

Hertfordshire Community NHS Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Community Adults, including podiatry	Hertfordshire and Essex Hospital, Bishop's Stortford	RY448
Community Adults, including podiatry	Crossbrook Street, Cheshunt	RY4
Community Adults, including podiatry	St. Albans City Hospital	R409
Community Adults, including podiatry	Hemel Hempstead – Safari therapy unit	RY4X6
Community Adults, including podiatry	Potters Bar Community Hospital	RY402
Community Adults, including podiatry	Rickmansworth Health Centre – Avenue Clinic	RY4
Community Adults, including podiatry	Avenue Clinic, Watford – Early Supported Discharge	RY4
Community Adults, including podiatry	Queen Victoria Memorial Hospital	RY412
Community In patients	Danesbury Neurological Centre	RY407
Community In patients	Gossoms End Rehabilitation Unit	RY409

Summary of findings

Community In patients	Hertfordshire and Essex Hospital, Oxford, Cambridge Wards and Minor Injuries Unit	RY405
Community In patients	Langley House	RY411
Community In patients	Potters Bar Community Hospital	RY402
Community In patients	Queen Victoria Memorial Hospital	RY412
Community In patients	St Peter's Ward (Hemel Hempstead Hospital)	RY414
Community In patients	St Alban's City Hospital Sopwell and Langton Wards and Holywell Neurological Unit	RY4X6
End of Life Care	Apsley One	RY4
End of Life Care	Gregans House	RY4
Children and Young People's Services	Child Health, Ascots Lane, Welwyn Garden City	RY4
Children and Young People's Services	Danestrade Health Centre, Stevenage	RY4
Children and Young People's Services	Florence Nightingale Centre, Harlow	RY4
Children and Young People's Services	Hemel Hempstead Travellers' site	RY4
Children and Young People's Services	Nascot Lawn	RY4X4
Children and Young People's Services	Pat Lewis Centre, Hemel Hempstead	RY4
Children and Young People's Services	Peace Children's Centre, Watford	RY4
Children and Young People's Services	Queensway Health Centre, Hatfield	RY4
Children and Young People's Services	St Albans Children's Centre	RY4
Dentistry	Harmony Dental Unit, St Albans City hospital.	RY4
Dentistry	Dental Department, Peace Children's Centre, Watford.	RY4

Summary of findings

Dentistry

Dental Clinic, Hoddesdon.

RY4

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider

Requires Improvement



Are services safe?

Requires Improvement



Are services effective?

Requires Improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires Improvement



Summary of findings

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Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We found that the provider, overall, was performing at a level which led to a judgement of Requires Improvement.

The Trust board were a stable team with most board members having been in post for at least 2 years the Chief Executive having been in post since 2012. The Chief Executive was highly respected by all staff we spoke with.

All the executive team told us that recruitment was the biggest risk to the trust, we found there was lack of clarity amongst the executive team relating to the vacancy position and how this was being managed. The vacancy position was addressed through the Trust's committee structure. However, there was lack of a sufficiently detailed and effective plan in place to address this in a timely manner.

We found the trust safeguarding adult policy to be confusing and ambiguous which meant that staff were not clear on the actions they should take, meaning that there was a risk that patients may not always be protected from the risk of harm. At the time of the inspection the trust did not have a current Children's Safeguarding policy although there was an awareness this needed to be completed.

The Trust said they had a clear strategy to become a leading light in the provision of innovative programmes of care supported by the creation of a clinical strategy. However, this was not clear as some staff said they were uncertain as to the direction and objectives of the organisation.

The development of a clinical strategy had been led by the executive team and there was evidence of both staff and stakeholder involvement in its development.

Staff were aware of the trust's values and able to describe them.

There were no clear goals set from the trust for all services that staff could describe. We found that there was some disengagement with the leadership of the trust in one service which had recently been through some significant change.

There were a significant number of change projects taking place at the same time. Some had been extended beyond the original deadlines. The trust told us all projects are assessed for feasibility against suite of criteria including: effectiveness, patient safety, patient feasibility, project feasibility and capacity was increased to support management of individual projects. However there was concern amongst some staff about delivering all at one time whilst also providing the current service.

The quality of patient's records varied between units. Records of care planning, evaluation of care and essential communication about patients were not always complete and information was not always stored in an organised manner. Nursing assessments and care plans were used but they were not personalised or holistic to enable people to maximise their health and well-being.

Food provision was positively rated by patients. Monitoring of fluid intake was not fully completed or evaluated which meant there was a risk of ineffective nutritional management and lack of fluid intake.

Generally services were provided in clean and hygienic environments, which helped protect patients from the risk of infection. However, hand washing practices were not always consistently practiced when delivering care between patients.

There was evidence care and treatment was provided in line with national guidance. Multidisciplinary teams worked effectively together to provide care for patients. The management of pain relief and use of recognised tools to assist assessment of pain levels varied between wards.

Generally, we found there were effective induction programmes provided including induction for students and agency staff. Staff received annual appraisals. There were opportunities for professional development of staff.

We found some areas of good practice, dental services had implemented a The "Purple Star" strategy. Whilst this

Summary of findings

is a local initiative within Hertfordshire the skills and knowledge staff acquire, are put into practice across all groups of patients who attend the specialist dental service. The Purple Strategy is a joint health and social care initiative which informs service providers and empowers people with a learning disability and their carers to get fair non-discriminatory health and social care. It has been developed with service users and stakeholders to promote and highlight quality health and community services that have been reasonably adjusted to meet the needs of people with learning disabilities.

The stroke team had been nominated by the trust management for the “life after stroke” award from the Stroke Association.

The introduction of the Home First’s rapid response teams who were able to respond to peoples’ needs within one hour.

The children and young people’s services within the trust were working towards achieving level one of the UNICEF baby-friendly initiative and were implementing a new trust service to be called ‘PALMS’ – Positive Behaviour, Autism, Learning Disability, Mental Health services. It would be an innovation for the trust and was based on a new model dealing with children with complex neurodevelopment disorders in conjunction with the challenging behaviour psychology service at the Hertfordshire Community Trust.

There were specific meetings to discuss end of life care for people with learning disabilities instigated by doctors with an interest in learning disabilities.

Summary of findings

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

We always ask the following five questions of services.

Are services safe?

Overall we judged that the services provided as requires improvement for safety. Improvement was needed within community inpatients and community adults. Services for children and young people, end of life care and dentistry were judged to be good.

All the in-patient units were clean, although hand washing practice at some was observed to be sub optimal and not in line with trust policy.

The trust had previously made significant reductions in the number of HCAI particularly C.difficile. At the time of the inspection the trust had notified two cases, but were still within their trajectory for achieving end of year ceiling.

Incident reporting across all services was variable. Generally feedback and learning was shared across some teams and at some levels, but not others. This meant the Trust could not be assured that learning was shared universally throughout the trust to reduce the risk of further incidents occurring.

We found that there was a significant number of vacancies in some areas particularly in the inpatients services where vacancies were at an average of 14.7% of the workforce, with hotspots where the vacancy rate was higher at 25%. This resulted in the need for a high use of temporary staff who were not always available. Although this was recognised as a significant risk for the organisation there was no assurance that there was a robust strategy to address this with pace.

Health Visitors were carrying caseloads beyond the optimum levels agreed nationally.

Most staff were aware of their responsibilities for safeguarding and had received training. They were supported by leads for adult and child safeguarding. We found the trust safeguarding adult policy to be confusing and ambiguous which meant that staff were not clear on the actions they should take meaning that there was a risk that patients may not always be protected from the risk of harm.

At the time of the inspection the trust did not have a current Children's Safeguarding policy although there was an awareness this needed to be completed.

We found in the dentistry service there was some confusion amongst both staff and safeguarding leads as to how concerns should be reported, for both adults and children, which could have

Requires Improvement



Summary of findings

led to those being responsible for abuse not being reported to the correct authorities. Furthermore, safeguarding concerns were not routinely reported via the trust's electronic reporting system. This meant there was not an accurate oversight of safeguarding within individual services or the trust as a whole.

We looked at the arrangements for the storage and security of medicines at in-patient units. In general we found these were safe. However, due to lack of resources within the pharmacy team some sites received infrequent visits by a pharmacist. There was therefore a risk that inappropriate management of medicines would not meet the pharmaceutical needs of patients. We were satisfied that this had been identified and included in the Trust's risk register with action plans to address this by May 2015. We found regular checks were made on controlled drugs. Controlled drugs (CDs) are medicines that require extra checks including special storage, recording and disposal arrangements. We found one safety concern with regards to reconciliation of CDs.

Equipment seen had been maintained across the majority of the sites and annual safety checks had been carried out. However appropriate equipment checks of resuscitation equipment were not always carried out in the inpatient areas.

Are services effective?

Overall we judged that the services provided as requires improvement for effectiveness. Improvement was needed within community inpatients and end of life care. Services for children and young people, community adults and dentistry were judged to be good.

Most of the inpatient units used a variety of methods to record patient care. Therefore in some areas there was not an easily accessible record of the whole patient episode of care. Furthermore, risk assessments were not correctly used and evaluation of care was not always completed. Nursing assessments and care plans were used but they were not personalised or holistic to enable people to maximise their health and well-being. However, therapy notes were comprehensive to enable staff to share decisions about patient's mobility and ability and for plans for rehabilitation to be developed.

In most services we saw evidence that multidisciplinary teams worked together to provide effective care for patients. Management of pain relief and use of recognised tools to assist assessment of pain levels was good in the community, however, this varied between in-patient wards. In the end of life care service, there were no recognised tool used to assess or review pain, it was carried out on an informal basis.

Requires Improvement



Summary of findings

Food provision was positively rated by patients. Monitoring of fluid intake was often not fully completed or evaluated which meant there was a risk of ineffective nutritional management and lack of fluid intake.

Audit was used in all services, although less widely in most in-patient areas and in the end of life care services, to monitor patient risks and outcomes to determine the effectiveness of care and treatment. However, the limited availability of physiotherapists and occupational therapists (OTs) in some of the smaller hospitals meant that falls management programmes, as part of a patient's rehabilitation, were not being carried out in line with accepted best practice. However, despite this, in July 2013, 4% of patients were reported to have fallen. This was 2% above the NHS average. By February 2015, this had decreased to 2% of patients reported to have fallen and was slightly below the NHS average.

Policies and procedures were accessible for staff. Staff were able to guide us to the relevant information using the trust's intranet. Care was monitored to demonstrate compliance with standards and national guidance, particularly in the community and end of life care, where there were good outcomes for patients.

Some referrals to wards were not always appropriate with some patients having to be referred immediately back to the acute ward they had been discharged from. There was a strong focus on discharge planning, which was commenced on admission to the community in-patient wards.

The use of technology to enable patients to monitor their conditions at home via remote tele-health systems had a positive impact on them being able to remain in their own homes

Generally, we found there was effective induction programmes provided, including induction for students and agency staff. Staff received annual appraisals, although this depended on the service they were working in. As at February 2015, 83% of Trust staff had received an appraisal within the previous 12 months. Some areas of the service reported lower rates than others. The Trust rating for well-structured appraisals compared to other community Trusts was within the "average" scoring range.

There were opportunities for professional development of staff, for example training courses. However most staff said they had not received regular clinical supervision.

Staff demonstrated a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and their assessments of mental capacity were detailed. However, in end of

Summary of findings

life care services, we found that in some instances that mental capacity assessments were not always completed or reviewed where patients were identified as not having the capacity to make decisions around end of life care.

Are services caring?

We judged the care provided by staff to be good across all the core services and in all the places that we visited apart from in dental services where we found it to be outstanding.

All staff we saw and spoke with demonstrated commitment to the delivery of safe, effective and caring treatment.

We observed staff responding to patients, their families and carers with kindness, compassion and in a professional manner.

People were mostly well supported, treated with dignity and respect and were involved in their care. Patients, their relatives and carers spoke very positively about the compassion and care they received from staff both in community hospitals and in the community settings.

We saw staff taking time to talk to people in a supportive, kind and appropriate way.

Patients and their relatives told us that they felt reassured and were confident to ask questions and make requests.

In the end of life care service, staff had received training in communication and we saw that staff used appropriate communication skills with patients.

Staff did their best to support families and told us that sometimes they visited in pairs so that one person could provide care to the patient while the other staff member provided advice and support to their carer.

In dentistry we saw staff had completed the T.E.A.C.H workbook as part of the Purple Strategy a joint health and social care initiative which informs service providers and empowers people with a learning disability, this had been developed with service users and stakeholders to promote and highlight quality health and community services that have been reasonably adjusted to meet the needs of people with learning disabilities.

The Quality Account for 2013/14 showed that the care patients said they received was good to excellent, 99% of patients using inpatient services said they were treated with dignity and respect.

Good



Are services responsive to people's needs?

We judged the responsiveness of all the services provided as good.

Good



Summary of findings

Peoples' needs were met through the way that services are organised and delivered. The services were organised in a way that took account of peoples' choices, enabled continuity of care and valued the importance of flexibility. Patients appreciated the slower pace of the community inpatient wards where they felt staff had time to plan and deliver the care they needed before being discharged home. There was an integrated approach to planning and delivering care in a way that supported people to receive and access care as close to their home as possible.

However, in the dentistry service we found that patients could not access treatment and urgent and emergency care when required as there was no commissioned out of hours service and no hospital out of hours specialist dental provision. This meant people were told they had to use the NHS 111 service or pay privately for that service if they felt they could not wait.

The needs of different groups of people, including vulnerable people, were taken account of. Teams were located throughout the county to be able to respond promptly to patients' healthcare needs and staff worked as part of multidisciplinary teams to ensure the patients' needs were met responsively.

Learning and changes as a result of complaints was achieved through accurate recording, reflection and cascade of information. However, the dentistry service did not record complaints and it was unclear how they were responded to.

Are services well-led?

We judged that the services provided as required improvement for being well led.

The trust board were a stable team with most board members having been in post for at least 2 years, the Chief Executive having been in post since 2012. The Chief Executive was widely known and highly respected by all staff we spoke with.

There were arrangements for identifying, recording and managing risks however we found that not all key risks were dealt with appropriately or in a timely way.

All the executive team told us that recruitment was the biggest risk to the trust. However, we found there was lack of clarity amongst the executive team relating to the vacancy position and how this was being managed.

The vacancy position was reviewed through the trust's committee and meeting structure. However, there was lack of a sufficiently detailed and effective plan to address this in a timely manner that was clearly understood.

Requires Improvement



Summary of findings

We found the trust safeguarding policy to be confusing and ambiguous which meant that staff were not clear on the actions they should take meaning patients were not always protected from the risk of harm. At the time of the inspection the trust did not have a current Children's Safeguarding policy although there was an awareness this needed to be completed.

There were no clear goals set from the trust for all services that staff could describe. We found that there was some disengagement with the leadership of the trust and the staff working in palliative care services.

There were a significant number of change projects taking place at the same time. Some had been extended beyond the original deadlines. The trust told us all projects were assessed for feasibility against suite of criteria including: effectiveness, patient safety, patient feasibility, project feasibility and capacity was increased to support management of individual projects. However there was concern amongst some staff about delivering all at one time whilst also providing the current service.

The Liverpool Care Pathway (LCP) was withdrawn nationally and locally in July 2013. The trust had not implemented a replacement care plan. There was no specific end of life care plan.

The trust said they had a clear strategy to become a leading light in the provision of innovative programmes of care supported by the creation of a clinical strategy. However, we found there was a lack of understanding of the strategic vision amongst staff. Some staff said they were unclear as to the direction and objectives of the organisation.

Governance processes were in place such as clinical and internal audit to monitor quality and safety of care and there was evidence of effective use of patient feedback to improve services through the use of patient survey and complaints information. However there was limited sharing and learning from incidents trust wide.

We noted that the implementation of improvements had been slow following the service review in community paediatric services in West Essex.

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. At the time of our inspection, detailed work on this project had not been commenced. 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.

Summary of findings

The trust had a process for leading professional practice, with a Clinical Supervision Framework Policy in place. This set out the requirements on local services to put in place appropriate supervision arrangements within a prescribed set of requirements, for example, governance framework committee groups and task and finish groups and through the clinical quality leads group, AHPs and Doctors fora.

We found however, there was no robust process in place for appropriately leading all professional staff in their practice. This was particularly evident for nursing staff, where some staff told us and evidence demonstrated that reporting lines, for professional issues were unclear.

Newly qualified health visitors did not immediately carry a safeguarding caseload and all Health Visitors were allocated a Supervisor.

We saw evidence of systems being implemented by managers where gaps in the service were identified, however the forecast and planning of these issues had not been implemented by the trust.

There was a clear local leadership and management structure; each clinical lead had defined areas of responsibility. However, within the senior nursing team this was blurred. Some staff told us that they were unclear where they reported to managerially and professionally.

Staff were aware of the trust's values and able to describe them.

Summary of findings

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.

Why we carried out this inspection

We inspected Hertfordshire Community NHS Trust as part of our comprehensive community health services inspection programme.

Hertfordshire Community NHS Trust is an organisation providing NHS services and therefore we used our NHS methodology to undertake the inspection.

How we carried out this inspection

During our inspection we reviewed services provided by Hertfordshire Community NHS Trust across the county of Hertfordshire and West Essex. We visited community hospital wards, a minor injuries unit, outpatient, dental, podiatry and specialist children's clinics. We accompanied district nursing and palliative care teams on visits to people in their homes, where they were receiving treatment.

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 each core service and asked other organisations to share what they knew, this included Health Watch and the local Clinical Commissioning Groups. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, 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 carried out an announced visit on 02 March 2015.

Information about the provider

Hertfordshire Community NHS Trust provides NHS healthcare services to a population of 1.1 million people in Hertfordshire and since 2012 to 68,000 children living in West Essex. The Trust provides community-based services for adults and older people, children and young people, and a range of ambulatory and specialist care services. They serve the communities of Broxbourne,

Dacorum, East Herts, Hertsmere, North Herts, St Albans, Stevenage, Three Rivers, Watford and Welwyn/Hatfield. The Trust also provide children's specialist community services in West Essex

There are around two million contacts with people during the course of a year and the services deals with people from before birth until death.

Summary of findings

The Trust employs approximately 3,000 staff, one of the largest employers in the local area. In 2013/14 the Trust had an income of about £130.7m

The demographics in Hertfordshire mirror that of England, but deprivation in Hertfordshire is lower than average. However about 13.7% (30,000) children in the area, live in poverty. Life expectancy for both men and women overall is higher than the England average, but in the most deprived areas of Hertfordshire, life expectancy is 7.0 years lower for men and 6.0 years lower for women.

