

Croydon Health Services NHS Trust

RJ6

Community health services for children, young people and families

Quality Report

Croydon Health Services NHS Trust
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RJ6X1	Community Services	Community health services for children, young people and families	CR7 7YE







This report describes our judgement of the quality of care provided within this core service by Croydon Health Services NHS 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 Croydon Health Services NHS Trust and these are brought together to inform our overall judgement of Croydon Health Services NHS Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Croydon Heath Services NHS Trust provides an integrated acute and community health service for children and young people living in the south London borough of Croydon. The trust emphasis is to provide this service when and wherever it is needed.

Croydon Health Services NHS Trust is commissioned to provide a range of services to children and young people including health visiting, school nursing, speech and language therapy, and hospital at home services, which includes a specialist asthma service, a community nursing team, a diabetes team, special school nursing team, community nursing service for children with special needs, specialist learning disability nurse, continuing care assessments, and a palliative and end of life care team, including the bereavement service called Willow. There is also the multidisciplinary team that works out of the Crystal Children's Centre, which includes community paediatricians, physiotherapy, occupational therapy and an audiology team. There is a family nurse partnership practitioner (FNP), a Looked After Children (LAC) team and a safeguarding team.

We inspected the following regulated activities that the trust is registered with CQC to provide:

- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury.

Children and young people and their carers received safe services from Croydon Health services NHS trust and were protected from harm and abuse. Staff understood their responsibilities to raise concerns and to record and report safety incidents. Lessons were learned from incidents and action was taken to improve the service. Staff demonstrated a good awareness of safeguarding issues and knew the procedures to follow if abuse was alleged or suspected.

Staffing levels were too low in some areas and caseloads were high. However, services were continually reviewed to ensure that children and young people received safe care and treatment.

Children and young people in Croydon had care and treatment provided in line with legislation, best practice and evidence-based guidance. The outcomes of care and treatment were evaluated at a local level and within

specific services. There was limited participation in national and local audits and no trust audit department driving improvements within this core service. Where audits were undertaken, the results were used to improve outcomes for children and young people using the service.

Children, young people and their families were involved in making decisions about their care and treatment. Staff showed a sound awareness of why, when and how consent should be sought.

Staff had the relevant skills, knowledge and experience to deliver effective care and treatment. Staff were supported through supervision and annual appraisal, and personal development was encouraged, although not always facilitated when required.

There was collaborative and effective multidisciplinary and multi-agency working to understand and meet the needs of children and young people using the service. This included the arrangements for young people moving to adult services.

Children, young people and their families were treated with dignity, respect and kindness. Staff ensured that children, young people and their families understood and were involved in their care and treatment.

Children, young people and their families were positive about the care and treatment they had received and about the staff providing the service.

Children and young people's services were planned and delivered to take account of the needs of the local population and of individual needs. Access to care was good, with waiting times from referral to first appointment well within the trust's target of 18 weeks.

Complaints and concerns were taken seriously. Information about how to make a complaint was displayed in the clinics we visited.

Communication within teams was good and staff felt supported by their immediate line manager. Staff felt confident that issues and concerns could be discussed with their line manager but were not convinced that the trust executives would be as supportive.

Summary of findings

Governance is not embedded within the community, children and young people's services and staff were unaware of the governance structure and knew little about clinical governance. Clinical audits only occurred where services were innovative and motivated to do so. There was no internal audit plan other than the two mandatory audits.

The executive team were not visible within the community but staff felt the trust was 'getting there'. Most staff were aware of the Listening into Action events but few had participated and felt these were more aimed at hospital services.

There was a lack of involvement of people who use services in the planning and delivery of new services.

During the inspection we held focus groups with health visitors and spoke to seven parents and children. We reviewed individual care plans, risk assessments and a variety of team-specific and individual service-based documents.

We sought feedback from external partner organisations and reviewed online feedback.

