Central London Community Healthcare NHS Trust

RYX

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RYXY8	The Medical Centre	The Medical Centre	SW1E 6QP
RYXY8	Oak Lane Clinic	Oak Lane Clinic	SW1E 6QP
RYXX4	Central London Community Healthcare NHS Trust Headquarters	St Charles Centre for Health and Wellbeing	W10 6DZ
RYXX3	Parsons Green Health Centre	Parsons Green Health Centre	SW6 4UL
RYXY8	Bessborough Street Clinic	Bessborough Street Clinic	SW1V 2JD
RYXX4	Central London Community Healthcare NHS Trust Headquarters	Richford Gate Primary Care Centre	W6 7HY

This report describes our judgement of the quality of care provided within this core service by Central London Community Healthcare 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 Central London Community Healthcare NHS Trust and these are brought together to inform our overall judgement of Central London Community Healthcare NHS Trust

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service Good

Overall, the services provided by Central London Community Healthcare NHS Trust to children and young people and to those accessing sexual health services were good.

However, the safety of Children and young people's services required improvement. This was because there were significant staff vacancies within the division and in some specific roles. Whilst the trust had plans in place to increase recruitment, the impact of vacancies was that many staff were trying to manage caseloads well above nationally accepted caseload numbers. Staff worked hard to minimise the impact on patients however vacancies meant that services were reactive rather than proactive.

Children and young people's services and sexual health services were effective. Although some performance measures were being missed, care and treatment was evidence based, staff were competent, people using the service were protected from inappropriate care or treatment for which they had not given proper consent. There were policies and procedures in place to support staff and ensure that service were delivered effectively and efficiently.

Services delivered by the trust were very caring. Staff were dedicated to their patients and worked hard to ensure that patients received the best treatment and support possible. Patients were involved in decisions and understood the services being delivered to them. Emotional support was available to patients who were dealing with difficult circumstances.

Children and young people's services and sexual health services were responsive to the need of the people who used them. Comments, complaints and concerns were taken in to consideration when developing services. On the whole, services were delivered to the right people at the right time within the commissioning framework of the trust. There were services in place to help protect vulnerable young people and children.

At a local level, staff believed they were well led however there were a number of disconnects between front line staff and senior managers and also between Boroughs. Some staff did not feel engaged with the trust as a whole however they were dedicated to their teams at a local level. There were governance arrangements in the division however these were yet to be fully embedded at a local level. We heard mixed reports about the culture of the organisation, with some staff feeling that there was a bullying culture. Other staff had no concerns about the culture of the service.

Summary of findings

Background to the service

Central London Community Healthcare NHS Trust provides services to children and young people up to the age of 19 and mothers across the Boroughs of Westminster, Hammersmith and Fulham, Kensington and Chelsea and Barnet.

The organisation provides services such as health visiting, school nursing, community children's nursing, physiotherapy, occupational therapy and speech and language therapy across the four Boroughs. Other specialist services such as the sickle cell service and dietetics are provided in Hammersmith and Fulham, Westminster and Kensington and Chelsea but not Barnet, due to commissioning arrangements.

Services are provided to people in their own homes, in schools and in clinics across all of the Boroughs.

In addition, the organisation provides sexual health services in these Boroughs, and since April 2015 it has been commissioned to provide sexual health services in Hertfordshire.

During this inspection, we visited a number of locations across the four Boroughs, spoke with 15 senior managers and team leaders, eight therapists, 17 health visitors, six school nurses, 14 other nursing staff, six administrative staff and 14 parents and young people. We also held focus groups for school nurses, health visitors and therapists.

We observed staff practice in clinics and with the consent of patients, in patient homes. We looked at 19 clinical records. Prior to and following our inspection we analysed information sent to us by a number of organisations such as the Royal College of Nursing, the local commissioners, Healthwatch and the organisation.

Our inspection team

Our inspection team was led by:

Chair: Paula Head, Chief Executive, Sussex Community NHS Trust.

Team Leader: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Specialist Dental Adviser , Community Paediatrician, Palliative Care Consultant, General Practitioner, Community Matron, Intermediate Care Nurse, District Nurses, Health Visitors, Physiotherapists and Experts by Experience (people who had used a service or the carer of someone using a service).

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

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

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

Before visiting, we reviewed a range of information we held about the core service and asked other

Summary of findings

organisations to share what they knew. We analysed both trust-wide and service specific information provided by the trust and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 7 to 10 April 2015.

What people who use the provider say

Children, young people and their carers told us that they were treated with compassion, dignity and respect. An ongoing trust patient survey showed that between May 2014 and February 2015 between 94% and 97% of patients stated that they were treated with dignity and respect. Between 76% and 88% of patients stated that they were involved in their treatment planning and decisions about their treatment as they wanted to be. Between 91% and 97% of patients definitely understood the explanation about their treatment they were given.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust must:

- Review recruitment and retention of staff in health visiting, school nursing and occupational therapy.

The trust should:

- Review safety and access to some buildings by non trust staff
- Review and improve performance measures for the FNP and Healthy Child Programme
- Review the engagement with staff in Barnet and work on the perceived bullying culture and the way grievances are dealt with by the Human Resource department.

Central London Community Healthcare NHS Trust

Community health services for children, young people and families

Detailed findings from this inspection

The five questions we ask about core services and what we found

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

The safety of Children and young people's services required improvement. This was because there were significant staff vacancies within the division and in some specific roles. The trust had plans in place to increase recruitment, and bank and agency staff were used regularly by the organisation to cover vacancies however the recruitment process was slow and despite the recruitment process, significant vacancies remained. The impact of vacancies was that many staff were trying to manage caseloads well above Lord Lamming's 2009 recommended number of 300 families per health visitor. This is a nationally agreed government target. Staff worked hard to minimise the impact on patients however vacancies meant that services were reactive rather than proactive. There were increased risks that due to high caseloads and responsive working that vulnerable children and families may not be identified early before any harm occurred. We were informed by the trust that high caseloads in this service were a result of commissioning decisions around the numbers of required Health Visitors.

Staff told us that the organisation promoted training. Data supplied to us showed that mandatory training was not meeting the 90% trust target across the board. Some services had limited numbers of staff trained to the appropriate level for safeguarding vulnerable children. Despite the organisation having some severe staffing shortages in some teams, arrangements were made to assist staff to attend training.

Requires improvement

Are services safe?

The organisation used an electronic system to record incidents. Staff were better than the national average for reporting incidents. The majority of incidents related to record keeping. Incidents were investigated where appropriate and action taken.

