Hertfordshire Community NHS Trust

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Community health services for children, young people and families

Quality Report

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Date of inspection visit: 17 - 20 February 2015
Date of publication: 06/08/2015

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)
RY448	Howard Court	Queensway Health Centre, Hatfield	
RY448	Howard Court	St Albans Children's Centre	
RY448	Howard Court	Peace Children's Centre, Watford	
RY448	Howard Court	Pat Lewis Centre, Hemel Hempstead	
RY448	Howard Court	Florence Nightingale Centre, Harlow	
RY448	Howard Court	Child Health. Ascots Lane, Welwyn Garden City	
RY448	Howard Court	Danestrate Health Centre, Stevenage	
RY418	Nascot Lawn		
RY448	Howard Court	Hemel Hempstead Travellers' site	

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Good l

We found overall that services were safe, effective, responsive, caring and well led. The staff were well trained and competent in their roles.

We visited services for children and young people in a range of environments, including outpatient's clinics, community settings, a school and vaccination clinics, where staff from Hertfordshire Community NHS worked with other professionals and external organisations. Services for children and young people were developed and delivered in keeping with best practice guidance. All the staff we spoke with told us that the patient was at the centre of everything and this was reflected in the vision and values of the organisation.

Most areas reported staff shortages, but these were being locally monitored, particularly where there were safeguarding issues. However, there had been an influx of newly qualified health visitors and there was some concern how these would be supported, particularly around safeguarding supervision.

All staff received mandatory training and there was a high level of compliance consistently at, or above, 90% which was in line with the trust's target. Communication between the services dealing with children and young people was described as good. There was evidence of learning from incidents and complaints to improve the quality and safety of services.

Staff were compassionate and respectful in their approach to providing care and treatment; this was reflected in the feedback from parents, young people and children who told us they felt supported.

The service was dealing with a number of changes and restructuring programmes at the same time and these were stretching the capacity of the service in some areas. There was some concern expressed about creating a more generic workforce and blurring of professional roles. However, the leadership was well respected, the strategy was clear and most staff were engaged.

We spoke with 25 staff including health visitors, school nurses, therapists, consultant paediatricians and administration staff. We spoke with 15 parents/carers and 12 young people. We spoke with young people who use the services and their parents. We observed how children and young people were being cared for. We looked at and reviewed eight care and treatment records.

Summary of findings

Background to the service

Background to the service

Hertfordshire Community NHS Trust provided a range of services for children and young people throughout the county of Hertfordshire and West Essex. The services it provides included:

- Children's occupational therapy
- Children's Physiotherapy, both in Hertfordshire and West Essex
- Children's speech and language therapy
- Children's community nursing, West Essex and a separate team in West Hertfordshire
- Health Visiting service
- School Nursing service
- Special dental service
- Step 2 which provides a mental health service for children and young people up to the age of 19 years.
- Children's diabetes team
- Children's eye service
- Children's sickle cell service
- Community Paediatric service
- Family Nurse Partnership, to support young parents
- Nascot Lawn, respite unit, for children and young people with a severe learning disability and additional complex health needs
- Newborn hearing screening and audiology services
- A specialist bladder and bowel service
- Sexual health clinics for young people
- Children are also seen in the Minor Injuries Unit in Bishop's Stortford, which will be reported on in the inpatient care services core service report.

Staff were based in community hospitals, community centres, clinics and schools. However, the majority of the children were seen and/or treated within clinic settings. Services for children and community health services, covered all services provided to pregnant women, babies, children, young people and their families. Services may be provided in the home, community clinics, children community centres and schools.

During this inspection we visited a number of clinics providing a variety of services to children and young people, both routine for example immunisations and specialist, for example sexual health and specialist bladder and bowel clinics. We visited an inpatient respite unit observed a Team Around the Child (TAC) multidisciplinary team meeting in a school with a specialist bladder and bowel nurse. We conducted interviews with the safeguarding children's lead and other staff in their teams, individually and in focus groups.

Services include universal health services, which involves children and young people 0–19 years to be healthy, stay safe, enjoy and achieve and services that are designed to promote public health such as health visiting and school nursing. Delivery and coordination of specialist or enhanced care and treatment including specialist nursing services, therapy services and community paediatric services. These services provided and coordinated care and treatment for children and young people with long-term conditions, disabilities, multiple or complex needs and children and families in vulnerable circumstances.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Director of EJ Consulting Ltd, Bradford Hospitals NHS Foundation Trust.

Team Leader: Helen Richardson, Head of Hospital Inspections, Care Quality Commission.

The team of 29 included CQC inspectors and a variety of specialists: district nurses, a community matron, a GP, a community physiotherapist, a community children's nurse, palliative care nurses, a specialist safeguarding nurse, specialist sexual health nurse, a dental nurse, a governance lead, registered nurses, and an expert by experience who had used community services.

Summary of findings

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme. An early inspection was requested by the provider to support the trust's submission as an aspiring foundation trust

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 16th February and 20th February 2015. We visited eight locations. During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

We spoke with 15 parents/carers and 12 young people. We spoke with young people who use the services and their parents. We observed how children and young people were being cared for. We looked at and reviewed eight care and treatment records.

Most patients told us they had a good service which reflected the needs of the child or young person and involved the rest of the family. Furthermore explanations were given in child appropriate language. Most of the patients we spoke with were positive about the care and attention they received. They felt they were treated with dignity and respect and felt involved in decisions about their care. Patients commented how they were kept informed of progress and plans for their discharge.

Patients said "The staff are warm, friendly and approachable." "The environment is safe and hygienic. Our need was responded to with the right care and at the right time."

Good practice

- The children and young people's services within the trust were working towards achieving level one of the UNICEF baby-friendly initiative.
- The monthly Children's Services bulletin to enable effective communication within e service
- The speech and language drop in service
- Mandatory training at or above the trust target

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Ensure that notes specifically reflect who the patient is and whether they are present during a visit.

Action the provider SHOULD take to improve:

- Ensure robust action is taken to manage the risks surrounding recruitment and vacancies
- Implement the recommendation of the Paediatric and Chid health report from 2014.
- Ensure that record keeping audits are completed to ensure that records are of a high standards reflecting care provided and are in line with good practice nationally
- Ensure there is a vision or strategy for nursing and health visiting, which would be an important tool for recruitment, appraisal and leadership but instead these critical professions are blended into a generic Clinical Strategy
- Ensure antenatal visits by Health visitors reach the target of 95%
- Ensure that there is both a short term and strategic plan to address recruitment and retention of staff
- Finalise the trust's policy for safeguarding children

Hertfordshire Community 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

We did not see evidence of routine monitoring of case records or record keeping audits across all teams at local level. This meant that the service could not be assured that records held appropriate information and adhered to national record keeping standards.

There was currently no trust policy for children's safeguarding, however, there were guidelines that staff were working within.

The service had good support for safeguarding including supervision and caseload monitoring. There were staffing pressures in community paediatrics, speech and language therapy and in the health visiting services covering Welwyn and Hatfield and North Hertfordshire. These pressures were being managed in the interest of patients and staff.

We found that health visitor caseloads although monitored were above an acceptable recommended level.

The provider has a good track record on safety across services and care settings. Where concerns arose they were addressed in a timely way. The provider identified the things that were most important to protect people from abuse and to promote safety. Safeguarding procedures were coordinated with other agencies so that people's protection plans were implemented effectively.

There had been long standing vacancies within the children's services. At the time of our inspection 5% of budgeted posts were unfilled, 9.3% of staff were temporary workers, bank or agency and there was a 15% staff turnover. This was recognised and actions were in place to mitigate risk.

The provider had plans in place to manage and mitigate anticipated safety risks, disruptions to staffing or facilities, or periodic incidents such as bad weather or illness.

