North Tees and Hartlepool NHS Foundation Trust

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RVWAE	University Hospital North Tees		
RVWAA	University Hospital Hartlepool		

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall, we rated community health services for children, young people and families as good.

Children and young people's services were safe. Staff knew how to manage and report incidents and we saw there had been learning following a serious case review. There were good safeguarding processes in place and staff received regular formal supervision. Staffing levels and caseloads were manageable and recruitment plans were in place to ensure health visiting vacancies were filled. In addition, the clinics and children's centres we visited were clean.

Children and young people's services were effective. Although some performance measures were being missed, care and treatment was evidence based and staff were competent. The trust had also successfully implemented evidence based programmes, such as the family nurse partnership programme. There were policies and procedures in place to support staff and ensure that services were delivered effectively and efficiently. There was good evidence of multidisciplinary and multi-agency working across the services.

Children and young people's services were very caring. Staff were passionate about delivering high quality care and were very dedicated to their patients.

Children and young people's services were responsive. Services were planned and delivered to meet the needs of the local population in line with the commissioning framework of the trust. Staff worked hard to meet the needs of children and families in vulnerable circumstances and there were support networks in place to ensure children and young people were protected.

Children and young people's services were well-led. The majority of staff we spoke with understood the vision and strategy for their own service and also the wider trust. There were issues with some aspects of the leadership structure due to the prolonged absence of a senior member of the team. However, plans were in place to address the shortfall. We found the culture was open and transparent and there was strong evidence of collaborative team working across all services.

Summary of findings

Background to the service

Information about the service

North Tees and Hartlepool NHS Foundation Trust provided services to children and young people up to the age of 19 across Stockton and Hartlepool. Some teams were also commissioned to provide services in County Durham.

The trust provided services such as health visiting, school nursing, community children's nursing, looked after children, the family nurse partnership, physiotherapy, occupational therapy and speech and language therapy. Services were provided to people in their own homes, in schools and in clinics across all the local area.

In Stockton and Hartlepool , children and young people under the age of 20 years made up 24.6% of the population.5.1% of school children in Hartlepool and 9.4% of children in Stockton were from a minority ethnic group.

The health and well-being of children living in the North Tees area was generally worse than the England average. Infant and child mortality rates were similar to the England average.

The level of child poverty in Hartlepool and Stockton was worse than the England average with 30.6% and 22.5% respectively of children under 16 years living in poverty. The rate of family homelessness was better than the England average in both localities.

During this inspection, we visited a number of locations across Stockton and Hartlepool, spoke with eleven senior managers and team leaders, fourteen therapists, nine health visitors, seven school nurses, five community nurses, nine other nursing staff, two administrative staff and nine parents and young people. We also held focus groups for nursery nurses, health visitors and therapists.

We observed staff practice in clinics and, with the consent of parents, in patient homes. We looked at 27 clinical records. Prior to and following our inspection we analysed information sent to us by a number of trusts such as the local commissioners, Healthwatch and the trust.

We visited six locations across Stockton and Hartlepool. Locations we visited included the University Hospitals of North Tees and Hartlepool, Ragworth Neighbourhood Centre, Lawson Street Health Centre, Sunrise Children's Centre and Rossmere Children's Centre. We also attended four baby clinics, went on three home visits with health visitors, observed a nursery nurse led weaning group, visited two primary schools and one secondary school drop-in session and observed a paediatric outpatient clinic.

We reviewed 27 sets of clinical care records. Nine of those were from the school nursing service; six were from the health visiting service, five from the family nurse partnership and seven from the children community nursing service.

Our inspection team

Our inspection team was led by:

Chair: Helen Bellairs, Non-Executive Director, 5 Boroughs Partnership Trust

Team Leader: Amanda Stanford, Head of Hospitals Inspection, Care Quality Commission

The team included: CQC inspectors and a variety of specialists, Health Visitors, District Nurses, Physiotherapists, Occupational Therapists, Community Matrons, Dentist and Experts by Experience (people who had used a service or the carer of someone using a service).

Summary of findings

Why we carried out this inspection

We inspected this core service as part of our comprehensive acute and community health services inspection programme.