There were robust safeguarding policies and procedures in place. Staff received regular safeguarding supervision and were knowledgeable about their responsibilities regarding safeguarding vulnerable people.

The organisation managed risks to staff and to patients both at a local level and at division level. Risk assessments were carried out with patients and information about vulnerable people was communicated amongst health professional where appropriate. Communication from some hospital midwives to trust staff about vulnerable families needed improvement. Staff risks were managed and the organisation was in the process of rolling out lone worker devices to staff based on risk assessment . There were however some concerns about the security of buildings, previously identified by the trust, which had not been addressed.

Policies and procedures were in place to manage the storage and administration of medications. Lessons had been learned about past medication errors and action taken to minimise the risk of further recurrence. Staff received training about medicines management and used specific directions when prescribing some medications.

There was sufficient serviced and maintained equipment to meet the needs of patient and staff. Most environments were clean, tidy, suitable and safe although there were some concerns about security in some clinics which left staff feeling vulnerable. Staff were able to access personal protective equipment, had undergone training about infection control and made sure that equipment was cleaned appropriately between patient use.

Senior managers told us that there were business continuity and major incident plans in place however staff were unaware of these plans. All staff said they would take direction from their line managers in the event of a major incident.

Detailed findings

Safety performance

- According to the national NHS staff survey 2014, the organisation scored higher than the national average for. “percentage of staff reporting errors, near misses or incidents witnessed in the last month” at 94% compared to the national average of 91%. This information was not available specifically for children and young people’s services or sexual health services.
- There had been no never events. Never events are incidents determined by the Department of Health (DoH) as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented correctly.
- An electronic incident reporting system was in place and all the staff that we spoke to were able to tell us and demonstrate how they used it.
- There were three serious incidents requiring investigation (SIRI). Two of these were reported on STEIS. They all related to documentation.
- The organisation used an electronic reporting system to record all incidents. Incidents were discussed by team leaders and business unit managers at regular meetings.
- We saw examples of incidents, how they were reported, investigated and action taken as a result. For example, the trust had undertaken work to address management of the cold chain as a result of incidents relating to the storage of vaccines in the community.

Incident reporting, learning and improvement

- Staff told us they were open with patients when incidents occurred. They were aware of the principles of duty of candour –being open and honest about incidents and errors with those patients involved in the incident.
- The children and young people’s division had reported 383 incidents between 1st February 2014 and 31st January 2015. Of these, 9 had been classed as moderate harm, 15 as low harm and 359 as no harm.
- 57% of all incidents related to documentation, including electronic and paper records, identification and drug charts.
- Of the moderate harm incidents, three related to access, admissions, transfers, discharge and missing patients, two related to medication, two to clinical assessments one to medical devices and one to documentation.
- School nursing and health visiting reported three moderate harm incidents, sexual health reported three, community paediatrics reported two and speech and language therapy reported one.

Requires improvement

Are services safe?

- Health visiting and school nursing teams reported the most incidents across all levels of harm (178), followed by community paediatrics (172).Staff told us that they were encouraged to report incidents even if they weren't sure if it was an incident or not. They gave us mixed reports about whether they received feedback, but all thought that incidents were taken seriously.

Safeguarding

- The organisation had safeguarding policies and procedures in place and it was clear what action should be taken if children missed appointments or attended accident and emergency.
- There was a system in place for highlighting and monitoring children where there were safeguarding concerns.
- All of the staff we spoke with told us that they underwent regular safeguarding supervision with a member of the organisation safeguarding team at least every three months.
- The safeguarding team was accessible to staff and staff were able to give examples of when they had needed to speak with the team as well as the advice they received. During our inspection, we saw this happen.
- All of the clinical staff we spoke with told us they were up to date with their safeguarding vulnerable children training to level two or level three where appropriate. Evidence provided to us by the organisation showed that results across teams were mixed for all levels of staff. For example, most teams of clinical staff were above 85% however Barnet's safeguarding team was at 50% for level one (administrative staff) but they were compliant for levels two and three. It was noted that there only two members of staff who were required to undertake the module. The Inner Boroughs Family Nurse Partnership (FNP) and Itchy, sneezy, wheezy services had no clinical staff trained to level three.
- Staff demonstrated a good awareness of safeguarding processes and were able to describe to us in detail, actions they would take if they had any safeguarding concerns.
- We saw evidence within patient records of detailed information recorded about vulnerable children and families, as well as details of how they were being supported by other agencies such as the local authority.
- Within children's and young people's services, staff told us that if they had any concerns about children and young people, they would arrange home visits in order to assess the home environment and thus the level of risk. Occasionally this was done in conjunction with other services or agencies to minimise disruption to families.
- Staff told us that each school nurse had a named safeguarding nurse employed by the Trust .
- The safeguarding team had strong links with external agencies and was well represented on the Multi-agency safeguarding hub (MASH) team. This ensured that important information was shared between agencies.
- Within the Sexual health team, staff were aware of action they should take if they had any safeguarding concerns about patients attending.
- All of the staff we spoke with had undergone training about female genital mutilation (FGM) and were aware of the action they should take if they identified a patient at risk. School nurses also delivered awareness sessions to children through school assemblies to raise awareness amongst children and parents.
- The organisation had systems in place to monitor and track looked after children and we were given examples of when staff had travelled to visit children who had been placed outside of the area to carry out health checks.

Medicines

- The organisation had a process and standard operating procedures to manage the cold chain for the storage and transportation of immunisations and vaccines to schools. There had been historic problems with breaks in the cold chain however the organisation had learned from these problems and modified the process.
- Medicines, including first aid boxes, were kept secure and handled safely. Staff were aware of the organisation's protocols for handling medicines so that the risks to people were minimised.
- We checked fridge temperatures in the sexual health department and three school nursing departments where medication was stored. Daily temperature checks had been carried out. On the school nursing team fridges, there was information for staff about what action to take if fridge temperatures had exceeded the safe parameters set.
- Some health visitors were independent prescribers. They were able to access support for this role via the organisation pharmacy department.

Requires improvement

Are services safe?

- Patient group directions (PGDs) were used by staff to enable them to give children immunisations and vaccinations. The PGDs used had been reviewed regularly and were up to date.
- Sexual health teams stocked a small number of drugs and medication such as the oral contraceptive and local anaesthetics. These were stored securely and appropriately. Nurses and doctors dispensed medication to patients attending clinics.
- The trust had undertaken 20 medication audits in children and young people's services between June 2014 and March 2015. Action plans had been developed to address any issues highlighted by the audits. As of 4 March 2015 two teams had completed their action plans. Tracking of the progress against action plans was being monitored by the Medicines Management team and reported to the Medicines Management Group .