Summary of findings

Background to the service

There is a high proportion of children and young people in Croydon, with 26.9% of the total population under 20. Some 66.2% of school children are from a minority ethnic group. The health and wellbeing of children in Croydon is generally worse than the England average. Some 25.2% of children under 16 are living in poverty and the rate of family homelessness is worse than the England average. The average levels of obesity are higher than the national average, including 10.3% of children aged four to five years and 21.9% of children aged 10 to 11. There was a higher than average rate of emergency hospital admissions of children and young people because of asthma.

We visited a range of clinics and services as a representative sample of the variety of health service centres across the Borough. We observed staff working with children in the community and at clinics. We spoke to 45 staff across the service, including health visitors, specialist nurses, the children's hospital at home team (including staff within the diabetes and asthma teams), admin staff, the audiology team, physiotherapists, occupational therapists, speech and language and dietetic managers, community paediatrician and service managers.

Our inspection team

Our inspection team

Chair: Jan Filokowski

Team Leader: Margaret McGlynn

The team included a CQC inspection manager and a variety of specialists, including specialist advisors for management and nursing, and a community occupational therapist and a paediatric physiotherapist.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 16 and 19 June 2015. During the visit, we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and administration staff. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the services.

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

What people who use the provider say

Parents and carers were positive about the care they received from the community children's services. They talked about kind and supportive staff. The feedback from people was very positive, with people telling us staff were approachable and reliable.

We were not able to speak with any children who used the service as the inspection took place during school hours but we saw feedback from two children about a particular service who said the following:

'Talking me through my condition and telling me what to do was really useful and it is really working.'

'I think you did a really good job as nothing has happened to me with my condition.'

Good practice

We found the following areas of good practice:

The community nursing service provided at St Giles special school was dynamic, organised and well led. There were good examples of multidisciplinary and multi-agency working, ensuring the child was at the centre of decision-making and involved in their care. The school was bright, positive and a fun environment to work and learn.

The Children's Specialist Asthma Service took an innovative approach. For example, staff had developed social media networking to provide additional support to children with asthma aimed at maintaining good health and reducing admissions.

Chatterbox is a language development service for pre-school children. Speech and language therapists and

children's centre staff work together to deliver targeted care to address the speech, language and communication needs of pre-school children. They provide support and advice to families and ensure timely referrals to speech and language therapists for more specialist assessment and treatment. They also signpost to other services.

The children's specialist nurse diabetic service supports children and young people along with their carers to manage their disease and are part of a 24-hour helpline so parents and young people can access the advice and care they need at all times.

The Willow bereavement service was set up to provide counselling for terminally ill children and their siblings.

Areas for improvement

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

The provider should ensure that clinical governance processes are embedded across local community teams.

An internal audit programme should be developed to ensure services formally evaluate and improve service provision.

Action the provider **COULD** take to improve

Croydon Health Services NHS 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

Children and young people and their carers received safe services and were protected from harm and abuse. Staff understood their responsibilities to raise concerns and to record and report safety incidents. Lessons were learned from incidents and action was taken to improve the service. Staff demonstrated a good awareness of safeguarding issues and knew the procedures to follow if abuse was alleged or suspected.

Staffing levels were too low in some areas and caseloads were high. However, services were continually reviewed to ensure that children and young people received safe care and treatment.

Incident reporting, learning and improvement

- We found a robust incident reporting system and staff used Datix, which is a computer-based recording system. All staff were aware of the how to report incidents and used the system effectively. The staff we

spoke to said there was good monitoring and feedback about the investigation and that they were informed of the outcome. Learning was shared within individual teams but there were no central meetings to discuss learning from trust incidents. There had been 69 incidents reported since December 2014, which demonstrated an open and transparent approach to incident reporting and how embedded this was within the trust.

- For example, one member of staff reported that the operating cords on venetian blinds were dangerous following an incident involving a child in a clinic. The staff member was dissatisfied with the risk rating the investigating officer had given it and pursued the incident further, ensuring that the trust listened to the concerns raised. The risk rating was changed and all health clinics now have different blinds that are safe.

Are services safe?