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before visiting, we reviewed a range of information we held about the core service and asked other trusts to share what they knew. We analysed both trust-wide and service specific information provided by the trust and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well-led. We carried out an announced visit from 07 to 10 July 2015.

What people who use the provider say

During the inspection we heard many positive comments from families and carers of children and young people.

Parents told us they felt respected, well supported and that staff were always polite and helpful with any concerns they had.

A young mum expressed her feelings about the FNP and told us that the service had turned her life around and felt she could approach her named nurse about anything. The mother of the new mum told us that, due to the support and guidance from FNP, her daughter had: "changed from an unruly pregnant teenager to a confident, aspiring young woman who was a competent and caring mother."

During a home visit, a parent told us that staff were really easy to talk to and she felt "comfortable talking to them about anything".

A young, single mother who was seeking asylum in the UK with her children told us the specialist health visitor who worked with refugee and asylum seeking families in Stockton made her feel 'safe'.

Good practice

The health visiting service provided for refugee and asylum seeking families was outstanding. This was largely driven by the specialist health visitor and her team. They demonstrated a clear passion and dedicated insight of the issues facing ethnic minority women and children seeking refuge in Stockton. The health visitor not only provided care for the children but ensured the parents were also supported to integrate into local society and minimise the risk of social exclusion.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust should:

- Have systems in place to enable staff to complete mandatory training within the required timescales.
- Use interpreting services to meet the needs of children, young people and families.
- Complete and record lone working risk assessments in all appropriate documentation.
- Monitor the delivery of the Health Child Programme by reviewing and improving performance measures.
- Have standard operating procedures in place to support the transition of young people from community children's services to adult services

North Tees and Hartlepool NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

The safety of children, young people and family services was good. Staff knew how to manage and report incidents. They told us they received feedback on incidents reported to the trust and serious case reviews. On the whole, staff felt lessons were learned across the trust.

Every member of staff we spoke with understood the principles of the Duty of Candour although there was no evidence of it being applied. Some staff had already received formal training while others were scheduled to attend.

The children's safeguarding team was embedded in all services for children, young people and families. There were robust safeguarding policies and procedures in place. Staff received regular safeguarding supervision and were knowledgeable about their responsibilities regarding safeguarding vulnerable people.

The clinics, health centres, children's centres and school premises we visited were clean and had appropriate access to facilities such as hand hygiene. For instance, at clinics, all staff cleaned equipment and prepared equipment between each use.

The trust was in the process of transitioning all paper records to 'SystmOne', an electronic record system. There were systems in place for the safe retrieval of archived records and staff were able to identify those children who had both a paper and electronic care record.

The trust managed risks to staff and to patients both at a local level and at directorate level. Risk assessments were carried out with patients and information about vulnerable people was communicated amongst health professionals where appropriate.

Staff told us that the trust promoted training. Data supplied to us showed that mandatory training was not meeting the relevant trust targets across the board.

Good

Are services safe?

Policies and procedures were in place to manage the safe storage and administration of medications.

Caseload levels for the majority of health visiting teams were below Lord Laming's recommendations of 300 families per health visitor. Plans were in place to recruit new staff in line with the national health visitor recruitment campaign.

Detailed findings

Safety performance

- There had been no never events. Never events are incidents determined by the Department of Health (DoH) as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented correctly.
- The trust used an electronic reporting system to record and monitor incidents. We were told incidents were discussed at local team meetings and departmental business meetings.