Environment and equipment

- We found that all the equipment in use had been PAT (portable appliance test) tested.
- Weighing equipment was calibrated annually by the medical electronics team of the organisation.
- Health visitors each had their own set of scales which they took with them to clinics and on home visits.
- Staff told us that they had enough equipment to deliver care and they had no problems ordering equipment. The paediatric therapy teams reported they had good access to equipment for children using the service, and most items were readily available and delivered promptly.
- We visited a number of buildings where clinics were held. We found that the environments were clean and tidy and suitable for children and their families.
- Some team offices were in buildings that had poor or no security. For example, one team office, where patients were able to 'drop in' did not always have a receptionist and had no secure entry system. This meant that patients who attended without an appointment could be left sitting unattended indefinitely.

Quality of records

- The organisation used an electronic record keeping system and was in the process of moving to a new electronic record system called SystmOne.
- SystmOne is also used by many of the neighbouring GPs within three of the four boroughs covered by the organisation. This meant that once the SystmOne was fully implemented, staff would be able to access more information about patients as patients would have one record across the organisations.
- Some staff were unaware of any standard operating procedures about what information needed to be recorded about vulnerable children and families and whether the information needed to be added to each member of the family's record. They told us they had not undergone training about what information they should record on the system about children from vulnerable families.
- We looked at 19 care records across school nursing, health visiting and looked after children. We found that records including those of vulnerable children contained enough appropriate information. Additions were made in a timely manner.
- Staff were awaiting mobile working devices such as tablets or laptops. This meant that they were writing records by hand and then typing the information in the electronic record back at the office. Staff felt that this process was time consuming and meant that they were working extra hours rather than take time away from patients to make sure records were kept up to date.
- A record keeping clinical re-audit had been carried out and results showed an overall improvement in the standard of record keeping within the divisions.

Cleanliness, infection control and hygiene

- Staff had access to personal protective equipment (PPE) and were aware of how to dispose of used equipment safely and in line with infection control guidelines.
- The majority of staff had undergone infection control training in the last 12 months. The average across the localities and department was 87%.
- We saw that clinics visited were clean and tidy and there were rotas in place to make sure areas were cleaned regularly.
- On the whole, staff were observed using hand gel to clean their hands when they visited patient homes. In patient homes, equipment such as scales were cleaned after use using cleaning wipes.
- On the whole, staff were observed in clinic following good hygiene practice however we did note one clinician with long hair which was not tied back.
- In baby clinics, equipment was cleaned between patient use using cleaning wipes. It was also covered with paper roll which was changed after every patient.

Requires improvement

Are services safe?

Mandatory training

- The organisation used an electronic monitoring system to manage staff mandatory training.
- Staff told us that they were responsible for making sure that they were up to date with all of their training. They could access their training records online and were also sent reminder emails when their training was due to expire. Reminder emails were also copied to the line managers of staff so that they were aware of the training status of all staff.
- Staff told us that the organisation placed a high importance on training and managers made sure that staff attended mandatory training.
- Within the sexual health service, mandatory training levels were above 85% other than for resuscitation, which was 79% and infection and prevention which was at 83%.
- The trust target for completion of mandatory training was 90%.
- Within children and young people's services, mandatory training levels varied across Boroughs and services. Most teams had compliance levels above 80% for all training.
- Some teams were not meeting the 90% completion levels for all mandatory training.
- These were;
- Health visiting in Barnet, infection control,
- School nursing in Hammersmith and Fulham, infection control,
- Child development, information governance, safeguarding adults and level two safeguarding children,
- Clinical business unit management team, fire, information governance, moving and handling, safeguarding adults, safeguarding children,
- Inner Boroughs school nursing, resuscitation,
- Barnet complex care team, information governance and safeguarding children level two,
- Barnet FNP, safeguarding adults, resuscitation and safeguarding children level one, front of house, fire, information governance, safeguarding adults, safeguarding children level one,
- Orthotics, fire, infection control and moving and handling,
- Itchy, sneezy , wheezy, equality and diversity, fire, health and safety, moving and handling and safeguarding children level 3,
- Inner Boroughs dietetics, resuscitation.

Assessing and responding to patient risk

- There were mechanisms in place to identify patients at risk, such as vulnerable women and children. Details were recorded in electronic records which all clinical staff had access to.
- Staff told us that communication from midwives about vulnerable women who had recently given birth was variable depending upon the area. For example, in the Barnet area, health visitors are informed that a person is vulnerable, but not given specific information about why they are classed as such.
- Some team offices were in buildings that had poor or no security. This meant that staff were left vulnerable, especially if they worked late at night.

Staffing levels and caseload

- Within the sexual health services teams, There was a vacancy rate of 36% for qualified nursing staff. These vacancies had been covered by bank staff. No agency staff had been used.
- The organisation had a significant number of vacancies particularly in health visiting and especially in Barnet. There were seven long term agency health visitors working for the trust in Barnet. The vacancy rate for the 0-19 teams was 22%. The organisation had paid for 16,266 agency and bank hours to cover these vacancies from April 2014 to February 2015. In Kensington and Chelsea there was 52% vacancy rate for allied health professionals and a 22% nursing vacancy rate. The nursing vacancies had been covered by 14,757 agency and bank hours. Across the organisation in children and young people's services, including administrative services, there was an average vacancy rate of 10.6%. Bank and agency use across the organisation in children and young people's services totalled 127,192.75 hours.
- Agency staff had been employed by the organisation on a long term basis and had undergone an induction prior to working with patients.Health visiting staff caseloads exceeded the Lord Lamming 2009 recommended case load level of 300 families per health visitor for the majority of staff. In some instances, caseloads were more than double the recommended level. For example, the Torrington team staff had 603 families on their caseload, Vale Drive had 691, Grahame Park had 495,

Requires improvement

Are services safe?

Oak Lane had 742, Edgware had 612 and Childs Hill had 652. We were informed by the trust that high caseloads in this service were a result of commissioning decisions around the numbers of required Health Visitors.