Safeguarding

- There were appropriate safeguarding procedures and processes across children and young people's services. There were three named nurses for the trust and a lead community paediatrician for safeguarding. The three nurses split the services so that they each had a portfolio but covered for each other when necessary. Staff we spoke to were aware of who the leads were and how to raise safeguarding issues.
- We found that staff were provided with adequate training to be aware of and report safeguarding concerns. All staff that we spoke to had completed levels one to three of the safeguarding training according to their role. Records showed that the numbers of community paediatric staff that had completed levels one and two were good, with 90% achieving level one and 76% level two. However, we had no data regarding level 3 training.
- Staff received appropriate levels of supervision in safeguarding and felt supported to raise concerns. The named nurses provided support and supervision to a range of nurses across the children and young people's teams.

Medicines

- There was evidence of robust procedures for checking and monitoring allocation of medicines and feeds in the special school. All medication was kept in a locked cupboard.

Environment and equipment

- The clinics we visited were in a poor state of repair and we saw exposed plaster and paint peeling from the walls. The Crystal Centre building was in need of improvements. However, access to and within the building was safe and a lift was available to access clinics on the first and second floors. The trust had a plan for relocating the centre by September 2016.

Records systems and management

- Staff told us they use a community electronic system to record information about assessments and treatment interventions. We saw two care plans that demonstrated multi-professional entries for the community team only. Social care services have a separate system and the hospital also uses a different system to record information. This makes it difficult for staff to know the

interventions a child has received outside of the community team and in all cases, but especially safeguarding cases, community staff are unable to track a child's or their families pathway electronically.

- Staff said they were able to record contact information electronically but that comprehensive assessment and treatment plans were recorded on paper. This meant that not all the information about an individual was available to all health professionals involved in a child's care.

Cleanliness, infection control and hygiene

- Infection control audits were carried out by the infection control nurse, located in the hospital. This primarily related to hand-washing audits. The special school staff said they had regular meetings with the infection control team but this was not universal. We observed the aseptic non-touch technique (ANTT) being used on a home visit.
- The buildings we visited appeared clean but we observed bins in toilets that were not foot operated and bare plaster on the walls in some treatment areas. We observed cleaning schedules in operation in two buildings.

Mandatory training

- There was a programme of mandatory and statutory training (MAST) available for all staff, which covered areas such as moving and handling, information governance and infection control. Staff told us they were encouraged and supported to attend this training. Managers had oversight of training completed by their teams and alerted staff when training was due.
- Data from the trust showed that 88% of all children and young people's staff had attended mandatory training. Figures varied but only 50% of children's services staff at Lennard Road had received resuscitation and moving and handling training.

Assessing and responding to patient risk

- Risk assessments and risk management were included in the care plans for children and young people using the service. For example, each child or young person seen by the asthma team was given a folder of information. This included a detailed plan of what to do when they have an attack and how to identify if the condition is getting worse.

Are services safe?

- In the special school, staff competencies were identified in order to undertake a treatment or intervention, together with the associated risks. Training was given to non-nursing staff in order for them to undertake low-risk procedures.
- We were told about the general risk assessments that physiotherapists undertook regarding the environment and for manual handling. A risk profile was given to each child to ensure their safety at home and at school. Each piece of equipment and the environment where it was to be used was risk assessed.
- The specialist nurse diabetic service played an important role in identifying the risks to the child and their family and ensured teachers were educated to recognise the child's symptoms. This meant that teachers were able to be first responders to an emergency situation, ensuring the child receives prompt and appropriate care.

Staffing levels and caseload

- We found there were vacancies across most specialities and, despite the trust-wide recruitment initiative, staff

were working with high case loads. This was particularly evident in health visiting. This service was looking at ways to address the shortfall with skill mix and geographical placing.

- In other services, such as occupational therapy and physiotherapy, a waiting list was in operation. Speech and language therapy also had high waiting lists and under the Balanced System 2™ framework had developed a range of services, such as the Chatterbox groups, which enabled early identification of speech, language and communication needs. Children and their families attended these groups to receive support and advice whilst waiting for more specialist intervention. The Crystal Centre staff were also trained, reducing the need for specialist speech and language intervention.