Staff knew how to report incidents using the trust's electronic reporting system. They told us that they received

Good

Are services safe?

feedback following incidents and that learning from incidents was shared with them, via a regular children's services bulletin. We saw an example dated February 2015, which contained feedback from incidents, a mandatory training update and training dates and alerts and specific information for particular professional groups.

Staff took an active role in delivering and promoting safety, learning and improvement.

Staff ensured that equipment used was safe and clean and were aware of children's equipment needs. Staff were able to assess and respond to patient risk. There were some processes in place to respond to staffing shortages and to manage foreseeable risks.

Detailed findings

Incident reporting, learning and improvement

There was a trust wide electronic incident reporting system which all staff we spoke with had received training on how to use it and were confident about reporting incidents. Incident reports were completed routinely for clinical, environmental and administrative issues.

Policies and procedures had been amended to reflect learning from incidents. An example of this was a referral for intravenous medicine to be given to a child. The referral was faxed to the appropriate centre, but was not collected in time for the medicine to be given. Following this incident all teams were asked to consider the use of faxed information with regards to both sending information in a timely way and the use of confidential patient information. We saw further examples of entries on the electronic system, including one where a child's data had been incorrectly uploaded. We also saw that the service had made an immediate system change to ensure this could not happen again. In addition, we were informed by the senior manager in Child Health that the lessons learnt from this incident had been cascaded to staff within one working day. Another example of learning and change in procedure happened after a child managed to reach a cleaning tablet for a washing machine in one of the clinics. Following this staff were reminded, both in the service monthly bulletin and individually by email, to risk assess the environment thoroughly before starting a baby clinic. This showed staff were communicated with about incidents, changing processes and learning from incidents.

The staff we spoke with at the Child Health Centre in Welwyn Garden City and the Queensway Health Centre said that there was an open reporting culture. One locality manager said, "The organisation is open to sharing and learning from incidents and this requires no blame culture".

We saw recent copies of the Children's Services Business Unit monthly bulletin. This contained a section entitled, 'Sharing Lessons,' we saw examples of how learning from incidents had been used to change practice and improve safety. For example, there was an incident that occurred as part of an immunisation programme in a school where a fault with the equipment meant that a child did not receive the vaccine. The lesson learnt and recorded in the February 2015 edition of the bulletin stated that, "Under the protocol the vaccine should have been re-administered at the time of the event rather than the child having to attend the GP to have it at a later date."

The services' Quality Report for Quarter 1, 2014 – 15 (April to June) reported body bruising to the arm of a young person who attended Nascot Lawn respite residential centre. The bruising protocol was used in this case, which states that all children who are not independently mobile should be referred to the Children's Services and be for reviewed by a Consultant Paediatrician. The report said that the root cause of the bruising in this case could not be found, but recommended that body maps should be used routinely to record and confirm existing bruises or those acquired whilst in the care of the service. In addition, the November 2014 edition of the Children's Services bulletin reported that the family had been upset by the incident and reflected on the importance of checking the family's understanding and the issues that may have surrounded it at each stage of the incident. This would have given an opportunity to provide further explanation if required.

We spoke with four members of the senior management team and they told us about two unexpected child deaths in 2014. These deaths were also listed on the serious incident report of 30 November 2014 presented to the trust board meeting in January 2015. All were notified as serious incidents and were subject to multi agency serious case reviews which were continuing at the time of our inspection.

We discussed the trust's response to these events and, whilst recognising that the investigations were continuing, the locality manager said, "We have acknowledged very openly what could have been done better". We spoke with

a health visitor and they agreed that, "Lessons have already been learnt and now we are monitoring the allocation of high risk cases more closely and managing our capacity." The locality manager said, "If it happened again we would organise an extraordinary staff meeting and we have now developed a rapid response flow chart." We found that the locality manager and the health visitor we spoke with were open about the organisation's response to the child deaths in 2014. The locality manager described the initial response as 'inadequate' and said that systems have strengthened now.

This demonstrated that there was appropriate responses and learning from incidents.

Safeguarding

There were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse. The service identified the things that were most important to protect people from abuse and to promote safety. There was a proactive approach taken both internally and by coordinated with other agencies so that people's protection plans were implemented effectively, in order that those at risk of abuse were identified early.

However, we were told by the named nurse for safeguarding that there was currently no trust policy for children's safeguarding, but there were guidelines. The previous named nurse for safeguarding had used the policy of the Local Safeguarding Children Board (LSCB). The newly appointed named nurse was drafting a trust policy. We saw the impact of not having a policy was minimised by good training at a relevant level, and supervision. Furthermore, staff were clear with regards to their responsibilities and responses should there be safeguarding concerns. In addition other governance structures were in place and we saw that there was a safeguarding children committee and sub-committee, an action plan monitoring tool and a safeguarding dashboard for 2014/15. This demonstrated that 100% of health visitors and school nurses were compliant and had received safeguarding supervision. A family nurse informed us that, "Supervision is never cancelled." A team leader at Queensway Health Centre said that targeted caseloads were received as part of the safeguarding supervision and caseloads were reviewed at appraisals and one to one sessions. The team leader also said that the safeguarding team were supportive and always available by telephone.

The trust had a safeguarding team which included named nurses and nurse advisors who gave members of staff advice, training and planned supervision. We saw a copy of the safeguarding children annual report for 2013/14. This reported that there were three nurse specialists, four safeguarding nurses and an additional Health visitor had been seconded as safeguarding nurse until January 2016, to support the increased number of newly qualified health visitors.

Staff told us they had received appropriate training and had the right skills to treat children and young people. Trust records that we saw demonstrated that almost 100% of staff had received safeguarding training, up to level 4, appropriate to their seniority and involvement in safeguarding of children. Staff were clear about recognising possible signs of abuse or neglect in children and young people and their responsibilities in safeguarding processes. Staff were able to access safeguarding children advice as they required and there were formal safeguarding supervision arrangements in place.

The General Manager's performance report, dated January 2015, said that 97% of eligible staff had undertaken child protection supervision. Health visitors at a focus group told us that they felt, "Supported and safe dealing with safeguarding issues". They said that they had received one-to-one supervision every three months and the newly qualified staff had supervision more often. However, there was concern raised about the number of new in post health visitors, most of who were less experienced. This meant they would need more frequent support and supervision. The heath visitors said that the safeguarding leads were competent and approachable and that they responded to concerns in a timely way.

A team leader for school nursing said that school nurses were only attending safeguarding case conferences where there was an identified health need. This was enabling school nurses to deliver the public health promotional part of their work. This had been agreed in consultation with the safeguarding nurses and the county council. However, some school nurses told us that safeguarding occupied much of their time. They were often invited to attend meetings related to safeguarding which were not necessarily linked to the child having a health need.

Good

Are services safe?

We attended a 'core group meeting', which was held for family members and professionals to implement and review a child's protection plan. We saw that the meeting was effective in addressing the ongoing safeguarding concerns of particular vulnerable families.

The annual report (2014) said that there had been a significant increase in the number of child protection reports in Hertfordshire, which is identification of vulnerable families that needed to be managed and reported on by health visitors, school nursing teams and allied health professionals. The numbers had increased from 574 in March 2013 to 1146 in March 2014 which was a 98% increase. Additional support by managers and administration staff was being given so that there were no delays to finalising and verifying reports. This was confirmed in the annual report and by senior managers.