- Staff reported that they had high numbers of children on their caseloads that were classed as vulnerable.
- In some health visiting teams, caseloads were managed corporately; health visitors did not have specific families on their caseload. The impact of this was that continuity of care did not always happen as families could see a different health visitor at each visit.
- The school nursing service had vacancies which impacted on the size of their case loads. School nurses had nine schools each which meant it was a challenge to fully engage with school children and carry out their roles fully, for example, to carry out preventative and health promotion work. The frequency of this was unquantifiable as staff did not report when this happened as an incident on Datix.
- Staff told us that they worked hard to minimise the impact on patients of being short staffed. Staff told us that they worked extra hours and occasionally during their annual leave to make sure that patient care did not suffer.
- The NHS staff survey 2014 results showed that 74% of staff in the childrens' health and development division stated that they had worked extra hours compared with 72% of staff across the organisation as a whole. This figure was the second lowest of the five divisions within the trust.
- In the Children's Health and Development Division 40% of staff in the childrens' health and development division responded that they had suffered work-related stress in last 12 months.
- The impact of high caseloads was that staff felt that they were reactive rather than proactive. They told us that they could do the basic work their roles required but were unable to do preventative and health promotion work.
- The sickness rate across the children and young people's services for all staff over a 12 month period was 5%. Some services had significantly higher sickness levels. Most of the higher sickness rates were in the administrative and clerical teams.
- The sickness rate within the sexual health services teams was 6%.
- The organisation had identified that staffing levels were a risk to the organisation for health visiting, school nursing and some therapy posts. Health visiting staffing levels were not recorded on the corporate risk register however vacancies were regularly discussed by team leaders and senior managers at management meetings. A continuous recruitment drive was underway.

Managing anticipated risks

- The Divisional Director of Operations and Clinical Business Unit Managers explained that they were fully aware of anticipated risks associated with staffing which were being actively managed locally.
- Staff did not feel that the risks to vulnerable children were well managed. They were concerned that they may not be aware of some vulnerable children in the community because of their inability to work proactively in communities.
- We talked with a number of staff who told us that risks were communicated to them well by managers.
- On the whole staff felt listened to when they reported concerns that may become a risk. We were however informed about a building which had no security entry. It had been identified in 2014 that keypad entry should be installed however this had still not happened. Staff were concerned that the public could enter all areas of the building unchecked thus potentially posing a risk to staff working alone.

Major incident awareness and training

- The organisation had major incident protocols and standard operating procedures in place.
- In the event of a major incident communication with staff is initially by text message, to inform them of any risks and action to take. We were informed that both personal and work mobile numbers were recorded by the organisation to facilitate communication with staff.
- Staff and some managers were unsure of whether the organisation had major incident and business continuity plans. They told us that if there was an incident they would contact the on call manager for advice.

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

There were processes in place to ensure that care and treatment delivered by staff followed best practice, such as NICE and other guidelines.

The organisation had achieved UNICEF level 3 for breastfeeding in the 3 Inner Boroughs; Barnet was at the registration of intent, certificate of commitment stage. There were some support mechanisms in place for women who needed support in breastfeeding or advice about how to ensure that children were receiving the nutrition and hydration they needed to remain healthy. There were support services in place to try to deal with the above average levels of obesity in the Boroughs.

The organisation was measuring patient outcomes using a number of different indicators. Some of these, such as for immunisations were not always met however patient and parent choice impacted upon these measures.

Comprehensive patient needs assessments were carried out and patients received the care they needed to meet their health needs in an effective way.

Patients received care from clinicians who were competent. Staff received an induction to the organisation and to services as well as regular safeguarding supervision and annual appraisals. Clinical supervision was not always carried out formally and some staff chose to participate in informal clinical supervision organised locally to ensure they received the support they needed. Newly qualified staff were offered preceptorship by the organisation.

The organisation had good policies and procedure to ensure that multidisciplinary and multi-agency work took place. Additionally, there were good arrangements in place to support young people who were transitioning to adult services.

Staff had a good understanding of how to obtain consent. Fraser and Gillick guidelines were followed to ensure that people who used the services were appropriately protected. Sexual health services staff were aware of the Mental Capacity Act and how this could impact on who was able to give consent and whom should be involved in making decisions for vulnerable people.

Detailed findings

Evidence based care and treatment

- The organisation had a number of policies and procedures in place which were based on NICE (National Institute for health and clinical excellence) or other nationally or internationally recognised guidelines.
- There was evidence of discussions about NICE guidance and local procedures and policies being discussed at team meetings. There were clinical care pathways in place across the organisation, using NICE and other national guidance.
- Staff we spoke with in the therapy, health visiting, school nursing and sexual health teams were aware of the national guidelines relevant to their sphere of practice. They were supported by the organisation to follow this practice.
- We observed staff to make sure they were following these guidelines. Most staff we observed were aware of current guidelines however we did observe one health visitor who did not weigh and measure a baby following best practice for the child's age group.
- There were policies and standard operating procedures in place to ensure that looked after children and children with long term and complex needs had their needs met in appropriate ways.
- The organisation had an FNP team. FNP is a voluntary health visiting programme for young and first time mothers. It is underpinned by internationally recognised evidence based practice. The FNP were able to provide us with evidence of how they followed the national programme, including meeting targets and achieving key milestones with participants of the project.
- The organisation followed the national initiative called the healthy child programme. This is a Department of Health programme of early intervention and prevention for health visitor contacts with babies and children. It

offers regular contact with every family and includes a programme of screening tests, immunisations and vaccinations, development reviews and information, guidance and support for parents. In Barnet however, the health visitors were not carrying out one element of the programme, 6-8 week checks, because they had not been commissioned by the local clinical commissioning group (CCG) to do so.

Nutrition and hydration

- During our inspection we saw that staff gave parents up to date and relevant advice about breastfeeding, weaning and nutrition and hydration in children.
- The organisation had achieved United Nations Children's Fund (UNICEF) Stage 3 BFI Full Accreditation in the tri-Boroughs. This was achieved because of an organisation wide project to promote breastfeeding. The project lead was no longer in place and staff reported to us that they missed the support they received from the project team. Barnet were at register of intent / certificate of commitment and have not undergone any formal UNCIEF BFI assessment as yet.
- Breastfeeding initiatives are currently managed by the dietetics team. Health visitors told us that some breast feeding support groups were in place with lactation consultants and breastfeeding peer supporters in Barnet. There was no specific lead to support mothers with complex breastfeeding problems. Health visitors were able to refer mothers to these specialists for advice about breastfeeding concerns.
- We observed that health visitors and school nurses provided parents with helpful, practical advice about children who were fussy eaters.
- Children in Barnet, Hammersmith and Fulham and Westminster had rates of obesity at age 4-5 and 10-11 equal to the England average. Children in Kensington and Chelsea had above average rates of obesity at ages 4-5 and 10-11 at 12% and 25% respectively.
- The breastfeeding rate after six weeks in Hammersmith and Fulham was 76% and was better than the England average. Information about the other Boroughs was unavailable.
- Health visitors offered support and advice to parents of children whose body mass index (BMI) fell outside the expected level. They are able to refer to specialist services such as dieticians to offer families support.