Managing anticipated risks

- The trust had a policy to protect staff who may be lone workers. Staff were aware of the policy and of their own local team arrangements for lone working. Staff in the health visiting service had been given electronic devices to record their entry and exit on a home visit. This had recently been removed and the team were using a buddy system. Managers and staff were not aware of when the replacement device would be provided.

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

Children and young people in Croydon had care and treatment provided in line with legislation, best practice and evidence-based guidance. The outcomes of care and treatment were evaluated at a local level and within specific services.

There was limited participation in national and local audits and no trust audit department driving improvements in this core service. Where audits were undertaken, the results were used to improve outcomes for children and young people using the service.

Children, young people and their families were involved in making decisions about health care and treatment. Staff showed a sound awareness of why, when and how consent should be sought.

Staff had the relevant skills, knowledge and experience to deliver effective care and treatment. Staff were supported through supervision and annual appraisal and personal development was encouraged.

There was collaborative and effective multidisciplinary and multi-agency working in most areas, to understand and meet the needs of children and young people using the service. This included the arrangements for young people moving to adult services.

Evidence based care and treatment

- Care and treatment for children and young people was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- The Children's Specialist Asthma Service had been set up in response to the National Review of Asthma Deaths (NRAD) recommendations and followed the British Thoracic Society guidelines on the management of asthma for children under five, five to 12, and 12 and over. The team also followed National Institute for Health and Care Excellence (NICE) guidelines and accessed asthma UK along with other resources.
- The family nurse partnership programme is an evidence based, preventative programme for vulnerable first time young mothers. Staff in this team delivered a licensed

programme in a well-defined and structured service model. Continuous audits were undertaken to ensure compliance with the national Family Nurse Partnership (FNP) guidelines and FNP programme Licence for Supervision in FNP.

- NICE and other national guidelines were followed for the healthcare of looked after children (children in care). The team worked closely with social services to ensure the health assessments for this group were undertaken annually.
- The Health visiting and school nursing teams delivered the Healthy Child Programme (HCP) to all children and families up to the age of 19. They ensured they met the new-born checks within the specific timescales and were responsive to the one- and two-year developmental checks.
- Speech and language therapy follow the Malcomess care aims, which is a national programme developed to improve services that are person-centred, evidencebased and use systematically reflective decision-making and processes to improve outcomes.
- The diabetic service works to the national standards of paediatric diabetic care and follows the best practice tariff.
- Therapy and nursing teams were seen to involve parents in planning children's care, including consent, and they followed the national guidance on consent for children assessed as competent.

Patient outcomes

- Key performance indicators are based on commissioners' requirements and are quantitative, relating to waiting times. Qualitative outcome measures are not well established across the community children and young people's service. Regular audits of outcome measures were not undertaken and it was therefore difficult to establish the systematic effectiveness of the service as a whole.
- Staff we spoke to described how they developed individual outcome targets for the child. These targets were developed in partnership with the child, parents and other professionals where appropriate. For example, a young child with a disability wanted to learn

Are services effective?

to skip. The parents wanted the child to walk well and the therapist set a different goal. A video was taken to help those involved assist the child to learn the stages of skipping and so that the child could see what needed to change. Through collaborative working, the child achieved the desired outcome and learned to skip.

- Staff were dedicated in ensuring the outcomes for the individual child were achieved. For example, one child refused to attend a hearing clinic as it was too scary. The staff worked with the child in the car and then introduced them to the clinic waiting area before attending the department. Once the child felt confident, a stick-on earring was given to the child so that they were able to get used to something being on their ear. The child readily accepted the hearing aid when provided.
- In special schools there was a multi-agency approach to the development of outcomes and an inclusive approach to ensure all the needs of the child were met. Care plans were comprehensive and included both health and social outcomes for the child. The outcomes identified what support was needed, when it would be provided, the people responsible and the resources required.

