident relating to the cold-chain transport of vaccines. The incident prompted a root cause analysis which included a review of the thermal stability of vaccines, resulting in a new cold chain management process.
- The trust had a system for cascading and monitoring the implementation of central safety alerts so that relevant staff completed actions in a timely way.

Safeguarding

- Staff understood the trust policies and procedures for safeguarding children and young people. They had good access to and support from the trust children's safeguarding team and could state how they would seek advice and training.
- Staff identified children and young people with safeguarding concerns on the electronic records system with appropriate flag indicators, to ensure other staff were aware of the child and any risks associated with their care.
- At Manor Green respite unit we observed leaflets explaining safeguarding to parents and staff, including contact details of whom to contact if they had concerns or suspected abuse.
- We saw examples of safeguarding incidents described, reported and escalated appropriately to safeguarding boards in minutes of clinical governance meetings.

Good

Are services safe?

- The trust ensured there was learning from safeguarding incidents. For example, following an incident and serious case review a new trust policy, flow chart and leaflet had been developed about bruising in immobile babies to ensure staff knew what actions to take.
- Child protection cases were only managed by school nurses qualified as specialist community practitioners.
- Data showed staff in all areas received safeguarding supervision at least once a term. Nurses in the looked after children's service received group supervision three times a year and at other times if requested. School nurses timetabled their supervisions to ensure this took place. Staff could also access a child protection emergency or general helplines.
- Sexual health services had protocols and procedures for safeguarding children and vulnerable adults from abuse. These included guidance on escalating concerns relating to female genital mutilation (FGM).
- The trust's deputy director of nursing held the lead role for safeguarding children and led a team of six named nurses for safeguarding, a named nurse for children and adolescent mental health services, a specialist practitioner for domestic abuse and three administrators. Staff in children and families services said they received good support from this team.
- The FGM training was delivered to the sexual health team and the legal information regarding reporting of FGM had been cascaded to health visitors and school nurses. Staff were trained to the appropriate level for their roles, where nurses, therapists and health advisors had completed level 3 training.
- A Multi Agency Safeguarding Hub (MASH) was in place in Reading and others were planned to start across Berkshire in 2016. Safeguarding leads also attended Multi Agency Risk Assessment Conference (MARAC) for sharing information about high risk domestic violence and abuse cases. Staff were trained in domestic abuse, stalking and honour based violence (DASH 2009) and used the risk identification checklist.

Medicines

- Staff ensured medicines were stored at suitable temperatures by monitoring room and fridge temperatures. The fridges were fitted with data loggers to monitor temperatures continuously. Most sexual health clinics and the school nurse service staff managed medicines safely in line with trust polices. There were potential risks associated with the storage of medicines in Skimped Hill sexual health clinic as the medicine storage temperatures were not monitored each day as service was only operational two days a week. However prior to clinical sessions staff download the fridge temperature log to check the fridge remained within the required temperatures for drug storage.
- Systems were in place for staff to check medicines were in date and a pharmacist was available at The Garden Clinic in Slough to support the service and patients from Monday to Friday.
- Sexual health nurses and school nurses delivering vaccination programmes were competent to administer medicines under patient group directions (PGD) to support nurse-led services. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.
- The PGD steering group had reviewed PGDs and these were up to date.
- Following an incident relating to the transport of chilled vaccines, a revised cold chain procedure had been implemented and was in use by the school nurse vaccination team.
- The care plans for children and young people with complex needs, attending specialist schools or respite centres, included clear instructions for managing medicines. Safe systems were in place for checking that people had their correct medicines on admission or at school.

Environment and equipment

- The equipment in children's respite centres was regularly safety checked. This included resuscitation equipment which was checked and labelled to ensure the contents were correct and in date.
- In Manor Green Respite Unit, staff had arranged for additional safety checks of hoists to ensure they were secure following building works, which was good practice.
- Maintenance staff regularly tested the trust's portable electrical appliances. The spreadsheet of tests showed these were completed at clinic sites, respite centres and hospitals.

Good

Are services safe?

- The therapy rooms used by Children and Young People's Integrated Therapy (CYPIT) staff provided suitable, welcoming environments for families. There was adequate space and light, and staff ensured that appropriate equipment was available.
- CYPIT staff told us they completed a visual check of play equipment, such as plastic toys and mats at the start of each therapy session, to ensure they were safe to use.
- We visited health visitor clinics and found the environments were welcoming and suitable. Staff checked the rooms for safety hazards at the start of each session.
- The trust provided evidence of equipment servicing logs and sample certificates. These showed maintenance contractors regularly serviced items such as scales and audiometers.
- The resuscitation trolleys reviewed within sexual health services were accessible and checked.
- There was a lack of equipment in Skimped Hill sexual health clinic to keep staff safe. There were no panic alarms and there was limited access to telephones should staff need to call for assistance.
- The laboratory and sluice cupboard in Skimped Hill clinic, which contained hazardous chemicals, were not locked. These were located next to the waiting room, which presented a risk to members of the public and staff. Staff were not able to observe this area constantly to minimise the risk of people entering the laboratory. There was no sluice hopper for safe disposal of urine and sharps boxes and fridges were accessible. The examination table was also damaged. Clinical governance minutes showed an incident had occurred at this site, when a member of the public had obtained access to the clinical areas.

Quality of Records

- Health visitors completed clear and concise electronic health records and these were up to date showing family history, issues and agencies involved in the child's care.
- School nurses maintained effective records and reviewed their cases every term.
- A review of a record keeping audit showed good results and staff said the electronic records system was easy to use.
- The alignment of therapy services into CYPIT included standardisation of assessments and reporting templates. Staff reported these were concise, allowed free text to describe specific aims and goals and included key actions and responsibilities. Those we saw were completed with all the necessary information.
- Staff had developed person-centred, detailed care plans for children and young people with long-term conditions or complex needs who attended special services. The plans were up to date, clearly structured and included individual protocols, for example in relation to medicines. This was particularly evident in Ryeish Green respite service. Staff had implemented a readmission procedure, to check for any changes in people's health in advance of the admission date, to ensure they were suitably prepared.
- Children and families services used a recognised electronic records system and this had mostly replaced paper records. This system was not used by the sexual health services, which used a mix of paper and a (different) electronic records system. This meant there was a risk staff might fail to transfer information accurately.
- The paper records created by sexual health services were organised and stored securely in locked cupboards. Staff transported the paper records from the St Marks clinic to the main hub in a locked bag. The Caldicott guardian had approved this procedure as a temporary measure. The records were signed and dated and included all information required to meet service standards for record keeping in sexual and reproductive healthcare. Records included plans, decisions and the names of chaperones if used. Patient identification labels were hand written, but this was an interim measure that had been risk assessed, pending the introduction of an electronic records system. Medicine prescriptions were stored in an electronic format.
- Looked after children (LAC) services used the trust's main electronic records system. Patient records were comprehensive and included health assessments, a clear chronology of events and progress notes. However, the report summaries and action plans tended to be written in a way that meant there was a risk that key points could be overlooked in the narrative.
- The records for looked after children were not always completed by the most appropriate staff. For example, we found examples where the assessing health professional did not write the health assessments, health summaries and action plans but delegated this to other staff. This is contrary to the Code of Professional

Good

Are services safe?