The Quality Report for Quarter 1 of 2014 to 2015 also reported on safeguarding children. The report said that safeguarding continued to be a high priority for the trust. At the end of June 2014 there were 1034 children subject to child protection plans. This was a substantive reduction from the 1146 at the end of March 2014. However, the report continued, 'The complexity of the families that the staff work with has not decreased and the number of case conferences attended has remained fairly constant. During the period April to June 2014 there were 553 case conferences of which 99% were attended by either a Health visitor or School Health Nurse. The report specified the importance of safeguarding by saying, "The safeguarding children team continues to work closely with children's universal services to ensure that, where there is reduced staffing, teams are clear as to their child protection and safeguarding priorities."

There was a variety of clinics throughout the county for young people that offered advice and care with regards to sexual health. Many of these centres operated a 'drop in service.' However, there were few services for specific groups for example those vulnerable to sexual exploitation. We spoke to some of the staff who were responsible for providing some of these services. They were very aware of how to identify and report safeguarding concerns should they suspect a young person was being sexually exploited.

Medicines management

There were procedures in place to ensure medicines were handled and stored safely to minimise the risk of harm to patients. This included a policy, available for all staff on the trust's intranet, which had last been updated in November 2011. It is good practice for policies to be updated every three years.

At Nascot Lawn, the children and young people brought their medicines in with them when they came in for the day or for respite care. We saw that the medicines were checked by staff and signed in. They were safely stored in a locked medicines trolley, which was clean and well ordered. All the medicines were clearly marked with pharmacy labels. We saw that the young people with medicines for seizures also had an epilepsy protocol in their care plan.

In the community settings where vaccines for immunisation were administered. We saw they were stored appropriately. We checked a sample and they were all within date. We saw effective cold chain procedures at the immunisation session in Hemel Hempstead. This meant that medicines that required refrigeration were kept at the required temperature during transportation by means of cold boxes.

In community settings, National Institute for Health and Care Excellence (NICE) guidance was followed when prescribing medication for individual patients. We observed the giving of insulin which was in line with these guidelines for patients diagnosed with type one diabetes.

Safety of equipment

Some staff we met held clinics in premises not managed by the provider. In the clinics we observed, children were seen in generic rooms which were not specifically designed for children. Staff were aware of children's needs, had carried out a risk assessment and provided appropriate toys and other methods of distraction.

Community hospital outpatient departments providing care for children had been designed and equipped for children; there were toys available and posters on the wall.

Staff told us they had the equipment they required to care for children and young people safely. Equipment was serviced, checked and cleaned regularly by the trust's estates department. This included portable appliance testing. However, we saw that one of the scales used by the

school nurses at one of the health child session we attended had not been checked according to usual schedule and its PAT testing sticker was out of date. We informed the senior nurse at the time.

We saw well maintained equipment at Nascot Lawn respite centre, including a sensory room for children and young people with severe learning and physical disabilities.

Records and management

The service did not always have robust systems in place to ensure that records were appropriately maintained.

Staff used mostly electronic notes to record the treatment and care given to children. However, there were concerns with regards to connectivity; staff reported they often came back to their office base to write notes as it often was difficult to connect to the trust's system in a community setting. Others told us they found the use of electronic devices were sometimes a barrier between the healthcare professional and the family. This was a concern for those who worked in people's homes.

There were no reported breaches of data security. Records were stored securely and were accessible to health staff as appropriate, apart from electronic records which were affected by sub optimal connectivity.

An electronic system was used to organise appointments and clinics. Staff told us that this electronic system was also used to record multi-agency meetings and telephone discussions.

At Queensway Health Centre, we looked in detail at ten children's electronic notes where there were child protection plans in place. We found that five of the ten sets of notes had some information missing such as a chronology and timeframes indicating the frequency of visits to the child required by the Health Visitor. Where there were details about the frequency of contact with the child, it was not clear from the notes that the requirements of the protection plan were being adhered to and whether the contact was face-to-face. The notes were ambiguous as they state contact with the 'patient.' They did not state the meeting was face to face with the child, or give the child's name. Therefore it was ambiguous whether or not the child was present. This meant that the record was not robust enough, particularly as the children concerned were subject to a protection plan.

We reviewed further records at Queensway Health Centre after a core group meeting. We found that there was a safeguarding icon on the system indicating that there was a vulnerable child with a child protection plan. We saw evidence of screening results a new baby review carried out at 14 days and a detailed assessment was recorded. We also saw evidence of parental consent for a physical examination and notes from a multi-agency care group meeting. All case conferences were recorded along with the usual measures on growth charts such as head circumference at six weeks. A complete record.

We looked at three care plans for the young people receiving respite care at Nascot Lawn. Each one contained a photograph, contact and emergency contact details, consent to treatment forms and detailed risk assessments for the unit environment and the young person's health issues.

Cleanliness, infection control and hygiene

The service had clear and effective systems in place to ensure all children and young people were protected from the risk of infections, Staff knew and followed the trust's infection control and prevention procedures.

We observed good infection prevention and control in the children's clinics and health centres we visited. We saw thorough hand washing and the equipment, scales and baby mats, were cleaned between clients with disinfectant wipes. Staff used personal protective equipment, for example gloves where appropriate.

Infection control and hygiene was observed by the health visitor at the traveller's site when undertaking immunisations. There was careful storage and appropriate disposal of equipment.

When we visited Nascot Lawn, the home was visibly clean and fresh .The manager told us that if a child was unwell, other than their usual medical or physical condition, they were not admitted. This minimised any infections being spread to other children in the unit.

Mandatory training

There was compliance beyond the trust's target of 90% with all mandatory training within the children and young people's service. This included safeguarding mental capacity act, fire safety, patient moving and handling and infection control.

Good

Are services safe?

Information governance training had only 49% compliance in September 2014 but this had increased to 90% compliance by the end of January 2015.

Staff told us that training was delivered to meet their needs and that they were able to access training as they needed it.

Assessing and responding to patient risk

Comprehensive risk assessments were carried out and risks were managed positively. Risk assessments and management plans followed national and professional guidance and were reviewed regularly. For example, we saw health visitors working with children and their families to assess and respond to risk with regards to the preparation and delivery of child protection plans. They were involved with colleagues in social services to enable this. They attended clinics and core group meetings and visited the child and family in the home.

There was effective working within teams, across services and with other agencies to promote safety for individuals, particularly those with multiple or complex needs. For example, staff were able to access specialist medical advice for children when they needed it. We were told of several incidences across these services when specialist medical advice was sought and then delivered in a timely way.

We saw staff giving advice to parents on how to recognise and respond appropriately to deterioration in their child's condition.

We observed a multi-agency meeting for a child with complex physical health needs in the community. Arrangements were put in place to manage the risks for this child. We observed protocols being amended to reflect changes in the child's condition and the care required.

We saw that there had been some significant improvements to some aspects of the Looked After Children's (LAC) service. All health assessments had been reviewed, which reflected the individuality of the child and ensured that each child received care that was appropriate to their needs and their age. This complies with Statutory Guidance on Promoting the Health and Wellbeing of Looked After Children (DH 2009)

Staffing levels and caseload

Staffing establishments, which included levels and skill mix, were reviewed to keep people safe and meet their needs. This was despite imprecise plans from board level down, how this should be managed.

The General Manager of Children's services told us that there had been a number of changes to the staffing structure in recent months. Reporting to the General Manager were three heads of service leading specialist services, children's therapies and universal services. There were eight locality managers for the geographically based service teams for health visiting, child health and school and family nursing. One of the locality managers said, "Staffing difficulties are a recurrent theme, we are never fully staffed and vacancies take time to fill". Sub optimal staffing levels were a feature on the trust's risk register, all staff we spoke with were aware of this. The main areas where demand for services was exceeding the capacity of the service to supply services, were in Welwyn and Hatfield and North Hertfordshire. In addition, there were capacity issues in community paediatrics in both Hertfordshire and West Essex and in speech and language therapy.