Competent staff

- New staff had an appropriate induction for their role. Staff told us their induction had covered everything they needed. One member of staff was impressed with the thoroughness of their induction, saying they felt completely supported and provided with the training and information needed before undertaking the role.
- Staff told us they had regular supervision and an annual appraisal. In some services competencies had been developed and an assessment of individual ability was undertaken. Where a member of staff lacked the required competency, support and training was provided.
- Training needs were identified and staff were supported to undertake training and personal development. A few staff felt that funding was sometimes an issue but said at the money would be provided eventually.
- Data from the trust showed that all staff in community health services for children and young people had received an annual appraisal in 2014/2015.

Multidisciplinary working and coordinated care pathways

- Multidisciplinary working was good but not systematic. There were plans to develop structured multidisciplinary working at the Crystal Centre. There were good links with external organisations and agencies to ensure the care needs of the child and their family were met.
- In the special school, weekly multiagency meetings were held between health and school services. The special school nurses took part in Team Around the Child (TAC) meetings. The TAC approach brought key practitioners together in regular face-to-face meetings. A single plan of action was agreed and then modified and added to in subsequent meetings.
- Speech and language therapists had developed an early intervention assessment and advice service called Chatterbox. These sessions were held in a variety of venues and were supported by the children's centre staff. All staff kept records of attendance and intervention and met regularly to review care plans and discuss any issues.
- We observed the community nursing service daily handover meeting, where all children seen that day were discussed. The team discussed conversations that had taken place that day with the acute paediatricians, social services and the nursing team on Rupert Bear ward.
- Health visitors and school nurses told us they worked closely with social services and were easily able to refer to speech and language therapy. Multidisciplinary working with GPs was sporadic and worked well where services shared premises.
- Occupational therapists and physiotherapists worked closely with school staff to ensure a safe, effective and positive transition from pre-school to mainstream education.

Referral, transfer, discharge and transition

- Children and young people were referred by their GPs for assessment and treatment to the specialist services. Speech and language therapy services accepted referrals from others, such as referrals from teachers or parents and other health care professionals.
- The transition of children and young people between services and from children's services to adult teams was good. Children in special education had comprehensive

Are services effective?

care plans that were transferred to further education establishments. A transition pathway was in the process of being developed for those children transferring from special schools to colleges to formalise the process.

- The diabetic team had a dedicated joint transition clinic for 16 to 19-year-olds once a month to ensure safe transition between the two services.
- Health visitors and school nurses completed a transfer form when children or young people using the service moved to another service or school. The transfer arrangements included a detailed risk assessment of the child's needs.
- The children's hospital at home service worked closely with the child or young person and their families to determine the best service provider in end of life care planning.

Access to information

- Staff told us that information about the child's health care was recorded on the community electronic system. However, this was neither comprehensive nor compatible with other health, social care or education services. For example, contact information from speech and language therapists was included on the electronic system but detailed treatment intervention was recorded on paper and held by the therapist. Equally, the hospital had a different electronic system so comprehensive information was not easily available.

- One young person and their family told us how impressed they were with the information they had received in order to make an informed choice about their treatment intervention.

Consent

- We saw that children and young people were involved and supported by staff in making decisions about their health care and treatment. Where necessary, written consent was obtained from parents or carers.
- Staff demonstrated a good working knowledge of relevant legislation about consent and applied it where necessary.
- Staff used 'Gillick competencies' and 'Fraser guidelines' to determine whether a child was mature enough to make a decision and give consent.

Note: 'Gillick competence' is a test in medical law to decide whether a child of 16 or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge. 'Fraser guidelines' were set out by Lord Fraser in his judgement of the Gillick case in the House of Lords (1985) and apply specifically to contraception. They are used to decide whether a girl of 16 or under can be given advice or treatment without the consent or knowledge of her parents.

Are services caring?