Standards of Practice and Behaviour for Nurses and Midwives, Nursing and Midwifery Council 2015. There was a risk that records could be misinterpreted with this split of responsibilities.

- The care plans for looked after children reflected a multi-disciplinary approach to their health care and were clear and comprehensive. The records had an alert flag and looked after child status identified on the demographic page.

Cleanliness, infection control and hygiene

- Staff within CYPIT explained they used a range of toys and equipment but ensured they were cleaned regularly. Respite centres for children had rotas for cleaning toys and staff gave examples of the advice they had received from the trust's infection, prevention and control team.
- Compliance with mandatory Infection Prevention and Control (IPC) training was high. Community staff undertook refresher training every two years, based on risk.
- The IPC team carried out a range of audits of children's services. For example, the team audited hand hygiene facilities, hand hygiene procedures, enteral feeding practices, mattresses and laundry management at the two children's respite centres. They also audited patient equipment used by health visitors, school nurses and a respite centre. The team provided a report and action plan to service managers and clinical directors for follow up. From October 2015, services had been asked to provide confirmation to the IPC team that they had completed the actions.
- Almost all premises were visibly clean and staff showed us completed cleaning rotas. However, the Skimped Hill clinic for sexual health services were not cleaned effectively and clinical areas were visibly dusty.

Mandatory training

- Trust wide, over 85% of staff were up to date with their statutory and mandatory training, in areas such as fire safety, health and safety, manual handling, information governance, safeguarding adults and children, infection control and basic life support. Within children's services, results showed 95% compliance with information governance and infection control and 91% with children's safeguarding. Staff were also over 90% compliant with fire safety, health and safety and manual handling training. This was against a trust target of 85%.
- Staff could monitor their own training using the trust electronic staff database, and received 90 days warning of expiry dates. This helped them maintain compliance with training.
- Staff said access to training was good and were satisfied with the quality of the training courses.

Assessing and responding to patient risk

- Services for children and families reflected the Healthy Child Programme (HCP) and National Child Measurement Programme (NCMP). These programmes included assessment stages and tools to identify and respond to children and young people between 0 and 19 years of age who may be at risk of harm, disorder or ill health. The HCP meant that risks relating to parental or child welfare of child development could be identified at routine checks carried out by health visitors, nursery nurses, school nurses and medical staff.
- Staff used a colour coded flagging system on children's electronic records to describe their specific needs and risks. This helped advise all staff involved in the child's care of their individual risks quickly. For example, health visitors reviewed higher risk children and young people more frequently.
- Assessments were recorded in a timely way. We reviewed a range of records across the services, and the risk assessments were up to date and well completed. Health visitor records included risks relating to domestic violence.
- Staff identified when children required more targeted care and referred them to specialist services.
- At Manor Green school, specialist therapists assessed children for the risk of choking and created feeding plans, called 'passports' which included visual displays to help staff understand how to prepare food and drink safely. These were updated to reflect current risks. At Ryeish Green respite unit the food textures were not adequately described in care plans and lacked sufficient detail to enable staff to prepare food consistently to the required consistency.
- At Ryeish Green respite service, staff had implemented a readmission procedure, to check for any changes in people's health, sufficiently in advance of the admission date to ensure they were suitably prepared. This was because people's health and risk assessments might have changed since their previous visit, necessitating a different type of care or equipment to keep them safe.

Good

Are services safe?

- The Care Aims Model used by CYPIT provided a consolidated risk assessment tool for occupational therapists, dieticians, speech and language therapist and physiotherapists. Staff used the tool to triage referrals and to direct patients to the most appropriate type of intervention or treatment, based on their clinical risk and needs profile. The decision-making process for this approach required staff to consider the likelihood of patients deteriorating, or improving participation in their daily life, as a result of professional intervention.
- Staff completed risk assessments with looked after children at both the initial and review health assessments. They then made referrals as needed to local services.

Staffing levels and caseload

- Occupational therapists (OTs) reported an increased number of referrals to the service. Although there was one staff vacancy in the service, staff continued to deliver the care aims clinical decision approach working closely with families. This involves an integrated workforce of therapists working to deliver individualised care. Staff were confident that staff shortages had not impacted on the safety and quality of care, however they felt under pressure and concerned for future performance. They had worked additional hours to reduce waiting times, however there were 42 patients on the waiting list. They felt there was an increased risk of the service breaching its 18-week referral to treatment time following a recent staff resignation.
- Additional staff had been recruited to other professions within CYPIT and the service had created rotating posts to improve skill levels. Skill mix had been reviewed and the service was recruiting additional Band 4 staff to work with children and young people with complex needs.
- The average caseload per health visitor was 441, against a commissioned level of 410. The Community Practitioners and Health Visitors Association (CPHVA) recommended that caseloads for health visitors should be a maximum of 400 with an average caseload of 250 in the most deprived areas with the most need. The CPHVA stated that if caseloads were not manageable this can have a detrimental effect on the relationship a health visitor has with a family or can impact on a health visitors ability to properly assess needs in line with the Healthy Child Programme.
- Health visiting staffing levels were on three of the six locality risk registers due to a high turnover of staff. Trust data showed there were 11 WTE health visitor vacancies against a target establishment of 159 in October 2015. This represented an average 7% vacancy rate. Vacancies were highest in the Slough locality where the vacancy level was 15%. However, staff did not report any concerns with staffing levels and said they had manageable caseloads. The staff shortfall was covered by bank and agency staff and recruitment was in progress.
- School nursing services reviewed staff caseloads every half term. The service had no vacancies, with new staff recruited to start in January 2016 in the stand-alone immunisation service. School nursing services had been reviewed to help staff work efficiently. For example, staff offered fewer drop-in sessions in schools and replaced these with booked groups sessions. Although the service was staffed to budgeted levels, caseloads were high in all localities apart from Reading, at 6,000 to 7,500 per WTE. In Slough, the local authority with the highest level of child deprivation, the average caseload was 6,500 per WTE. The service had reconfigured their team and stopped drop-in sessions at secondary schools to meet the child protection demands of their work. The school nurses were not allocated one per 'school pyramid'.
- The family nurse partnership (FNP) was fully staffed to support young mothers and their babies.
- Data for April 2015 to June 2015 showed that children's community services had a low usage of agency staff (eight whole-time-equivalent (WTE) or 2%) against vacancies for 35 WTE. Permanent staff tended to cover gaps in staffing.
- Sexual health service had one WTE vacancy for a Band 2 health carer, against an establishment of 3.3 WTE health carers, equivalent to a 30% shortfall.
- There were vacancies in the looked after children (LAC) services for West Berkshire. There was no designated nurse, band-4 coordinator or administrator. The designated nurse in the East had been covering both areas since September 2015 and was reviewing the most effective structure of the service going forward.
- The trust regularly hosted student health visitors, having between 70 and 20 on the programme between April 2014 and March 2015. The trust was training two additional community practice teachers.

Good

Are services safe?

Managing anticipated risks

- Staff showed us risk assessments for premises, for example for places where they held clinics.
- We observed trust business continuity plans in the locations we visited. These were up to date and relevant.

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

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.

We rated effective as good.