In September 2014, the General Manager presented a business unit performance review which included the staffing position. This demonstrated a reduction in vacancies within children's services from 162 whole time equivalents in April 2014 to 109 in September 2014. However, at the time of our inspection 5% of budgeted posts were unfilled, 9.3% of staff were temporary workers, bank or agency and there was a 15% staff turnover. This was recognised and actions were in place to mitigate risk. However, the service had the lowest absence levels due to sickness in the whole trust.

We saw from records that the trust provided that health visitor caseloads were monitored. Caseloads were discussed with one of the locality managers at the Queensway Medical Centre and average numbers were confirmed at from 495 to 544 for a full-time health visitor.

We found health visiting caseloads had been modified to reflect the local needs. For example caseloads in the most deprived areas health visitors would have a caseload of 250 children. Operational leads within health visiting told us the largest caseloads per health visitor were 500 in a low deprivation area.

We found that health visitor case loads although monitored were above an acceptable recommended level. The

community practitioner and health visitor association (CPHVA 2009) made recommendations that 400 should be a maximum caseload and 250 was the ideal caseload number for any health visitor.

A health visitor we spoke with at the core group meeting told us that there was close monitoring of caseloads. There was a limit on the number of cases each health visitor could take who were subject to a child protection plan. Similarly, at the focus group the staff said that managers were reviewing caseloads constantly and particularly where there were newly qualified staff and vacancies in teams. Individual teams used a spreadsheet to track the cases and to ensure a manageable distribution of what the health visitors called, 'highly dependent families'. This meant the trust was not meeting the recommendations of the CPHVA.

There was a record on the trust's risk register with regards to the team at 'Welhat' (Welwyn and Hatfield) because of their caseloads and high level of safeguarding referrals. Health visitors were being recruited to fill vacancies.

The General Manager told us about progress with the implementation plan for recruiting a 30% increase in Health visitor's numbers into the service by the end of March 2015. The trust was on schedule to achieve the target number of 229 Whole Time Equivalent (WTE) health visitors and that had meant 80 students joining the service over a short period of time. However, the Trust recognised the challenge with regards to supporting these newly qualified staff, despite the emphasis already placed on ensuring caseloads were manageable, particularly with regards to high risk families.

The Head of Universal Children's Services said that with all this investment in health visiting, which had been a national initiative, the school nursing service felt like the poor relation. The Head of Children's Universal Services told us that, "Historically it's a small service with vacancies". School nurses we spoke with confirmed this and told us, "We need greater clarity about our role so that we can focus our efforts where they are needed most". There was one part time vacancy, in the special school nursing services, out of an establishment of 3.25WTE's. However, other vacancies were included within the locality health visiting and school nursing services, so it was difficult to break down exactly.

A speech and language therapy team leader at Queensway Health Centre said that they were using a particular formula for caseload management and that any heavy loads were reallocated so that work was assigned fairly. Locums were available to cover vacancies or period of absence of permanent staff.

The consultant paediatricians told us that appointment times had been shortened from 45 minutes to 30 in an effort to reduce waiting times. This had been seen as a poor decision and concern was that quality of care could be affected. Extra clinics had been scheduled and a locum doctor had been employed to assist with these.

The speech and language therapists had re-organised themselves to reflect the 'developing special provision locally' (DSPL) education-based area groupings and there were now 12 vacancies in a workforce of 122. In order to attract candidates they were offering flexible contracts for colleagues wanting to work during the term time only and they would be offering mobile working. In addition, there was an agreement to retain staff on fixed term contracts for a further 12 months, the service was visiting local universities to 'advance recruit' students and the service was considering whether to over-recruit in anticipation of a normal attrition rate.

At Nascot Lawn, a residential respite unit for children and young adults with complex health needs, there were concerns that there were with only two members of staff at night. However, the manager told us that if an unwell child should need taking to hospital, parents would be contacted as would the additional staff member who was on call. This meant there would always be two members of staff in the unit at night.

All the professional groups told us that the geographical spread covered by some of the teams caused time wasted travelling in between visits. Some told us that when caseloads were being allocated, location was taken into account.

Managing anticipated risks

The trust had plans in place to manage and mitigate anticipated safety risks. A risk assessment for lone working was not made available to us during the inspection; however, we did find a policy, which the trust sent us, dated January 2014. Within this policy was a risk assessment to be completed for all workers who worked alone. The teams we spoke with were not aware of this policy or risk assessment document, and told us arrangements for lone working were 'informal.'

Good

Are services safe?

The trust used a buddy system for safety and protection when working alone, for example completion of a diary. All staff had mobile phones and emergency contacts. There were also code words to use if staff were at risk during a home visit. The teams often worked in pairs and were clear how to escalate concerns.

The School Nurses at Hemel Hempstead told us that they completed a diary and there was a buddy system for late visits. However, they also said that the risk assessment was 'informal' and they did not have an 'end of the day' system that tracked whether nurses had completed their shift safely. The staff were unaware that there was a formal risk assessment in order that risks to them whilst working alone could be formally identified and minimised.

Community nursing teams had contingency plans in case of adverse weather conditions. Patients were categorised by need which ensured that in the event of a major disruption those requiring the most urgent care were prioritised.

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

The children and young people's services, within their teams were following best practice according to evidence and all were involved in regional and local forums.

We saw several examples of the use of evidence based care and treatment particularly guidance from the National Institute of Care Excellence. The trust was working towards achieving level one of the UNICEF baby-friendly initiative and had a Family Nurse Partnership (FNP) team.

Outcomes for children and families were monitored using the 'health child' framework.

We saw there was a multidisciplinary and collaborative approach to care and treatment. Staff were appropriately trained and competent at the right level to carry out their roles. We saw that consent was obtained prior to commencing treatment.

Most of the people who use the services received care, treatment and support that achieved good outcomes.

There was team dedicated to ensuring young people were able to transfer to adult services with minimal disruption.

Appraisal was utilised appropriately and gave professional staff the opportunity to discuss their career aspirations and explore training opportunities. Regular supervision allowed them to discuss caseloads operational and professional matters.

There were several examples of multi-disciplinary working with the trust and between the trust and other agencies. Information was freely available and shared using the trust's electronic systems where they were available.

Detailed findings

Evidence based care and treatment

The service ensured that people's care, treatment and support achieved good outcomes, promoted a good quality of life and was based on the best available evidence.

The overall rate of babies who were breastfeeding in quarter one of 2014 was 51.4.4% which was better than the national rate of 48%. We found the service was using a range of initiatives to improve breastfeeding rates which included information at antenatal visits and peer support groups.

The service was working towards level one of The United Nations Children's Fund (UNICEF) baby-friendly initiative. This baby friendly initiative is based on a global accreditation programme of UNICEF and the World Health Organisation. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care. One parent told us, "I thought breastfeeding would be easy. It wasn't. I was desperate to feed my baby myself. The support I've had has been fantastic. Everything is fine now. Thank you."

We saw a number of instances of the trust following the guidance of the National Institute of Care Excellence (NICE). For example, the new pathway for Autistic Spectrum Disorder. The guidance advises that a multidisciplinary group (the autism team) should be set up. The core membership should include a paediatrician and/or child and adolescent psychiatrist, speech and language therapist and a clinical and/or educational psychologist. The service ensured that diagnosis was made in a timely manner, liaison was made with all the multi-disciplinary team and the child's school, so the child and family and teachers were supported and management of the disorder was optimised.

We saw from review of cases in school nursing that NICE guidance was being used in the management of an overweight child. This guidance makes recommendations on lifestyle weight management services for overweight and obese children and young people aged under 18 and are just one part of a comprehensive approach to preventing and treating obesity

A clinic for enuresis (bed wetting) support was available for school age children and again, was delivered in line with NICE guidance, offering support appropriate to the child and their age in conjunction with the multi-disciplinary team, although school nurses were the main leads for this service.