Technology and telemedicine

- Within the school nursing service, work was underway to develop a number of internet based support services for children and young people. For example, to allow young people to ask questions via an email, rather than having to see the school nurse. The website will also provide young people with information and advice about a number of public health matters.
- The dietetics team used skype calls to involve both parents in meetings when one parent wasn't able to attend in person.

Patient outcomes

- Health visiting staff from Barnet told us that they were not meeting the Healthy Child targets set.
- The immunisation rates for measles mumps and rubella (MMR), diphtheria, polio, tetanus, pertussis and HIB across the organisation were worse than the England average.
- The England average MMR rate was 92%. In Kensington and Chelsea it was 81% at age two and 73% at age five, in Hammersmith and Fulham, 84% at age two and 81% at age five, City of Westminster, 77% at age two and 75% at age five and in Barnet, 88% at age two and 78% at age five.
- The England average rate for combined diphtheria, polio, tetanus, pertussis and HIB was 96%. In Kensington and Chelsea it was 89%, City of Westminster, 82%, Hammersmith and Fulham, 92% and Barnet, 94%.
- Staff told us that patient and parent choice impacted on the uptake rates for immunisations but that they worked closely with families who had concerns about immunisations to try to address these concerns.
- FNP Key performance indicators for the tri-borough (Kensington and Chelsea, Fulham and Hammersmith and Westminster) showed that targets were not always being met. For example, expected visits during pregnancy (eventual goal 80%) 41%, expected visits during infancy (eventual goal 65%) 36%, data forms completed accurately and within required times (goal 90%) 70%, weekly and monthly supervision sessions met (goal 90%), 85%.
- We saw evidence that patient needs were thoroughly assessed before care and treatment started and there was evidence of care planning. This meant that children and young people received the care and treatment they needed.

Good

Are services effective?

- The continuing care team provided comprehensive packages of care to patients with complex needs both at home and in other settings such as schools.

Competent staff

- Staff and managers told us that most staff other than new starters had had an annual appraisal.
- Information provided by the organisation showed that the appraisal rate for staff within the children's and young people's division was 82%. This figure varied from team to team. Most clinical teams had appraisal rates above 80% with the exception of one therapy team and one nursing team. Administrative and clerical staff teams had a lower average appraisal rate than clinical staff, 69% compared to 89%.There was a rolling programme in place to ensure staff received appraisals.
- Within sexual health services, the appraisal rate for clinical staff was 91% and for administrative staff it was 93%.
- All new clinical staff were offered a preceptorship period of six months. During this time they were supported to develop their confidence, skills and professional competencies.
- All staff new to the organisation underwent a corporate induction in addition to a local induction.
- Staff told us that they didn't have regular 1:1 meetings with their managers however they generally felt well supported by managers.
- Staff in some areas told us that they did not have formal clinical supervision because there were no staff trained to be clinical supervisors.
- Health care assistants in some areas had made a decision to establish clinical supervision fora as an informal support network.
- Children's community nurses were able to regularly access psychologists for support because they worked with children with complex care needs and children at end of life.
- Across the organisation, the percentage of staff receiving job-relevant training, learning or development in the last 12 months is above average at 84% in 2013 and 2014.

Multi-disciplinary working and coordinated care pathways

- There was an emphasis on multi-disciplinary and multi-agency working within the organisation.
- For example, staff gave many examples of how they had worked with other clinicians and other organisations to be able to meet the needs of children and their families.
- We spoke with staff about looked after children and young people not in education, employment of training. There were examples of clear lines of communication and examples of multi-disciplinary and multi-agency working.
- Staff told us that they had good working relationships with GPs, school staff, social services and the police. This meant that information was shared readily and cross agency working ensured that where there were concerns about vulnerable children, these were shared and managed.
- There was good attendance at multi-agency safeguarding hub meetings. Staff reported that attendance at meetings was given priority.
- Staff had a good awareness of the services that were available to children in the area they worked and were able to contact other teams for advice and make referrals when necessary.
- We visited a school which looked after children and young people with special needs. We looked at the records held and found that they contained entries from a number of different staff including nurses and therapists.

Referral, transfer, discharge and transition

- There were procedures in place to ensure that as young people made the transition to adult services, this was done sensitively and when the patient was ready to start the transfer process.
- The organisation used a continuum of need. This made sure that each person involved in a patient's care was aware of the level of need and support of the patient.
- The process of transition to adult service usually began as the person approached the age 14 however this was dependent on each individual, their maturity and their wishes.
- Where patients were transferred from acute hospital services to community services, communication on the whole, from the acute organisation was good. Detailed needs assessments were carried out to ensure that an appropriate care package was in place prior to the patient being discharged.
- There were policies and procedure in place to make sure that as children transferred from health visiting to school nursing, relevant and important information was

passed to the receiving clinician. Both health visitors and school nurses told us that they worked closely with each other to make sure that vulnerable children and their families were discussed and important information relayed.
- In the case of looked after young people transitioning to adulthood and adult services, a care plan remained in place for the person up to the age of 26.
- We were given examples of when staff from children's services worked with staff from adult services. Staff told us it was common for them to train adult staff and check their competencies for young adults transferring to adult led services.
- Within the sickle cell service, during the period of transition, patients initially attended joint clinics until they felt confident to attend clinics run by consultants specialising in adult sickle cell. There was a similar process in place in the dietetics service

Access to information

- The organisation had a child health information hub which was used to coordinate information received about children and young people from a variety of sources including accident and emergency departments and other organisations. There had been major problems with the receipt and recording information over the last 12 months leading to a large backlog of information which had not been processed. This meant that there had been a risk that important information about potential vulnerable children was delayed and not actioned in a timely manner. The organisation was fully aware of the issues and had taken action to make sure that the backlog had been addressed. They had an action plan in place, had amalgamated a number of systems and no longer had a backlog.
- Staff were able to access electronic records about children and young people who were transferring between services, such as from health visiting to school nursing, or to adult services. With the implementation of SystmOne, staff could also look at GP patient records.
- The intranet was available to all staff and contained links to current guidelines, policies, procedures and standard operating procedures and contact details for colleagues within and out with the organisation. This meant that staff could access advice and guidance easily.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff within the sexual health services described to us how they obtained consent from young people attending the service. They were also able to give examples of when they had held multidisciplinary team meetings to discuss the needs of vulnerable adults who attended the service when a best interest decision had to be made.
- School nursing and sexual health staff worked within Fraser and Gillick guidelines to make decisions about whether young people had the maturity, capacity and competence to give consent themselves.
- School nurses acknowledged that it was not always easy to obtain consent from parents to give young people immunisations. They had processes in place to make sure that consent was in place before giving young people their vaccinations. This included administration of the process by the education facility, but also contacting parents directly to address any concerns they may have and carrying out home visits if necessary.
- Within the FNP, consent was obtained formally as patients signed an agreement to join the programme.
- Services told us they took in to consideration the voice of children and young people when obtaining consent.
- School nursing and health visiting teams asked parent to opt out of participation in the national child measurement programme if they did not wish their child to be measured and weighed.
- Staff told us that they used implied consent in some situations. They took in to account not only verbal communication, but also non-verbal communication when deciding whether a parent or young person was giving consent.