Hertfordshire Community NHS Trust provides the following core services:

- Community adults
- Community inpatients (207 beds in eight locations)
- End of life care
- A minor injuries unit
- Dental and podiatry services

- Children and young people's services

Hertfordshire Community NHS Trust has a total of 12 registered locations, although care and treatment is delivered from 106 locations across Hertfordshire and West Essex. This includes 8 hospital sites offering in-patient services. These have an occupancy rate as at January 2015 of 92.7% and an average length of stay of 23 days (Stroke) and 27 days (Non-stroke). However, one unit, Danesbury has an AVLOS of 45 days, which reflects the complex needs of its patients.

Hertfordshire Community Trust's hospitals and community services have been inspected a total of 13 times since their registration with the Care Quality Commission in 2010. At the time of this inspection, all locations previously inspected were compliant with the Regulations.

What people who use the provider's services say

Most patients told us they had a good service and were helped to understand what treatment they needed and how it would be given.

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 and particularly praised the cleanliness of the wards.

The people we spoke with who used the dental service told us they were very satisfied they had a service that offered care to those who could not access dental services easily due to their specific health, communication, or disability needs. They told us they were never rushed and usually saw the same dentist who got to know what they liked or disliked.

Patients and carers were positive about the care and treatment their relative had received, saying that staff were polite helpful and responsive to people's needs.

The friends and family test told us that 79% of patients would recommend the service to their friends and family. The Quality Account for 2013/14 showed that the care patients said they received was good to excellent, 99% of patients using inpatient services said they were treated with dignity and respect.

41% of all complaints received were about standards of care (23%) and date for appointment (18%) respectively. These issues are being addressed through a 6 C's working group with a focus on driving up care and compassion across the organisation.

Good practice

- Dental services had implemented a The "Purple Star" strategy. The Purple Star Strategy is a joint health and social care initiative which informs service providers and empowers people with a learning disability and

their carers to get fair non-discriminatory health and social care. It has been developed with service users

Summary of findings

and stakeholders to promote and highlight quality health and community services that have been reasonably adjusted to meet the needs of people with learning disabilities.

- The stroke team had been nominated by the trust management for the “life after stroke” award from the Stroke Association.
- Wards were found to be clean and this was frequently commented on by patients at all locations.
- Patients praised the quality of the food provided.
- All patients commented on how caring staff were.
- There were good, innovative systems to minimise the risk of patient falls. The trust made good use of champions to lead and cascade good practice for certain aspects of care, for example falls and dementia.
- Work being done to reduce the incidence of pressure ulcers, which at the time of the inspection was lower than the national average
- Multi-disciplinary teams worked well and there was evidence of effective discharge planning.

- The children and young people’s services within the trust were working towards achieving level one of the UNICEF baby-friendly initiative.
- The Clinical Nurse Specialist’s expertise and multi-disciplinary working at the Hertfordshire and Essex Hospital to prevent admission to the acute hospital.
- The Home First’s rapid response teams were able to respond to peoples’ needs within one hour. If they were unable to meet the referral time staff said they continued to do background checks.
- Referral times were being met at the time of our inspection.
- There were specific meetings to discuss end of life care for people with learning disabilities, instigated by doctors with an interest in learning disabilities.

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 in conjunction with the challenging behaviour psychology service at the Hertfordshire Community Trust.

Areas for improvement

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

Action the provider **SHOULD** take to improve:

- Ensure there is learning both at trust and local level for incidents and complaints
- Ensure that all complaints whether written or verbal are recorded and there are lessons learnt from them
- Ensure that nursing staff receive an annual appraisal and that objectives set, are followed up at intervals through the year
- Ensure that the staff have arrangements made so that clinical supervision is available to them
- Review the arrangements for liaison between midwives and health visitors so that women are reviewed by a health visitor prior to the birth of their baby, in line with national standards
- Review arrangements for specialist Chlamydia screening for young people
- Review the requirement to have a strategy, vision and policy in place for End of Life care

- Review the need for a pain scoring tool in end of life care and in some in patient units, so that pain relief can be objectively measured
- Consider the use of clinical audit in end of life care in order to measure the effectiveness of the service
- Review arrangements for measuring the 15 minute wait target in the Minor Injuries Unit at The Hertfordshire and Essex Hospital

Action the provider **MUST** take to improve:

- Ensure robust action is taken to manage the risks surrounding recruitment and vacancies
- Ensure that there is a trust policy for safeguarding children
- Review the adult safeguarding policy
- Ensure the safeguarding leads report all safeguarding concerns to the local authority
- Ensure all the staff are aware of the importance of reporting safeguarding concerns to the local authority

Summary of findings

- Ensure that all safeguarding concerns are reported via the trusts electronic reporting system promptly, thus enabling the trust to have an overview of concerns within their organisation
- Ensure all staff complete their mandatory training to reach the trust's target
- Ensure that health visitors caseloads reflect national best practice
- Ensure that nursing record keeping in the inpatient units is improved so that care interactions are recorded in one document and all care is evaluated
- Ensure patients are not admitted or transferred between units during the night
- Review the arrangements for developing of the 'preferred priorities of care' to replace the Liverpool Care Pathway, including the introduction of the Care Plan for the dying patient.

Hertfordshire Community NHS Trust

Detailed findings

Requires Improvement 

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We judged that the services provided as requires improvement for safety. Improvement was needed within community inpatients and community adults.

Services for children and young people, dentistry and end of life care were judged to be good.

Staff were aware of safeguarding procedures and knew how to report safeguarding concerns, however, within the dental service there was some confusion about where and what should be reported.

Equipment seen had been maintained across the majority of the sites and annual safety checks had been carried out. However appropriate equipment checks of resuscitation equipment were not always carried out in the inpatient areas.

Staffing levels met the needs of the patients in most areas at the time of our inspection. Gaps in staffing were met using bank and agency staff, but there were significant vacancies and temporary staff were not

always available meaning that patients could not always be assured of receiving safe care. The trust had developed a number of measures to monitor staffing levels and mitigate the risk of unsafe care.

We found that there was a significant number of vacancies in some areas particularly in the inpatients services where vacancies were at an average of 14.7% of the workforce, with hotspots where the vacancy rate was higher at 25%. Although this was recognised as a significant risk for the organisation there was no assurance that there was a robust strategy to address this with pace.

There had been 361 reported incidents of staff shortages between September 2014 and February 2015.

Health Visitors were carrying caseloads beyond the optimum levels agreed nationally.

There were a number of reported incidents of patients being transferred from the acute trust during the night, often with inadequate records. This was not on the trust risk register.

Are services safe?

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

Services were provided in clean and hygienic environments, which helped protect patients from the risk of infection. Hand washing practices were inconsistently practiced when delivering care between patients.

The trust had previously made significant reductions in the number of HCAI particularly C.difficile. At the time of the inspection the trust were breaching their monthly trajectory with two cases that month but were still within their trajectory for achieving end of year ceiling.

Processes for decontamination and sterilisation of dental instruments complied with Department of Health (DH) guidance

The quality of patient's records varied between the inpatient units. Records of care planning, evaluation of care and essential communication about patients, services in the in-patient units were not always safe. In addition there was a variety of informal means of recording patients' care/interventions which meant that essential information could have been missed.

Nursing assessments and care plans were used but they were not personalised or holistic to enable people to maximise their health and well-being.

Staff uptake of target mandatory training such as fire safety training and moving and handling was below the trust's target in some areas.

Feedback about incidents to staff overall was variable and dependent on the types of risk reported.

Medicines were mostly safely managed both in the inpatient units and in community settings.

hospitals and care homes where the pressure ulcers had been acquired. Some had been caring for themselves when pressure ulcers had developed. The trust's staff reported all pressure ulcers they found, despite many of them being acquired elsewhere or not directly related to care patients had received from trust staff.

There had not been any 'never events' reported in the 12 months to February 2015. Senior managers we spoke with believed there was a good incident reporting culture and information was used to improve safety of patients. An example given was the service wide work undertaken to reduce the incidence of patient falls in the inpatient units. This had involved a multidisciplinary team approach since the middle of 2013, whereby nurses and therapists worked together to devise an assessment and monitoring tool when patients who were at risk of falls were clearly identified on admission, their risk continually monitored and their care adjusted accordingly. Patients who were at risk of falling had a shooting star symbol above their bed or on their room door to alert all staff of the risk. Falls were discussed weekly at all inpatient units, reported through to the deputy director of nursing and the board. We saw evidence of this at both unit meeting minutes and board meeting minutes. This approach, highlighting falls and acting to decrease them, had reduced the number of falls within the trust, which was a significant safety improvement.

In July 2013, 4% of patients were reported to have fallen. This was 2% above the NHS average. By February 2015, this had fallen to 2% of patients reported to have fallen and was slightly below the NHS average.

There was a trust wide electronic incident reporting system. The staff we spoke with confirmed that they had received training on how to use it. Access to this system was available on all wards visited and staff were able to demonstrate they understood how to use it correctly. We saw minutes of staff meetings which included review of safety issues such as pressure ulcers, falls and infections. These topics were standing agenda items for ward staff meetings at each unit.

All locality managers met trust wide to review incidents.

Our findings

Incident reporting, learning and improvement

The trust reported a total of 239 serious incidents requiring investigation between January 2014 and January 2015. Of these 27 were related to unexpected or avoidable death or severe harm of one or more patients, staff or members of the public. The vast majority, 170, were related to pressure ulcers. However, the majority of these had not been acquired because of poor care within the community. People had been discharged into community care from

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An example of shared learning where an incidence of Methicillin Resistant Staphylococcus Aureus (MRSA) had been investigated and as a result changes to the trust's temporary staff induction programme had been introduced to minimise the risk of reoccurrence.

Staff reported to us that although all types of incident were reported, they often did not get feedback. Staff felt if the incident was not related to a key national target, for example pressure ulcer incidents then feedback was not provided. Examples given were the continued reported incidents of inappropriate patient transfers to in patient units and related to patients who were transferred to the wards in the middle of the night and early morning (11pm -6am). It was reported that patients were transferred with poor quality photocopied patient records, often arriving on the ward without medicines charts or medicines that they required.

This type of incident was not reflected on the trust risk register. Therefore opportunities were lost to enable appropriate action to be taken and learn lessons so that similar incidents were not repeated. Staff felt little had been done to prevent occurrences and that they were not subject to external scrutiny. We did find evidence that there had been discussions with an acute trust with regards to the transfer of patients out of hours, with inadequate notes. However, at the time of the inspection this information had not been disseminated to the trust's staff.

Patients and visitors were made aware of each wards' performance with regard to safety issues such as patient falls and hospital acquired pressure ulcers. A monthly chart was displayed on each ward, which showed how many days had elapsed since the since a patient had experienced any of the above.

Safety alerts were displayed on the wards. These were managed by senior nurses who actioned and communicated these to the rest of the team. The trust's escalation procedure was displayed in staff areas on the wards. This provided guidance and contact numbers for staff to use in the event a staff member became aware of an incident that had the potential to disrupt operational continuity. This included existing or imminent major incidents, emergency or business continuity incidents that would have an immediate effect on service, or issues such as bed pressures capacity, staffing issues or a serious or notifiable infection control outbreak.

Safeguarding

The trust report, Dec 2014, 89% of staff had received Safeguarding Adults training and 86% had received Mental Capacity Act training during past 3 years.

Staff had been trained to recognise and respond to safeguarding concerns in order to protect a vulnerable patient. Records showed that 100% of staff had received training during their initial induction to the workplace. Staff also received safeguarding training as part of their annual mandatory training. Overall 87% of staff had been trained to level 1; this was slightly below a trust target of 90%. The training records showed that appropriate staff had undertaken Level 2 training in safeguarding. We also saw that staff's refresher training due dates were included in the training record.

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.

We reviewed the adult safeguarding policy, dated July 2013. The policy was lengthy and staff told us they found it confusing and were not clear about who they should contact or what process to follow. We found the policy to be confusing and ambiguous, some staff were not clear on the actions they should take meaning patients were not always protected from the risk of harm. The flow chart in the appendix of this document did not clearly outline the processes, for example, the actions staff were instructed to take when a person was thought to be at immediate risk were not clear. This means that there may have been a delay in the Local Authority being contacted in the case of a safeguarding incident.

At the time of the inspection the Trust did not have a current children's safeguarding policy although there was an awareness this needed to be completed. We were told by the named nurse for safeguarding that there was currently no trust policy for children's safeguarding, but there were guidelines. In the children's and young people's services, we saw the impact of not having a policy was minimised by good training at a relevant level, and

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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.

We saw that with regards to children in the community setting, safeguarding concerns were raised appropriately to the local authority by the safeguarding leads. There were leaflets available on safeguarding, with details of the named safeguarding champion staff could contact.

The Children and Young People's 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 health 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.

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 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.

Staff working in the in-patient units and in both adult and child services within the community were aware of safeguarding procedures and what may constitute a safeguarding concern. Staff we spoke with during our

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inspection told us that any safeguarding concerns should be reported to their local safeguarding lead that would escalate the concern to the local authority. All the staff we spoke with, except in the dentistry and end of life teams, knew they could, as individuals, report safeguarding concerns to the local authority or Care Quality Commission. In the adult community setting we saw records that included assessment documentation which had been amended to include the screening of people who were considered as being at risk of exploitation. We saw an example of where this had led to a prosecution in relation to safeguarding concerns.

We observed a situation where a person was at risk of receiving incorrect treatment in an environment that a Specialist Palliative Care Nurse attended. We saw that the member of staff noticed the risk immediately, and took steps to ensure that the person was safe. Although the member of staff immediately informed their line manager, the team were unsure of the trust's procedure for reporting a safeguarding incident, and telephoned the trust's safeguarding team for advice. The team were unable to make immediate contact with someone from the trust safeguarding team. This meant that a delay occurred before the trust contacted the Local Authority safeguarding team to ensure that actions were taken so that this person and other people in a similar situation were not also at risk of harm. We saw that immediate actions were taken to resolve the issues for this individual. However, staff were unaware of their wider reporting responsibilities.

In the dental service, we saw a record of training for the whole dentistry service which demonstrated that all the staff had completed training in line with trust policy, with regards to safeguarding vulnerable adults and children. Staff we spoke with during our inspection told us that any safeguarding concerns should be reported to their local safeguarding lead who would escalate the concern to the local authority. We saw that with regards to children, safeguarding concerns were raised appropriately to the local authority by the safeguarding leads. For example, a safeguarding alert to the local authority had been raised, when it was found that parents were not following an agreed be treatment plan. Subsequently, the child required multiple dental extractions due to severe decay.

When we spoke with staff in the dental service about safeguarding vulnerable adults, there was some lack of clarity and understanding. Discussion with staff highlighted

that they were not aware that the local authority took the lead for safeguarding for people who lived in their own home or in a care home. Staff told us they had raised concerns about people who had arrived for treatment from some care homes. Following raising this with the safeguarding lead, in accordance with the policy, the staff were advised, incorrectly, to contact the care home manager to raise these concerns, not the local authority.

In another example staff told us they would contact the care home and if they were not satisfied with their response, would ask the home manager's consent to make a safeguarding referral. This meant that people, who may be responsible for neglectful care, were continuing to provide care for people and the relevant local authority had not been notified about the concerns. In both examples staff told us they had not completed a safeguarding concern on the trust's incident reporting system as they were unaware and had not been advised by the safeguarding lead they needed to do so. However, the trust's policy dated July 2013 outlined the requirement for any safeguarding concerns to be recorded on the incident reporting system. This meant that safeguarding concerns had not been recorded accurately leading to the trust not having accurate oversight of safeguarding. Two staff we spoke with said they had to ask patients and their relatives if a safeguarding referral could be made for an adult or a child. They told us that consent from either a relative or parent would be required to make the safeguarding referral. This demonstrated that some staff were confused about the difference between having to get legal consent to provide treatment and the process to follow if they had concerns that someone was at risk of abuse. All the dental staff we spoke with did not know they could, as individuals, report safeguarding concerns to the local authority or Care Quality Commission.

Deprivation of Liberty Safeguards (DoLS) were used and completed appropriately. Staff generally, were knowledgeable about the process of DoLS, and were able to describe a recent application for DoLS. Staff in one of the inpatient units described to us how an application was made when a patient had complex behaviour and cognitive problems, and after an initial mental capacity assessment, the case was escalated to the clinical psychologist who applied for a DoLS to ensure the patient would be supported safely.

Medicines management

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Staff had access to guidance about medicines via the trust's electronic medicines management policy although this had not been reviewed since November 2011. Policies should be reviewed every three years as a minimum. This meant staff may not have had access to guidance that was reflective of current best practice. Staff also had a supply of British National Formularies dated 2015. These were stored on medicine trolleys to enable staff to easily refer to during preparation and administration of medicines.

We looked at the arrangements for the storage and security of medicines at in-patient units, including the children's centre at Nascot Lawn. In general we found these were safely managed in that medicines were stored in secure cabinets and there were stock rotation systems in place. Quarterly Controlled Drugs (CDs) reconciliation checks of CDs stored with the drugs register had been completed by the pharmacist and at all but one site, Queen Victoria Memorial Hospital, (QVM) were found to be in order. We found at QVM that two types of CDs that had been dispensed as take home medicines, were present in the CD cupboard, some three weeks after they had been dispensed. Despite weekly checks by both the visiting pharmacist and nursing staff, these medicines had not been reconciled as present in the cupboard. The Chief Pharmacist was made aware of this and took immediate action.

We found boxes of prescription only dressings stored next to a computer server at Queen Victoria Memorial Hospital. Although we did not use a thermometer to check the room temperature, it was clear that it was in excess of 25 degrees centigrade. The boxes that the dressings were stored in were warm to the touch. This meant that dressings were stored in an environment that would have decreased their potency. The ward sister agreed to review this immediately.

We observed medicines rounds being undertaken where staff wore tabards marked, "Do Not Disturb" to minimise interruptions and risk of drug errors whilst administering medicines. Medicines were appropriately signed for and discontinued, were signed and dated at the date of discontinuation and crossed through. We saw one chart where reasons for non-administration of medicines were clearly given.

Pharmacist support was available across all hospitals. Pharmacy reviews were undertaken by a pharmacist on each in-patient area once or twice a week. Staff reported

there had been incidents when patients were transferred from a local acute hospital with only a photocopy of the patient's medicines record. A photocopy of a prescription record is not a legal document from which medicines can be administered or used for recording of medicines provided to a patient. During the evenings, nights and weekends, this meant delays in provision of care to patients until an out of hours doctor could attend to prescribe medicines. Staff reported occasions where they had to wait as long as six hours for a doctor to attend or staff had had to arrange for a taxi to collect the medicines and chart. We saw these incidents had been reported using the electronic reporting system but there was no evidence to show this matter had been addressed. Incidents of this nature had been reported to the senior managers who had advised staff to report such incidents on the trust's electronic recording system, but this had not been added to the risk register. There was also no evidence to show there had been any pharmacy involvement or guidance sought to help prevent this type of incident reoccurring.