Incident reporting, learning and improvement

- The trust had an incident reporting and investigation policy. Every member of staff we spoke with could explain the reporting process and felt confident incidents were dealt with robustly and in a timely way.
- Staff felt they had enough support to use the reporting system and help was readily available from the patient safety team.
- Between 01 May 2014 and 31 May 2015, there were 79 incidents in children and young people's services. The information sent to us by the trust was categorised by level of harm (low, moderate and significant).However, it was unclear how 'significant harm' was defined and how those incidents related to serious untoward incidents. The trust's incident reporting policy defined levels of harm as 'low', 'moderate' and 'severe'.
- Of the incidents that occurred, 56% (44) were graded as low, 25% (20) were graded as moderate and 19% (15) were graded as significant. We received further information which included the narrative detail of the incidents but not the corresponding level of harm.
- Incidents included a leak of patient identifiable information and the outcome included changes to the way in which information was requested from the local authority. There were no discernible themes or trends.
- When incidents occurred, staff told us they were open with patients. Every member of staff we spoke with was aware of the Duty of Candour (DoC) and could explain the principles of being open and transparent with patients, families and carers. Staff told us they had either already received training about the DoC or were scheduled to attend a training session. We saw evidence that staff from the health visiting service and the safeguarding team has attended a training session.
- Paediatric therapy services produced a monthly newsletter called "The Special Ones" which served as a tool to share information about incidents, risks, complaints and compliments. Staff told us they valued the publication and said it was informative, easy to read and kept them updated on what was happening within the service.
- Staff told us they felt confident that lessons were learned as a result of serious incidents although they acknowledged that information was not always shared or fed back consistently across all teams.
- Everyone we spoke with was aware of the recent serious case review involving the trust and the lessons that emerged. Outcomes were shared on the trust intranet and the children's safeguarding team developed a presentation about the key themes and an action plan.

Safeguarding

- The trust had a safeguarding policy and procedures in place and every member of staff we spoke with told us they felt confident about keeping children safe. Staff knew who to contact for advice and told us they would speak to their line manager or the children's safeguarding team. Staff were able to describe to us in detail actions they would take if they had any safeguarding concerns.
- Staff received regular formal supervision sessions from the safeguarding team every three months. We were told that the structure of the supervision session had recently been reviewed to strengthen the safeguarding process. The new policy included the discussion of themes, case management, and issues with other agencies relating to all vulnerable families and not only child protection cases.
- Staff told us they were all trained to the relevant safeguarding level. Administrative staff from the child health team had achieved 80% of the 100% target for Safeguarding Children Level 1. The target for Level 3 training (clinical staff working with children, young

Good

Are services safe?

people and families or carers) was 100%. Health Visiting Hartlepool had achieved 90% compliance, while Health Visiting North Tees had achieved 80% compliance. School Nursing North Tees achieved 62% and Children's Speech and Language achieved 97%.

- The safeguarding children named nurse and senior nurses had a high profile across the community children and young people's services. All of the staff we spoke with knew their named nurse and told us they could seek advice and support whenever they felt it was necessary. Everyone we spoke with was very positive about the safeguarding team.
- The paediatric therapy service told us that they do not usually make referrals to the safeguarding team and only became involved once a referral has been made by another service.
- The 'Family Nurse Partnership' (FNP) supervisor was a member of both the Safeguarding Children Professionals Group and the steering group and contributed to the development of policies and practices. The FNP is a voluntary health visiting programme for first-time young mothers, underpinned by internationally recognised, evidence-based guidelines.
- The FNP supervisor also met with the safeguarding children named nurse on a monthly basis to discuss individual cases and any issues.
- Safeguarding information on the intranet (which staff could access easily), included actions and lessons learned regarding recent serious case reviews.
- The children's safeguarding team had established practice clinics for all staff and told us each successive clinic had seen an increase in attendance. The clinics focused on raising awareness of, and providing guidance about, child protection and safeguarding. Recent topics had included domestic abuse and guidance about bruising on immobile babies.
- The safeguarding children named nurse was a member of the 'Local Safeguarding Boards' (LSCBs) in Hartlepool, Stockton-on-Tees and County Durham. Senior nurses were also members of the Multi-Agency Children's Hub (MACH) and the Hartlepool Strategic Vulnerable, Exploited, Missing and Trafficked (VEMT) group. Information and learning was shared with staff across all community children and young people's services.
- The safeguarding team had also held a promotional event for all staff at University Hospital of North Tees to raise awareness of child sexual exploitation (CSE) and the VEMT agenda.
- The safeguarding team was accessible to staff who were able to give examples of when they had needed to speak with the team as well as the advice they received.
- We saw evidence within patient records of detailed information recorded about vulnerable children and families, as well as details of how they were being supported by other agencies such as the local authority.
- All of the staff we spoke with were aware of or had undergone training about female genital mutilation (FGM). They knew what action they should take if they identified a patient at risk. School nurses, to raise awareness amongst children and parents, also delivered awareness sessions to children through school assemblies.
- We saw evidence of the systems in place to check and track looked after children. The team received weekly notifications from the local authority and would plan the initial health assessment. If a child was transferred straight into the justice system, the LAC team were not always informed when that child was discharged. Staff were working jointly with social services and the local authority to improve the system.