Staff participated in clinical excellence groups to review and update assessment and care delivery processes to ensure they were in line with standards and evidence based practice. They provided a range of evidence of using nationally recognised tools, procedures and pathways.

Outcomes for children and young people were monitored so staff could assess children's progress. Most of these measures were performance measures relating to the numbers of children assessed and treated. Systems of monitoring outcomes as a result of achieved goals were still being developed. There had been some delays in completing health assessments for looked after children, but the factors contributing to the delays were known and staff had taken action to improve procedures.

Children, young people and families received care, treatment and support from competent staff, trained for their roles. Access to training and professional development was good and new staff reported participating in an effective induction and mentoring programme. Almost all staff had an annual appraisals and regular supervisions.

Observations and records showed that staff obtained consent from children and young people to care and treatment.

Staff collaborated well both within and across teams to provide joined-up services. Key areas of weakness were working effectively with children and adolescent mental health services (CAMHS) and social care services for looked after children in the west of Berkshire. Staff escalated barriers to effective partnership working and managers and staff worked to find solutions. Service managers were fully involved in multi-agency partnerships, including those for child protection. Partners commented on their effective contribution.

Staff used technology to improve the way they worked with children and young people. For example, the school nursing service had set up a system for young people to text them with queries and also social media to share information. Staff in most services were able text appointment reminders to people, however sexual health services were not equipped with the technology to do this efficiently.

The service had effective processes for referring and transferring children and young people within health and social care services. These were supported by a unified records management system across all services except for sexual health services.

Evidence based care and treatment

- Staff joined clinical excellence groups, which met regularly to review professional standards and evidenced based care and treatment. Practices reviewed included the Nuffield dyspraxia programme and how to identify Specific Language Impairment (SLI).
- The trust's children's and families services delivered NHS England's Healthy Child Programme (HCP), which provided families with a programme of screening, immunisation and health and development reviews, supplemented with advice about health, wellbeing and parenting.
- Health visitors provided a service for families with children under five years old based on the HCP for early life stages. This included carrying out a universal programme of health and development reviews and identifying those families requiring specific, additional support and intervention.
- The West of Berkshire health visiting team had achieved accreditation under the UNICEF Baby Friendly Initiative, set up to encourage and support mothers with breast-feeding. A recent audit to prepare for re-accreditation in October 2016 had identified areas for improvement and an action plan was in place.
- The trust's school nursing team delivered the National Child Measurement Programme (NCMP) across the six Berkshire localities. Member of the team measured the weight and height of children in reception class and year

6 to assess weight and obesity levels. The measurement programme provided an opportunity for staff to engage with children and families about healthy lifestyles and identify concerns and initiate support where needed.

- School nurses provided a pan-Berkshire immunisation service to support the delivery of the Healthy Child Programme (5-19). As a stand-alone service, they offered school-based vaccinations for children in mainstream and special schools and were starting to deliver the childhood flu immunisation programme.
- Children and Young People's Integrated Therapy services (CYPIT) were fully integrated to simplify referral pathways and to coordinate effective treatment programmes.
- Within CYPIT we found a variety of examples of evidence based practice being delivered. For example, therapists had adopted the Malcomess Care Aims Philosophy and Care Aims Model for clinical decision making, for impact based assessments.
- The speech and language therapists used the recognised Michael Palin approach to support children with a stammer. This involved therapists and family members evaluating a child's speech and developing fluency.
- The CYPIT had a pathway for supporting people with autistic spectrum disorders, incorporating a multi-agency assessment and a range of referral options. Staff reported the pathway was effective, but waiting lists were long. They had also introduced a new approach to encourage language development in children with autistic spectrum disorders, but without necessarily having a diagnosis. This 'bucket group' teaching method was based on a national programme, and was proving effective according to parental feedback.
- Therapists used a recognised tool to assess the motor skills of children and young people at risk of, for example, developmental co-ordination disorder. Physiotherapists used the gross motor function measure (GMFM) to measure change in gross motor function over time in children with cerebral palsy. This is a standardised observational tool.
- Other services provided for children, young people and families were informed by relevant guidance. For example, the enuresis policy and procedure was based on NICE guidance and the care plans for those with asthma incorporated Asthma UK guidance.
- Services provided by the sexual health team reflected guidance issued by the Faculty of Sexual Reproductive Healthcare (FSRH) and the British Association of Sexual Health and HIV (BASHH). In addition, health advisors followed the British HIV Association (BHIVA) clinical guidelines for the management of HIV infection.
- The trust implemented the National Chlamydia Screening Programme (NCSP) recommendations, for example by having a system for retesting positive patients and offering young-people friendly services.
- Staff in the looked after children service used a range of recognised tools as part of their health assessments, These include the DUST (Drug Usage Screening Tool) tool for children aged 11-18, and the Strengths and Difficulties Questionnaire (SDQ). Staff used the results of these to refer people to services.
- The trust had Patient Group Directions (PGDs) in place for the supply and administration of medicines for by school nurses and sexual health professionals, following the National Institute for Health and Care Excellence (NICE) guidance. PGDs are instructions for the safe administration of medicines to patients in specific circumstances, where a patient-specific prescription is not required.

Technology and telemedicine (always include for Adults and CYP, include for others if applicable)

- Patients and their relatives generally said there were effective systems to inform them of appointment times and test results. However, patients using sexual health services said a text to remind people of their appointment would have been helpful. The IT system used by sexual health services did not have this facility.
- Therapy administration managers said they texted appointment reminders 48 hours in advance, to minimise missed appointments.
- Health visitors said the trust's agreement to provide laptops with remote access meant they were able to work remotely from their offices more effectively.
- Nurses in the Family Nurse Partnership used computerised tablets and smart phones to improve their accessibility and support for clients.
- The school nursing service set up a texting service to enable children and young people to communicate with them and ask questions directly. They also launched a social media page accessible to children over 13 years. Over 5,000 children had used this technology to access guidance. Staff used tablets to support remote working.

Good

Are services effective?

Patient outcomes

- Staff routinely collected and monitored information about children and young people's care, treatment and outcomes. This information was primarily performance data, although some qualitative data was collected by specific services, to improve care.
- Performance measures for the HCP showed that most babies and children received regular development checks. Each locality monitored when these checks were completed and results showed they had struggled to attain the targeted number of visits. Performance showed an improving trend over the past year in each locality.
- Performance reports showed that in each locality, the percentages of newborn visits completed within this timeframe increased each quarter over the previous six quarters to September 2015. Health visitors carried out six to eight weeks checks, one-year reviews and two year reviews. The percentage and timeliness of these checks was monitored, and they were used to assess breast feeding prevalence.
- In addition, health visitors carried out antenatal visits in order to improve health outcomes. This was a new role, and rates were lower than targeted, partly because pregnant mothers did not expect to see the health visitors until they had given birth and partly because they are often not available during the daytime. Staff had identified this as an area for improvement.
- The school nursing team monitored the health of children in their school reception year by measuring their height and weight, completing a health questionnaire and carrying out hearing and vision tests. The vision tests were only commissioned for the three localities in the east, with a different provider delivering these services in the west. Results showed screening uptake rates between 93% (Wokingham) and 98% (Bracknell Forest and Royal Borough of Windsor and Maidenhead). The trust monitored the number of health questionnaires that required a follow up by the school nurse team, showing between 8% and 18% resulted in further investigation or intervention.
- The school based immunisation programme results for April 2015 to July 2015 showed that 91.5% of children received the first human papillomavirus vaccine (HPV1), and 84.5% the second vaccine (HPV2). There was a decline in administering the second HPV, particularly in West Berkshire (80%) and Slough (78%). Records showed that 91% of children received the Meningitis C and the teenage booster vaccinations.
- The school based immunisation team had also just started to implement the childhood flu vaccination programme.
- Nurses in the family nurse partnership service of Berkshire West monitored outcomes for young mothers and their families based on health checks, breast-feeding, contraception and immunisation. For example, the service reported supporting 67% of young mothers to reduce their smoking and achieved 100% immunisation rates. The service also monitored the number of early interventions prompted by questionnaire responses.
- Staff in the Children and Young People Integrated Therapies (CYPIT) service used goal-based treatment plans however they recognised they needed to develop a system for collating results of people's outcomes more effectively.