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. All the medicines were clearly marked with pharmacy labels. We saw that the young people with medicines to prevent seizures also had an epilepsy protocol in their care plan.

Vaccines for immunisation were stored appropriately in the centres where they were administered. We saw effective cold chain procedures at the immunisation session in Hemel Hempstead.

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 by registered nurses, which was in line with guidelines for patients diagnosed with type one diabetes.

Staff prompted people to access their medicines. Senior staff told us that staff did not administer medicines but encouraged and prompted people to access their medicines using a Monitored Dosage System (MDS). The MDS is a multi-dose reusable storage system designed to simplify the administration of medicines. The administration of medicines was discussed at community nursing team handovers to ensure that patients received their medicines safely and at an appropriate time.

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The Home First service in Cheshunt had identified that people were being treated with multiple medicines. They identified the need for a pharmacist to be a part of the team to support people in this aspect of their care. We saw that the trust had acknowledged this and a pharmacist was due to join the Home First team on a one year pilot scheme.

Safety of equipment and facilities

In most areas equipment was found to be clean and safely stored. There were dated stickers to indicate it was clean and had labels to show it had been subject to a safety check. Maintenance was carried out by the trust's maintenance department. Staff told us they experienced some delays in getting equipment repaired, such as blood pressure machines, but we did not see or hear of any direct adverse impact on patient care. There was awareness within the trust about maintenance of equipment and was this was an item on the trust's risk register.

Generally resuscitation equipment was checked daily to ensure it was complete and in date, records of checks made by staff were consistent over preceding months. One resuscitation pack, in the Minor Injuries Unit, was recorded as having been checked daily, however on inspection equipment such as airways tubes, cannula needles and blood sample bottles were found to be out of date with some dating back to 2013. The matter was raised with the nurse in charge and immediate action was taken to address this. In addition at QVM, an Electrocardiograph (ECG) machine was found to have a faulty cable and was not fit for use. Staff were aware of this and a new main cable had been ordered in January 2015. However the machine had not been used but removed from the emergency equipment. We spoke with staff who agreed it should be removed from use and labelled not fit for purpose. An alternative ECG machine was made available.

Separate anaphylaxis medicines kits were available to treat severe allergic reactions and oxygen cylinders were full and in working order.

Community staff could make a request to an external company for equipment for example, pressure relieving mattresses and the company responded within 24 hours to three days. However, there were no deliveries available at week-ends. Staff had access to equipment stored at their base office, which included for example, commodes and walking frames. Staff said that during weekends and out of

hours there were problems with stock being taken and not replaced. We did not see a system in place to monitor the whereabouts of equipment. Staff said they had to try and track the equipment which was time consuming. The lack of a system to effectively monitor equipment stock and whereabouts impacted adversely on the efficiency and responsiveness of the service.

Staff at the Lister Hospital said there were no systems in place to monitor the testing and calibration of equipment. For example, the portable appliance test (PAT) date for a syringe driver was out of date. Staff said they relied on patients informing them when a piece of equipment needed testing. We saw electrical leads trailing across the floor which could have caused a trip hazard for staff and people visiting the Lister Hospital clinic. We saw the gym equipment at the Safari therapy clinic had been regularly tested. However, we saw that not all electrical plugs had the required PAT testing sticker which meant there was a risk that some electrical plugs may not have been appropriately checked to ensure their safety. Managers said they were aware of these issues and were looking at ways of monitoring equipment in the community.

At the Avenue Clinic we observed multiple items of electrical equipment running from extension leads. This included for example, the trust's electronic recording system and a photocopying machine. We found that the gym equipment was dusty and did not have stickers to identify they had been cleaned. These concerns were reported to the locality manager for this service.

We saw treatment being carried out in single rooms which were well equipped with couches and hand washing facilities. The gymnasium at the Safari therapy clinic was well equipped. However, we did not see stickers to identify the equipment's cleanliness. We saw that some of the examination rooms used by the rapid response team at St Alban's Hospital had peeling wallpaper, cracks in walls and damaged plaster. Staff said they had reported the damage to the maintenance department but had not been given any indication of when it would be repaired. Some rooms where clinical care took place were small and cramped. Staff were unable to use a hoist should a person fall to the floor due to the small environmental space. This meant that staff and people could be at risk of injury from poor manual handling practice.

Records management

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

In the inpatient units, the patient notes and all associated clinical work, such as medicine administration, were all done on paper records. There was a plan to upgrade these to more secure, efficient electronic records. We were told that this was going to be implemented later in 2015. However, staff were not aware of implementation dates.

We saw examples of the electronic system in use at the Minor Injuries Unit which showed details including a patient medical history, treatments, tests ordered and results and referrals for treatment. Children who were subject to safeguarding orders were flagged with relevant contact names and telephone numbers of the relevant social worker and nurse. We also spoke with some of the district nursing staff who were piloting the use of laptops to record care remotely, using an electronic recording system. They were very positive about the benefits of the electronic system. Some nursing staff had to scan paper records into the electronic system and reported they sometimes had to spend up to seven hours to complete this task. Medical records were stored securely and risk assessments and some care notes were stored at the patient's bedside. Entries to medical records were mostly legible, signed, timed and dated. During the inspection we looked at 24 sets of patient records.

Hertfordshire and Essex Hospital, Queen Victoria Memorial Hospital and Danesbury Neurological Unit had multiple systems for keeping records. When reviewing patient records there was little evidence of whom the patient was. There was no information about their personal history such as past jobs, life experiences or preferences. Where fluid balance charts were used we found inconsistency in the input and output being totalled to effectively evaluate the patient's status and whether further interventions such as encouragement for more fluids were required in at least six of the records seen.

We identified and confirmed with staff that in some areas there were at least nine separate places where patient information was recorded which were as follows.

- The patient folder at the patient's bedside containing risk assessments
- The handover sheets which were updated and disposed of daily

- A communication book containing such information as details of patient appointments
- A document referred to as a 'Kardex' which was completed intermittently including some evaluation notes
- A 'jobs for doctors' book containing requests/reminders for such things as blood tests
- The patient's medical record
- Notice boards including a patients estimated discharge date and such information as resuscitation status
- An allocation book which included messages about patients' care arrangements
- Therapy notes

This meant there was the potential for key information to be missed or not communicated which could impact on the safety of the patient.

Staff used printed handover sheets which seemed a practice in place at most of the inpatient units. We were told these were updated daily by the nurse in charge of each shift. The handover sheet contained vital, confidential information about the patient's diagnosis, their progress and any plans. During the inspection at The Hertfordshire and Essex Hospital, one handover sheet had been left on a trolley in the ward corridor. This was brought to the ward sister's attention and it was removed.

We observed there was a strong reliance on the handover sheets which were used for multi-disciplinary team meetings in addition to handovers between staff. We found the handover sheets on two occasions were not up to date. For example the Do Not Attempt Resuscitation (DNAR) status of three of the five patients were missing from the handover sheet that had been assessed as not being for resuscitation. This meant staff could potentially make an inappropriate response if a patient collapsed. The concern regarding patients DNAR status was reported to staff at the Hertfordshire and Essex Hospital during the inspection.

We observed these handover sheets being used as main nursing care record. Therefore vital information about the patient was not kept in their notes, but on pieces of paper that we were told were destroyed at the end of each shift. One care assistant told us that they had sometimes taken their sheet home in error which meant that confidential information was leaving the hospital and may not have been securely destroyed.

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There was no evidence of a document control system for the secure management of handover sheets which contained patient identifiable information. The large bins used for the disposal of confidential paper waste were overflowing in both ward offices at the Hertfordshire and Essex Hospital, from which papers could be easily removed.

All the forms we saw being used to record patient information were of poor quality in that they appeared to have been repeatedly photocopied. Staff told us that they were waiting for an electronic system to be implemented; however there was no awareness when this would be.

The trust had introduced an electronic and ‘paper light’ system. We observed the paper light notes did not include details of a patient’s consent to care and treatment and the sharing of information or their individualised care plans. This meant that visiting professionals may not have up to date information to support patients’ choices.

Staff reported to us information technology (IT) connectivity issues and had to complete patient’s records either on return to their office base or within their own homes. There was a risk of discrepancies being recorded between the paper and electronic records which may place people at risk of inappropriate treatment and care. However the trust told us that there was a Mobile Working Operational Policy which included guidance on workaround actions in the event of poor connectivity.

In children’s services 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 stated 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 unclear 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 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.

Within End of Life care we saw that most records were held on an electronic system. A Specialist Palliative Care Nurse showed us how they accessed the computer system remotely via a secure laptop. They were able to access information about people in order to carry out their roles effectively. The nurse told us that they did not use the system in public, but that their mobile access allowed them to update their documentation in a variety of private locations so that personal information about people who used the service was protected.

This electronic system was shared across the majority of the trust, but in both areas we inspected Specialist Palliative Care Nurses told us that some GPs did not have the same system. This caused issues with data sharing. For example, the trust used paper forms for, Do Not Attempt Resuscitation, (DNACPR) as some GPs could not access this information from the electronic system. The trust told us that they were aware of this issue with the computer system and were working on resolving it.

Both palliative care teams spoke to us about the “message in a bottle” system that the community teams put in place for people being cared for in the community. We saw the “bottle” that was a brightly marked container kept in the patient’s home. It was used to hold documents containing important medical wishes and information. This meant that staff from other services, for example, paramedics, nurses, doctors and social workers could access this information in an emergency and act on the information contained within it. This meant that people who used the service were protected from receiving inappropriate treatment.

We looked at the electronic records of seven patients attending podiatry, lymphoedema and retinal screening

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clinics. The records showed that information included patient's medical history and allergies. We saw the records were updated immediately after each consultation with the therapist/clinician.

The trust had introduced a new electronic system within the service. Staff said they had received good training and had a "buddy system" in place to support them with any problems. The trust had introduced a paper light operational process alongside the electronic system. The paper light documents were for the use of professionals visiting the patient in their home. This included emergency patient contact details, communication records of visiting professionals and staff. We observed the paper light notes did not include details of a patients' consent to care and treatment or the sharing of information. The paper light notes also did not contain patients' care plans. This meant that visiting professionals may not have up to date information to support patients' choices.

The district nurses' forms were not available on the hospital's electronic system which meant they had to print off a copy and e-mail the information. This meant there was a risk of patient's information being transmitted to the wrong person.

We saw the trust's electronic system was not compatible with the social service's recording system. District nurses were also unable to access the "Pathweb" system which was used for test requests by GPs and hospitals by using bar codes and patient stickers. Nurses said they had to duplicate the information. This meant that staff were not always able to access up to date records from other practitioners particularly at weekends and evenings.

We observed a staff member accessing the electronic system which took over five minutes before losing the signal. This meant that they were unable to update their records. Staff said that 50% of their records had to be updated either on their return to their base or in their home environment. Staff said they had to remember the information which meant there was a risk of inconsistent recording of the treatment provided.

We examined three records completed by the integrated discharge team. They were clearly completed and structured which included patient's personal details. The records however, did not contain a section for the recording of safeguarding concerns.

All areas visited were visibly clean and tidy. Patients told us they thought the wards were very clean and had no concerns about the cleanliness of the facilities. Cleanliness was audited monthly by the senior staff and submitted to the trust's infection control team. However, the tool that was used was ambiguous and consisted of ticking boxes. For example, it asked that five equipment items were checked for cleanliness, but didn't specify what these were. Furthermore it asked that individual staff member's food safety training was audited, but no evidence was requested.

We observed a patient was being nursed with their catheter bag trailing on the floor which posed a risk of infection to the patient. This was indicated to staff. Although there had been a decrease in the incidence of urinary tract infections requiring a catheter during the previous year it was noted that mandatory training for catheter care in Oxford and Cambridge wards, Hertfordshire and Essex Hospital had a level of only 44% compliance. This was below the trust target of 90%.

The patient led assessment of the care environment (PLACE) for January 2014 to June 2014 achieved a high score of over 95% for most areas. The assessment included evaluation of aspects of the environment including cleanliness and condition, appearance and maintenance of facilities. The PLACE scores for Oxford and Cambridge wards, Hertfordshire and Essex Hospital, for January 2014 to June 2014 showed all aspects of the assessment to have been scored below the England average and the lowest score within the trust. A previous ad hoc infection control audit reported eight commodes were found to be dirty.

The general appearance and maintenance of wards was variable with some units having been recently refurbished such as Danesbury, whilst others such as Sopwell and Langton wards at St Albans City Hospital were in need of refurbishment. The general appearance and maintenance score of 82% for the trust was well below the England average of 90%.

Staff had access to personal protective equipment (PPE) such as gloves and aprons. Sanitising hand gel was available throughout the areas inspected. Posters were displayed about effective hygiene encouraging staff and visitors to help maintain a safe environment for the patients. Monthly audits of hand washing were seen which recorded a high level of compliance. Equipment had 'I am

Cleanliness and infection control

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clean' stickers on them showing the last date and time they had been cleaned. Hand washing practices were inconsistently practiced when delivering care between patients.

Bedside curtains were labelled with the date they had been changed and when they were due to be replaced. All were noted to be clean and within date. We saw there were processes and systems in place to check that mattresses were clean and fit for purpose.

There was an awareness of the trust policies in relation to infection control. Most staff were 'bare below the elbow,' although we did see some staff wearing inappropriate jewellery. This was removed as soon as we indicated that it conflicted with trust policy. All staff uniforms appeared clean and in good condition. Gloves, aprons, and masks were available and we saw these being used appropriately.

In community services we observed staff cleaning instruments and surfaces with antiseptic in the treatment areas. Staff cleaned the couch after each patient. However, we did not find consistent practice across the trust regarding the use of a sticker system to inform staff that an item had been cleaned. This meant that staff could not be sure whether or not items had been cleaned, ready for re-use, in accordance with trust policy.

All the dentistry services we saw were clean and well maintained. All had separate decontamination facilities. Infection control procedures were followed and there was full compliance with HTM 01-05, a Department of Health standard for prevention and control of infection in dental units.

Mandatory training

Within the Inpatient Units there was a mandatory training matrix with a trust target of 90% completion rate for all topics such as fire safety and manual handling.

The completion of fire training was variable and between 73% and 96% with the trust target at 90%.

The majority of the inpatient units had not achieved this target.

Mandatory training was delivered either on line or through attendance to centralised dedicated sessions. Some staff

reported they found travelling to attend sessions a challenge with some having to manage a four hour round trip for a couple of hours training which impacted their level of compliance.

In Oxford and Cambridge wards, Hertfordshire and Essex Hospital (H&EH) we did not see any evidence to show compliance with mandatory training was monitored. There were poor levels of compliance on these wards. For example training records showed fire training was out of date for ten staff members. Catheter care was out of date for 15 staff which equated to a 56% level of compliance, basic life support training for four staff out of date with one staff member not having received an update since 14th June 2013. There was no action plan in place to remedy this.

In Potters Bar Community Hospital fire safety training had been completed. Although no fire drills had been undertaken, a fire evacuation system flow chart was displayed showing steps to take in emergency and how to determine if an evacuation should be attempted. Patients levels of mobility had been documented to aid staff should an incident occur that necessitated the need to evacuate the premises.

In Adult Community and End of Life Care there was a mandatory training matrix that showed that apart from safeguarding and MCA training, the trust's target of 90% compliance had been missed. The most concerning variance was that only 75% of community staff had completed their moving and handling training. This was a risk to both patients and staff. In addition completion of fire training had not achieved the trust's target of 90% at 74%.

In Children and Young People's Services Trust records demonstrated that the trust's target for mandatory training had been achieved, with the exception of fire training. The trust were planning to hold additional training sessions to rectify this.

Assessing and responding to patient risk

The safety thermometer results for new pressure ulcers had been relatively low for community inpatients throughout the past 12 months. A pressure ulcer working group was in place at the trust to monitor trends and identify areas of risk.

We reviewed 24 sets of nursing notes across all the inpatient units. Risk assessments and the care plans were

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completed. The care plans included the malnutrition universal screening tool (MUST) score, a pressure ulcer risk assessment tool, use of anti-embolism stockings, moving and handling risks, falls prevention and bedrail assessments.

We saw good evidence in the inpatient wards of measures taken to reduce the incidence of falls with harm. Falls management champions had been introduced to support ongoing learning for staff and introduce risk reducing measures such as the use of sensor mats, used to alert staff, when a person who needed assistance when trying to mobilise unsupervised. Colour coded wrist bands worn by patients had also been introduced to indicate level of assessed risk and the degree of assistance/supervision required. Units such as Danesbury which consisted mostly of single patient rooms ensured patients assessed as being at high risk of falls were located near to the duty station to enable closer observation. Some patients assessed as being at high risk received 1:1 nursing where indicated.

If a patient became unwell during their stay, the visiting GP or consultant reviewed them, this service was only available during the office hours in the week. During out of hours, the Hertfordshire on call GP service was contacted for further advice and treatment. However, if a patient became very unwell or collapsed, the 999 service was used and the patient transferred to the local Accident and Emergency department for further treatment. Vital signs were well documented at most sites. Because of the low acuity of the patients and most were medically stable, observations of vital signs were done only once per day. We found that at the Queen Victoria Memorial Hospital the routine observations at QVMH were not carried out until 10pm at night, this meant that if there was a problem identified that needed to be escalated; this had to be done via the on call doctor service, rather than the GP who visited the unit 3 times a week.

The trust had implemented the National Early Warning System (NEWS). This is a system that alerts nursing staff to escalate, according to a written protocol, any patient whose routing vital signs fall out of safe parameters. We saw that in two cases patient care had been escalated correctly.

At Oxford and Cambridge wards, Hertfordshire and Essex Hospital, there was a key worker who worked closely with both the GP and the twice weekly visiting consultant physician. The clinical nurse specialist had advanced skills

whereby they were able to clerk patients when they were admitted; prescribe certain medications, including antibiotics and intravenous fluids and discharge patients. They worked during the week and every other Sunday. This meant that patients at the H&EH did not have to be transferred to the local acute trust if they became unwell, unless they were critically ill, as they could be managed locally.

The dental service offered a domiciliary (home visiting service) for those who were not able to attend the surgeries, for example people who were housebound because they were infirm, or had profound disabilities. Each centre had a domiciliary kit, which included equipment required for check-ups and basic treatment. There was a system of checking these kits and we saw signed and dated checklists.

We saw a comprehensive policy, for the administration of both types of sedation within the dental service. The policy had been reviewed regularly. Each patient attended a pre-assessment visit with one of the dentists, to consider medical history and assess any individual risks, prior to any such treatment being considered or commenced. Inhaled sedation was available and could be titrated, whereby the mix of nitrous oxide and oxygen could be altered. This meant that sedation could be altered, to ensure a safe amount of sedation was administered according to the patient's individual needs.