Medicines

- We saw processes and standard operating procedures to manage the cold chain for the storage and transportation of immunisations and vaccines to schools. There were up-to-date, documented procedures for vaccine spillage, disposal and vaccine transport. The trust also had procedures for the storage of, and routine childhood vaccination scheduling for, Hepatitis B vaccinations.
- Medicines, including first aid boxes, were kept secure and handled safely. Staff were aware of the trust's protocols for handling medicines to ensure the risks to people were minimised.
- Some health visitors were independent prescribers. This meant children and young people had timely access to medicines and treatment. Staff were able to access support for this role from the trust pharmacy department.

Environment and equipment

Good

Are services safe?

- We found that all the equipment in use was clean and had been 'PAT' (portable appliance test) tested. Staff were aware of the process to follow if they needed to report any faults.
- Weighing equipment was calibrated according to the trust policy by the medical electronics team. Health visitors each had their own set of scales which they took with them to clinics and on home visits
- The majority of staff told us that they had enough equipment to deliver safe care and had no problems ordering equipment.
- The buildings where clinics were held which we saw were clean and tidy and suitable for children and their families.
- The paediatric therapy services team had a joint waiting area shared by adults and children and did not cater for children specifically. For example, there were no toys in the waiting room.
- We observed a storage cupboard in the community children's nursing department. It was neatly organised and every piece of stock had a child's name attached to it.

Quality of records

- The trust had a standard operating procedure for record keeping. This applied to all community children and young people's services. We saw evidence that clinical heath records were audited on a monthly basis and the outcomes were discussed with staff during 1-1 meetings with their line manager.
- We saw filing cabinets in secured rooms for the storage of paper records.
- The majority of services were in the process of moving from paper records to a new electronic record system called SystmOne. The health visiting service transitioned from paper records to SystmOne 2 years ago. As a result, some children had both electronic and paper records. Based on a child's date of birth, staff would know whether a child had both paper and electronic records.
- The method of retrieving archived paper records was simple and straightforward and there was a policy for this. Archived records could be retrieved within a four hour timespan when required from an off-site storage facility.
- Some staff told us they had concerns about the transition process from the previous system to SystmOne and the training they had received. Some staff had a large gap between their original training and the start of using the new system. We were informed that refresher training was available to staff on request.
- The trust safeguarding team told us that SystmOne enabled them to update the school nursing or health visiting record directly onto the system which negated the need to keep separate notes. All of the data was stored in one record.
- We saw patient notes being safely transferred from community visits back to the staff base in sealed bags.
- We looked at 27 care records across school nursing, health visiting, FNP and children's community nursing. We viewed both paper and electronic records. Most of the records we saw were clearly set out, legible, complete, dated and signed, including risk assessments, action plans and relevant pathways when required. Additions were made in a timely manner. However, we found a number of care records from the children's community nursing service were dis-organised and did not include a summary update at the front of each set of notes.

Cleanliness, infection control and hygiene

- Staff were aware of safe infection prevention and control (IPC) measures and knew how to access the IPC policy on the intranet.
- The clinics we visited were clean and tidy. The staff we observed followed good hygiene practice. We observed staff using hand gel to clean their hands and adhering to the bare below the elbows guidance.
- In baby clinics, between patient use, the equipment was cleaned using cleaning wipes and covered using fresh paper roll.
- There was not a policy about the cleaning of toys. FNP staff told us they cleaned the toys themselves, using antibacterial sanitary wipes, after every use.
- Staff had access to Personal Protective Equipment in cases where there was an infection risk. The trust had a Needlestick Policy and Occupational Health department for personal injury if staff were accidently exposed to sharps.
- The majority of staff had undergone infection control training in the last 12 months. Compliance at the end of March 2015 was 97%.
- We saw evidence that 'Essential Steps' IPC audits were undertaken monthly. Staff showed they met IPC requirements.

Good

Are services safe?