Competent staff

- All staff commented that induction training and access to role-specific training was excellent. This included feedback from administration staff, trained staff at all levels and managers.
- They also commented on receiving regular supervisions with their line managers. Staff reported effective systems for clinical supervision. They booked dates in calendars and most staff reported these occurred six times a year at a minimum.
- Some managers described the 'excellent manager' training they had done, and how this had helped them in their roles.
- Newly recruited staff said they had the support of mentors when they started as well as opportunities to complete preceptorships, which helped them develop their skills and confidence.
- Staff in CYPIT reported the integrated approach to delivering services had enabled them to learn from each other and share good practices. They had joint learning sessions, where staff delivered presentations in topics such as eating disorders and enteral feeding. In addition, nursery nurses working in services for children and young people with complex needs used an

adaptation of the Coventry and Warwickshire Competency System. This is a teaching and assessment tool used to train nursery nurses with key skills such as ventilation and enteral feeding.

- Speech and language therapists ensured staff in respite units have advice to manage aspiration and to support the specific needs of children. They also offered support and advice to health visitors and school nurses to support children and young people with basic eating and drinking skills.
- The trust supported therapists to attend outside training and conferences to improve their skills. For example, speech and language therapists had obtained advice from specialist staff internally from Augmentative and Alternative Communication (AAC) therapists and attended special interest groups. This helped them to communicate with children and young people with severe speech or language problems. Physiotherapists reported attending the Association of Paediatric Chartered Physiotherapists conference, and various neuro-muscular courses.
- The trust had also supported therapy assistants with their own training days, and with opportunities for career development and to enrol on allied professional training courses.
- Nurses recruited to the family nurse partnership (FNP) completed training programmes created by the FNP national unit, designed to help them and their supervisors provide the necessary support and guidance to young mothers.
- Almost all staff employed to work in children's services and sexual health services had participated in an annual appraisal. The trust appraisal system was based on values and behaviours, and the trust aimed for 97% compliance. Staff commented their appraisals were useful, two-way discussions with their manager, where they considered development needs and career opportunities. Their objectives were linked to service priorities.
- For staff in looked after children services across Berkshire competency levels are in line with the intercollegiate competencies, March 2015.

Multi-disciplinary working and coordinated care pathways

- Commissioners reported good partnership working with service managers and a strong commitment to deliver improving services. They recognised this was particularly challenging for trust staff, given the number of different commissioners of children and family services and the recent changes in commissioning arrangements.
- Service managers were fully involved in partnership working with the local children's safeguarding boards, health and wellbeing boards and Multi Agency Safeguarding Hub (MASH). Partners commented on their effective contribution.
- Acute providers reported an excellent relationship with the trust, and in particular with the paediatric speech and language therapists. They said the therapists engaged well with multi-disciplinary team working.
- In the CYPIT teams, occupational therapists and physiotherapists carried out joint assessments. This enhanced the quality of assessment and care planning process, made it more timely and reduced duplication of work.
- Therapy staff reported good links and communication with partners working in schools. This was supported by the Care Aims clinical decision making framework, which had promoted more collaborative working.
- Staff said it was sometimes difficult to involve staff from children and adolescent mental health services (CAMHS), but they anticipated this improving with further planned integration of services.
- We observed multi-disciplinary team meetings, which were well attended with relevant professionals. For example, at a common assessment framework meeting, we observed effective sharing of information between school nurses, a paediatrician, school staff and family members. The meeting was run professionally and there were clear outcomes, including referrals and agreed dates for next steps.
- School nurses and health visitors, involved in child protection meetings, demonstrated effective interactions with the family and other professionals and were well prepared for the meetings. The meetings were constructive and information was shared sensitively.
- The designated doctor for looked after children had good links with nursing staff, safeguarding teams and unitary authority staff. This enabled effective, coordinated medical support and care for children and young people.
- Leaders in the LAC service were establishing better working arrangements with social care staff to improve collaboration on health assessments. However, we

found there was no clear process to ensure the 'Strengths and Difficulties Questionnaires', completed by social services teams, were always available to inform the health review process.
- In East Berkshire Community Paediatricians provided a range of integrated services, working with health and social care professionals supporting children and young people with complex medical needs.

Referral, transfer, discharge and transition

- There were clear referral protocols for children and young people to access therapy services. They could self-refer or be referred by their relatives or health professionals. All referrals were triaged and prioritised. The administration staff responded to the referrer in writing, with details of possible waiting times and the appointment system.
- Arrangements to support children and young people with complex conditions to transfer into adult services, using the 'Ready, Steady Go' model for phased transition, were being embedded. This was a trust 'Commissioning for Quality and Innovation' (CQUIN) initiative which the service was working on to help support people transition across services.
- Young mothers on the family nurse partnership programme were supported into education and training as well as given appropriate signposting for adult services. The FNP nurses guided them into looking after themselves and their children.
- Staff were notified when children and young people were discharged from care. For example, when looked after children were no longer in local authority care; their care needs were transferred to the most appropriate children's service. The use of shared information systems supported this process.
- Children and young people in receipt of therapy services were able to self-refer to advice clinics post discharge, without having to be re-referred and join the waiting list. This meant there were effective arrangements to review people's needs post discharge.
- The treatment plan records created by CYPIT included prompts for describing discharge arrangements. Staff said they discussed discharge arrangements with the family and with schools in order to meet the child's specific needs.
- There were protocols for transitioning children from the health visiting to the school nursing service. Health visitors prepared transfer summaries and gave verbal handovers to the school nurse for those children in receipt of additional services and continuing to require community health support.

Access to information

- Staff across children and families services used a recognised electronic records system, which supported integrated working and the safe management of patient information. However, sexual health services did not use this system, which meant they were not immediately alerted if their clients were already known to health or social services. Plans to move to electronic records were dependent on decisions on future commissioning arrangements for this service.
- The IT used by sexual health services was not configured to enable staff to text test results and staff reported this meant communicating test results was inefficient and cumbersome.
- Staff in children's services said the integrated electronic record systems had helped improve links with Children and Adolescent Mental Health Services (CAMHS), where historically, information sharing had been challenging as well as with social services.
- Health summaries and action plans created by the looked after children service were shared with foster cares and/or child or young person.
- The health summaries and action plans for looked after children were sent by secure email to a single point of access within social services for sharing with the relevant social worker.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- The local authority obtained parental consent for initial health assessments of looked after children, under local authority care. However, there was no pathway to update consent prior to a review health assessment. This was an area for improvement that had been recognised and was being followed up with the different local authorities.
- Within the CYPIT services, staff gave examples of how they had offered treatment choices to young people and gained their consent. The service requested parental/carer consent to use email communication, and obtained their consent to email records to the local authority, GP and school. They were aware of the

Good

Are services effective?

assessment of competency using the Gillick guidelines for children and young people. This framework was used when deciding whether a child or young person was mature enough to make decisions without parental consent.