Intravenous (IV) sedation, which allowed sedation for nervous or more challenging patients, was primarily carried out at Hoddesdon and St Albans clinics. There was a qualified Lead Sedationist, who provided IV sedation and they were available to receive referrals from other members of staff from other clinics.

Nervous patients who were referred via their own dentist were seen and assessed, using a recognised scoring tool, according to their anxiety levels. Any patients requiring treatment under general anaesthetic were referred to the dental team at The Lister Hospital in Stevenage. A team of clinicians worked alongside dental/hospital staff to provide dental investigations and treatment under general anaesthetic. All the nurses and dentists who undertook these procedures had comprehensive training to do so. This meant patients were thoroughly assessed and then treatment given according to their dental, physical and psychological needs.

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In Children and Young People's Services comprehensive risk assessments were carried out and risks were managed positively. Risk assessments and management plans follow 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.

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)

In end of life care, we saw that the Specialist Palliative Care Nurses, District Nurses, and other members of the multidisciplinary team (MDT) had regular meetings to discuss their patients, their level of need and any risks. We observed a multidisciplinary meeting at Gregans House where staff discussed the needs of people who used the service. This included a discussion regarding a person using the service and the fact that they had identified that the full time carer of this person required extra support. The team were able to discuss the options available to them. As the person using the service had expressed that they did not wish to have support of the palliative care team, but the family member did, staff told us that it was not usual procedure, and that "they were not allowed" to assist the carer if the person using the service had declined assistance. They told us this was a common problem that had not been addressed

Staffing establishments, which included levels and skill mix, were reviewed to keep people safe and meet their needs. Staffing establishments and skill mix were set using available tools, for example, RCN guidelines for inpatients and externally set numbers for health visitors under the HV implementation programme. Staffing establishments for all services were set at the beginning of each year as part of the budget setting process. Where vacancies or absence meant that the full establishment was not available, there was a safer staffing escalation process. However, often staff were not always available to cover the shortfalls.

Despite all the board members and executive team we spoke with telling us that staffing was a major risk for the trust there was lack of a sufficiently detailed and effective plan in place to address this in a timely manner.

Most services reported a high number of vacancies, high caseloads and high use of locums and agency staff, when they were available.

Staff were aware that staffing shortages and recruitment difficulties was a key risk on the trust's risk register. Most of the wards we visited had vacancies at all levels for nursing and allied health professionals such as physiotherapists and occupational therapists.

Overall vacancies within the inpatient areas were at 14.7% of the establishment with some areas having higher levels of vacancies up to 25%. Vacancies varied from service to service. Two of the inpatient units had the largest variance. There were negligible vacancies at Potters Bar Hospital, yet at Sopwell Ward and Langley House, the highest, at 17 vacancies at each site.

Where available temporary staff were being deployed to fill the gaps. However temporary staff were not always available and in some areas there was a 'fill' rate of only 63%. Trust data demonstrated that for Hertfordshire and Essex Hospital reported an average fill rate of Registered Nurses, below 80% for seven consecutive months, to January 2015. In the service's safe staffing report, dated January 2015, three out of the eleven wards reported fill rates below the trust target of 90%. In December 2014, five of the eleven wards were below the trust target for staffing levels. This included both Registered Nurses and care staff.

Staffing levels and caseload

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There was an escalation process in place where staff could raise concerns relating to shortage of staff and there were a total of 163 occasions across the whole trust where staff had reported this through the incident reporting system between September 2014 and January 2015.

Patients reported to us that they felt safe, however, told us staffing levels on some wards were of concern on occasions and although they felt call bells were usually answered promptly there were delays when the ward was short staffed.

Staff had signed a waiver to work extra hours beyond the recommended hours specified within the European Working Time Directive. Ward managers were aware of who was working extra hours and monitored this closely to ensure staff were safe to practice. If staff had a recent episode of sickness absence, they were not permitted to work additional hours.

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% 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 found that health visitor caseloads although monitored were above the 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.

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. This meant the trust were not meeting the recommendations of the CPHVA.

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.

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'.

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 visitors' 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, there was concern 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

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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".

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 speech and language therapists had re-organised themselves to reflect the 'developing special provision locally' (DSPL) education-based area groupings and there were 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.

The speech and language therapy service were offering flexible contracts for colleagues wanting to work during the term time only. 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.

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.

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.

When we visited each community dentistry location, they appeared to be well staffed, although senior staff explained there were some vacancies due to staff sickness and people leaving. Staff told us the workload had increased over the last year and there were "pressures" on the service. They said this was because there was an increased need for the service and current staffing levels were not sufficient to manage the increase. In fact, when we looked at trust data the service was overstaffed against the budget by one 0.8WTE and had a 3% sickness rate. This was slightly below the trust average of 4%. Waiting lists had increased from 148 people at February last year (2014) to over 270 in February this year, leading to patients having to wait longer in-between appointments. All the staff we spoke with told us demand for community dental service was increasing but staffing levels were still the same as they had been. However the clinics were able to see patients who needed to be seen urgently, for example, if were in pain, often on the same day and were able to take the time they needed when treating patients. Staff confirmed they were able to meet patients' needs, but that they had to wait longer for routine appointments.

New agency staff were given a brief induction to the inpatient unit where they were working. This included emergency procedures and general policies, for example use of personal protective equipment. We saw copies of these at the Hertfordshire and Essex Hospital. The staffing rota was planned and staff worked on a rotational basis on days and nights. Because all the units operated from different locations across the county, it was difficult to move staff from one place to another.

Managers were constantly reviewing caseloads particularly where there were newly qualified staff and vacancies in teams.

Managing anticipated risks

There were security systems in place such as the use of keypad controlled access to certain inpatient and service areas. Signing in and out of visitors to units were used to ensure there was a record of how many people were in the building in the event of a serious incident such as a fire. The

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ward sisters were aware of trust wide emergency plans. Hospitals had contingency plans and equipment to help respond to emergency situations such as loss of essential services such as supply of water or electricity. The equipment and instructions were easy for staff to access and in good order. Fire escape routes were clearly signposted and unobstructed. The completion of fire training overall was between 73% and 78% which was below the trust target of 90%.

Safety alerts from National Patient Safety Alert System were received by the trust risk team and disseminated to the individual locality managers for action. At Queen Victoria Memorial Hospital we saw the important messages relevant to their unit were printed off and staff signed to say they had seen and read it. At the Hertfordshire and Essex Hospital we saw that any relevant alerts were discussed at staff meetings, displayed for staff to see and shared in staff meetings and at handover.

We observed patients had their call bells placed within easy reach. Some patients were assessed as having a high risk of falls with bed rails in use; however risk assessments had not been completed to ensure the bed rails were safe for use for the individual patient.

Staff were able to describe actions taken for deteriorating patient such as calling the doctor or if urgent calling the emergency services.

A risk assessment for lone working was not made available to us during the inspection. However, there was a policy in place 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. 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.

In community adults services each location had a local risk register. For example, the services visited identified recruitment as an area of concern. The local risk registers identified the actions taken and the areas they were unable to address. We saw that the offices and meeting rooms were well maintained, fire risk assessments and records were in place, staff signed in and out of buildings, and there was a secure system at main entrances to maintain security. This meant that systems were in place to ensure the risk of fire was monitored.

Major incident awareness and training

Safety alerts were displayed on the wards. These were managed by senior nurses who actioned and communicated these to the rest of the team. The trust's escalation procedure was displayed in staff areas on the wards. This provided guidance and contact numbers for staff to use in the event a staff member becoming aware of an incident that has the potential to disrupt operational continuity. This would include existing or imminent major incidents, emergency or business continuity incidents that would have an immediate effect on service, or issues such as bed pressures capacity, staffing issues or a serious or notifiable infection control outbreak.

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.

Are services effective?

Requires Improvement 

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 of findings

We judged that the services provided as requires improvement for effectiveness. Improvement was needed within community inpatients and end of life care.

Services for children and young people, dentistry and community adults were judged to be good.

Most of the inpatient units used a variety of methods to record patient care. Therefore, there was not an easily accessible record of the whole patient episode of care. Most information appeared to be held on daily 'handover sheets' which were destroyed at the end of each shift, often not securely. This meant essential information about patients could have been lost, not handed over correctly, or not been kept confidential. Furthermore, risk assessments were not correctly used and evaluation of care was not completed. Nursing assessments and care plans were used but they were not personalised or holistic to enable people to maximise their health and well-being. However, therapy notes were comprehensive to enable staff to share decisions about patient's mobility and ability and for plans for rehabilitation to be developed.

New care planning processes were being developed by the end of life care service following the discontinuation of the Liverpool Care pathway but had not yet been implemented. There was not an appropriate person centred end of life care planning process fully in place. Care plans were in place for individual patients to reflect their choices and wishes but they were not specific end of life care plans.

A specific end of life care policy was not in place for staff to follow at the time of our inspection.

There were no pain scoring tools used to assess objectively, the effectiveness of prescribed analgesia.

The service did not have robust auditing systems to monitor the service and ensure that evidence based practice was implemented and regularly reviewed.

In most services we saw evidence that multidisciplinary teams worked together to provide effective care for patients. Management of pain relief and use of

recognised tools to assist assessment of pain levels was good in the community; however, this varied between in-patient wards and was not in place in end of life care service.

Food provision was positively rated by patients. Monitoring of fluid intake was often not fully completed or evaluated which meant there was a risk of ineffective nutritional management and lack of fluid intake.

Policies and procedures were accessible for staff. Staff were able to guide us to the relevant information using the trust's intranet. Care was monitored to demonstrate compliance with standards and national guidance, particularly in the community and end of life care, where there were good outcomes for patients.

Audit was used in all services, except in most in-patient areas and end of life care, to monitor patient risks and outcomes to determine the effectiveness of care and treatment. However, the limited availability of physiotherapists and occupational therapists (OTs) in some of the smaller hospitals meant that falls management programmes, as part of a patient's rehabilitation, were not being carried out in line with accepted best practice.

There was a strong focus on discharge planning which was commenced on admission to the community in-patient wards. Some referrals to wards were not always appropriate with some patients having to be referred back to the acute ward they had been discharged from.

The use of technology to enable patients to monitor their conditions at home via remote tele-health systems had a positive impact on them being able to remain in their own homes

Generally, we found there were effective induction programmes provided including induction for students and agency staff. Staff received annual appraisals. There were opportunities for professional development of staff. However most staff said they had not received regular clinical supervision.

Our findings

Evidence-based care and treatment

Are services effective?

Requires Improvement 

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Policies and procedures were developed in line with national guidance and were available for all staff on the trust's intranet site. At Hemel Hempstead Hospital staff had adopted a form for use produced by the Royal College of Nursing in conjunction with the Alzheimer's Society titled 'This is me.' This document was completed by staff with the patients and family members and gave staff relevant information about the patient, their needs, wishes and life history.

We saw that patients at risk of falling were identified and had risk assessments in place. At Danesbury, people identified as being at a high risk of falls were identified by a 'shooting star indicator' – a picture of a shooting star on their room doors. This meant staff were alerted to a risk but this system ensured the person's dignity and respect were not compromised. There were also posters describing how visitors could help to reduce falls. At Danesbury Neurological Unit and Queen Victoria Memorial Hospital we saw evidence of trust wide initiatives regarding falls prevention in place and evidence that both units had achieved a reduction in falls.

There was access to specialist nurses such as infection control and tissue viability nurses however access to therapists such as physiotherapists were limited for some wards due to shortages of physiotherapists.

The safety thermometer results for new pressure ulcers had been relatively low for community inpatients throughout the past 12 months. The incidence of pressure ulcers had been slightly higher than the national average since March 2013 at 7% of patients. However, since the introduction of a pressure ulcer working group at the trust to monitor trends and identify and act on areas of risk, the incidence was in January 2015, was 4%, lower than the national average and showed a continued downward trajectory.

Nursing staff used nationally recognised tools to assess risk such as the Waterlow scoring tool to assess patient's risk of developing pressure ulcers. However we were not able to see a record of evaluation of the effectiveness of the care provided on a day to day basis. For example a skin assessment had been completed, but there was no evaluation recorded of progress of healing.

Where risk assessments had been completed and plans developed to minimise the identified risk, there was no evidence to show the plan had been adhered to.

In Community Adults services care and treatment was being delivered in a holistic manner which promoted not only patient's physical health needs but also addressed their psychological needs.

Staff were able to show how they provided care and treatment to both patients and carers in line with the National Institute for Health and Clinical Excellence (NICE) guidelines. For example, the records identified the involvement of patients in partnership with their health and social care professionals and the stroke team followed the Royal College of Physicians and NICE guidelines.

The records we saw showed staff adhered to the NICE guidelines for the prevention of pressure ulcers. We saw pressure prevention equipment in place for example cushions and mattresses. The diabetic nurse specialist said they frequently had representatives bringing in NICE guideline updates for their review.

The trust reported to the Commissioning for Quality and Innovation (CQUIN) framework to improve the quality of services and the delivering of better outcomes for patients. We saw the results for 2013-14 which outlined the actual achievements made by the trust. For example the trust had achieved 100% in the actions taken to implement the National Dementia Strategy and 75% in their achievement of venous thromboembolism (VTE) risk assessments.

The records showed that staff within the lymphoedema clinics provided treatment in line with the Cochrane International Lymphoedema guidance. Therapists used the Malnutrition Universal Screening Tool (MUST) to raise awareness of a person's risk of malnutrition. This tool was used during the initial assessment of a person entering the service. The diabetic retinopathy screening followed the Royal College of Ophthalmologists clinical guidelines.

The integrated community team contributed to the Sentinel Stroke National Audit Programme (SSNAP). However, because the audit was initiated in several acute hospitals that transferred their patients into a community setting, results were not available for Hertfordshire as an individual community trust.

In the Children and Young People's Service, 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

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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.

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 NICE guidance questions to assess the mother's mood.

The trust was working towards level one of the 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.

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 use of peer support groups.

In Dentistry, care was given according to available evidence of best practice, for example National Institute for Clinical Excellence (NICE), British Dental Association (BDA) and General Dental Council (GDC).

Staff undertook a number of audits to monitor performance such as timescales for new patient referrals, 'did not attend' (DNA) rates and x-rays, to ensure they were adequate. Local, inhaled or intravenous pain relief was administered according to the treatment required and the setting where the treatment took place. To support the verbal advice the dentists gave following treatment, written advice leaflets were available at all the centres, which gave advice on pain relief for when the patient returned home.

In End of Life Care staff told us that they were implementing the, "Preferred Priorities of Care" plan following the discontinuation of the Liverpool Care Pathway nationally, in 2013. We were told that this new plan had not been implemented fully and staff were modifying a general care plan. However, work was continuing to progress this project. This meant that the trust did not ensure that patients who were subject to an end of life plan did not have one in place that reflected their particular needs.

Staff attended networks with an End of Life network, and gold standard framework meetings, in order to learn and share the latest developments in end of life care. This included the latest research for effective pain relief during a patient's end of life care. This information was disseminated at multidisciplinary meetings so that other clinicians benefitted from this knowledge.

The palliative care nurses were able to prescribe medicines in order that symptoms could be relieved quickly. Furthermore, many of the patients had boxes of medication in their homes that had been prescribed, 'just in case'. This was so symptoms could be relieved immediately, should they arise.

We were told that the trust met regularly with the local hospice to network within end of life care. Staff attending these meetings learn latest evidenced based practice and news relating to end of life care and share it with the multidisciplinary team to improve practice.

We saw that doctors from the local hospices provided support to the trust, however there was no evidence that the trust had its own system in place to ensure that they were acting on the latest research and practices. For example, the doctor we spoke to mentored staff and

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implemented their own audits and meetings relating to specific clinical need in the area. However there was no evidence that the trust were involved or monitoring this research and resultant practice.

Pain relief

Patients indicated they mostly received pain medication when they required it. Some wards used an assessment tool to determine if people were in pain. However, this was not universally used throughout all the inpatient units.

We saw evidence of good pain management on Langton ward. Patients' pain had been assessed including pain experienced when moving around and a pain control chart had been introduced. Patients' comments regarding the effectiveness of their pain control had been recorded and goals regarding pain management had been set.

Some patients told us they often had to wait for pain relief in Oxford and Cambridge wards, Hertfordshire and Essex Hospital. Care planning and evaluation of pain management was limited, particularly recorded outcomes as to what actions had been taken to relieve pain and how effective it had been.

We did not see evidence of the use of a pain control evaluation chart in use at the bedside. When asked we were shown a copy of a pain chart in the patient file, but this had not been completed and was difficult to read due to the size of the font of the text and poor quality of the photocopy.

In the end of life care service, the specialist palliative care doctor told us that spinal cord compression research took place, but pain management audits were not part of the audits carried out by staff.

We saw that during the first visit by a member of the end of life team, pain scores were included in the initial assessment in the patient's homes. Pain levels and response to analgesia (pain relieving medicine) was reviewed at each visit and recorded. However there was no formal pain scoring tool used to objectively assess a patient's pain and their response to prescribed analgesia. Furthermore, this meant a patient's pain was not measured quantitatively and therefore could not be audited, to ensure patients received the most effective pain relief.

Nutrition and hydration

Patients spoke positively about the food they received, they were given a range of choices and told us meals were served hot when they were supposed to be. The food was served individually, from large trays, so patients could have a portion according to their appetite and needs. Both patients and staff told us the food was good.

Meal times were protected (with no visitors allowed) and where wards had a dining room patients were encouraged to eat together as part of their rehabilitation. We saw that individual hand wipes were available on the tables in the dining areas. However, we noticed that these were not routinely offered to patients who required assistance or had their meal in their room or bay. We observed staff assisting with the serving of food but noted not all staff had recently attended food hygiene training. This meant patients may be put at risk from inappropriate food handling.

Assessments were made of patient's risk of malnutrition using a nationally recognised tool. Where patients were identified as being at risk of malnutrition, plans were developed to address this. This included monitoring patient's food and fluid intake, provision of food supplements and referrals to dietitians. There were red tray and cup systems used to alert care staff to people who had specific needs or required support with food and fluid intake.

The patient led assessment of the care environment (PLACE) for January 2014 to June 2014 achieved a high score of over 95% for most areas. The assessment includes evaluation of aspects including ward food and organisation of food. The national average score for England for organisation of food was 91.35% and the overall trust scored 89.83%. However Queen Victoria Memorial Hospital and Hertfordshire and Essex Hospital reported lower scores of 72% and 68% respectively. We saw an action plan dated 2014, but the month of the plan was not specified. The action plan stated that many of the identified actions had been completed, for example basic cleaning of equipment. Some were scheduled to be done during 2015, for example replacement of worn flooring. There was also some evidence on the action plan that particular areas had been revisited and reviewed. This meant that there were efforts to ensure improvements were sustained.