Mandatory training

- Staff told us the trust placed a high importance on training and managers made sure that staff attended mandatory training.
- Staff told us they were responsible for making sure they were up to date with all of their training. They also received monthly RAG reports by email which highlighted what training was required and by when. We were informed these reports were discussed at 1:1 meetings with line managers.
- Within children and young people's services, mandatory training levels varied. Staff told us they were fully compliant with all of their mandatory training requirements. Evidence provided to us from the trust demonstrated that targets had not been met across every service. Some of the key highlights were: The child health team achieved 80% of the 100% target for safeguarding children level 1. The children's safeguarding team achieved 88% of the 95% target for information governance. They also achieved 63% of the 80% target for resuscitation training. The FNP achieved 75% of the 100% target for local induction and 50% of the 80% target for object handling.
- Health visiting Hartlepool achieved 95% of the 100% target for safeguarding adults level 1. Health visiting Stockton achieved 90% of the 100% for safeguarding adults level 1, 85% of the 90% target for medicines management and 58% of the 80% target for object handling. Students from the health visiting service in Stockton were below target on the majority of mandatory training including bullying and harassment (60% of the 95% target), consent (80% of 95%), dementia level 3 (20% of 50%), local induction (40% of 100%), information governance (60% of 95%), infection control (60% of 95%), medicines management (60% of 90%), object handling (20% of 80%), resuscitation (20% of 80%) and violence and aggression (20% of 95%).
- LAC nurses were similarly below the required target in several areas including bullying and harassment (75% of the 95% target), health record-keeping (75% of 90%), infection control (75% of 95%), patient handling (50% of 80%), safeguarding adults level 1 (75% of 100%) and violence and aggression (75% of 95%).
- School achieved: bullying and harassment (83% of the 95% target), health record-keeping (75% of 90%), incidents complaint and claims (83% of 95%), local induction (83% of 100%), safeguarding adults level 1 (83% of 100%) and violence and aggression (83% of 85%). School nursing Stockton achieved: fire (67% of the 80% target), consent (85% of 95%), resuscitation (69% of 80%) and safeguarding adults level 1 (85% of 100%).

Assessing and responding to patient risk

- In the 27 sets of records we observed, the majority of patient risk assessments were completed well and updated as required.
- Staff across all services told us assessing risk was a standard part of their role. For example, risks within the FNP were identified through various means including 'DANCE' (Dyadic Assessment of the Naturalistic Caregiver Experience) assessments. DANCE helps to enhance the relationship between the parent and child and educates the parent on the benefits of two-way interaction. It is also a means to identify risk in the relationship between the new mum and her baby.
- Staff from the children's community nursing team told us, due to risks identified in the home, there were two children who were seen at school. This was documented and recorded in the patient's care record.
- We were told Quality Audit Panels were embedded in children's community services. The panel met monthly, to ensure quality for looked after children (LAC) and those at risk of harm, in assessment, planning and outcomes.
- We saw evidence the trust had policies in place to ensure risks were mitigated in relation to escalation. This included visits to families where more than one member of staff should be present and families who did not attend appointments. For example, if a health visitor attempted to visit a family twice without success, it was reported as a serious incident (SI). A letter was sent to the family and the GP. The health visitor would continue to reassess and, if there was a cause for concern, would escalate in line with the trust's DNA policy.

Staffing levels and caseload

- Each service submitted a daily 'sit rep' which enabled the management team to recognise where potential staffing pressures were by identifying how many staff were in the department and how many were sick or absent. Staff we spoke with told us staffing was a standard agenda item at all team meetings.
- Up to and including May 2015, the number of whole time equivalent (WTE) health visitors in Stockton and Hartlepool was 61.93. The trust was aiming for the

national trajectory goal of 73.5 WTE. By September 2015 the service expected the workforce to increase to 71.0 WTE. Since the launch of the 'Health Visitor Implementation Plan – A Call to Action' recruitment drive, most of the health visitors we spoke with felt that staffing levels had improved significantly.