Good

Are services effective?

We looked at a number of health care records and found in the majority of records a full assessment of the person's needs had been undertaken. In one health visiting record we looked at we found an assessment of the mother's maternal health including postnatal depression had been undertaken. We saw within the care plan the practitioner had used questions, based on NICE guidance, to assess the mother's mood.

Approach to monitoring quality and people's outcomes

The organisation took part in a number of national clinical audits, reviews and benchmarking. For example, outcomes and key performance indicators in health visiting were the milestones of the 'Healthy Child Programme (HCP) the government's early intervention and prevention public health programme which includes all agencies working with children and young people from conception to 19 years.

The outcomes from this programme, for example the percentage of developmental checks carried out, were monitored on a monthly basis and reported in the General Manager's performance report. Some of the indicators, reported for health visiting in September 2014, included that 98.4% of babies had face to face contact with a health visitor within 14 days of birth and 99% of babies born in West Hertfordshire had hearing screening within four weeks of birth.

The speech and language therapy (SALT) service had a clearly documented three year plan with regards to patient outcomes. When we questioned them about these outcomes they said that they were doing 'before and after' research which demonstrated that children were improving in terms of education and curriculum levels following SALT intervention. We saw that the service was meeting 70% of their outcomes for 2014/15 for training support, community training, parent advice sessions and language development in children centre settings from the end of school Year 2. Progress against the plan was being monitored manually at the time of the inspection The therapists said that they were also receiving positive feedback from schools, parents and from the children themselves.

The SALT service used the East Kent Outcome Measure to consider their patients' outcomes. This meant that every patient had a tailored plan of care to ensure that treatment was optimised according to their needs.

We saw that at the beginning of 2014, from information the trust supplied, that the school nursing service had not been reaching their targets for measuring the height and weight of children in their reception year at school and then again in year 6. Furthermore, targets with regards to children receiving a vision and hearing test whilst in school were not being reached; all at 63% against a target of 90%. By the end of 2014, tremendous progress had been made and 90% of these targets were being reached. This meant that school age children were being screened in line with national benchmarks.

Within the sickle cell service we found the staff worked closely with a range of other professionals including hospital consultants, GP's, health visitors, school nurses and staff in education facilities.

Competent staff

There was a comprehensive induction for new staff. This included both a trust wide induction and local induction, specific to their area of work. New staff were offered a mentor and supervisor.

Staff training and appraisals were carried out to ensure that staff were competent and had knowledge of best practice to effectively care for and treat patients. Therapy staff we spoke with reported they had regular appraisals where they could discuss their work. They confirmed that they could discuss performance and career aspirations with their line manager and they found the appraisal process useful. The appraisals were followed up during the year to ascertain progress against targets. Therapy staff reported they had monthly supervision and 1:1 interviews with their manager/ supervisor.

The General Manager's performance report delivered in September 2014, demonstrated that 92% of staff in children's services had received an appraisal in 2013/14. This was in line with trust's target. In addition, 100% of eligible health visitors and school nurses had clinical supervision three times a year. 93% of eligible allied health professionals, working with children, had clinical supervision twice a year.

Good

Are services effective?

Staff working in the speech and language therapy service hosted two clinical excellence regional networks. These had a focus on autistic spectrum disorder. All staff were encouraged to attend these networks both locally and further afield.

The team leader at Queensway Health Centre, who was relatively new in post, said that there was clinical supervision bi-monthly with her manager. Supervision was delegated appropriately so more senior staff supervised juniors. The band 5 nurses were working through the Royal College of Nursing competencies. The team leader also said that they had completed the management and leadership training course provided by the trust which was a day a month study off site and additional homework. The team leader said, “It was a good course with HR input and content on change management and leadership styles".

School nurses in Hemel Hempstead informed us that they were not having regular supervision because of a shortage of staff. However, supervision was due to recommence and would take place three times per year.

Multi-disciplinary working and coordination of care pathways

We saw many examples of well managed multi-disciplinary team work. This included the young people’s health transition service and the speech and language therapy service. The therapist attended ‘provision panels’ (where a parent had requested certain special provisions) and decisions were made on a multi-agency basis. There were also joint visits and assessments and joint problem-solving with colleagues in social services and education.

We saw that the speech and language therapy service in Stevenage worked effectively with paediatricians from the East and North Hertfordshire Trust. They had developed an autistic spectrum disorder pathway for young people who had been diagnosed with an autistic spectrum disorder. However, because there was some difficulty getting all the different professional groups to meet, there had been some delay finally signing off the pathway so that it could be utilised.

A coordinated antenatal pathway was being developed by representatives from midwifery, health visitors, GPs and commissioners. We attended a workshop to progress this project. The workshop identified gaps and barriers with key partners in order to improve communication. However, at the workshop minimum standards were agreed in order that the pathway could progress to benefit pregnant women and their babies.

We were provided with and observed a range of evidence which showed how services worked with other agencies to meet the needs of children and young people. For example health visiting teams told us they worked closely with local children’s centres to meet the needs of children and their families.

Within health visiting and school nursing we found staff worked less closely together to meet the needs of children and young people. Staff reported they were involved in child protection at the same time but did not routinely undertake joint working with a family.

Referral, transfer, discharge and transition

The main concerns of the relatives we spoke with were about managing the transition into adult services and receiving support after the young person reached 19 years of age. We spoke with the lead nurse for the young people’s health transition service. This service was set up to create a bridge into adult services in health, social care and education. The service was currently supporting 39 young people aged between 14 and 21 years old to facilitate a smooth transition into adult services.

We accompanied a health visitor on a home visit to two siblings with profound disabilities. The health visitor told us, “Our aim is to promote independence for as long as possible and the service has a different focus according to the stages of the transition process”. The focus for this visit was to ensure continuing to support the parents to manage their individual needs. Counselling was made available for the family should they require it. Home tutoring had been organised for one of the siblings who had missed school because of deteriorating health. Some of the services were being sourced from outside the county, for example learning disability and mental health services. The approach was holistic and centred on the individual and the changing needs of each of the siblings and the family.

Availability of information

Information was available through the trust’s electronic system or through paper-based records. Staff were looking forward to greater availability of information when more colleagues had access to the electronic system. There was

Good

Are services effective?

also a project to improve connectivity and to enable staff to work remotely. This would mean that information would be readily available to staff to complete their records without having to return to their office.

We looked at three care plans for the young people receiving respite care at Nascot Lawn. Each one contained a photograph, contact and emergency contact details, consent to treatment forms and detailed risk assessments for the unit environment and the young person's health issues. The unit manager also showed us a separate book entitled 'This is me'. This book was designed to go with the young person to hospital if required and contained summary information on diagnosis, nutrition and breathing, medication and communication. The unit manager said it was also useful for as a summary for any bank staff on the shift.

Consent

Guidance was available for staff in relation to consent. We reviewed the consent policy dated January 2014 and the Mental Capacity Act (MCA) policy for the service. We saw evidence of consent for treatment in the care plans at both the respite centre and consent for vaccinations at the child health office. Staff were clear with regards to the law reflected in the trust's policy when gaining consent. They could also describe to us the Gillick competencies and Fraser Guidelines and their relevance when treating children and young people.

We spoke with a range of professionals who were involved in running the range of 'drop in' services for young people to gain advice on sexual health, contraception and emergency contraception. They were very clear on the trust's policy and best practice when gaining consent from young people who may be vulnerable and not have the support of a parent, guardian or carer.