We observed lunch being served at Queen Victoria Memorial Hospital (QVMH). Patients could change their minds and have something different if they didn't want

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what they had ordered the day before. We observed that patients did not always receive the support they needed at mealtimes. A care assistant told us they did not have enough staff to help every patient who needed support with their food.

In some inpatient areas where patients had been identified as being at risk of malnutrition the care plans were not always followed. For example one person who had difficulty swallowing, experienced problems getting an appropriate diet. They told us that as a result their family brought in suitable food for them to eat. We looked at the patient's record and saw an assessment had been completed by the speech and language therapist (SALT) on 16th February 2015 which advised the patient should have mashed soft food. There was nothing in the care plan to reflect this, or a record to show what the patient had eaten. This meant that the patient may have had food that was unsuitable and could have been at a higher risk of choking.

During the inspection we noted a diabetic patient being offered sweet biscuits by catering staff. This was reported at the time of the inspection. Another patient who was insulin dependent explained they managed their own tests at home and did a blood sugar test before breakfast. The staff now did this in the evening after dinner when the reading tended to be higher.

We saw four examples of daily fluid balance charts in use that were not completed. We looked at charts of the previous days and saw that intake and output totals had not been calculated and there was no evidence to show evaluation of this aspect of care in the numerous places where patient information was recorded. Where monitoring of fluid intake or urinary output was not fully completed or evaluated means there is a risk of insufficient fluid intake not being identified.

One fluid chart showed a person who was verbally reported at handover as dehydrated, had not had fluids for over six hours according to their fluid chart. We raised this matter with the nurse in charge.

In the end of life care service, we saw that patients' nutrition and hydration needs were assessed informally by the palliative care team once a patient had been referred to them. We attended a visit and observed a palliative care nurse discuss diet and fluids with a patient to ensure that nutrition and hydration needs were being met in their home. We saw a palliative care nurse reviewing prescribed

high calorie drinks for a patient. However, there was no formal structure or risk assessment in place to assess, review or audit the nutrition and hydration needs of patients.

Approach to monitoring quality and people's outcomes

In Community Adults services we saw that the stroke team had established measurable goals for patients. These were written in user friendly language which encouraged the patient to take ownership of their individualised goals.

District nurses said that some ambulatory patients would be better served by their GP's surgery rather than use their services for example, for the administration of injections. The district nurses said this would allow them to manage their caseloads and capacity better. One of the locality managers said they were in conversation with GP's to see how they could manage patients more effectively who could attend their GP surgeries.

The trust had a system where there was a duty nurse available during working hours to take calls from people who used the service, prioritise or triage their care requirements, then allocate tasks for the nursing team. This meant that people who used the service had access to a clinical professional for advice or for further support, thereby minimising delays. This meant that there were systems in place to provide a prompt and effective service.

Staff told us they attended multidisciplinary meetings. There was good professional input from specialists and medical staff where present. Plans for progress and the resolution of issues for people were decided at the meeting. Staff were clear about the next steps for people who used the service.

In Children and Young People's Services, 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. This is a government led initiative which promotes a universal preventative service for children under 5 years of age. It focuses on providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and

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parenting. It is led by health visitors. These were monitored on a monthly basis. 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.

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. This is within the recommendations of the healthy child programme.

The main area of concern was 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. We were informed that this was due to health visitors not always receiving contemporaneous and accurate information from midwifery services. There were robust plans in place to improve this process utilising multidisciplinary working.

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 and improvement action had been put in place. 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 speech and language therapy (SALT) service had a clearly documented three year plan and with regards to patient outcomes. 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 performance report that was submitted to the trust board in January 2015 reported that community paediatric

services in Herts Valley were breaching the target in that the maximum waiting time for treatment should be no longer than 18 weeks. There was an action plan in place to reduce waiting times by offering additional clinics on a Saturday, although this had not been implemented at the time of our inspection.

Outcomes of care and treatment

In inpatient settings quality and performance information was displayed on notice boards in public areas of the ward. This included data about the workforce, the numbers of complaints, and the numbers of reported patient incidents such as falls or pressure ulcers. We saw evidence this was regularly updated. Minutes of meetings provided evidence that this information was used and discussed to identify shortfalls and improve outcomes.

Patient outcomes were monitored through use of standardised goal attainment scores. However some staff we spoke with were unaware if the scores were utilised to plan further care.

The average length of stay was monitored and staff could quote the figures of the average length of stay for their respective units. Delayed transfers of care were comparatively high for the trust. We saw that there was a variety of reasons for these; however, the trust broke them down by social and NHS delays. The rate of delays differed between each unit and the data we were shown, broken down as a percentage of delayed days against available bed days. The highest NHS delays were at Langley House at just over 7%, the lowest was Danesbury at 0%. There were similar percentage delays for social reasons, although this affected different units. Overall the lowest percentage of delays occurred at Sopwell (2%) and the highest at Langley House at 15%. To understand more fully the situation an exercise called a "Perfect Week" was undertaken. This helped identify the actions that needed to be taken to ensure patients were managed appropriately and discharged to a setting which reflected their care needs on a timely basis. There were contributory factors to take into account including those people that were non-weight bearing and those waiting for social care placements to be made available.

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

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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.

Competent staff

Within the inpatient settings here was a comprehensive induction for new staff. This included both a trust wide induction and local induction. There was one designed for permanent staff and students and another for flexible workers, such as bank and agency staff. We spoke with two agency staff who told us they received a good induction and were shown around ward to help them orientate to their place of work. We saw an agency nurse receiving an induction to the workplace at the Hertfordshire and Essex Hospital.

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.

However, amongst the nursing and care staff this was not the case. Some reported having an appraisal in the last year, most said their appraisal was due. We spoke with several staff, some at a senior level who said they had not received an appraisal for over a year. One told us their last appraisal was in 2010. All confirmed that appraisals were not followed up. This meant that any there was not a monitoring process to ensure agreed objectives were met. Nursing or care staff that we spoke with told us they had not received supervision or 1:1 interviews with their line manager to help them reflect on or identify improvements in their performance.

Staff were given the opportunity for specialist training. Many of the senior staff reported that the trust was responsive to requests for higher degrees or other courses

to assist staff gain enhanced knowledge in the chosen speciality. Examples given were opportunities to attend leadership development courses, undertake specialist practice degrees and child assessment courses.

To ensure staff were competent to provide safe care and meet the needs of the patients and the service examples of specific training and assessment of competencies were evidenced including phlebotomy skills training for health care assistants. Other competencies of staff assessed included safe use of syringe drivers, measuring blood glucose and monitoring intravenous infusions. Staff told us they were being supported to obtain skills in mentorship to support student nurses when they were allocated to the wards.

If the department they had to use temporary staff to cover unplanned absence such as sickness they had two temporary staff they used who were familiar with the department and had accident and emergency care experience

Within the Minor Injuries Unit, Hertfordshire and Essex Hospital, there were no paediatric trained nurses on the team, but arrangements were in place for staff to receive clinical supervision from a paediatric nurse practitioner. One staff member in the department had not received an appraisal for five years. As a consequence they had set their own objectives.

In Potters Bar Community Hospital staff reported they received training a variety of training including how to care for people with challenging behaviour. Training time was protected and external speakers sometimes attended to provide training updates for staff on topics such as safeguarding and use of the national early warning score system. We looked at records and saw within the past 12 months 28 out of 34 staff had been appraised, though staff reported prior to this recent series of appraisals they were inconsistently provided. There was evidence of professional development through the introduction of specialist link roles for example a specialist lead in diabetes. Competency assessments had been completed for a variety of tasks such as use of syringe drivers and blood glucose testing.

The trust had made a strategic decision to increase the number of independent prescribers in the community team. Staff said this has been difficult to achieve due to the challenges of releasing staff for training. Specialist nurses said they received specialist two day training in their field

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as well as a university course for the running of clinics which enabled them to support others within their practice. Staff said they had completed their level two training in communication. The sexual health teams training were provided in line with the British Association of Sexual Health Education (BASHE) guidelines.

Staff said the trust were "exceptionally" supportive of specialised training for groups of staff. For example they funded the practice of metachromatic leukodystrophy (MLD) updates every two years. Metachromatic leukodystrophy is a rare inherited disorder characterized by the accumulation of fats in cells.

Some staff had undertaken the Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) training. Staff said that DESMOND would enable them to discuss and educate people in the self-management of diabetes-related changes.

The clinical psychologist for stroke told us they trained rehabilitation assistants and patients in mindfulness to ensure that they were able to provide the correct care and welfare for people who use the service. Staff said they undertook "Stroke – decision making and update" and "motivational interviewing" external courses through the University of Hertfordshire. The records for annual appraisals showed variances of between 55% to 76% completed appraisals across the service. Senior managers said they were aware of the shortfall and arrangements were in place for all staff to receive their appraisals.

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.

Children and Young People's Services more than 90% of staff in children's services had received an appraisal in 2013/14. The target was 90% compliance for 2014/15 and performance up to and including September 2014 for this service was 94%. 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.

School nurses in Hemel Hempstead informed us that they were not having regular supervision because of a shortage of staff. We were told it was due to begin again soon and would be three times a year.

In Dentistry all new staff underwent a comprehensive induction. This included being allocated a mentor who ensured that the new member of staff was supported during their first few weeks.

The clinical staff were registered with the General Dental Council, (GDC.) The GDC is an organisation which regulates dental professionals in the UK.

Staff throughout the service reported that they were supported and encouraged to work across the dental network to ensure both business continuity and share skills. We saw evidence that clinical staff participated in Continuing Professional Development, (CPD) in line with GDC requirements.

Trust wide figures showed that over 90% of staff had completed some of the community Key Performance indicators (KPIs) detailed in the "Dental Services Learning and Development Plan". For example: 97% of staff had completed infection control and 100% had completed Level 1 Safeguarding training. Some staff described study days and courses that the trust had sponsored them to complete. Staff told us they were satisfied with internal and external training opportunities and they had the opportunity to have regular one to one meetings with their manager. The staff we spoke with in the dental service said they had regular appraisals in order that they had the opportunity to discuss their performance and career aspirations with their manager.

The trust Board Performance report for January 2015 stated that for the current period the whole trust performance for appraisal was 83% with the 2014/15 target as 90%.

Multi-disciplinary working and co-ordination of care pathways

In most inpatients units we saw evidence that multidisciplinary teams worked effectively together to provide care for patients. For example in the Hertfordshire and Essex Hospital the therapists assisted the nurses get patients out of bed, get washed as dressed in the mornings as part of the patient's therapy. However, at Queen Victoria Memorial Hospital, this was not the case. The therapists did not get to the ward until between 9am to 9.30am. Both nurses and therapists confirmed there was no formal daily discussion between them, to ascertain, for example if a patient had been unwell overnight and may not be well enough for therapy.

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At the Hertfordshire and Essex Hospital, there was a morning "sweep meeting," where all the staff had a brief handover so that all were aware of any problems or information that may affect patient care.

All the units we visited had a weekly multidisciplinary team meeting (MDM). This was attended by the senior nurse, therapists, the doctor, either the visiting general practitioner (GP) or consultant and social workers. These meetings were held to discuss patient's progress against their goals and to plan discharge from the hospital effectively. We saw evidence of discussions from MDM's regarding patient discharge communicated to GP & community rehabilitation teams.

Community teams told us that multi-disciplinary working was good. Staff felt able to consult with their colleagues. Specialist nurses were available to provide consultation when required. Community nursing teams and the specialist nurses worked well together and conducted joint visits where the assessed needs of patients required this.

Matrons worked in the Home First team and were available to provide advice to the integrated community team. Therapists worked across both teams. Patients were supported by different teams if their assessed needs changed. Patients had a named responsible clinician. The Home First team met GP's monthly to discuss the managed care of patients.

The therapist for hand therapy and rheumatology attended joint clinics with the acute services' consultants. Weekly meetings were also conducted with consultant surgeons. Staff had recently worked alongside the mental health team to review the Improving Access to Psychological Therapies (IAPS) therapies.

In Children and Young People's Services 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.

In Dentistry staff worked in partnership with other primary and specialised dental services to ensure a responsive and patient focussed service. For example, we saw evidence of referrals to other professionals such as facial/maxillary and oral surgeons. Staff we spoke with were able to explain the procedures for screening and making referrals to other specialists outside of the community dental service and showed us examples of referrals made by staff.

Referral, transfer, discharge and transition

Patients were referred to inpatient areas in the main from an acute hospital setting. The trust wide bed bureau was responsible for ascertaining where empty beds were and allocating according to patient need. There was a process in place where the nurse in charge carried out a paper or telephone assessment prior to the patient being accepted. Staff reported they were able to decline inappropriate transfers but this was often overridden by a senior manager. Occasionally the information provided from the acute hospital was inaccurate.

Transfers from the acute hospitals were undertaken very quickly. After a bed had been requested, most were transferred within 48 hours. This meant that their rehabilitation programme or their particular needs could be met quickly in a suitable environment. Once a patient was admitted, their expected discharge date was planned according to their needs and social circumstances.

Staff were knowledgeable about the purpose and aims of setting estimated discharge dates (EDD) and subsequent planned discharge dates (PDD). During the patient's stay the multidisciplinary team developed a planned discharge date (PDD) which was recorded and given to the patient to discuss with their relatives. A discharge report was

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prepared approximately 48 hours before discharge. Ward managers explained PDD's and EDD's were being collated to examine trends and obstacles to not achieving the PDD but as yet no firm conclusions had been reached.

Discharge summary processes were good. We observed the process being completed by staff on two occasions where a copy of the patients discharge summary was provided to the patient to take home. In addition, a copy was faxed and also posted to the patient's general practitioner. A self-medication sheet was provided which was clearly written; explaining what each item of medicine dispensed to take home was for. This was given in advance to allow the patient to sufficient time for the patient to question anything they were unsure about.

The trust had recently appointed a patient flow coordinator who acted as a link between the patient, nursing medical and staff, therapists and relatives and community services. This meant that staff time was freed to manage direct patient care. For example they ensured transport bookings involved family members to avoid barriers to discharge such as family going away on holiday when the discharge was planned. The average length of stay had reduced from 37 days and was, at the time of the inspection, 19 days.

In Community Adults Services individual caseloads were reviewed which included the time frame for discharge from the service. Discharge was subject to a package of care being in place. Some staff said there were concerns with the discharge system from local acute hospitals. On occasions, the community teams were not being informed when patients needed the support of district nurses.

We saw that stroke patients who had been identified by the early support discharge team had goals in place prior to discharge for example, more physiotherapist input to improve mobility. The stroke team told us the information provided on discharge was not always accurate regarding the patient's condition and needs. Staff said they followed up hospital discharge problems by reporting them as incidents and speaking to ward staff.

Patients were given copies of all correspondence submitted to their GP or hospital consultants with the exception of discharge letters. Staff said patients did not get a copy but confirmed the discharge letter was sent to their GPs.

The community health services received referrals from various sources for example, direct from the public or the

GP services. The response time could range from one hour to a few days dependent on a patient's need. When referrals were received into the lymphoedema clinic they were screened by the specialist nurse.

The community rheumatology orthopaedic and pain services (CROPS) received their referrals from GP's. Staff said that they saw 80% of the patient's referred with the other 20% being either referred to the orthopaedic department or back to the GP. There was a waiting list of 180 patients at Hemel Hempstead and 220 at Watford with a waiting time of between ten and twelve weeks. Patients accessed the CROPS service for a maximum of five weeks. Staff that there were available appointments within the clinics for emergencies.

In Children and Young People's Services 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 supporting 39 young people aged between 14 and 21 years old to facilitate a smooth transition into adult services. The Community Paediatricians told us that the services were good for those with profound disabilities. However, the Child and Adolescent Mental health Service (CAMHS) service for young people with mental health problems was said to be, "Fraught." There was lack of access to the psychology service and the interface with social care for young people with mental health problems was said to be the most difficult problem. The paediatricians acknowledged this was a national problem.

Availability of information

In inpatients settings details of the team caring for the individual patient were displayed above each bed in addition to patient's personal goals. Some units used a document called 'Going Home', this contained useful contact numbers of services the patient may require, for example, team members that would visit the patient at home, if required.

We saw a variety of patient information in all the units we visited. This included information on prevention of falls and moving in bed to prevent pressure ulcers. The therapists had a variety of patient information leaflets regarding correct limb positioning and exercises to aid recovery.

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Some patient information had details about how to obtain copies in large print, braille, or audio tape, or if a person required the information interpreted in their own language. There was an interpreting service, with details of which languages were covered. There was a falls information board, written in an easy read format with illustrations, giving information on the frequency of falls in the unit, risks and how to avoid them. There was also information on local and national organisations, including Carers in Hertfordshire, The Alzheimer's Society and The Stroke Association. Information documents also included contact details of other organisations that could provide further information such as the National Institute for Clinical Excellence (NICE) or the Patient Advisory Liaison Service (PALS).

In Community Adults services the trust had access to interpreting and translation services from which they could arrange both face to face and instant telephone interpreting services. The interpreting service also included the translation of documents. Staff said they had used the facilities of the British sign language services.

The trust had produced literature to people accessing the community health service. This meant they had a good understanding of the service being provided. This could be requested, when required, in a different language or format and was available on the trust's intranet.

In Children and Young People's Services information was available through the 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 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.

Consent

The trust had a consent policy, updated in 2014, that reflected national and regulatory requirements.

We saw evidence that consent for treatment were obtained and recorded in accordance with the trust's policy. However it was noted that several patient records included photographs of their wounds to assist with the planning of their wound care. Of the records seen, written consent to have the photographs of their wounds taken had not been obtained from the patient.

Therapists recorded that they had gained the patient's consent prior to treatment and we saw documents used to record care included a prompt for the staff member to request consent from the patient prior to providing treatment. Patients told us that they were asked for consent before any treatment or procedure.

Most staff demonstrated awareness of the Mental Capacity Act (MCA) 2005. They had received training and guidance regarding the MCA which was confirmed in the training records viewed. However, we saw that nearly half of the Royston community team had not completed their MCA training. This was brought to the attention of senior trust staff

In Community Adults services staff were aware of the issues relating to confidentiality when entering a patient's house using the safe key system. Staff knew where the box number was kept and by whom.

Patient's records included their consent to care and treatment and the sharing of information with others for example, their GP.

In Children and Young People's Services 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 and Fraser Guidelines and its relevance when treating children and young people.

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.

In Dentistry the trust's consent policy provided clarity for practitioners working within the service. All staff we spoke with were clear on the process they needed to follow to gain consent from people.

The dental service provided care, treatment and support to a large number of vulnerable patients who lacked capacity to make decisions about their treatment. Clinical records we saw provided evidence that the mental capacity of patients had been taken into consideration when both assessing new patients and obtaining consent or agreement for treatment. Staff were clear as to what action

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should be taken when an adult patient did not have the capacity to give or withhold consent, in order to justify best interest decision making processes. We reviewed patients' notes and saw evidence of discussions that had taken place regarding treatment plans.