Good

Are services caring?

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

Summary

Children, young people and their carers told us that they were treated with compassion, dignity and respect. They were involved in discussions about treatment and care options and able to make decisions. Information was provided in a number of formats to enable young people to understand the care available to them and help them to make decisions about the care they wanted to receive.

During our inspection we observed children, young people and their family and carers being treated with kindness and compassion. We observed how staff ensured that confidentiality was maintained.

Parents, carers, children and young people told us they felt listened to, able to express their opinions and were included in making decisions about future care and treatment plans.

Detailed findings

Compassionate care

- All staff we spoke with were very passionate about their roles and were very dedicated to making sure that the people they cared for were provided with the best care possible.
- Staff told us that they often worked above their employed hours to make sure that patients received the care and treatment they needed. Some staff told us that they occasionally worked on their administrative tasks during their annual leave to make sure that they were able to spend more face to face time with their patients.
- We observed the way children and their parents were treated both in their homes and in clinic settings. Staff were kind, patient and informative.
- Patients were treated as individuals and we saw that staff and patients had built up good working relationships.
- Parents told us that they had confidence in the staff they saw and the advice they received.
- An ongoing trust patient survey showed that between May 2014 and February 2015 between 94% and 97% of patients stated that they were treated with dignity and respect. This was against a target of 95%. The organisation failed to meet the target twice during that period.

Understanding and involvement of patients and those close to them

- Parents and carers of children told us that staff focussed on the needs of them and their children.
- Parents and carers felt involved in discussions about care and treatment options and told us that they felt confident to ask questions about the care and treatment they were receiving and make decisions based on the information they received.
- Staff told us that whenever possible they supported children and their parents and carers to manage their own treatment needs. Staff told us that they would discuss goals with families and give them advice about how they could make progress to achieving these goals.
- An ongoing trust patient satisfaction survey showed that between May 2014 and February 2015 between 76% and 88% of patients were as involved in their treatment planning and decisions about their treatment as they wanted to be. This was against an organisation target of 80%. The organisation missed the target on three occasions.
- Between 91% and 97% of patients definitely understood the explanation about their treatment they were given. This was against an organisation target of 90%.

Emotional support

- Children, young people, their families and carers were supported by staff from the organisation in the first instance. Should further more specialised support be needed, staff were able to make referrals to other services such as child and adolescent mental health services (CAMHS), psychologists, GPs and counselling services.
- Staff in most health visiting teams managed their own caseload. This meant that mothers met the same health visitor at each appointment. Consistency meant that health visitors were able to build up relationships with mothers and children. In Barnet, some health visiting teams managed their caseload corporately which meant that it was likely that children and their parents would see a different health visitor at each appointment.
- There were drop in services and clinics which offered support to new parents, parents about fussy eaters, children with allergies and enuresis (bed wetting).

Good

Are services responsive to people's needs?

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

Summary

The organisation followed the NHS complaints policy and staff were aware of how to deal with complaints or escalate them as required. Learning from complaints was shared locally and more than half of staff felt that feedback from patients influenced how services developed.

There was sufficient equipment to ensure that people with disabilities were able to access services and buildings complied with the Disability Discrimination Act 1995.

There were policies and procedures in place to ensure that people in vulnerable circumstances were able to access the services they needed in a timely manner.

Patients were mostly able to access the services they needed in a timely manner although some services were missing their performance targets due to staffing pressures.

Services were tailored to the needs of local populations and most staff were able to access training specific to the needs of the populations they supported. There was access to interpreters however written information in different languages was not always available.

Detailed findings

Planning and delivering services which meet people's needs

- Some services across the organisation such as the sickle cell service and some health visiting teams offered extended opening hours as well as early morning and evening appointments. This was put in place to meet the needs of people who used the service and as a way to reduce the number of patients not attending or cancelling appointments (DNAs).
- Across the division, the DNA rate was consistently better than the organisation target of 5%. In Barnet, the average rate between April 2014 and March 2015 was 3%.
- Due to commissioning differences, some services, such as the sickle cell service was not available to people who lived in Barnet. Patients had to be referred to services elsewhere within the organisation.
- Most staff had a good knowledge of the people they had on their caseload, or who attended the schools they looked after. They were aware of the needs of the population and the type of support they needed.
- Some of the localities within the organisation had recently changing populations. Some staff felt that they had not received enough training to be able to understand the cultural needs of populations that had moved in to the organisation catchment area over recent years. For example some staff told us that they had received training about how to identify people at risk of radicalisation, however not all staff had received this training.
- One team within the Barnet area told us that they were not allowed to carry out home visits before 9am. When we discussed this with other services in Barnet, they told us this was not the case and that although early morning visits were unusual; they had the flexibility to do them if this was requested.
- We found that access to organisation facilities was good. Clinics were held in easily accessible locations such as children's centres and staff and people who used the service told us that home visits were available if requested.

Equality and diversity

- Services were designed with the needs of vulnerable people in mind.
- Buildings were easily accessible and adhered to the Disability Discrimination Act 1995
- Staff were able to access interpreters for people whose first language was not English, or who had a sensory disability.
- Staff told us that accessing written information in different languages for people who use the service was not always possible. They told us they made sure that people understood information before they left the service when written information was not available for them to take away.
- School nurses worked closely with pupils to help them to understand cultural differences, such as about forced marriage and female genital mutilation.

Good

Are services responsive to people's needs?

- Most staff were aware of the ethnic and religious make-up of the people who used their services and were able to describe how they could make modifications to ensure they were culturally sensitive.
- People who used the services told us that they were treated as individuals.
- We observed a number of occasions when staff tailored their advice to make sure that it took in to account cultural sensitivities, for example about nutrition advice for people of specific religions.
- There was equipment available to support people with disabilities.