- We observed that staff correctly documented consent in records, and that staff asked for people's consent before carrying out any tests or investigations.

Good

Are services caring?

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

Summary

We rated caring as good.

People in receipt of services spoke highly of the attitude of staff. They said they were friendly, kind, caring and good listeners. They showed empathy and were attentive to people's privacy and dignity. They were skilled in gaining children's trust and promoting their involvement and confidence in care programmes.

Staff engaged well with children and young people and parents, and checked their understanding of care and treatment plans. They ensured people were fully involved in decisions about their care by explaining options carefully. Staff also took people's emotional wellbeing and family circumstances into account when discussing and planning their care.

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

Compassionate care

- During the inspection we visited a range of clinics, schools and children centres and also joined staff on home visits and telephoned people. We spoke with 28 patients or family members. We observed staff treated people with respect and respected people's privacy and dignity at all times. Staff were professional, listened actively and showed understanding.
- Feedback from young mothers was consistently positive about the value of the family nurse partnership service, primarily because of the skills of the staff in providing support and care in way that was patient and non-judgemental. They said they felt at ease with the staff and they valued their sensitive and professional approach.
- People in receipt of sexual health services praised the staff for their professional, friendly and caring manner. They also commented on their discretion.
- CYPIT staff monitored patient feedback, and collated and reported it quarterly. The report for July- September 2015 included 47 verbal comments collected by staff, which showed people were pleased with the attitude of staff and the way they interacted with children and young people.
- Our observations of health visiting clinics shows staff were warm and caring. Staff put people at ease if they were nervous. They recognised when people wanted a private conversation and offered them this opportunity in a tactful way.
- School nurses treated young people with compassion and understanding. They ensured people had the time and reassurance to talk openly and staff listened attentively.
- Staff in looked after children services interacted well with children. Staff showed empathy and kindness and encouraged children, giving them time they needed.
- When we visited the specialist children centre's we noticed that staff placed a strong emphasis on gaining the child's trust and increasing their confidence.

Understanding and involvement of patients and those close to them

- We observed excellent interactions between therapy staff and children and their relatives. Staff provided clear explanations and discussed goals. These were very patient-focussed and relatives understood their involvement in continuing with exercises in between therapy sessions.
- The care aims approach to care and treatment used by the CYPIT service meant parents and schools were fully involved in the treatment programmes, and there was a shared commitment to delivering the programme.
- Children and their families said they had good experiences of care and treatment. They appreciated being fully involved and treated as equals in the care programme.
- CYPIT team staff discussed with parents when and how to practice specific exercises between therapy sessions. Parents said they found the CYPIT staff helpful and they appreciated the way they reinforced their understanding of the programme with printed guidance and pictures. One speech and language therapy group was

specifically designed to support parents by providing practical demonstrations of therapy and the option for the parents/carers to try out the activity with sensitive guidance from the therapy team
- Staff said that if children, young people or their relatives required interpreters or advocates they could access this support, and knew how to do this.
- Nurses in the family nurse partnership worked closely with young parents and their relatives and helped them make decisions independently. They had also involved young parents in their staff recruitment interviews, to ensure the team employed staff with the right skills for the role.
- We observed health visitors having open, helpful discussions with parents. Parents told us they felt listened to and appreciated the caring but professional approach taken by staff.
- Our observations of staff/client interactions within sexual health services showed staff explained different options to people and listened to their views. They checked and confirmed people's support needs and made sure they understood the results process and what the results meant.

Emotional support

- We observed a clinical overview meeting for looked after children where staff considered the emotional and mental health of children and young people and the impact of any interventions on their wellbeing. Staff reflected on the individual's needs and amended their healthcare arrangements to ensure the child was at the centre of the decision making.
- Observations of therapy appointments showed staff explored children's emotional wellbeing, as well as family history, social skills and any anxieties. Staff showed empathy and consideration of the child's relationships with its siblings and companions.
- We observed a school nurse showing exceptional understanding of young people's emotional needs at a school drop-in session.
- Parents of children with complex conditions appreciated that staff considered and understood the needs of the wider family, and helped support them as well as the child referred for their services.

Good

Are services responsive to people's needs?

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

Summary

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

We rated responsive as good.

'Health profiles' showed that overall, child health indicators in Berkshire were similar to or better than the England average. Slough had the highest proportion of indicators of poor health.

Service leads liaised with commissioners and other providers in planning services and sharing knowledge about the needs of children, young people and families. Integration of specialist children services across the county had helped identify and address any service inequalities. For looked after children there was still an inconsistency in service provision between the east and west of Berkshire, and delays in undertaking health reviews for those placed out of area. Access to sexual health services was available across east Berkshire, although provision was focused in Slough, with clinics available in Bracknell two days a week and only a few appointments a week available in Maidenhead.

Staff supported the specific needs of children and young people in a range of ways. They facilitated meetings in locations suited to the family's needs, involved the right professional staff and prepared person centred care and treatment plans. There was evidence that staff took account of people's specific needs and ambitions when agreeing treatment goals. There were systems in place to identify and support vulnerable and hard to reach children and young people.

Staff monitored the timeliness of assessments, referrals and interventions and waiting times for most services had improved. Where children had to wait a long time for an Autistic Spectrum Disorder diagnosis, the Children and Young People Integrated Therapy Service (CYPIT) continued to support children with individualised plans.

The services received few formal complaints, only nine in the year to August 2015. However, there was a lack of written guidance on the complaints process for people using the services. Staff said any informal concerns or complaints were addressed locally. Although there was a risk from omitting to identify and share learning, we saw evidence in meeting minutes that complaints were taken seriously, including informal ones, and learning was shared between teams.

There were no guidance documents written in languages other than English on display with the services, which might hinder people from minority groups accessing the services. Staff said they used translation services when they were aware of the need.

Planning and delivering services which meet people's needs

- Child health data for Berkshire showed very few indicators worse than the England average. Of these, most were in Slough where infant mortality, obesity and low birth weight indicators were significantly below the England average. In the six local authorities, teenage mother and under 18 conception rates were better than the English average.
- The trust's adult community services managed sexual health services, as opposed to their children and families service. However, CQC reports on sexual health services under the children, young people and families core service reports. The trust was commissioned to provide sexual health services in the east of Berkshire only.
- The looked after children service provided health services for children and young people placed under the care of the Berkshire local authorities. The service had recently restructured to improve the quality of service provision in the west of Berkshire, however, there was still an inconsistency in service provision between the east and west of the county. There was also a high proportion of children placed out of area which put pressure on the service. There was a need, in conjunction with Clinical Commissioning Groups (CCGs) and Local Authorities to review the needs of relevant and former relevant care leavers.
- The structure of children and families services had changed significantly over the previous two-three years, with services across the county merging and standardising. This had improved equality of service provision, whilst retaining the ability to meet local needs.