The trust learning and development plan identified that 100% of staff had completed Mental Capacity Act (MCA) training and this was confirmed by all the staff we spoke with. Furthermore, all the staff we spoke with were aware of the impact that the MCA had on the care of their patients with regards to gaining consent.

Are services caring?

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

Summary of findings

We judged the care provided by staff to be good across all the core services and in all the places that we visited apart from in dental services where we found it to be outstanding.

People were mostly well supported, treated with dignity and respect and were involved in their care.

Patients, their relatives and carers spoke very positively about the compassion and care they received from staff in both in community hospitals and in the community.

We saw staff taking time to talk to people in a supportive, kind and appropriate way. Patients and their relatives told us that they felt reassured and were confident to ask questions and make requests.

Staff did their best to support families and told us that sometimes they visit in pairs so that one person can provide care to the patient while the other staff member provided advice and support to their carer.

Patients and their relatives told us that they felt reassured and were confident to ask questions and make requests.

In the end of life care service, staff had received training in communication and we saw that staff used appropriate communication skills with patients. Staff did their best to support families and told us that sometimes they visited in pairs so that one person could provide care to the patient while the other staff member provided advice and support to their carer.

In dentistry we saw staff had completed the T.E.A.C.H workbook as part of the Purple Strategy a joint health and social care initiative which informs service providers and empowers people with a learning disability, this had been developed with service users and stakeholders to promote and highlight quality health and community services that have been reasonably adjusted to meet the needs of people with learning disabilities.

The Quality Account for 2013/14 showed that the care patients said they received was good to excellent, 99% of patients using inpatient services said they were

treated with dignity and respect. The Friends and Family Test, (FFT) January 2015 showed that 91% of patients would recommend the service to their friends and relatives.

Our findings

Dignity, respect and compassionate care

In the Inpatients setting we spoke with 24 patients and relatives during our inspection. Most patients told us they were treated with kindness and respect. Staff usually responded compassionately to pain and discomfort in a timely manner.

The majority of staff were kind and had caring positive attitudes towards patients and their families. The friends and family test showed 99% of people using inpatient services advised they were treated with dignity and respect. The Friends and Family Test, (FFT) January 2015 showed that 91% of patients would recommend the service to their friends and relatives.

The Patient Led Assessment of the Care Environment (PLACE) survey results for 2014 regarding privacy, dignity & wellbeing showed the trust average score to be 75% which is below the England average of 85%. However, three of the eight locations we inspected had achieved very good scores:

- Potters Bar Community Hospital, 97%
- Gossoms End Rehabilitation Unit, 96%
- Danesbury Neurological Centre, 96%

There was promotion of dignity and respect awareness through training for staff plus notices and educational material were also displayed for staff. Patients told us staff were kind and took time to explain things. There had been 22 complaints regarding care for inpatient services between Oct 2013 and September 2014 of these 41% related to standards of care and 14% to staff attitude and behaviour.

In Langley House staff told us that they tried to fit each patient's care around the patient's needs. For example, one patient wanted to be able to eat and drink independently, and staff supported the patient through the process, by supervising and advising them. We noted that all care plans included a form titled "This is who I am and how I wish to

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be cared for". This detailed how the patient wished to be involved in their care, and gave examples of their likes, dislikes, how they wished to be addressed, their perception of their care and therapy needs, and their own goals. For example, one patient wanted to regain mobility following a fracture. The care plan detailed how this goal would be achieved, with the use of physiotherapy and nursing care. Review dates were included in this care plan.

We found that nurses checked on patients regularly, and documented any issues in the two hourly rounds checklist. The checklist was used to check the patients status and comfort such as, if the patient was awake, asleep, comfortable, in pain or required assistance, for example with a drink or to go to the toilet.

Feedback from patients and staff at Queen Victoria Memorial Hospital was varied. On arrival we observed visitors being greeted in a warm and friendly manner. Relatives spoke positively about the care provided. One patient reported their dignity and privacy were not respected. They reported that they had long waits for care.

The PLACE score at QVMH for privacy, dignity and well-being was 68% which was the lowest score in the trust. We saw an action plan arising from the audit and although there were no actions in place to address this directly, there were plans to ensure that different height chairs were available, these had been ordered. In addition there were plans to make some areas more dementia friendly, although the plans to complete this were imprecise.

In the community adults services we saw positive examples of staff and people's interaction. Patients were positive about the community nursing team. We observed staff introducing themselves and ensuring patients were comfortable with our presence in their home. Staff treated patients with kindness and respect. They explained to us how they delivered care to the different people and demonstrated they had a good understanding of different needs.

In Children and Young People's Services the staff were aware of providing compassionate and respectful care. We received 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.

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 saw 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.

In Dentistry all the patients we spoke with during our inspection made positive comments about the service and we saw that staff were friendly and respectful. Staff described how they ensure they have appropriate staffing levels for the needs of their patients, to allow enough time when patients are attending appointments. Staff told us they were able to give patients as much time as they needed. Staff told us that they had completed equality and diversity training and confirmed their awareness of the value base of the trust and the unique needs of the patients they cared for. We observed that patients were treated with respect and dignity during their time at the practice. During treatment we observed patient's supported to feel comfortable and ask questions. They were shown equipment that would be used and able to touch it prior to treatment to see how it felt.

In End of Life Care services we spoke to all levels of staff in the palliative care teams we visited, and all of them told us that the patients experience was important.

We watched staff interacting with people who used the service in a polite and tactful manner. Staff told us that they would look for cues from the person so that they did not ask unnecessary questions which may have upset them. All of the staff we spoke to told us that they had taken part in communication training. This helped them in their role when asking people sensitive questions about their choices for end of life care, or in discussing bad news with patients, their families and carers.

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We attended a visit with a Specialist Palliative Care Nurse and saw them identify the level of care the patient needed. They were able to give advice on the benefits that they were eligible to receive, and arranged for this to be put in place. This was an example of outstanding practice that we saw during the inspection.

Patient understanding and involvement

In inpatient settings staff generally involved patients in planning their care and provided support where needed. Staff explained how they would provide support to patients who were confused or anxious through taking time to talk to a patient, tell them their name, smile, be relaxed and try and to help the patient relax. We saw this being practiced. Staff introduced themselves and explained the date and time of day to help orientate patients. Staff explained what they were going to do when delivering care, and why. They also explained, for example, when medicines were due, when staff changed at handover who would be looking after the patient, or what arrangements had been made for medical tests such as x-rays. Medical staff took time to explain to patient's changes to their planned treatment and involved family members where appropriate.

There was little evidence in patient's records that patient's preferences had been ascertained when planning care. Weekly timetables were developed for patients so that family visits and other appointments could be built into the patient's daily plan of care and therapy.

We observed in one area handover took place in the ward corridor and did not involve the patients.

An interpreter service was available however this was not always proactively use by staff.

In Community Adults we saw staff took time to ensure that patients understood their care and treatment and were involved in making decisions. For example, we saw staff showing a patient where they were going to take a wound swab and why.

One patient, who was under the care of the podiatrist said they carried a card and antibiotics which they could take at the first sign of infection. This had prevented admission into hospital for intravenous antibiotics.

Written information was available to patients about their care and treatment and medical conditions. These could be requested in a different language when required.

People were able to raise concerns and comments during their initial assessment meeting.

In Children and Young People's Services we spoke with a nurse at the Peace Childrens Centre in Watford who said that the service welcomed the involvement of parents and the nurses were always interested in their feedback.

The speech and language therapy service was collecting feedback from parents on the implementation of a new model of working. This information was being shared across the service so that they could learn lessons from the sites that were implementing the new model first.

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".

In Dentistry patients and their relatives told us that they were involved in their care. The use of individualised patient treatment plans enabled patients and their relative to understand and participate in their treatment wherever possible.

Emotional support

In the inpatient settings most patients we spoke with felt supported and were given encouragement where needed. Some wards had quiet areas where discussions with patients or relatives could be held in private. Visiting times were flexible to allow access to visitors. Ward notice boards included details about chaplaincy services.

There was evidence a geriatric depression score tool was used to assess patient's mental well-being. At weekends a chaplain visited the ward to provide communion for those patients who requested it. There was a chapel available for patients and families to use. Contact details of the ministers were displayed advising a visit could be arranged if patients requested it.

In Community Adults services we observed the community nurses providing emotional support to people and relatives who were distressed. They spoke calmly and with respect whilst respecting the person's dignity.

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In Children and Young People's Services we saw examples of children and their families receiving emotional support from staff at the children centres and clinics. We also saw caring support and attention at the home visits we attended.

We saw completed comment cards which described how pleased parents were with the care that had been provided for their child.

Dental services had implemented a The "Purple star" strategy. Whilst this is a local initiative within Hertfordshire the skills and knowledge staff acquire are put into practice across all groups of patients who attend the specialist dental service. The Purple Strategy is a joint health and social care initiative which informs service providers and empowers people with a learning disability and their carers to get fair non-discriminatory health and social care. It has been developed with service users and stakeholders to promote and highlight quality health and community services that have been reasonably adjusted to meet the needs of people with learning disabilities.

In End of Life Care we observed a multidisciplinary team meeting at Gregans House where we listened to staff discussing the emotional needs of patients identifying a number of ways they could assist the patients and their families.

Staff told us that a psychiatrist was available to the team to provide support to people who used the service. We spoke to the psychiatrist and they told us that they would visit people in their own home to provide support if it was identified that emotional support was required.

Promotion of self-care

In inpatient settings Patients were encouraged to become as independent as possible prior to their discharge. Room exercises were provided for patients to practice under supervision and to take home. Where appropriate patients were allowed to self-medicate once they had been assessed as safe to do so. This meant patients became familiar with the medicines they needed and had time to raise any concerns they had prior to their discharge home.

There were protected meal times for lunch (which meant visitors and interruptions by care staff were not allowed) but friends and family were encouraged to visit and be

involved at all other times. On St Peter's ward at Hemel Hempstead Hospital, patients were encouraged to use the day room where activities were organised for them such as bingo, quizzes and musical events.

In most settings there was evidence promotion of self-caring to avoid patients becoming too dependent especially when in hospital for a long period and help prepare them for discharge home. The units had assessed and made arrangements to enable patients to go on overnight/weekend leave as a trial to assess how they coped in community and this allowed the family and patient more time together in a non-clinical environment. In Queen Victoria Memorial Hospital this was more limited; there was an average of two sessions of therapy a day, one of which may have been a group activity.

In Community Adults services staff supported patients to manage their own health care and maximise their independence. For example, we observed a health care assistant talking to a patient and giving practical advice to increase their mobility. Staff in the diabetic and high risk foot clinic gave verbal and written advice to patients.

In Children and Young People's Services 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. Parents and families were taught to manage feeding and respiratory equipment in the home. Respite and day care was offered to support families to care for the needs of children with complex and long-term conditions.

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.

In Dentistry we observed how the dentist gave oral hygiene advice to patients at each visit. The dental service provided an oral health service both in the clinics and in the community. For example, they went into schools and care homes and ran sessions to carers on maintaining good oral health to people with special needs. Staff also gave patients a leaflet which explained how to take care of their teeth in easy to read language with pictures. This meant that patients and professionals/carers were given specific advice according to patient's particular needs.

Staff working within the two palliative care teams told us how they felt it was important to them to be able to help people to be as independent as possible in their own

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homes, if they chose to receive their care there. A team manager told us that they worked together with district nurses and occupational therapists to provide equipment and support. Equipment provided included electric

adjustable beds, pressure relieving mattresses, and mobility aids. This enabled patients who used the service to manage at home and care for themselves as far as possible.

Are services responsive to people's needs?

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

Summary of findings

We found that generally, services were organised so that they met people's needs. We rated responsiveness as good across all services.

Patients appreciated the slower pace of the community inpatient wards where they felt staff had time to plan and deliver the care they needed before being discharged home. There was an integrated approach to planning and delivering care in a way that supported people to receive and access care as close to their home as possible. Facilities and premises were appropriate for the services planned and delivered. Care was planned and delivered to meet the needs of people with complex needs such as those living with dementia. Dementia champions had been introduced to help ensure best practice was used to meet the needs of vulnerable people.

Staff showed an awareness of the need to respect different cultures and religious needs. Access and response to translation service needs were limited and not always sufficient to meet patient's needs.

Patients when asked were aware of the complaints procedure and could describe how they could report a concern. Complaints were taken seriously, investigated and changes made where appropriate. Concerns and complaints were often dealt with and resolved at ward level by the ward sisters which avoided the need for a more formal approach and ensured people's concerns were addressed promptly, but this was not reflected in all services, particularly dentistry where not all complaints were recorded.

The services provided a range of specialist therapeutic interventions. The trust was aware of the diverse needs of the people who use the service and provided a range of support as required, including some translation services, the needs of travellers and those with a learning disability. However, although leaflets and consent forms were available, not all staff were aware how to access these.

National waiting time targets of referral within 18 weeks were not being met in some specialities.

We found that patients could not access treatment and urgent and emergency care when required as there was no commissioned out of hours service and no hospital out of hours specialist dental provision. This meant people had to access care via the NHS emergency 111 service or pay privately for that service if they could not wait.

It was unclear how verbal complaints were recorded or processed as staff told us they did not record these.

All the staff we spoke with were passionate about providing good quality care in response to people's individual needs.

We found that the trust provided information to people in a variety of different ways. Leaflets were available in different languages, interpreters were available in person or over the telephone, and easy read information was developed for people with learning disabilities.

The trust held specific meetings to discuss end of life care for people with learning disabilities. We were told that no other trust carried out such meetings. They were however, instigated by doctors with an interest in learning disabilities and not part of a formal plan from trust level.

Our findings

Planning and delivering services which meet people's needs

Patients were transferred from the acute hospitals for rehabilitation nearer their home and these transfers were coordinated through the central bed bureau. Most had been admitted from fast paced acute medical or surgical wards and appreciated the slower pace and the emphasis on maximising their mobility and independence.

Referrals were received from the bed bureau and were screened by staff for suitability. Staff reported there had been a number of inappropriate admissions which had been reported using the trusts electronic incident reporting system. Staff told us they often found bed managers at a local acute trust rude and were told they had to take the patient. Staff told us even when they had raised concern

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about the appropriateness of admissions the patient "just arrived". Staff felt their managers had been supportive and had requested incident reports were completed if inappropriate transfers were made or staff were rude.

Staff we spoke with at the various hospitals, including doctors and nurses, expressed concerns about the poor quality of patient information they received when patients were transferred to their respective units from other hospitals. Staff showed us incident reports they had generated regarding the poor quality of photocopied patient records provided from the local acute hospital. They explained that a decision had been taken by the referring hospital to no longer transfer the original whole patient record with the patient but only provide a photocopy of the recent episode of inpatient care. They told us there had not been any consultation regarding this decision. Doctors expressed concern as they did not have a complete picture of the patient to effectively evaluate patient's treatment. Staff were unaware whether any protocol had been developed to determine what information should be copied and transferred with the patient.

Staff we spoke with at the various hospitals, including doctors and nurses, expressed concerns about the poor quality of patient information they received when patients were transferred to their respective units from other hospitals.. Staff told us that they brought this to the attention of their managers and had begun to complete incident forms on the trust's electronic reporting system. Formal reporting of these incidences was fairly new, however, data was available which showed there were a total of 144 incidents reported between September 2015 and February 2015, where patients had been either inappropriately transferred or transferred without suitable notes. There had been 77 inappropriate transfers, fifteen of which were late transfers, that is transferred after 10pm. There were 67 incidents related to incomplete or insufficient records. Staff though had not been informed of any actions taken to address this. We brought this to the trust attention during the inspection.

There was a community bed discharge manager whose key role was to ensure safe sustainable discharges, ensure effective coordination of the whole care team and achieve a 20% reduction in the average length of stay. Since

December 2014, the average length of stay had been monitored to measure the effectiveness of the service but it was too early to draw any conclusions about how effective the service has been at this stage.

The Minor Injuries Unit at the Hertfordshire and Essex Hospital, provided a service between the hours of 9am and 5pm Monday to Friday with the majority of patients seen on Mondays and Fridays. Patients seen in the Minor Injuries Unit were offered a choice of which hospital they were referred to if they required further treatment based on where they lived. Staff explained the unit was open from 9am – 5pm but the x-ray service provided by the acute trust usually closed down at 4.45pm which meant any patient attending after this time had to return the following day. Patients said they had been referred to the unit when seen by their general practitioner or following a phone consultation with their GP.

The integrated community teams offered a range of services dedicated to treating patients' requirements which included prevention of admission and the supported discharge service. The service was able to provide a range of different treatments and therapeutic interventions which included a physiotherapy and falls service.

The Home First's rapid response teams were able to respond to peoples' needs within one hour. If they were unable to meet the referral time staff said they continued to do background checks. Referral times were being met at the time of our inspection. The records showed that the introduction of the Home First team had reduced the attendance to accident and emergency department by 14%.

The staff at the Avenue clinic told us they had an overnight nursing service so that if a late call was received this could be dealt with by this service. The overnight service at the Avenue clinic was made up of one nurse and one health care assistant and provided an urgent response service for patients and their families.

There were 14 community clinics for lymphoedema. They saw people who had a diagnosis of lymphoedema due to cancer. Community nurses carried out Manual Lymphatic Drainage (MLD) on patients with hand, neck and trunk lymphoedema. Staff provided information leaflets for patients and their relatives.

Waiting times for the leg ulcer clinics were variable for example; Hitchin clinic had a waiting time of nine weeks

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whilst Baldock clinic did not have any waiting time. Patients could be offered other clinics as deemed appropriate. We saw assessments of people's needs including pain management were comprehensive.

People who had not previously had a diagnosis of lymphoedema due to cancer were seen within four weeks. Staff said they had achieved a target of seeing new patients within two weeks. The clinics did not have a waiting list for intensive therapy or review appointments. The lymphoedema clinic reported monthly on non-clinical activity performance. This had resulted in the trust increasing the bandaging of patients with lymphoedema to twice a week. This had reduced waiting time for intensive treatment and there were no changes to patient's outcomes.

The waiting list for the musculoskeletal services from August 2014 to January 2015 showed breaches for each month. However of the 29 apparent patient breaches appearing over 18 weeks, 13 were discharged in accordance with HCT Access policy, 12 were legitimate breaches, two were data quality issues, in which case the patient was seen within 18 weeks. During this period there were two actual beaches resulting in referral: treatment time which was longer than 18 weeks.'

Staff at Potters Bar Hospital said they were monitoring the, did not attend, (DNA) figures by reviewing the appointment letters and telephone text messages. They said it was a work in progress and that it was too early to review the effects of these new initiatives on improved attendance. Patients who did not attend their appointments were offered another appointment. Patients were discharged if they did not attend again without a valid reason.