Meeting the needs of people in vulnerable circumstances

- The organisation ran health visitor clinics for homeless people.
- The organisation had a system in place for monitoring homeless children. This was done through the multi-agency safeguarding hub. Staff tried to engage with homeless young people, monitor their health and provide advice to them about maintaining their safety.
- Within the sexual health services, staff worked closely with vulnerable people to try to maintain their independence and support them in making decisions about their sexual health. For example, social workers, family members and independent advocates had been involved to support vulnerable people in making decisions.
- There were very good networks of support in place for looked after children. Staff worked closely with young people and built up close working relationships with them. Staff were very dedicated to supporting looked after children and even when children moved out of the area, still worked hard to maintain contact and continue to deliver support.

Access to the right care at the right time

- There was effective communication between departments within the organisation. This meant that referrals were made easily. Most staff told us they could make a call to refer a patient as long as this was followed by a formal referral.
- Patients referred urgently to therapy services such as speech and language therapy were seen in a timely manner. Patients referred routinely joined waiting lists and were usually seen within 6 weeks. Services were meeting the 18 week referral to treatment times.
- Within Barnet, the health visiting team were consistently not meeting the commissioner target of 95% of all new births being seen within 14 days. Between April 2014 and December 2014, this target was only met once. Rates ranged between 91% and 96% and averaged 92% across the period. The longest a patient had to wait was 25 days and 39 patients in total breached the target.
- Within Kensington and Chelsea, commissioners had set a target of 95% of new births being seen within 14 days. This target was missed four out of nine months. The longest wait was 29 days. The average across the 9 month period was 95% and rates ranged from 92% to 97%.
- From May 2014 to February 2015, between 79% and 92% of patients were satisfied with the amount of time they had to wait for their appointment. This was against a target of 80%. The organisation missed the target on one occasion.
- There were many examples of multiagency and multidisciplinary working to make sure that patients were able to access all of the services they needed. For example, comprehensive care packages were put in to place in a timely manner for patients who had complex needs and who were due to be discharged in to community care.
- School nurses offered regular drop-in sessions for pupils to attend and discuss concerns or questions they had about sexual health, smoking, alcohol consumption, drugs or general health.
- School nurses delivered health promotion in schools, usually at school assemblies. These focussed on topics such as smoking, alcohol and drug taking, sexual health, information about immunisation and vaccinations, forced marriage and female genital mutilation.
- The organisation recorded the number of patient contacts per day, per full time equivalent member of staff. Between April 2014 and March 2015 for Barnet, this was 11.8 compared to a organisation target of 5.3. For the tri-boroughs, this was 11.4.
- The organisation recorded the patient facing time of health visitors. This is the amount of time staff spend dealing directly with patients. Between April 2014 and March 2015, in Barnet, 53% of staff time was spent face to face with patients. This was better than the organisation target of 49%. In the tri-boroughs, 49% of time was spent face to face with patients.

Learning from complaints and concerns

Good

Are services responsive to people's needs?

- There had been seven formal complaints about children and young people's services between 1 January 2014 and 31 January 2015. The main themes were; attitude of staff (2), missed/insufficient treatment/poor advice (4), breach of confidentiality (1). There were two formal complaints received by the sexual health service. One related to the attitude of a doctor and the other related to poor communication after cervical smear.
- There had been one informal complaint about children and young people's services and one informal complaint about sexual health services. These had been dealt with locally.
- The organisation had received 33 PALS (patient advice and liaison service) contacts about children and young people's services between 1 January 2014 and 31 January 2015. Themes were; appointments, (13), attitude of staff (4), clinical care (1), communication (8), potential abuse (1), access to services (4), staff relations (1). There had been nine about sexual health services. Themes were; appointment issues (3), attitude of staff (2), clinical care (2), privacy (1) and staff relations.
- Children's services followed the organisation complaints policy. There was information about how people could make complaints displayed in waiting areas and there were leaflets available for patients to read.
- Staff told us they knew how to handle complaints and when to escalate a complaint to a manager.
- Complaints and concerns were discussed at team meetings although staff told us they didn't often find out about concerns raised about other teams, or share learning across teams. Team leaders fed back to staff about complaints and concerns and the outcome of any investigations. They communicated with staff about any learning and any changes which resulted from complaints. Staff confirmed that this was the case.
- When complaints involved more than one person, or team, a lead was identified and an investigation carried out. Feedback was delivered in joint meetings with all those involved, as well as individuals when necessary.
- According to the national NHS staff survey of 2014, 56% of staff believed that feedback from patients/service users is used to make informed decisions in their directorate/department. This was better than the national average of 52%. The information was not available specifically for children and young people's service or for sexual health services.
- The organisation produced a newsletter which highlighted common themes of complaints.

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

Overall, we rated well led as good. There were governance structures in place. These had been introduced fairly recently and were yet to be embedded however staff did have regular team meetings and receive communication from the organisation about complaints and incidents as well as news about the organisation as a whole. The organisation was keen to engage with patients and staff. Patients were able to express their views using the friends and family test and other patient satisfaction surveys. Staff were encouraged to participate in the national NHS staff survey and there was regular contact from the organisation executive team in an attempt to engage with staff. We found that there were small pockets of innovative practice across children and young people's services and sexual health services however due to low staffing levels, staff focus was mainly on making sure their routine work was completed to good standards. There was a programme of clinical audit in place and evidence that 11 audits had been completed in the division from 1 April 2014 to 31 March 2015.

However, some staff were unclear whether the organisation had a strategy for children and young people's services. On the whole, staff felt well led at a local level however there were some concerns about the disconnect between front line staff and executive managers and between the Boroughs covered by the trust. This was particularly the case for staff from Barnet. Staff thought the organisation had an open culture for reporting incidents however some staff felt that some services had a bullying culture which had not been addressed by the human resources department. They felt unable to express concerns about the management styles of some managers and feel confident that issues would be addressed. National staff survey results supported this. There were different commissioning arrangements for Boroughs in the organisation which led to some Boroughs, particularly Barnet, feeling as though they did not fit well with the rest of the organisation.