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

Summary

We rated this core service as good because children, young people and their families were treated with dignity, respect and kindness. Staff ensured that children, young people and their families understood and were involved in their care and treatment.

Children, young people and their families were positive about the care and treatment they had received and about the staff providing the service

Compassionate care

- We observed children, young people and their families being treated with compassion and kindness by staff. Staff treated children and young people with dignity and respect. We observed staff being respectful, caring, attentive and professional.
- Parents we spoke to felt they were treated with dignity and respect by community staff. We observed individual community staff treating parents, carers and children with respect. They were approachable and encouraged questions and listened to parents' concerns.

Understanding and involvement of patients and those close to them

- Systems for collecting the views of children, young people and families using the service were in use across the service. The Friends and Family Test was well established and staff were made aware of the feedback received. Trust data showed that on average 90% of feedback would recommend the service but in May 2015 this was 100%. There was no data regarding the response rate.

- Children and young people were involved in their care and treatment using appropriate language and explanations.
- Staff talked through the activity/intervention so that the child was able to anticipate what was happening. They monitored non-verbal and verbal communication to determine distress or refusal.
- We saw that parents and carers were involved in assessments and consultations of their child's needs. Nurses ensured there were opportunities for parents and carers to ask questions.
- Parents told us that staff listened to them and they worked together to make decisions and solve problems. One parent said they thought the service was excellent and they felt very supported by the ongoing and accessible care and advice.
- Health visiting offered an open clinic service for one- and two-year developmental checks. This provided choice for parents about where and when they attended.

Emotional support

- A parent using the health visiting service told us they were able to discuss concerns about their child's behaviour with the health visitor and felt relieved and reassured having done this.
- Three parents involved in the Chatterbox sessions valued the opportunity to discuss concerns with staff involved in the sessions and found the group understanding and supportive.

Are services responsive to people's needs?

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

Summary

Children and young people's services were planned and delivered to take account of the needs of the local population and of individual needs.

Access to care was good, with waiting times from referral to first appointment well within the trust's target of 18 weeks.

Complaints and concerns were taken seriously. Information about how to make a complaint was displayed in the clinics we visited.

Planning and delivering services which meet people's needs

- Data supplied by the trust showed there had been no breaches in any of the commissioned services in meeting the 18-week target for waiting times between referral and treatment. The average wait for specialist speech and language therapy was 11 weeks, whilst in physiotherapy it was six to eight weeks, for occupational therapy 18 weeks and for community paediatrician appointments eight weeks.
- Community health services for children, young people and their families were provided at sites across Croydon, including at the Crystal Children's Centre. Although the building was old and there were plans to relocate the services provided there, there was good access to all treatment areas. Facilities and equipment were child-friendly, including a bright, colourful waiting area with a range of toys provided.
- The community nursing service worked shifts to accommodate longer days of service and to provide a more flexible service. This meant children could be seen after their school day and it was also helpful for working parents. There was an on-call system to provide help and support out of normal working hours seven days a week.
- Health visiting services ran open clinics so that parents and their child could attend any clinic. We spoke to one parent who was very appreciative of this service as it meant it separated them from developmental checks from the unwell child, who would be seen at a different GP clinic.

- The Willow service, which is a bereavement counselling service, was set up to offer support to children and young people with a terminal illness. This service was also available to the siblings of a child with a life-limiting condition.
- Speech and language therapy structured the Chatterbox sessions in response to feedback received from parents. Parents did not want one long play session so the group was split into three parts, each targeting specific needs - for example, attention span, concentration, communication and behaviour.
- The children's hospital at home team were investigating different ways of communicating with children and young people and had developed a range of social media applications. The asthma service had an online chat service with 108 followers.
- The Children's Specialist Asthma Service used hand-held tablets to show children a video about how to cope with asthma. All children were given an asthma pack, which contained lots of information including how to deal with an attack and how to monitor the condition. The team were planning to develop an application specifically for young people so that they could be more engaged in the management of their disease.