Good

Are services responsive to people's needs?

- Health visiting services had unified and standardised their service provision 18 months previously and school nursing services had aligned their services across East and West Berkshire. They provided a range of services in people's homes, GP clinics and children's centres. Like other services, they offered a telephone advice line during normal working hours.
- The service leads for children and families had made strong links with the commissioners in the six local authorities and seven clinical commissioning groups. Further changes in service design were planned, including the integration of children and adolescent mental health services with CYPIT and full integration of all children's services at locality level.
- There were also planned changes to commissioning arrangements for different services. For example, The Royal Borough of Windsor and Maidenhead would provide school nursing services in-house from April 2016 and health visiting staff from October 2016. Staff would transfer across from the NHS under Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE). The service leads were heavily involved in discussions with commissioners to minimise any risks to service delivery that might result from these changes. They shared audit and performance data to ensure there was a mutual understanding of quality and safety outcomes. We received positive feedback from commissioners on the services' approach to the transfer of services, and the development of new services such as the childhood flu immunisation programme.
- The school nursing service was commissioned to provide services such as the National Child Measurement Programme (NCMP), enuresis treatment, support for children with long-term conditions and guidance on healthy lifestyles. The school nurse service no longer provided drop-in sessions in schools, which meant there were fewer opportunities for children and young people to access informal health guidance and advice. As an alternative the school nursing services ran referral clinics for groups of children in schools.
- Specialist children's services had restructured and integrated to meet the needs of a growing number of children with complex needs. The paediatricians, community nurses and the CYPIT were mostly co-located to facilitate the provision of joint clinics and assessments. Staff confirmed this enabled them to provide more person-centred care.
- Nursing support in special schools was well planned and of high quality, to meet the specific needs of the young people.
- The CYPIT service was able to deliver a multi-disciplinary team approach to assessments. CYPIT had implemented the care aims model of care delivery, with greater involvement of patients and their families in setting goals. To support this more individualised approach, they aimed to deliver their services in schools, including special schools, children's centres and nurseries. These were often more suitable environments for children and young people than clinics.
- The speech and language services offered a range of treatment packages to groups of parents and children and parents with children individually. This was provided from children's centres, nurseries and clinics.

Equality and diversity

- The trust covered a diverse area of population, and staff provided examples of how they supported and respected people's specific needs.
- Staff reported easy access to translation or interpreter services if these were required. Health visitors reported using these services regularly. However, the on-line toolkit, that staff in CYPIT referred people to for guidance and therapy strategies, was only available in English.
- In the children's and family services we visited, as well as sexual health services, we found leaflets and guidance information was only printed in English. It was not available in other languages, local to the area.
- The chlamydia screening team attended the Reading Pride event in September 2015 where they offered health advice and testing to the lesbian, gay, bisexual and transgender public community.
- Sexual health services were improving pathways to simplify referrals to Berkshire's sexual assault referral centre in Slough. Staff had removed unnecessary paperwork to make the referral processes more efficient and accessible.
- Staff had also given sexual health education at a Sikh women's temple and at schools.
- The records of health assessments for looked after children showed that risk assessments and care plans

took account of people's individual needs including those relating to ethnicity or culture. Records showed the impact of such factors were considered in an appropriate and sensitive way.

Meeting the needs of people in vulnerable circumstances

- Health advisors and nurses in sexual health services had an understanding of the needs of the population where they worked. Nurses provided a nurse-led contraception service, responding to patients needs and dispensing medicines directly. Health advisors provided point of care testing for those at high risk of HIV and they planned to start a rapid-testing clinic in 2016. A newly appointed outreach specialist nurse supported vulnerable families known to services. Berkshire's sexual health service also had its own website and a range of information and guidance. It included signposting to other services in the area.
- There was a wide range of on-line information about services provided by the trust. Each service posted contact details, including phone numbers if people needed support. The CYPIT toolkit could be downloaded from the website as useful resource for families.
- The health visiting service had created link roles to support engagement with homeless families in local hostels. This was mainly in the Reading area.
- Information leaflets were offered by most services. Health visitors for example, provided leaflets about breastfeeding, immunisations and development reviews.
- Staff at respite centres liaised closely with parents and relatives about their child's care and safety needs. Staff managed negotiations effectively, to promote the independence of the child, protect their safety and to reflect the wishes of parents.
- Therapy assistants ran a 'hands on' Parent-Child Interaction (PCI) group specifically for parents who needed additional encouragement and support to attend therapy sessions, due to their own particular circumstance or health needs.
- Specialist nurses for looked after children had set up creative ways for engaging with hard to reach young people and gaining their trust, including those at risk of not engaging with services. Staff provided examples of how they had encouraged young people to participate and engage with services in the community. A specialist nurse worked specifically with hard to reach young people, those who had experienced child sexual exploitation and pregnant young people.
- Staff ensured that looked after children were visited at a location of their choice and received a contact card, showing contact details of key people or services they might need to use at short notice. They could also arrange for video network meetings if that was the young person's preference.
- We observed specialist LAC nurses were flexible to meet the needs young people, for example, by maintaining continuity of health professional to encourage engagement. This was good practice.
- Specialist nurses for looked after children completed the health assessments for children placed within a 20-mile radius in addition to eligible care leavers aged 16 and 17 living in Berkshire. The nurses also quality assured all assessments completed by other health professionals regardless of area of placement.
- Speech and language therapists ran groups to support parents having difficulty accessing a parent-only group, for example due to learning or language difficulties, or childcare issues. Staff set up small groups or pairs and gave focused attention to parents, which could be extended to home visits if necessary, to meet their particular needs.
- The CYPIT service used the care aims model which was centred on children's individual risks and needs. Each patient had their own therapy plan and goals were discussed and agreed at each session. Staff created integrated therapy plans, showing goals and achievements which they shared with the parents and schools.
- At the sexual health clinic in St Marks Hospital, Maidenhead, the layout of the facilities meant there was a risk that patient privacy could be compromised. The clinic's medicines were stored in a locked cupboard in room 12, which was a room doctors used for private consultations with clients. There were occasions when staff interrupted the consultation to ask the doctor for medicines from the cupboard

Access to the right care at the right time

- Respite care for children and young people with complex health needs was delivered in two units on alternate weekends, in line with the commissioned specification. The service was only commissioned to

offer respite on specific days which meant the units were not open each week day. This was raised as an access issue, given the increase in number of young people with complex and chronic health needs.