We reviewed the rate of DNA across the rheumatology services and this averaged 12%. We saw the DNA rates for the community nursing services which showed an average rate of 0.8%.

The trust had set a target of 80% for all referrals to the rapid response team being seen within 60 minutes. This had been achieved with figures of between 97% and 100%.

We saw the referral to treatment times for the podiatry services. The trust's records showed that the service had breached the 18 week referral time by 0.67%. We asked the manager to quantify the number of patients this affected but they were unable to provide us with the information.

There was a consultant cover for the diabetic service. The diabetic specialist nurse (DSN) said that they were able to phone the consultants who were very willing to provide advice.

We observed staff discussing pain management with patients. We saw staff had good knowledge of pain management which they recorded on people's records. This ensured that people's needs were being discussed and provided.

The community rheumatology orthopaedic and pain service (CROPS) provided a service at Hemel Hempstead General Hospital and Watford General Hospital. The service was offered to adults with benign musculoskeletal (MSK) conditions where immediate surgery was not indicated and conservative treatment for example, physiotherapy had not been successful.

The trust ran a 12 week falls prevention course. The course invited patients who had been referred to the falls team. The physiotherapist technical instructor said that between eight and ten patients attended. However, this course was not commissioned for the patients living in the Royston area. The physiotherapist within this area has started a mobility clinic by undertaking assessments for patient's postural stability and falls risk and providing intervention guidelines. The physiotherapist said they currently held the mobility clinic monthly but would like to increase the frequency of these clinics.

The trust had responded to the National Dementia Strategy by forming a 'living well with dementia' project. The project aimed at improving the trust's approach to people living with dementia. The vision was to define the commissioning services' pathway by raising awareness and understanding through early diagnosis.

Patients attending the diabetic and high risk foot clinic were seen regularly, usually every three months, for a review of their condition and treatment. Patients were also able to phone the clinic with any problems between appointments and where required urgent appointments would be arranged. New patients attending podiatry, physiotherapy and dietetic clinics were given longer appointments. This allowed extra time for assessment of the patient's condition and needs.

The speech and language service offered speech 'drop-in' session. These sessions were held in various locations so that families who were concerned about their child's

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speech could easily reach a service nearby their home or the child's school. The child could then be referred on to formal speech therapy sessions if this was thought necessary.

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 if 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 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 this 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.

Staff reported that many patients were referred to the community dental service for short-term specialised treatment. On completion of treatment, patients were discharged to the patient's own dentist so that ongoing treatment could be resumed by the referring dentist.

Performance information showed that patients were seen within a variable time frame with some being seen within a few weeks and others waiting 21 weeks. National Health Service (NHS) guidelines say that people should wait no longer than 18 weeks. Staff told us that demand was high and this meant people had to wait longer for an appointment. People were sent a letter advising them to contact the service should their need become more urgent whilst on the waiting list.

Referral systems were in place, should the community dental service decide to refer a patient onto other external services such as orthodontic or maxillofacial specialists.

Staff told us patients who were in pain were prioritised for treatment and could be seen the same day on some

occasions. Staff showed us referrals where people had been referred for pain and had been fast-tracked for treatment. These referrals included extractions under general anaesthetic.

Where people found it traumatic or they were unable to attend a clinic, for example if they had a profound disability or were frail, then a domiciliary service was provided in their own home. Staff highlighted that good communication between the dental services and people's own GPs helped them to meet people's needs.

Where people had additional needs, such as a learning disability, staff encouraged parent, care worker and social care professionals to be involved. The clinic booked appointments around individual people's needs. Staff told us they would ask everyone involved in people's care what time was most suitable and tried to accommodate requests when booking appointments.

The service worked collaboratively with local hospitals to secure operating time for patients who required dental care in a hospital setting, for example, procedures under general anaesthetic. Because the dentists and surgeons worked collaboratively and the operating lists were regular, staff told us patients did not have to wait very long for treatment. We were unable to find information on exactly how long individual people waited as this information was not made available to us.

We saw that the centres had specialist equipment to enable people who for example were wheelchair users or who were obese, to receive dental treatment. Appointments were timed to last longer than is usual at dental surgeries to allow people with more complex needs the time they needed.

We noticed there was no information for patients regarding difficulties parking at some of the units. People's relatives and carers told us St Albans hospital had very limited parking and it was very expensive.

However, parking at St Alban's was not run by Hertfordshire Community Trust, but by another organisation and staff ensured that patients were aware of this arrangement and that discounted parking charges were available.

A palliative care manager told us that the community area covered by the trust was large and covers approximately 90 GP services with groups of people from different cultural backgrounds and spoken languages. To enable effective

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communication with patients and carers whose first language was not English, staff told us that leaflets were available in different languages. These could be accessed via the trust's intranet. Furthermore, staff had access to translators either in person or over the telephone to assist a person who used the service where English may not be their first language.

We saw that one person we visited did not speak English as their first language, and the staff member did not have this information prior to the visit. The member of staff chose their words carefully and spoke with family members to ensure what was said was understood. We were told that translators were available to the nurses on their visits. The nurse told us that if subsequent visits were required, they would ensure the translator was available so that the individual could communicate effectively more easily.

We were told by a specialist palliative care doctor about information packs had been developed for people with learning disabilities. They described the potential difficulties with communication and that regular multidisciplinary meetings were held in order to improve the service provided to this group of people.

At Apsley One we spoke with a palliative care specialist doctor who told us about multidisciplinary team meetings that were held in order to evaluate the care services in end of life for people with a learning disability. This allowed the team to expedite discharge from hospital, where the environment may have been unsettling for them. We were told about a resource pack that had been developed to inform these patients of specialist services available to them and numbers to call for assistance and support. We were told that this scheme is currently the only one known in the United Kingdom, but the doctor told us that this good practice was being shared and developed with another nearby trust.

Equality and diversity

All staff described how they would support patients' needs to reflect their particular needs. However, access to amenities, for example translation services seemed to differ across each core service.

Generally staff were knowledgeable about the strands of equality and diversity and what made each person an individual. Staff would respect different cultures and

religious needs. Staff we spoke with said all patients would be treated and cared for as individuals and adjustments would be made to ensure the outcomes for patients were as good as they could be.

If staff required an interpreter to translate they requested this via the hospital's switchboard. However, if patients did not speak English, a family member or a member of staff would provide assistance with translation.

Staff had access to a network of support for patients differing spiritual needs, both within the hospital and from the local community. The chaplaincy based at the hospital visited the wards regularly and specific visits could be arranged. At the Hertfordshire and Essex Hospital, there was a Chapel, which was used for services and as a quiet place for contemplation and prayer.

The community nursing teams assessed patients with a learning disability to ensure they had access to specialist community learning disability staff when needed. Staff liaised with these nurses to ascertain if a patient had mental capacity and could give informed consent.

In children and Young People's Services there were limited local translation services; if staff required an interpreter they were available on a pre-booked basis, but the service was not available seven days per 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 handling 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.

In Dentistry we found that people had individual holistic assessments which covered a number of areas including communication needs, physical needs such as specialist equipment they might need and any travel difficulty or

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caring responsibilities they might have. This enabled them to support people by, for example, arranging an interpreter, specialist equipment or appointment times to suit people's needs wherever possible. In another example staff told us some people needed to follow a specific routine due to their autism. Staff said they followed the same routine every visit including ensuring using the same waiting room, clinic room, and staff people knew. Staff said they had taken advice and information from all those involved in providing their care and support before starting treatment. They had a written copy of the behaviour care plan in the individual's assessment.

We observed three clinic visits where discussion took place on people's individual needs and what would need to be in place to enable successful treatment to take place. For example, one person needed to get used to the building and equipment before treatment could take place. Staff arranged for them to become familiar with equipment by touching and handling it. Staff showed them the mask they would use and allowed them to play with it and try it on whilst at the time explaining how it would be used. They then took it home to get familiar with it before any treatment would start.

The trust provided an interpreter service if needed. Staff told us it was very easy to access. We observed staff contacting this service on the phone and using during treatment to explain what was happening to the patient.

Meeting the needs of people in vulnerable circumstances

It was recognised that a number of patients admitted to the wards at any one time were living with dementia. Some staff had received training to understand and provide support people living with dementia. Dementia champions had also been introduced to ensure best practice was cascaded down through the team. Care plans met the needs of people living with dementia. Some of the units used the "This Is Me" document. This described the person, their life and likes, in an effort to help staff understand what sort of person they were and talk about things that may be familiar to them. We saw there were appropriate access facilities for people with limited mobility such as step free access.

The community nursing teams assessed patients with a diagnosis of learning disability to ensure they had access to specialist community learning disability staff when needed. Staff liaised with these nurses to ascertain if a patient had mental capacity and could give informed consent.

Community services had access to the Rapid Assessment, Interface and Discharge team (RAID) for patients who may have mental health problems alongside their physical health needs.

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 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.

We saw evidence of integrated working between the community dental team and other organisations. For example other health care services, including local dental surgeries, social workers, and care homes. The service worked with a range of groups including young children, teenagers, adults, vulnerable people and other health professionals to deliver better oral health in accordance with evidence based practice.

Access to the right care at the right time

Patients were admitted to all units swiftly and there were minimal waits for beds. All admissions were managed centrally via a trust wide Bed Bureau. Medical out of hours care was provided by the local on call doctor service. Staff

Are services responsive to people's needs?

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reported the service usually worked well and patients were seen within the hour except during peak demand such as during the winter months when requests were high. If a patient was in urgent need of medical attention staff called the emergency services. Patients told us most call bells were answered promptly if there were sufficient staff on duty.

Waiting times for the leg ulcer clinics were variable for example; Hitchin clinic had a waiting time of nine weeks whilst Baldock clinic did not have any waiting time. Patients could be offered other clinics as deemed appropriate. We saw assessments of people's needs including pain management were comprehensive.

People who had not previously had a diagnosis of lymphoedema due to cancer were seen within four weeks. Staff said they had achieved a target of seeing new patients within two weeks. The clinics did not have a waiting list for intensive therapy or review appointments. The lymphoedema clinic reported monthly on non-clinical activity performance. This had resulted in the trust increasing the bandaging of patients with lymphoedema to twice a week. This had reduced waiting time for intensive treatment and there were no changes to patient's outcomes.

The waiting list for the musculoskeletal services from August 2014 to January 2015 showed breaches for each month. For example, the service had breached its January 2015 referral to treatment time by 29 patients. This meant that 29 patients had waited more than 18 weeks for their first treatment.

Staff at Potters Bar Hospital said they were monitoring the, did not attend, (DNA) figures by reviewing the appointment letters and telephone text messages. They said it was a work in progress and that it was too early to review the effects of these new initiatives on improved attendance. Patients who did not attend their appointments were offered another appointment. Patients were discharged if they did not attend again without a valid reason.

We reviewed the rate of DNA across the rheumatology services and this averaged 12%. We saw the DNA rates for the community nursing services which showed an average rate of 0.8%.

The trust had set a target of 80% for all referrals to the rapid response team being seen within 60 minutes. This had been achieved with figures of between 97% and 100%.

Patients told us they had regular sessions of physiotherapy during the week and were provided with exercise plans to follow at the weekends when physiotherapy staff were not available.

Access to wheelchairs was a problem and often patients ended up buying their own when being discharged. There was an awareness of this shortfall and it was recorded on trust's risk register.

In the Minor Injuries Unit, Hertfordshire and Essex Hospital a board was displayed in the waiting area specifying the current waiting time e.g. five minutes and showed the names of the staff on duty. The target waiting time for patients to be seen was 15 minutes and there was evidence to show this was being met. All the MIU nurses were trained prescribers which meant patients could be treated promptly without waiting for a doctor to prescribe medicines.

Most staff in community teams said they could access standard pressure relieving cushions and mattresses. Bariatric equipment for obese patients was available when required.

Staff had access to the trust's speech and language therapist for advice and guidance to assist patients with communication difficulties. Referrals were made when necessary.

In Children and Young People's Services we saw that drop-in sessions for the speech and language therapy service were widely available across the county. However, the method of referring the child on for further therapy was done in a paper format. The staff were looking forward to the trust's electronic system being implemented county wide as this meant that the child could be booked electronically into the menu of options at the base nearest to the child's home.

We heard that waiting times for initial screening and appointments were reducing in a number of areas. Waiting times for initial screening with the challenging behaviour psychology service had been an average of nine months but the clinical psychologist we spoke with said that had been reduced to three months recently. Clinics were available at five locations and parents could also contact the clinic by telephone for advice and support.

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Both the occupational and physiotherapy services had reduced their waiting times for centralised referrals from 48 to 13 weeks.

In Dentistry some services were not provided at all four units. For example sedation, was not offered in all the centres. Some treatments, such as extractions, were not available in every centre, every day. This meant that for some treatments, patients had some distance to travel. However, this ensured the right facilities were available to them for specialist treatments.

A Hertfordshire Special Care Dental Service leaflet informed people about the service and what to expect when they visit. The leaflet included information on the interpreter service and transport arrangements.

We saw that information on the opening hours of the units were not written on the patient leaflets. There was no information on at what times or days the service was available at the four units. Information was available on how to contact the out of hours service.

One patient told us that they had rung the emergency out of hours number to get help for their child who had particular special needs and was in pain. Staff there had advised them go to the local hospital. However, emergency dental treatment was not available at the hospital and they were told they would need to see a dentist privately. They were given a list of dentists to contact. They told us they had not been able to get any help from the NHS dental service until the next day and then waited three days for an appointment, even though it was deemed to be urgent.

Staff we spoke with confirmed that was no out of hours service provided as this service was not commissioned by the local Care Commissioning Group (CCG). People were able to access emergency dental services out of office hours by calling the NHS 111 telephone number or calling a private service.

Staff told us that if a patient had suffered trauma, had a facial swelling or was bleeding they would be given an appointment on the same day, as they would be fitted in during or at the end of surgery. This meant that urgent clinical needs were assessed and acted upon during normal working hours.

Staff told us that the wait for non-emergency appointments used to be around a week, but due to demand it could be three or four weeks before a first appointment.

In End of Life Care we saw that the trust had a system in place where calls during the day were handled by a registered nurse with a palliative care background. This meant that assessments could be completed over the telephone and some advice given immediately to people who used the service without the need for people to be referred to another service. This staff member would also triage the calls, allocate visits to the palliative care team where necessary and provide visit information to the caller.

We attended a visit with a Specialist Palliative Care Nurse where they assessed a patient that had been newly referred to the service. They explained the service and gave an information pack to them and their carer so that they had contact details of any services they may wish to contact.

During this visit the nurse asked the patient questions relating to their care requirements that may have been required from other services, to ensure that they have access to the services best suited to their needs.

Complaints handling and learning from feedback

The trust had effective systems in place to gather information from service users, and had records about people's experience from patient surveys. However, recording and learning from complaints and learning from feedback varied across each core service.

We saw patient's surveys displayed on the walls in the units. "What you said." "What we did." This was being used to improve care, for example, addressing delays in answering call bells. Positive comments such as thank you cards and letters from former patients and their families were also displayed on wards for staff and visitors to read.

Staff were able to discuss and understood the complaints process and how to report and escalate concerns in accordance with the trusts complaints policy. We saw complaints had been logged on the trust's electronic incident recording system and were discussed at ward meetings to learn from incidents.

There was evidence the trust had used the feedback to improve services. For example, complaints regarding poor communication with families with regards to patient discharge, led to a review of staff communication and use of the discharge check list. It had been identified through audits that the previous use of the checklist had been poor and that the correct use of the checklist had now risen to 80% compliance. Another example related to concerns

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about lateness of meals being served. This had led to food hygiene training being provided to allow more staff to serve meals at correct times and ensure food served was at the right temperature.

Patients knew how to raise concerns and were able to describe examples of where they had been dissatisfied about an aspect of their care and that this was quickly resolved.

The trust had a strong focus on improving discharge processes. We noted 18% of the complaints received in the previous year were about in patient services and related to admission and discharge procedures. Patients now receive a letter explaining their expected date of discharge each week which they found helpful and were able to share the information with their families explaining why they were staying in hospital longer than anticipated.

Staff said the administration team were often the first point of contact for complaints. They said the administration team offered the complainant the opportunity of putting their concern in writing before referring them to the Patient Advice and Liaison Service (PALS) if they were unable to resolve the issue locally. Staff supported people, their relatives or carers to make complaints as required.

Staff told us they received feedback and shared lessons learnt from complaints. They said complaints were discussed at team meetings. We saw team meeting minutes across the community therapy services and found some evidence that complaints were discussed and that there was learning from them. The musculoskeletal and acute therapies undertook a retrospective review of complaints between 2013 and 2014 and this was shared with staff.

In children's services 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 quarter of 2014/15. However, the service as a whole 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.

In Dentistry a leaflet entitled 'PALS and Complaints' was available in reception areas. Posters were displayed in waiting areas regarding making a complaint. We found the service maintained records of any written formal complaints received within each sector, together with details of the outcomes and any action taken to improve the service. This provided evidence that written complaints were listened to and acted on.

Staff told us they would try to resolve any practice complaint immediately. If this was not possible, the complainant was referred to the service manager who followed the trust's complaints policy. However, we found that there was no threshold or guidelines regarding what constituted a recordable complaint. This meant that all complaints, particularly verbal, were not recorded and opportunities to improve the service lost.

Some patients and carers we spoke with were unsure whether a verbal complaint would be recorded and considered in the same way that a written one would be. One told us they had complained verbally and did not think anything was going to be done about it. They said they had complained on the telephone about the time it took to get an urgent appointment, but no one had said they would pass on their complaint and they felt no one was listening to them. No one had contacted them to follow up their complaint. They were not aware they could contact the Patient Advice and Liaison Service (PALS) to make a complaint until we showed them the leaflet in the unit.

We saw a number of posters inviting patients to provide feedback on the service they had received and saw an easy read leaflet with symbols for people if they could not read fluently. In St Albans, leaflets were not easily visible as they were on top of high units in a corridor. However each clinic we visited had a post box where comments could be left. Postcards were available for people to write their comments on. In one unit staff told us most of the comments were negative comments about the toilet facilities. Staff told us these were being acted on in order to improve the service. Some staff were unclear as to whether

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or how a verbal comment/complaint would be recorded and processed. However, minutes of staff meetings we saw, highlighted that patient experience was a topic for discussion and confirmed the organisation was monitoring feedback that it had received on an ongoing basis. Staff told us they had very few complaints and most were about the environment.

In End of Life care we were shown completed feedback forms, all of which showed positive comments. We saw no

negative comments. We asked staff about complaints that had been received about the service and no-one was able to describe any to us. We did not see a record of complaints in any of the areas we visited.