We saw in the immunisation clinic, the nurse explain to a baby's mother the risks and benefits of the immunisation she was about to give.

Good

Are services caring?

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

Summary

We saw that parents, carers, children and young people were treated with kindness, dignity and respect. People who used the service told us that they found the staff caring and that they felt well supported.

Staff took time to talk to children in an age appropriate manner and involved both children and parents as partners in their own care.

in their own care.

Staff in all the services we saw and visited were providing compassionate, sensitive care. Children and families were encouraged to be involved in their care.

The most recent Friends and Family test which took place in Q1 2014-15 showed a positive trend overall from the year before. Overall 73% of people who had used services said they would recommend the services the trust offered to friends and family.

Detailed findings

Dignity, respect and compassionate care

The staff were aware of providing compassionate and respectful care. We received some patient feedback via comment cards that we left at a number of venues across the trust. Of the 32 cards that were completed, 29 were positive. One patient said, “Staff are very caring and we were treated with dignity and respect. The environment is safe and hygienic. We were listened to and our needs were responded to with the right care and treatment at the right time. In all we received good service here.” Another, at the community paediatric service in West Essex a patient said, “Everyone has been fantastic. The doctor took a real interest in my son and really listened and responded to our concerns.”

The three less positive comments from patients, all mentioned the time it had taken to get an appointment. One said: “The waiting lists for Autism Diagnostic Observation Schedule clinic appointments are too long, up to one year. The doctors are not aware of the child’s needs prior to appointment; he had to use appointment time to read notes so time was wasted. I have to chase appointments by phoning.”

We saw that therapists used age appropriate language when carrying out sessions with children of different ages. In the larger clinics where privacy could have been an issue, we heard the nurses and health visitors lower their voices so that conversations could not be heard between them and their clients. We saw that confidentiality was respected at all times when delivering care, in staff discussions with children and those close to them and in any written records or communication.

The most recent Friends and Family test which took place in Q1 2014-15 showed a positive trend overall from the year before. Overall 73% of people who had used services said they would recommend the services the trust offered to friends and family. The new-born hearing screening service had the highest score at 97%. The lowest was at West Essex paediatric service at 52%

Patient understanding and involvement

We spoke with a nurse at the Peace Children Centre in Watford who said that the service welcomed the involvement of parents and the nurses were always interested in their feedback. For example, one mother was not satisfied that her child’s blood sample had been delayed by missing a transport link to a specialist centre. So it was arranged that the blood would be taken earlier in the day to ensure that it was ready in time.

The speech and language therapy service was collecting feedback from parents on the implementation of a new model of working, which involved a three tier service:

- Something for all children: that is, advice, support, training and prevention
- Something for some children: support and early intervention for children at risk
- Something for children who need direst support from the SALT team – assessment and intervention.

Good

Are services caring?

This data was being shared across the service so that they could learn lessons from the sites that were implementing the new model first including user feedback for the training packages.

We saw a 'Book of Hope' of user feedback at the Challenging Behaviour Psychology Service at St Albans Children's Centre. This contained some messages from parents about the service. One family said, "Feeling listened to, feeling heard and that people understand".

Emotional support

We saw that staff examples of children and their families receiving emotional support from staff at the children centres and clinics, this was apparent at routine immunisation clinics for example, that professionals carried out as a routine. They were aware that parents found their babies and children having injections upsetting and were supportive to their feelings. One parent told us, "Staff were lovely and made us feel looked after and well cared for." Staff in the specialist clinics, for example, enuresis (bed wetting) were aware of the social, emotional issues related to the conditions they treated. During the clinics and home visits we saw positive engagement and support for parents, carers and their children.

Staff supported parents and children emotionally. Parents and carers told us that they felt very supported emotionally by staff and felt able to ask questions if they did not understand what was happening.

A comment card completed at a child development centre said, "I am happy with the service that I have been provided with at my various visits to the centre. The staff are warm, approachable and friendly. Another patient said, "Staff were lovely and made us feel looked after and cared for. Thank you."

Within health visiting services staff assessed mothers for signs of postnatal depression and offered support to the mother if this was needed. For example, extra visits to listen to concerns or worries associated with post natal depression. Listening visits are associated with a reduction in depression or low mood, and an improvement in life satisfaction. This demonstrated the service followed best practice guidance in supporting women with low mood.

In the sexual health service for young people, advice was available with regards to healthy relationships and the emotions associated with them.

Promotion of self-care

Children and their families were encouraged and supported to take care of their own needs as far as they could and for as long as they were able. For example, skills were passed on to families so that they could attend to feeding and respiratory equipment in the home. Respite and day care was offered to allow families to continue to cope with the needs of children with complex needs and long-term conditions at Nascot Lawn

The children's diabetes team worked jointly with specialist nurses, dieticians and paediatricians. The child and their family were encouraged to become experts in their own condition so that they could learn to manage it themselves. There was a similar ethos within the sickle cell service, where specialist nurses liaised with other health professionals and schools to assist the child and their family manage this lifelong condition.

Good

Are services responsive to people's needs?

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

Summary

We found that the services were organised, planned and delivered to meet the needs of children and their families. We found that structures had been redesigned in response to the people's changing needs and the need to manage resources between 'universal' for example immunisations and routine developmental checks and 'targeted' services, such as caring for children and their families with diabetes and Sickle Cell Disorders.

Access and response to translation service needs were limited and not always sufficient to meet patient's needs.

There was an open and transparent approach to complaints and they were treated as an opportunity for shared learning and service improvement.

Staff told us that they wanted to shape services to meet the needs of patients. They responded to feedback and complaints openly and constructively. We saw that most of the services acted on feedback about the service and used this information to improve services.

We saw that the services understood the different needs of the children and young people they served and designed and delivered services which met the specialist needs of children. Two nurse consultants showed us how they worked creatively with commissioners and other leaders to plan ways to meet young people's needs.

There was an understanding of the need to respond to cultural differences in the area, including the needs of travelers and those with a learning disability.

Detailed findings

Planning and delivering services which meet people's needs

Children's services were provided in a number of settings including the patient's home, health centres, children's centres and the child or young person's school. Staff reported they offered out of hours clinics on a Saturday mornings. We found within health visiting, SALT and school nursing 'drop in' clinics were offered so patients could access the service without an appointment which meant the service was accessible. For example school nurses offered drop in clinics in schools each week.

Community staff were flexible with regards to children's needs and would see the child who needed treatment in one of the centres, in their home or at their school of this was appropriate. The therapists were very much aware that the parent was the expert with regards to their child and kept them informed and involved.

The speech and language service offered speech 'drop-in' sessions. These sessions were held in various locations so that families who were concerned about their child's speech could easily reach a service nearby their home or the child's school. The family could self-refer if they were concerned about their child's speech or had feeding problems. Referrals were also made from other health professionals, GPs, health visitors and school nurses. The child could then be referred on to formal speech therapy sessions if this was thought necessary. A therapist said, "This increases contact and maximises our availability".

The speech and language therapy service was introducing a new school and pre-school based, model of the service and a profiling tool to help identify and prioritise children's needs. The service had invested in a locum and staff on a fixed term contract so that the training programme could be expedited. However, the staff told us that it was challenging to work with the current model and caseload whilst training the workforce to deliver the new model.

We attended a traveller's site with a health visitor who was offering a range of services to an extended family, including immunisation to a child not often in school. The health visitor was the link to a range of other agencies including Great Ormond Street Hospital.

There were services to support pregnant teenagers via the family nurse partnership; however, there was no integrated strategy for prevention of teenage pregnancies through sexual health promotion.