Equality and diversity

- All services we spoke to were aware of the diverse needs of the population and planned for interpreter services where needed. Access to interpreter services was offered as a face-to-face service or to a lesser extent through LanguageLine, a telephone service. The need for an interpreter was identified before the first appointment so that suitable arrangements could be made.
- There was a lack of available signers for the deaf in the Croydon area so this service needed to be booked several weeks in advance.

Meeting the needs of people in vulnerable circumstances

- The trust's looked after children team worked closely with local authority social care teams to ensure children

Are services responsive to people's needs?

and young people in care had initial and annual health reviews. Where children were placed outside the area, the team would accompany the child and ensure all relevant assessments were undertaken.

- There was a specialist service offered for asylum seekers at the Rainbow Centre. Health visitors and the family nurse partnership team worked closely with the specialist adult team to provide child-focussed assessments for asylum-seeking children.
- The audiology service send an appointment confirmation, a map and a leaflet about the service to all new patients and this was available in the four most prevalent languages spoken in Croydon. The leaflet could be downloaded in other languages where necessary.

Access to the right care at the right time

- Information from the trust showed that waiting times from referral to the first appointment were well within their target of 18 weeks. This included waiting times for physiotherapy, occupational therapy, speech and language therapy, and community paediatricians

- Staff said there were low rates of children and young people not attending for appointments. This was reflected in the data provided by the trust.
- The diabetic service provided mainly education and training to children and young people diagnosed with diabetes but also to hospital staff, schools and parents and carers. A 24-hour advice line had been developed and we spoke to parents and a young person who felt very supported by this.

Learning from complaints and concerns

- Information about how to make a complaint was displayed in clinic reception areas and was available on the trust's website.
- Trust data showed there had been no recent complaints about the service.
- There was clear guidance for staff about how to respond to a complaint. Staff told us they tried to resolve concerns quickly and locally before they became formal complaints.

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

The service required improvement under the Well Led domain because governance was not embedded within the community service for children and young people. Staff were unaware of the governance structure and knew little about clinical governance.

The executive team were not visible within the community but staff felt the trust was 'getting there'. Most staff were aware of the listening in action events but few had participated and felt these were more aimed at hospital services.

There was a lack of involvement of people who use the services in the planning and delivery of new services.

Communication within teams was good and staff felt supported by their immediate line manager. Staff felt confident that issues and concerns could be discussed with their line manager but were not convinced that the Trust Executives would be as supportive.

Service vision and strategy

- Staff told us they felt that communication was improving and that the executive team were trying hard. Two staff mentioned the weekly newsletter and that the trust were trying to provide information in bite sized pieces, but staff generally did not feel directly involved in the development of the strategy or vision for community services.
- Staff told us about the listening into action sessions organised by the trust to promote the trust vision and better communication. Only a few staff had attended a session and most felt that these were focussed on acute services.
- The health visiting service was moving to a local authority commissioned service from October 2015. The consultation process had only recently started and so staff were not yet sure what the effect would be on their jobs. Some health visitors felt disconnected from the process and would have liked to be more involved in the decision making rather than simply informed.

- Staff were aware of the new IT system in the hospital and were frustrated by the lack of integration of the two separate IT systems.
- The alarm system for alerting entry and exit to home visits had been working well but these had been removed from health visitors and staff were not aware of when the replacements would be available. A buddy system was in operation to ensure staff were safe.
- There were plans to expand and improve facilities in the Crystal Children's Centre. Staff working there were aware of and managers were involved in the planning of the new centre. Staff were not aware of involvement of children and young people in the design of new services
- The children's hospital at home team were proactive in working with commissioners and had secured funding for a specialist nurse in epilepsy, a practice educator and were looking at a specialist nurse in cardiology. This was a good example of front line staff identifying an unmet need and driving change through local negotiation

Governance, risk management and quality measurement

- The trust governance board meet monthly. There were no local governance arrangements in place for the children and young people's service and staff we spoke with were not aware of the trust governance structure. Community paediatricians were members of the governance board but information was not cascaded to any other staff groups.
- Clinical audit was not embedded in the community children and young people's service. Mandatory audits such as hand washing and record keeping were undertaken and there was some participation in national audits in some services for example within the asthma and diabetic teams but this was locally driven and not trust initiated.
- There was no data regarding safeguarding level three training and mandatory training for other sites.
- Risks to individual services were identified through staff team meetings or other discussions with staff. Staff were aware of the risk register and this was reviewed and discussed at team meetings.