The trust told us that there had been three complaints for the year 2014 regarding the palliative care team, two of which had been upheld. The complaints had been investigated and responded to within 28 days, in accordance with the trust's policy. We were given an example of an action that had been carried out in relation to a complaint, to ensure that the same problem from which the complaint arose was not repeated.

Are services well-led?

Requires Improvement 

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Summary of findings

Instructions

We judged that the services provided overall as requires improvement for being well led. Children and Young People's Services, Community Adults and Dentistry were rated as good.

The Trust board were a stable team with most board members having been in post for at least 2 years the Chief Executive having been in post since 2012. The Chief Executive was widely known and highly respected by all staff we spoke with.

The Trust had a clear strategy to become a leading light in the provision of innovative programmes of care supported by the creation of a clinical strategy.

Some staff said they were unclear as to the direction and objectives of the organisation. There were no clear goals set from the trust for all services that staff could describe.

We found that there was some disengagement with the leadership of the trust and the staff working in palliative care services.

There was a clear local leadership and management structure; each clinical lead had defined areas of responsibility. However, within the senior nursing team this was blurred.

The trust had a process for leading professional practice, with a Clinical Supervision Framework Policy in place. This set out the requirements on local services to put in place appropriate supervision arrangements within a prescribed set of requirements, for example, governance framework committee groups and task and finish groups and through the clinical quality leads group, AHPs and Doctors fora. We could not find evidence of appropriate committee structures to support professional practice for nurses, health visitors or allied health professionals. However, the Trust recognised the challenge to supporting newly qualified health visitors, despite the emphasis already placed on ensuring caseloads were manageable, particularly with regards to high risk families and had implemented a preceptorship and induction programme to address these concerns.

There was a clear local leadership and management structure; each clinical lead had defined areas of responsibility. However, within the senior nursing team this was blurred.

There were arrangements for identifying, recording and managing risks however we found that not all key risks were dealt with appropriately or in a timely way.

All the executive team told us that recruitment was the biggest risk to the trust. However, we found there was lack of clarity amongst the executive team relating to the vacancy position and how this was being managed. The vacancy position was reviewed through the trust's committee and meeting structure. However, there was lack of a sufficiently detailed and effective plan to address this in a timely manner that was clearly understood.

We found the trust safeguarding policy to be confusing and ambiguous which meant that staff were not clear on the actions they should take meaning patients may not always be protected from the risk of harm. At the time of the inspection the trust did not have a current children's safeguarding policy. There was an awareness this needed to be completed.

There were a significant number of change projects taking place at the same time. Some had been extended beyond the original deadlines. The trust told us all projects are assessed for feasibility against suite of criteria including: effectiveness, patient safety, patient feasibility project feasibility and capacity was increased to support management of individual projects. However there was concern amongst some staff about delivering all at one time whilst also providing the current service.

The Liverpool Care Pathway (LCP) was withdrawn nationally and locally in July 2013. The trust had not implemented a replacement care plan. There was no specific end of life care plan.

Governance processes were in place such as clinical and internal audit to monitor quality and safety of care and there was evidence of effective use of patient feedback to improve services through the use of patient survey and complaints information. However there was limited sharing and learning from incidents trust wide.

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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. At the time of our inspection, detailed work on this project had not been commenced.

We also noted that the implementation of improvements had been slow following the service review in community paediatric services in West Essex.

We saw evidence of systems being implemented by managers where gaps in the service were identified, however the forecast and planning of these issues had not been implemented by the trust

Staff were aware of the trust's values and able to describe them.

and setting of objectives to ensure the values were mirrored in practice. To further promote awareness of the trust vision and values these were displayed on all staff computer screen savers

Staff received trust briefing notices to keep them informed of planned developments with the trust. Staff we spoke with in most services expressed their support for the trust's senior leadership team.

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. At the time of our inspection, detailed work on this project had not been commenced. 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.

There were no clear goals set for some services, that staff could describe, furthermore, some staff felt recent changes imposed on them integrating into the community locations had not been fairly consulted with the teams. This had led to staff leaving, the workload increasing and led to disengagement in the leadership of the trust for the staff, particularly in palliative care services.

Governance, risk management and quality measurement

There were arrangements for identifying, recording and managing risks however we found that not all risks were dealt with appropriately or in a timely way.

All the executive team told us that recruitment was the biggest risk to the trust, we found there was lack of clarity amongst the executive team relating to the vacancy position and how this was being managed. The vacancy position was addressed through the trust's committee structure. However, there was lack of a sufficiently detailed and effective plan in place to address this in a timely manner.

Staff working in the inpatient units had reported the continued practice of inappropriate referrals there was no evidence that actions had been taken to minimise the risks these transfers, particularly those undertaken at night, posed for the patients

Our findings

Instructions

Vision and strategy

The Trust had a clear strategy to become a leading light in the provision of innovative programmes of care supported by the creation of a clinical strategy.

The development of a clinical strategy had been led by the Medical Director and there was evidence of both staff and stakeholder involvement. However, some staff said they were unclear as to the direction and objectives of the organisation. They felt that the trust did not understand how things worked in the different localities especially the unplanned element of evening work which was very unpredictable.

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.

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".

Staff were aware of the trust's values and able to describe them staff described that these were linked to appraisals

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Incident reporting feedback and putting learning into practice was variable across different services.

A trust risk register was maintained and staff were aware of the high risks included in it such as staffing issues. The trust newsletter informed staff of incidents that had occurred elsewhere to raise staff awareness. For example, an attempted break-in at another trust property was highlighted, resulting in a reinforcement of security policies and procedures.

We found that documents such risk registers, the Board Assurance Framework and board and committee papers, such as the Healthcare Governance Committee minutes, lacked appropriate linkages from their issue to action, ensuring all staff and non-executives were clear about their roles and key risks and mitigations.

There was an audit committee which reported to and assured the Board about the effectiveness of the trust's risk management processes. The committee had access to external and internal audits plus actions arising from local audit results. There was a quality assurance action plan, which addressed a number of issues from patients' complaints, staff experience and quality assurance audits. For example, incidents of poor or incomplete documentation were highlighted and new checklists were introduced as a control measure.

Staff told us they did not receive feedback on completed audits.

Staff received information from the National Institute of Clinical Excellence (NICE), safety alerts and hazard warning notices by email. This information was then discussed at staff meetings.

There were good systems and leadership in place for Information Governance, even though the issue of mobile working connectivity was obviously high on the trust's agenda, it is clearly being managed.

Leadership

Staff were proud of the organisation as a place to work and spoke highly of the open culture.

Staff were universal in their praise of the chief executive officer who was visible, known and respected by all the staff we spoke to. Most staff told us he had visited their areas of work and actively listened to what they had to say. They reported that he and other executives took a personal

interest in them as individuals and were approachable. However, we could not find evidence that other key executives or their deputies were sufficiently visible in key areas of concern.

Governance processes were in place such as clinical and internal audit to monitor quality and safety of care and there was evidence of effective use of patient feedback to improve services through the use of patient survey and complaints information.

Overall complaints performance was good with the performance. However, this was inconsistent through all the core services. There were 199 complaints received by the Trust. 98% of these were responded to within agreed timescales between 1 October 2013 and 30 September 2014. During the same period approximately 4,094 service compliments were received.

All the executive team told us that recruitment was the biggest risk to the trust, we found there was lack of clarity amongst the executive team relating to the vacancy position and how this was being managed. The vacancy position was addressed through the Trust's committee structure. However, there was lack of a sufficiently detailed and effective plan in place to address this in a timely manner that was clearly understood.

Some board and executive members told us that they were assured that action was being taken; others told us that they were not assured. We were told by one member of the executive team that a contract for an overseas recruitment firm was under consideration whereas two others told us it was signed. There was a belief that the Human Resources Department were managing the situation.

The January Board Workforce and Organisational Development (OD) Report reported trust-wide figure for unfilled posts against budgeted establishment and identified a recognised need to consolidate the resourcing plan and improve reporting of recruitment progress against plan.

Whilst the trust had six Strategic Workforce Objectives currently in place supported by a five year action plan with progress reviewed through the Workforce and Organisational Development Committee, we found no evidence of decisive clinical leadership in getting the vacancy situation under control with any pace.

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Staff raised concern that the management of recruiting to vacancies was delegated to departmental level without a clear strategy in place and with limited support. This impacted upon the culture within which front-line staff were being expected to deliver services, against a background of inadequate oversight of staffing levels and no robust plan to plan for staffing gaps.

The trust did have a process for leading professional practice, with a Clinical Supervision Framework Policy in place. This set out the requirements on local services to put in place appropriate supervision arrangements within a prescribed set of requirements, for example, governance framework committee groups and task and finish groups and through the clinical quality leads group, AHPs and Doctors fora.

We found however, there was no robust process in place for appropriately leading all professional staff in their practice. This was particularly evident for nursing staff, where some staff told us and evidence demonstrated that reporting lines, for professional issues were unclear.

Newly qualified health visitors did not immediately carry a safeguarding caseload and all health visitors were allocated a Supervisor.

Ward managers told us they had adopted the six C's which are Compassion, Courage, Competency, Commitment Caring and Communication as their vision and strategy for nursing which had been a focus for the Trust.

Competency frameworks for clinical staff were developed by the clinical quality leads and signed off by the Patient Safety Committee which was chaired by the Director of Quality and Governance/Chief Nurse or Deputy. These were noted by the Workforce and OD Committee, chaired by the Director of Human Resources and attended by the Deputy Director of Nursing and Lead AHP.

We saw the Palliative and End of Life Care Network – “high level work plan,” dated 2014-2016 which lacked detail about what tasks were and how they were going to be achieved. Each had a red, amber, green rating (RAG) It was unclear whether this related to the inerrant risk or progress. Furthermore, it was uncertain where this was being managed or how the trust board were sighted on this.

Most staff we spoke with told us that the managers were very approachable and the culture within the service was seen as open and transparent. Most staff were aware of the practice ethos to provide a caring and responsive service.

Most told us that it was a good place to work and they felt well supported.

Staff at most locations in the community, described their managers as being approachable and using an open door policy. Ward managers told us they found the locality managers were supportive and quality leads provided useful help and advice. Ward managers explained they measured how well their patients were being cared for by the feedback they received when talking to patients and their families. Staff told us they valued the local clinical leadership.

Leadership training for staff was being provided and innovation amongst teams was encouraged to help develop and improve services. Staff said they were encouraged to develop new ideas and to make continuous improvement in the service provided.

Culture across the provider

The culture we saw within the service was open and caring. The interactions we saw between staff, families, and people using the service were kind, professional, and not rushed.

Staff's morale within the trust was variable. Some staff perceived that their shift pattern was not flexible enough to meet work life balance. Whilst there were challenges with recruitment and retention of staff for the community and in patient services there was some evidence seen that the provider was taking action to pro-actively recruit and retain staff.

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

The trust had a whistleblowing policy which was available to staff on the trust intranet. Staff consistently told us of their commitment to provide safe care regardless of the staffing difficulties they encountered at times. Managers were able to describe actions they would take when performance of staff was not consistent with the trust's values, which were in accordance with the trust's disciplinary policy.

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Staff spoke of the importance of raising concerns and that action was taken when staff had concerns.

In most areas staff said they worked well together and supported each other. They told us they felt valued and respected, but there were concerns across all services about the lack of staff.

Fit and proper person requirement

There was an awareness amongst most of the executive team of the need to have in place 'fit and proper person checks'. There was a process in place to ensure they were compliant with the requirement for fit and proper persons for executives and board members the necessary checks were found to be in place. We looked at three staff records and saw that the relevant information had been obtained for example, references and Disclosure and Barring Services (DBS) checks.

This is covered by Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014, which ensures that directors of NHS providers are fit and proper to carry out this important role.

Duty of Candour

All NHS trusts are required to be open and transparent. This includes a Duty of Candour that requires the trust to ensure any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered. This is regardless of whether a complaint has been made or a question asked about it.

Not all board members were clear on the Duty of Candour and what it actually meant.

We spoke with staff about Duty of Candour. Managers were aware of the Duty of Candour regulations and told us they were cascading this information to staff during team meetings. The nursing team had some awareness as the Nursing and Midwifery Council had produced a new Code of Conduct for nurses and Midwives, which included Duty of Candour. However, there was limited understanding of this amongst most staff in that it now went beyond professional guidance about being open and honest and that it was now a regulatory requirement.

Some staff had received a hand-out with guidelines about the Duty of Candour and its meaning; this included a flowchart for the next steps to take if an incident occurred.

There were processes in place to ensure patients and carers were appropriately informed of issues affecting their care in line with the Duty of Candour regulations.

Public and staff engagement

The trust had effective systems in place to gather information from service users, and had records about people's experience from patient surveys. We saw these displayed on the walls in the inpatient units. "What you said." "What we did." This was being used to improve care.

Staff in the community nursing teams told us about initiatives to involve and engage staff. This included regular e-mails from the chief executive to staff. Information was sent to staff regularly by e-mail and newsletter. The trust had a five year staff engagement plan (2012-2017) which included annual staff and leadership events. Staff spoke positively about the leadership training they were being offered.

In the most recent annual staff survey undertaken in 2014, there were statistically significant improvements in 10 key result areas compared to the 2013 survey and no areas of deterioration.

-The trust scored best for staff agreeing that they would feel secure raising concerns about unsafe clinical practice (8% points above average)

-The trust was comparable to the national Community Trust average for the percentage of staff reporting good communication between senior management and staff

-The trust scored worse than the national average for the percentage of staff working extra hours, percentage of staff feeling pressure to attend work when unwell in the last 3 months, work pressure felt by staff and percentage of staff feeling satisfied with the quality of work and patient care they were able to deliver.

Friends and family test responses indicated:

79% of staff would recommend the trust as a place to receive care

53% of staff would recommend the trust as a place to work.

81.50% of patients likely to recommend the service provided by the trust to friends and family

98% of patients advised the care they received was good to excellent (Quality Account).

Are services well-led?

Requires Improvement 

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.

99% of patients using inpatient services advise they were treated with dignity and respect (Quality Account).

There was a robust process evident for managing patient complaints with 90% of complaints being responded to within the time frame in December 2014. There was a process in place to review all complaints considered high level or red complaints and there was analysis of themes and trend to share learning evident within the trust board papers.

Overall complaints performance was good with the performance. However, this was inconsistent through all the core services. There were 199 complaints received by the Trust. 98% of these were responded to within agreed timescales between 1 October 2013 and 30 September 2014. During the same period approximately 4,094 service compliments were received.

41% of all complaints received were about standards of care (23%) and date for appointment (18%) respectively. These issues are being addressed through a 6 C's working group with a focus on driving up care and compassion across the organisation.

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

The trust has 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.

There was an active League of Friends who for example ran a snack bar at Potters Bar Hospital and trolleys selling newspapers and magazines on the wards.

Appraisal rates for the Trust were at 88% with all core services being above the trust target of 80% however some staff told us they have not had an appraisal for a number of years this was reflected within the staff survey results.

However some staff told us that in the past they felt that the trust did not listen to their views in changing the service and that tasks were sometimes allocated without consultation or explanation.

Innovation, improvement and sustainability

Group meetings for ward sisters had recently been introduced to share learning and innovation. The nurses attending the meetings were very positive about how effective they were. We saw minutes of meetings which included discussion of serious incidents complaint and safety alerts to ensure a consistent response to events and share learning from incidents. For example the audit results of Do Not Attempt Resuscitation (DNAR) had identified gaps in information not completed. This had resulted in unit wide dissemination of the information and its recommendations.

A recent trust initiative was rapid improvement week, which was set up to address the issues of extended in-patient stays and turnover. The programme led to changes such as on-site social workers at some bed bases to improve discharge planning. The trust had also introduced a method that simulated the television programme Dragons Den for staff to present innovations and requests for additional funding or support. For example one group had filmed some therapy activities with the patient's consent to present their case.

The stroke team had been nominated by the trust management for the "Life After Stroke" award from the Stroke Association.

The trust had very recently set up a task and finish group regarding recruitment. This was a new initiative exploring new development using an apprentice type scheme within the services. The locality managers said that four nurses had been recruited using this programme.

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.

In dentistry, staff told us that most of the staff had completed the T.E.A.C.H workbook. This is part of the Purple Star Strategy within Hertfordshire in collaboration with the Health Liaison Team and Community Learning Disability Nurses as part of health promotional strategy. The Purple Strategy is a joint health and social care initiative which informs service providers and empowers people with a learning disability and their carers to get fair non-discriminatory health and social care. It has been developed with service users and stakeholders to promote and highlight quality health and community services that have been reasonably adjusted to meet the needs of people with learning disabilities. Staff told us they have to

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undertake competency based training and are fully involved in evaluation, monitoring and review of The Purple Strategy. The strategy will help to raise awareness of the needs of people with learning disabilities and influence change in practice to deliver real improvements to services they receive.

The Home First's rapid response teams were able to respond to peoples' needs within one hour. If they were unable to meet the referral time staff said they continued to do background checks. Referral times were being met at the time of our inspection.

There were specific meetings to discuss end of life care for people with learning disabilities instigated by doctors with an interest in learning disabilities.

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

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
<p>Nursing care</p> <p>Treatment of disease, disorder or injury</p>	<p>Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse</p> <p>Regulation 11 2008 (Regulated Activities) Regulations 2010 Safeguarding service users from abuse</p> <p>1. The registered person must make suitable arrangement to ensure that service users are safeguarded from the risks of abuse by means of –</p> <p style="padding-left: 40px;">(b) responding appropriately to any allegation of abuse.</p> <p>3(d) neglect and acts of omission which cause harm or place at risk of harm.</p> <p>The Regulation was not being met because the provider did not ensure that service users were</p> <p>protected against the risks of abuse arising from lack of staff knowledge with regards to reporting safeguarding concerns appropriately. The trust had a lack of oversight on safeguarding concerns as these were not reported according to trust policy.</p> <p>Regulation 11 1(b) 3(d)</p>

Regulated activity	Regulation
<p>Nursing care</p> <p>Treatment of disease, disorder or injury</p>	<p>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records</p> <p>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records</p> <p>1. 1. The registered person must ensure service users are protected against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of-</p>

Compliance actions

(a) an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user and

(b) securely destroyed when it is appropriate to do so

Regulated activity

Diagnostic and screening procedures

Family planning services

Nursing care

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities)
Regulations 2010 Staffing

Regulation 22 HSCA 2008 (Regulated Activities)
Regulations 2010 Staffing

In order to safeguard the health and welfare of service users the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying regulated activity.

The Regulation was not being met because the provider failed to ensure that all people receiving a service were protected from potential harm due to inconsistent staffing levels which significantly impacted upon the care and treatment to people being delivered at the right time and in the right way. There was a lack of awareness of the number of vacancies there were and how this was being managed at board and executive level.

Regulation 22