The Children's Sickle Cell Service worked in partnership with specialist nurses, schools and paediatricians. All babies who were diagnosed with Sickle Cell Disorders were

seen by the specialist nurse by the time they were four weeks old and had been seen by a consultant haematologist by the time they were three months old. This approach was to ensure that visits to A & E and admissions to hospital were prevented and to ensure the child and their family managed their condition at home.

Equality and diversity

Although there were some areas within Hertfordshire where there were people who did not speak English as their first language, generally, the local population was not ethnically diverse. There was a local translation service; if staff required an interpreter they were available on a pre-booked basis, but the staff awareness about access to the service was not consistent as some staff reported it was not available seven days a week or out of hours. However, If patients did not speak English, a family member or a member of staff would provide assistance with translation. There are always concerns with family members providing translation, which staff acknowledged, however, often this was the only way to respond in a timely manner to the child or family's needs. Some staff told us translation services were good in 'pockets'. However, no-one we spoke with was aware of plans to improve this situation.

The community nursing teams assessed patients with a learning disability to ensure they had access to specialist community learning disability staff when needed.

We also observed the sensitive and appropriate handing of a mother with dyslexia who needed support to fill in a case history form. She was supported with the form discreetly and in a separate room.

Meeting the needs of people in vulnerable circumstances

There was an electronic 'flag' system for vulnerable children on a child protection plan, looked after children or those identified as children in need of additional support. This was to ensure that those who had contact with them, their families or carers were aware they were vulnerable and could support them accordingly. Vulnerable children and their families were seen as a priority for everyone who worked within the children's and young people's service.

We spoke with the clinical psychologist working with children with challenging behaviour in St Albans Children's Centre. The psychologist said that there were families coping under extreme pressure from a child or young person with challenging behaviour were given support and taught mechanisms to cope.

We attended a group supervision session with the named nurse for safeguarding and specially trained family nurses from the family nurse partnership. The family nurse partnership is a home visiting programme for first time mothers aged 19 or under. The team reported they were seeing a particular young mother regularly, from early pregnancy and would continue to support her until her baby was two years old.

There was varying involvement of school nurses in supporting the reduction of under 18 conceptions. There were drop-in centres offering C-Card scheme, emergency contraception and chlamydia screening and 1:1 support and advice. Some school nurses offered support to sex and relationship education programmes in secondary schools. Although many school nurses are highly trained and skilled in offering health promotion, contraception, pregnancy testing, many reported that practice and services had diminished over the past years.

According to a report commissioned by the trust in late 2014 to consider the school nursing service, there are a reported 400 home schooled children and young people across Hertfordshire. The School Nursing service was not commissioned to deliver services to home schooled children. There is no recording system to inform who or where they are. There is very limited contact with the school nursing service for these young people and their families and it is not proactively promoted to the families who school their children out of mainstream school. This is a risk in terms of young people having access to specialist services, unless they are sought by the parent and the potential that any safeguarding issues are not identified.

None of the school nurses currently offered sexually transmitted infections screening service, although there was a Chlamydia screening service that was part of the adult services. It is standard practice that this service is offered as part of the school nurse's role. There is little school nurse involvement in reducing alcohol and drug misuse. Advice is available however; there is little evidence of a screening tool to support identification of alcohol misuse in young people, or health promotion activities. There is no partnership working with other professionals to support young people who may need advice or support.

Good

Are services responsive to people's needs?

Access to the right care at the right time

The 18 week referral to treatment time (RTT) was being breached during most of 2014 for children waiting to be seen by a paediatrician. This was due in part to increased demand, a paediatrician vacancy, which had been filled by a part time locum doctor and staff absence due to sickness. However by the beginning of 2015, a new paediatrician had been appointed, additional clinics had been scheduled and the waiting time had been reduced. RTT targets, at the time of our inspection were being reached.

We saw that drop-in sessions for the speech and language therapy service were widely available in places 'where people go,' and where people 'struggle to travel'. This meant the service was widely available and accessible for those who needed it. The manager of the service said, "Once the electronic record system is county-wide, the fact that a child is seen at one drop-in clinic means that he/she can then be electronically booked into the menu of options at the base nearest to the child's home."

Waiting times for initial screening and appointments were decreasing in a number of services. Waiting times for initial screening with the staff from the challenging behaviour psychology service had been an average of nine months. The clinical psychologist we spoke with said that the waiting time had now been reduced to three months. Clinics were available at five locations and parents could also contact the clinic by telephone for advice and support.

Both the occupational and physiotherapy services had reduced their waiting times for a first appointment from 48 to 13 weeks. This happened as a result of centralised referrals and was now below the 18 week referral to treatment target.

There was a concern that antenatal visits were below the target, set at 95% to be achieved by end of March 2015. At the time of the inspection, the service was only achieving 20% of all contacts. This was because health visitors said they were not always receiving contemporaneous and accurate information from midwifery services. There were robust plans in place to improve this process utilising multidisciplinary working. This was being reviewed monthly at Board level to ensure improvements were being made.

The other area of concern had been in relation to the completion of initial health and statutory review assessments for Looked After Children. These were reported to be below the target rate for completion in May 2014. The board were informed that the Director of Quality and Governance/Chief Nurse would be monitoring, to ensure all performance standards for Looked After Children were reached. It was reported to the Board that, as of December 2014, 100% of initial health assessments were completed within the agreed ten day time scale.

The Children's Sickle Cell Service worked in partnership with specialist nurses, schools and paediatricians. All babies who were diagnosed with Sickle Cell Disorders were seen by the specialist nurse by the time they were four weeks old and had been seen by a consultant haematologist by the time they were three months old. This approach was to ensure that visits to A & E and admissions to hospital were prevented and to ensure the child and their family were able to manage their condition at home.

Complaints handling and learning from feedback

The Children's General Manager showed us a presentation that was delivered at the Children's Services Business Unit Performance Review. This demonstrated that there had been 33 complaints from 1 April to the end of September 2014. We reviewed the six complaints that had been received in September 2014. One concerned inaccurate records, one was about the lack of information and support for the family offered by the doctor and another was about the content of a letter about immunisation. The other three concerned waiting time for treatment. 100% of complaints were resolved with the timescale agreed with the complainant. The children's services bulletin for November described these complaints and the learning from them in the 'sharing lessons from complaints' section. This meant that learning from complaints was shared with the whole of the children's service.

The Operations Manager for children's speech and language therapy said, "We have few complaints, but those we do are about waiting times." However, was confident that the open access clinics would help to reduce these complaints as parents could have contact with SALT and immediate advice and ongoing referral, if appropriate.

The complaints ratio for children's medical services as a whole was higher compared to a trust overall for the first

Good

Are services responsive to people's needs?

quarter of 2014/15. However, the managers were confident that the reduced waiting times, and open access to speech therapy, would lead to a reduction in complaints regarding waiting times, which formed the majority 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

We heard about a significant number of projects to make changes to the services, all happening at the same time. Some had been extended beyond their original deadlines and one project had merged into another. Although the staff could see the benefits of making improvements, there was some concern about the capacity of the service to consider and progress so many projects all at one time whilst also delivering the current service. We noticed implementation of some improvements had been slow, particularly following the service review in community paediatric services in West Essex.

There was effective working within teams, across services and with other agencies to promote safety for individuals, particularly those with multiple or complex needs. We found evidence of a clear vision and strategy where the priorities of the trust with regards to the care of children and young people, were understood locally. The staff we spoke with told us the patient was at the centre of what they do and they were positive about working for the organisation. They understood the priorities of the service as a whole and that of their individual teams. There was a determination to deliver good quality care and staff knew their role in achieving this.

All staff told us that the leaders were visible and approachable. Staff told us they felt valued and respected as professionals.