- Access to sexual health services was limited. The Garden Clinic was the main clinic for sexual health services, with hubs in Bracknell and Maidenhead. The Garden Clinic was described as a 'one stop shop' and offered clinics Monday to Friday, with a mix of walk-in sessions and pre-booked appointments. In Bracknell and Maidenhead, services for adults were limited to one or two sessions a week, and for appointments only. This meant people would have to travel to Slough for a drop-in clinic. All three locations offered clinics specifically for under-18s on one afternoon a week, outside school hours. There were arrangements for emergency services.
- We received feedback from patients that they had difficulty accessing the Garden Clinic in Slough for sexual health services, and were not able to book appointments. The 'did not attend' (DNA) rates were high, with over 100 DNAs recorded in Slough each month between June and October 2015, which indicated the appointment system may not be effective.
- Waiting times for booked appointments for sexual health services were within the agreed timescales. Most of the care was delivered via walk-in clinics, and sexual health services complied with the national 18-week target waiting times for appointments. In Slough, demand for long-acting reversible contraception (LARC) procedures had increased because GPs were no longer commissioned to deliver this service. This was a referral-only procedure and staff reported that waiting times were increasing, but still within the 18 weeks. For intrauterine devices (IUDs) the waiting time was four-six weeks and three weeks for sub-dermal contraception implants. Urgent or emergency procedures were seen within two working days.
- Staff ensured people received positive test results from the sexual health service in a timely way. The service's health advisors communicated positive results within 10 working days, in line with BASHH guidelines.
- Health visitors completed most new birth visits and developmental reviews in a timely way. Between July and September 2015 (Quarter 2, 2015/16), they completed between 85% and 93% of face-to face new birth visits within 14 days, across the six localities. Over the same time-period, they completed between 87% and 96% of the 6-8 week developmental reviews (against a 95% target) and 71% - 91% of the 12- month and the 2-2.5-year reviews. Results were highest in the Bracknell locality and lowest in Reading. In 2015/16, data showed new birth visits were below target in quarters 1 and 2. Staff commented that in Reading, there had been some errors with data entry and some assessments had not been accounted for, which could have affected the results.
- Results for the summer term 2015 showed the school nursing service had met its targets for the National Child Measurement Programme (NCMP), having completed a catch up-programme for East Berkshire. School nurses attended all initial child protection conferences in two of the six localities. Staff in Reading only attended 64%, however that represented 23 conferences.
- There were long waiting times to refer children in specialist schools to the children and adolescent mental health services. Staff reported waiting lists for children with autistic spectrum disorders (ASD) of up to two years. The delay in diagnosis meant children did not receive the educational support they needed in school in a timely way. Even though the therapists continued with health support without the full diagnosis, they were not trained to support children's mental health needs.
- For CYPIT, staff reported the 'single point of entry' triage and entry system worked well in assisting people to receive a timely service. Staff triaged enquiries and directed people towards the most appropriate therapy service for advice. Therapists usually gave initial advice over the telephone and signposted people to the service's on-line toolkit resource. Appointments were prioritised based on need, with urgent eating and drinking cases seen within 48 hours. An initial evaluation was usually achieved within half a term, with interventions planned on a termly basis. This meant the waiting time was about six-eight weeks, organised around term-time schedules.
- CYPIT staff promoted the use of their on-line toolkit to parents and nurseries/schools. The toolkit provided self-help advice and children's responses to the activities provided useful information for staff if a referral was then necessary
- CYPIT administration managers said they texted appointment reminders 48 hours in advance, to

Good

Are services responsive to people's needs?

minimise missed appointments. Their DNA rate was less than 4% and monitoring results showed times when DNAs were most prevalent, which was useful management information.

- Speech and language therapy staff had reviewed their service design to improve access and reduce waiting times. Staff had found the diversity of therapy sessions made it difficult to prioritise their work and manage waiting lists effectively. They piloted a revised delivery model in one locality, with a reduced range of interventions (the most popular and well attended sessions) offered as group drop-in clinics. The pilot showed they were able to reduce waiting times to 4-6 weeks, with the initial assessment made at the group sessions. Other localities subsequently adopted this model to improve access and eliminate waits for speech and language early-years provision.
- CYPIT also used the care aims approach and supported parents and learning support assistants in schools to contribute to children's therapy plans. This improved their capacity to provide assessments in a timely way.

Learning from complaints and concerns

- Children and young people's services received only nine formal complaints in the year to August 2015. Of these, only one was upheld.
- During our visits we did not see any guidance, posters or leaflets instructing people on how to make a complaint. When we asked staff they were not able to provide us with any printed patient information on the complaints process.
- Staff reported that complaints were generally verbal and resolved locally. For example, at a respite centre, staff outlined the actions they had taken in response to parental concerns. For one issue, where a child had developed skin damage, staff had instigated a full review of care and implemented a skin assessment tool, training and daily monitoring. Learning from this was shared with the other respite unit to improve overall care. Within looked after children services, complaints were resolved locally and apologies given when services should have been better.
- Clinical governance meeting minutes showed that investigations and responses to complaints were discussed and learning or audits were carried forward. Complaints were taken seriously by the trust and used as a tool for improvement.
- We saw no evidence to show that locally resolved complaints were logged to enable patterns and trends to be identified and monitored.

Good

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

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.

We rated well-led as good.

Overall, there was good leadership of services for children, young people and families. Managers were well trained and built strong relationships both with staff and with partners outside the organisation. The local leadership of the sexual health services was good, but there was a lack of leadership capacity and senior management oversight. The service was facing commissioning changes and staff did not feel well informed or prepared.

Staff said there was a good culture of teamwork and they felt supported by managers. They were encouraged to contribute to service developments and they felt confident to raise concerns, citing examples of how this had led to improvements. All staff showed a passion to provide an improving service to children and young people.

Staff understood the structure of the services, how their roles linked with those in other service, and the governance arrangements. Locality risk registers were generally up to date and relevant, however we identified that risks that had not been included.

The staff meetings were held regularly and structured to share and promote learning. This meant staff were well informed and encouraged to improve service safety, quality and efficiency. Good practice, achievements and positive feedback were acknowledged and celebrated. Different services had their own arrangements for gathering feedback from children, young people and families and members of the public had been involved in some aspects of service design. Overall, this was an area staff intended to develop further.

Service vision and strategy

- The trust vision was 'to develop excellent services in local communities with people and their families, improving their heath, well-being and independence – the best care in the right place'. The trust's core values were to be caring, committed and working together. The vision and values were clearly communicated to staff, routinely in various publications and internal reports and on the intranet. Staff had a good understanding of these principles, and they were the basis for the staff appraisal process.
- The service where staff were most uncertain about the trust's strategy was the sexual health service. Staff said the commissioning arrangements for this service were complex with provision of services split across two providers. They were not aware of a service strategy.
- The designated nurse and doctor for looked after children in east Berkshire are situated within the trust, as commissioned by the CCGs and in alignment with statutory guidance. In Berkshire, the role of the interim designated nurse was assigned to the provider's operational lead. The service short-term priority was to deliver the health assessments and turn around a backlog of overdue assessments. There were two posts within the trust for designated nurses for looked after children, however there had been a vacancy for one of these posts since September 2015, which meant one designated nurse led both teams. Their priority had been to turn around a backlog of overdue assessments in the west of the county.
- The integration of therapy services for children and young people had been successful in combining services in east and west Berkshire and all staff commented that the model worked well and led to a significant improvement in ways of working. The integration had improved sharing of good practices and simplified care and treatment pathways. Staff said they applied a more patient-centred approach, which improved patient experience and motivation.
- Paediatric physiotherapists said the integration of services had been beneficial. They had used the opportunity to hold cross service meetings to review services and to carry forward best practices.
- Each service had developed a 'plan on a page' based on the five domains of safe, effective, caring responsive and well led. Staff reported these plans were developed to

link with corporate objectives, but with input from service front line staff. Staff felt they contributed to the service strategy and were able influence service development.