Are services well-led?

- We saw that action was planned and taken in response to risks. For example, the physiotherapy service identified that due to staffing levels they were not responsive to the needs of children with talipes. Referrals were directed to another service outside the trust, which had the skills and capacity to deal with this specialist service

Leadership of this service

- Staff told us there was good local management and leadership. Team working was good and this was encouraged by their managers. Staff said they felt valued and respected.
- Staff knew who the chief executive was but were not aware of other executives on the board and described them as invisible.

Culture within this service

- Staff told us they enjoyed working in the community service and that no two days were the same. Morale appeared good and staff were positive and enthusiastic about their jobs. This included staff in the health visiting service who maintained a positive and professional attitude despite their uncertain future.
- Staff said they felt respected and valued. They were able to raise concerns and bring new ideas to improve services and felt they were listened to by their immediate managers.
- There was a focus on the needs and experience of children and young people using the service. This was shown by initiatives such as training non-trust staff in the care of children with communication difficulties and in the special school for children with complex needs.
- Staff told us there was a strong ethos of team working and that emotional support from team members and managers was good. Consideration of a child's best interests, goal setting, communication and reflection were positively encouraged within one team.

Public engagement

- The family nurse partnership service and the asthma service have developed their own feedback forms specific to their client group.
- Speech and language therapy and the children's centre manager organised an annual conference to raise awareness of communication and language needs of pre-school children. Private and voluntary organisations alongside independent and maintained nurseries were

invited to attend. As a consequence more chatterbox sessions have been developed and there is on-going monitoring of the children when they attend primary school.

Staff engagement

- Staff told us they felt supported and listened to by their managers. The health visiting administration staff told us managers had supported the development of an admin group which was set up to investigate ways of improving the service they provided. There had only been one meeting at the time of the inspection so there was no feedback as yet but staff were positive about this opportunity.
- The service managers regularly communicated with the health visiting service about the planned move to a different commissioning arrangement. Staff we spoke to were positive about the engagement and involvement regarding this, but felt they could have been more integral to the decision making process and how the services would be configured.
- Staff said that the community services for children, young people and families felt separate from the acute part of the trust. However, they felt that their line managers were working hard to raise awareness of their specific issues and concerns with senior managers and the trust executive.
- Staff were aware of the listening in action events but few had attended as they felt these were more acute focussed.

Innovation, improvement and sustainability

- Within the community nursing services for children with special needs, staff had undertaken an audit of all contacts made over the last year. This identified that greater skill mix was required to undertake specific and lower risk interventions. A business case was submitted to the clinical commissioning group and the local authority and funding was provided for a clinical trainer to train teaching assistants to provide lower risk interventions. They are currently advertising the post and will monitor progress over the next year.
- The children's hospital at home service had been established for the last 20 years and had grown from 3 staff to 40 staff. The management continued to be proactive in securing additional resources and were responsible for the newly established asthma service.

Are services well-led?

- More posts were planned to meet the diverse needs of the local population, including specialist nurses in cardiology and epilepsy. Staff within this team were proactive in wanting to spearhead innovation and were interested in developing an app for their service users and to develop the service further for teenagers.
- Staff were working as part of the 'Croydon Best Start' initiative, building relationships so that families with babies and young children could get the services they

needed at the right time. The aim of this was to promote the healthy child and school readiness programme so that effectiveness of services were improved and positive benefits were achieved for babies and their families. 'Best Start' included parents with children from conception to school age, health visitors, early learning practitioners, children's centres and the community, working alongside midwives, GPs and some specialist services

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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