Detailed findings

Service vision and strategy

- The organisation had a non-executive director representative for children and young people's services sitting on the organisation Board. This person was responsible for making sure that the interests of the division as well as children and young people were considered by the board when making decisions.
- We asked staff and team leaders if they were aware of the organisation's strategy for children's services. Most staff were unaware of whether there was an organisation strategy for the future of the organisation although they told us that they organisation seemed to be expanding and extending services to new Boroughs around the Greater London area.
- The health visiting team was on course to meet the 'call to action' from the government to train and recruit new health visitors.
- The organisation was trying to recruit new staff however this was proving to be a challenge. Additionally, new staff told us that although the organisation had paid for them to retrain, following qualification, they were not guaranteed a job and had to be re-interviewed. They reported that after interview, they often had to wait prolonged periods of time before finding out whether they had been successful. In the meantime, some had been offered posts at other organisations.

Governance, risk management and quality measurement

- We spoke with the management team of the division. They acknowledged to us that new governance and risk management procedures had been recently introduced. The management team felt that the procedures were robust but were yet to be fully embedded or tested.
- The division had a risk register in place. This contained detailed information about the risks faced by the division as well as action being taken to mitigate and minimise risks.
- The division had recently introduced a suite of key performance indicators to monitor the quality of services. There were no results available at the time of the inspection.

Good

Are services well-led?

- The children and young people's division had carried out 11 clinical audits in 2014/2015. Staff told us that they found it difficult to find time to carry out audits due to current work pressures and staff vacancies.
- There was a process in place to feedback information to staff via newsletters, emails and staff meetings. Staff were informed about the outcome of complaints and incidents within their area of practice however staff felt that they did not always share learning across the whole organisation.

Leadership of this service

- Staff told us that they were aware of whom the senior management team of the organisation were, but most had never seen them in person. Some staff told us that after the announcement of the CQC inspection, senior managers had become more visible and had started to visit different teams across the organisation.
- Staff in some localities felt that there was a disconnect between the executive board, managers and staff at the front line. One person told us, "It feels like they are in an ivory tower and they don't really understand what it is like for us every day". We were, however, also informed about the deputy chief executive shadowing a health visitor on home visits to find out what it is like for staff. There were other examples of senior managers working in clinical areas periodically. For example, the chief nurse occasionally returned to clinical work on a Friday.
- Most staff felt that the organisation was running well, but were more concerned about coping with their day jobs than thinking about the overall organisation. They felt confident that the organisation was run as it should be.
- Some staff felt as though Barnet didn't fit in with the rest of the organisation because it had different commissioning arrangements, as well as being in outer London unlike the other Boroughs which were classed as Inner London.
- Staff told us that on the whole they felt well supported by their line managers.
- We saw that team managers were very dedicated to their teams and worked very hard to lead by example, however we also noted that some team managers were working extremely long hours and were at risk of burning themselves out.

Culture within this service

- We were given mixed information about the culture of the organisation. Some staff told us they felt there was a bullying culture and that grievances reported to the Human Resources (HR) team were not always treated fairly. One staff member told us, "HR always just seem to take the side of the manager when you raise concerns and put it down to a clash of personalities, but when a number of staff decide to leave because of a manager, it can't just be a clash. It makes you want to not bother reporting inappropriate behaviour from managers."
- The staff survey showed that 21% of staff working in the children and young people's division had experienced harassment, bullying or abuse from other staff in last 12 months. This was compared to the national average of 19%.
- One member of staff told us that they had raised a concern with the organisation and had been told not to discuss the concern with CQC staff.
- On the whole, staff felt that they were encouraged to report incidents and near misses, concerns from patients and identified risks to the organisation. Staff were confident that if concerns were raised in relation to patient safety, action would be taken.
- According to the national NHS survey of 2014, the organisation had scored worse than the national average for staff experiencing discrimination at work, 17% compared to the national average of 8%.
- One person told us they had never worked for an organisation where training was as good as at this organisation. Other staff agreed with this statement. Staff told us that managers encouraged them to train and develop.
- The organisation had a lone worker policy in place and was in the process of rolling out lone worker devices to staff based on risk assessment.

Public engagement

- The organisation took part in the friends and family test. A nation-wide initiative to help organisations to assess the quality of their services by asking people who used the service whether they would recommend the service.
- For the third month in a row, December 2014, January 2015 and February 2015 the proportion likely or extremely likely to recommend services provided by the Child Health Development division has fallen.

Good

Are services well-led?

- The organisation also used a number of other patient satisfaction measures. Since May 2014, up to February 2015, the percentage of patients who had rated their experience as good or excellent varied between 91% and 97%. The organisation target was 80%.
- School nursing in Kensington and Chelsea had held focus groups with young people about the best ways to engage with them.

Staff engagement

- Staff had taken part in the national NHS staff survey in 2014.
- The results were not available specifically for children and young people's services or sexual health services. The national staff survey showed that on a scale of one to five, with five being fully engaged and one being completely disengaged, the organisation scored 3.75. This was 0.01 worse than in 2013. Staff from CLCH had a similar engagement score to other community organisations of similar size.
- The organisation scored higher than the national average for staff motivation and work. On a scale of one to five, with five being enthusiastic, the organisation scored 3.91 compared to the national average of 3.87.
- The organisation ran occasional senior management panels. Staff were able to ask questions and receive a response from the panel.
- Staff from different Boroughs made mixed comments about whether or not they felt engaged with the organisation as a whole, or part of the organisation. In particular, staff from Barnet felt that they weren't really part of the organisation. This was not only because of their geographical location in relation to the other Boroughs in the organisation. Staff felt that Barnet was an afterthought in planning decisions and discussions. This was despite Barnet services being provided by the organisation for over three years.
- Staff told us, and we saw that there was frequent communication with them via emails and newsletters. During the inspection, staff received emails twice daily from the organisation to inform them of the progress of the inspection and what to expect should CQC wish to speak with them.
- Staff acknowledged that locally, within the Boroughs, engagement was good. They felt listened to by their managers and well supported.

Innovation, improvement and sustainability

- The organisation was continually looking to expand in to new areas. For example, just prior to the inspection by CQC, the organisation had been commissioned to deliver sexual health services across Hertfordshire.
- Staff told us that they were encouraged to suggest ways to improve services, however found that if the initiative needed additional funds, then the process became difficult and lengthy, which discouraged staff.
- Within the sexual health service, a new service called 'Test and Go' for STI testing had recently been introduced. People could submit a urine or swab sample and receive results by text within 7 days. There were mechanisms in place to identify people who may be at risk.
- One of the consultants within the sexual health service told us about a new technique they had developed for removing contraceptive implants when they were implanted too deeply in a person's arm. This improved the experience for the patient because they were left with minimal scarring and was also a quicker and less invasive procedure than was currently the standard.
- Team managers we spoke with were focussed on sustaining their 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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced staff in health visiting, school nursing and occupational therapy within children and young people services.