Detailed findings

Service vision and strategy

Staff we spoke with in the service expressed their support for the trust's senior leadership team particularly the chief executive. One locality manager said that the Chief Executive was very visible in the organisation and visited the teams. This locality manager also said that the vision for children and young people's services was clear and that there had been increased investment in the health visiting and school nursing services.

We heard about a significant number of ongoing projects. There had also been changes to the organisational structure. There was concern from some staff that these were all taking place within the services at the same time. Some of these were part of national programmes, such as the 'Closing the Door' project. This was a project where, to aid clarity with regards to providing services, families were being transferred to teams in the counties they lived in. This was in an effort to prevent cross county misunderstandings, where service to one family may have been provided by several different counties, particularly where families lived near county borders. There had been a phased approach to the management of this large project but the aim was that it was to be completed nationally by 1 April 2015.

Other projects were the result of changing commissioning decisions and provider relationships. These involved the transfer of staff under the transfer protection employment (TUPE) arrangements. This included transferring staff working in the Sure Start St Albans Children's Centre (where the trust had been unsuccessful with the tender) and the transfer of staff working in the sexual health services across Hertfordshire to the Central London Community Healthcare by 1 April 2015.

Several changes were being made from inside the service. For example, the occupational therapy services between Hertfordshire Community Trust and the local authority were merging. In addition, the trust was integrating occupational and physiotherapy services under a single manager. We spoke with both physio and occupational therapists at St Alban's Children's Centre who said that the new integrated structure was challenging, particularly for physiotherapists who may have their work managed by an occupational therapist.

The physio and occupational therapy restructure had been continuing for about nine months and had followed a restructure in speech and language therapy services. The speech and language therapy restructure in was intended to maximise the use of resources by concentrating delivery in school and pre-school settings. This restructure was well underway and staff were delivering an intensive training programme for schools.

The trust had successfully tendered to deliver a new service to be called 'PALMS' – Positive Behaviour, Autism, Learning

Good

Are services well-led?

Disability, Mental Health Services. This was intended to bring together a team from the Hertfordshire Partnership Foundation Trust with the challenging behaviour psychology service at the Hertfordshire Community Trust. This team would be dealing with who were dealing with children with complex neurodevelopment disorders, for example, Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorders.

Other projects included:

- Health visitor Implementation Plan – known as the 'Call to Action'. This was progressing well and on target, to be completed by April 2015.
- Mobile working within the community setting through improved connectivity with information technology systems.
- A review of the provision of administration with the children's' services
- School nursing – Following an external review in 2013
- The UNICEF baby friendly breasting feeding initiative - level one
- Implementing the action plan resulting from the external service review, which took place in 2014, of the community paediatric services at the trust by the Royal College of Paediatric and Child Health. This review was instigated by the medical director in response to a number of complaints. Progress had been slow and some clinicians did not feel that they were being included in the capacity planning.

Health visitors that we spoke with in their focus group confirmed that there had been a lot of change. One told us, "We are looking for some continuity now". A senior manager said, "It feels like we are on a constant treadmill".

School nurses were awaiting direction in terms of their focus on the public health agenda. This guidance was published by the Department of Health in March 2014 supports effective commissioning of school nursing services to provide public health for school aged children. It also explains how local school nursing services can be used and improved to meet local needs. At the time of our inspection, detailed work on this project had not been commenced. However, the trust told us they were working collaboratively with the local authority on service development and continued to implement the School and Public Health Nurses Association review recommendations, which were made in line with the Public Health Outcomes Framework.

Governance, risk management and quality measurement

There was effective working within teams, across services and with other agencies to promote safety for individuals, particularly those with multiple or complex needs. We saw evidence of effective governance structures and processes for the identification and management of risk, for example an entry on the risk register which described the high levels of safeguarding and capacity issues for the team at Welwyn and Hatfield. Extra management support had been dedicated to this team.

We saw an audit in the St Albans Children's Centre to assess whether therapists were confident about referring children for lycra orthosis. (Lycra suits are beneficial for daily living activities for children with cerebral palsy, for example) and whether they were following the agreed pathway. The audit demonstrated that up to 83% of therapists said that they understood the service but fewer, up to 78% were confident of using the service. There was a recommendation for therapists to improve their knowledge of this service, which was to be achieved by extra training.

Leadership of this service

Staff and team leaders in the service prioritised safe, high quality, compassionate care and promoted equality and diversity.

We attended a weekly team meeting at the Queensway Health Centre and heard how the service managers had supported staff following the child deaths in 2014. A health visitor said, "Our resilience training finished last week". The health visitor told us that staff had put together a flow chart of what support they would like to run in parallel with the incident reporting process. This included a 72 hour report investigation. The health visitor said, "This demonstrates the importance of developing compassionate resilience in health visiting and the how trust believe in investment in health and wellbeing".

We heard about effective leadership in the speech and language therapy service including pastoral support and careful caseload management and supervision.

Culture within this service

The culture was centred on the needs of the people who use the services, the children, young people and their families. All staff we spoke with understood what decisions they were required to make, knew what they were

Good

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responsible for and the limits of their authority. Staff told us that the organisation encouraged candour, openness and honesty. All staff spoke of the importance of raising concerns and that action was taken when staff had concerns.

Staff said they worked well together and supported each other. They told us they felt valued and respected.

A report was commissioned by the trust published in May 2014. The trust required the report to provide: "Independent, external assurance about the safety and capacity of the service and identify any changes that would improve it both for patients and for staff." The requirement from the report arose in part from the complaints ratio for children's medical services as a whole, which was high at 2.85 complaints per thousand interactions for the first quarter of 2015 compared to a trust average of 0.13 complaints per interactions per thousand. The report did not 'identify any aspects of the service which were immediately unsafe', although confirmed that workloads were creating long waits and delays for patients. There was a detailed action plan to which the trust responded and had submitted a new capacity plan to their commissioners.

We spoke with four consultant community paediatricians within this service. We found that the recommendations arising from the Royal College of Paediatricians report (2014) had caused some frustration as they were taking so long to implement.

Public and staff engagement

A school nurse we spoke with said that the children's services team bulletin, which was published monthly, "Lets staff know what is happening". A health visitor said that the bulletin, as well as including learning and development issues included 'softer' contributions, for example, recognising staff excellence with an award of the month. It also detailed and celebrated staff who were described as going 'the extra mile.'

In the most recent staff survey undertaken in 2014 the Trust rating for well-structured appraisals compared to other community Trusts was within the average scoring range.

Recruitment and retention of staff was spoken about by all staff, who reported that many staff moved to neighbouring trusts, for example to nearby London, where salaries were higher. The majority of staff reported working extra hours to their contract to complete essential tasks. Staff reported that financial incentives had been offered in certain areas of Hertfordshire to assist in recruitment. This is felt to be unfair by many staff. The majority of school nurses reported being dissatisfied within their roles. A number had plans to leave their posts. The school nurses described they felt like 'poor relations' compared with health visitors who were seen as being optimally staffed. Staffing levels within the school nursing service had been rated as amber on the trust's risk register.

There was publicly available information about the services provided by the trust on their website.

The trust had engaged both staff and public in questionnaires to seek feedback on the services provided.

The information from public was positive; however the trust did not seek feedback from the public in other formats, for example with public forums, meetings, or other means.

Innovation, improvement and sustainability

Staff told us innovation was encouraged and recognised. For example we saw innovative practice in the speech and language service with the open access clinics. Any new ideas to improve services were celebrated in the monthly children's services bulletin.

The General Manager told us that the new trust service to be called 'PALMS' – Positive Behaviour, Autism, Learning Disability, Mental Health services, was the first of its kind. It would be an innovation for the trust and was based on a new model dealing with children with complex neurodevelopment disorders with the challenging behaviour psychology service at the Hertfordshire Community Trust.