- We observed that different sites displayed the trust's wall chart, showing what staff were proud of, where improvements were needed and what they were working on. This helped ensure staff were aware of and working towards the trust's priorities.

Governance, risk management and quality measurement

- Services for children and families were underpinned by effective governance arrangements to support the delivery of the strategy and to promote good quality care. Staff were able to describe these arrangements and they demonstrated a good understanding of their service priorities.
- Services for children and families were delivered within six geographical localities. Smaller services, such as services for looked after children and the Family Nurse Partnership, were hosted by two localities, based in the west (Reading) or the east (Slough) and delivered across the trust. The trust was commissioned to provide sexual health services in the three localities in the east only, with a different provider commissioned for these services in the west. There was a manager for each locality and within each locality, team leaders for services such as health visiting, school nursing, community paediatrics, specialist children's service nursing team and integrated therapies. Despite the complexities of the model, staff understood their roles.
- Each locality held quarterly performance improvement meetings, which included children and families services. Staff discussed finance, quality and performance, risks, service developments and stakeholder and patient involvement at these meetings. Staff also held monthly management and clinical governance meetings. Locality clinical leads attended the trust's monthly clinical governance meetings. This structure enabled regular oversight and escalation of performance, quality and workforce issues.
- Locality risk registers were generally up to date and regularly reviewed.
- Staff had completed audits in line with the trust audit plans. These included a range of audits of sexual health services including compliance with faculty standards for emergency contraception and an audit of management of gonorrhoea. The audit report showed a high level of compliance and any actions were documented. Audits were also in progress for LAC health assessments, risk assessments for new birth contacts and school nursing assessments. There was evidence that staff used results from audits to improve services.
- Staff were familiar with the governance arrangements, how performance was monitored and areas for improvement. Information was cascaded effectively.

Leadership of this service

- Almost all staff commented the service and trust leaders were visible and approachable. Staff frequently gave examples of when their manager had been supportive and encouraging. They were also consistently positive about the trust's chief executive and the leadership teams initiatives, such as 'Big Conversations'. Staff had generally met the chief executive, for example at induction, and said they were approachable. We were told of various examples of how they had helped resolve issues for staff.
- One area where staff felt isolated from the senior management was within sexual health services. The staff delivering chlamydia screening knew their jobs were at risk due to commissioning changes but were not clear on the timescales of events and felt a lack of consideration and support.
- The interim manager covering the LAC team was highly regarded and had supported staff through some difficult changes. There was still a management vacancy in the team, which meant there was a lack of overall management capacity within the service to sustain this longer term.
- The trust offered the 'Excellent Manager Programme' to develop leadership competences. All new staff in a management role were required to commence the programme within their first 12 months and we received enthusiastic feedback from management staff on the skills and support this training provided. Newly appointed managers described how the recruitment process assessed people's personality and their 'fit' within the team. They felt this was beneficial.
- Most managers felt very well supported with time to lead effectively as well as the access to management training. They commented on the good relationships they had with the senior management and effective administrative support.

Good

Are services well-led?

- Staff monitored and managed sickness effectively and senior staff reported good support from occupational health and human resources.
- All staff said that they valued the strength of their teams, and new staff in particular commented positively about the teamwork. Most staff working remotely, felt connected to a team, and with other teams within the trust.

Culture within this service

- Staff said they felt respected and valued. Almost all staff said they enjoyed their jobs and liked working both in their team and for the trust. Staff demonstrated a passion and commitment for their work and said this was key to their job satisfaction. Staff were enthusiastic about new challenges and had career aspirations they felt could be met within the trust. We heard many positive comments from staff.
- Staff said they worked collaboratively to focus on the needs of patients. CYPIT staff reported that co-location at hospital venues had enhanced a culture of shared working, learning and sharing. Staff at different levels also attended peer support meetings which they valued.
- There was a culture of addressing any barriers to improving the quality of the service, and suggestions for innovation were welcomed.
- The trust encouraged and celebrated good managers by giving leadership awards.
- We were given examples of action being taken when staff behaviour and values were not in line with trust values.
- Staff working remotely were trained in personal safety and encouraged to carry safety alarms. Different staff groups used different strategies to protect their safety. The trust also offered staff resilience and stress management courses, for example to support staff working remotely.

Public engagement

- The trust published a newsletter called 'Learning Curve' in December 2015 to promote the importance of obtaining feedback from patients, sharing learning from serious incidents and complaints and implementing improvements in practice. This demonstrated a commitment to seeking more patient feedback and using it to improve the quality and safety of care and treatment.
- Services had different approaches to gathering feedback. Some staff in the CYPIT service said they received a lot of positive verbal feedback and they collected and celebrated compliments regularly. They also received informal feedback from the care aims approach to therapy, which includes parents and children in the goal achievement assessments. Speech and language staff commented on changes as a result of feedback, which included different course content and shorter, more practical sessions. They had also introduced some afternoon drop-in sessions, in addition to morning ones, as requested by parents and greater use of Makaton in sessions to increase the child's vocabulary. Other staff said they were not so good at gathering and recording parental feedback.
- Health visitors in Wokingham had identified a need to increase the uptake of children's' two year development reviews to 95%. They consulted with parents and held promotional events to determine barriers to attendance. As a result, they started texting reminders to patients and also set up clinics on Saturdays to improve access. This was the result of a trust 'listening in action' initiative.
- The LAC service provided courses for foster parents, for example on caring for vulnerable babies. Staff collected feedback from these which they used to improve subsequent courses.
- Looked after children were asked to complete a feedback form after their health reviews. Staff said these were audited and the results posted on the LAC intranet page. The last annual report stated that 100% of respondents rated their care as excellent or good.
- Sexual health services had planned a patient forum group for January 2016 to seek their views on the service.

Staff engagement

- The trust ranks amongst the top 20% of trusts for staff engagement.
- It was committed to gathering staff views and ideas in order to improve patient experience and clinical outcomes. They did this through 'Big Conversations' and using change management models where staff designed and delivered consultation projects.
- Staff recognised these approaches and said they were encouraged to participate in any of the initiatives. For example, health visitors said they had been able to demonstrate the value of mobile working, and had won

support to implement this. Many staff said they felt able to influence the way services were delivered, for example using video networking and social media to engage with young people.
- The development of CYPIT involved staff at all levels to plan the new ways of working, triage system and toolkit. Staff said they were proud of this successful initiative.
- Staff said their views were always welcomed. They reported being listened to and able to raise concerns. One staff group said they had raised a staffing issue with senior management, and this had been taken seriously and addressed.
- The trust's 'newsline' staff brochure provided an update on innovations, events and successes within the trust, highlighting where staff had made a difference and sharing news.

Innovation, improvement and sustainability

- Innovation was promoted by the trust. Areas of innovation within children's and family services included the use of technology by school nurses to improve communication with young people, and the introduction of tablets to help staff working remotely.
- The integration of therapy services had improved the sustainability of services and had enabled staff to review the model of care. They had introduced the Care Aims model of holistic, family and child centred support. They had also created a toolkit for families to use and for reference. This improved the efficiency of the service and involvement of children and families in setting realistic goals.