- The trust had an on-going recruitment drive in place with rolling job adverts for new health visitor posts.
- In October 2015 the commissioning arrangements for health visiting services were scheduled to transfer to the local authority. Staff told us this posed a risk to the service's ability to meet the current trajectory. Following the transfer, they were uncertain whether the funding allocation for the recruitment of health visitors would remain available.
- Health visiting staff caseloads were within the Lord Lamming 2009 recommended case load level of 300 families per health visitor. Only 3 teams exceeded this threshold: Stockton Central had 325 per WTE; Stockton South had 306 per WTE and Billingham had 346 per WTE (where, we were told, there were staff vacancies). This had an impact on the service's ability to meet its targets. Further details can be found in the Effective section of this report under 'Patient Outcomes'.
- Once the teams met the required staffing capacity, the caseloads were expected to reduce to approximately 270 per health visitor.
- The school nursing team in Stockton did not have a band 7 team lead role. The band 7 community practise teacher (CPT) was acting as line manager for the 6.9 WTE band 6 school nurses. Although staff felt this worked well, they had concerns for the immediate future. We were informed the band 7 CPT would be acquiring two more students to manage which would impact upon the line management responsibility for the band 6 school nurses.
- The Proposed Staffing for Service Delivery plan identified a need to increase the band 6 school nursing team from the current 6.9 WTE to 11.5 WTE. The plan did not include any consideration for a band 7 team lead role.
- The school nursing team in Hartlepool had a 0.7 WTE team lead role and 1.0 WTE CPT. There were 4.1 WTE band 6 school nurses and 4.3 band 5 school nurses. The Proposed Staffing for Service Delivery plan identified a need to reduce this by 1.9 WTE. This would be achieved through staff transfer.
- The FNP team expanded 15 months ago from 4.0 WTE to 6.0 WTE across Stockton and Hartlepool. The team was led by 1.0 WTE band 7 who covered both localities and was supported by 1.0 WTE administrative post.
- FNP caseloads ranged from 16 to 22 on average which was less the than national recommendation of 25.
- There was one 0.6 WTE infant feeding lead for the trust who was based in Stockton. We were told that a second infant feeding lead had not been commissioned in Hartlepool. Staff in Hartlepool told us they could contact the lead in Stockton for information and advice when necessary.
- Children's community nurses told us they did not have any standard caseloads. This was managed on an individual basis with support from the wider team when necessary, for example, if a child was on an end of life pathway.

Managing anticipated risks

- The trust had a lone worker policy. Staff from most community children and young people's services told us they were trained in the use of, and had access to, the DAKS system using their mobile phones. This enabled them to alert others in situations where they felt vulnerable or unsafe.
- Staff told us they undertook risk assessments when working in the community. For example, when visiting a new family in their home for the first time, school nurses would visit in pairs or to inform their risk assessment, gather information from different sources. If a risk was identified, the team had a strategy meeting to determine the most appropriate way to address and minimise the risk. Risks were shared with the wider team by an alert on SystmOne
- We found there was inconsistency in the recording of lone working risk assessments. Heath visitors and managers confirmed that all staff should be completing these. However, several health visiting records we saw did not include the relevant documentation.

Requires improvement

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

Overall, we found children and young people's services required improvement for effective.

The 'Healthy Child Programme' was delivered by health visitors, staff nurses, nursery nurses, and school nurses. Staff assessed and delivered treatment in line with current legislation, standards and recognised evidence based guidelines. However, the health visiting team were not delivering 3-4 month contact assessments or meeting the antenatal contact target.

The 'UNICEF Baby Friendly Initiative' was not universally adopted within the trust. Staff were unclear about the progress of the programme across Hartlepool and Stockton.

The trust had policies and standard operating procedures to ensure that multidisciplinary and multi-agency work took place. However, there were no clear processes in place to support young people who were transitioning to adult services and we saw no evidence of any standard operating procedures.

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

Patients received care from clinicians who were competent. Staff received an induction to the trust and to services as well as regular safeguarding supervision and annual appraisals. Clinical supervision was carried out formally and informally amongst peers. Newly qualified staff were offered preceptorship by the trust.

Staff had a good understanding of how to obtain consent. Fraser guidelines were followed to ensure that people who used the services were well protected.

Detailed findings

Evidence based care and treatment

- Children and young people's needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence based guidance.
- We were told the National Service Framework (NSF) for children, young people, families and maternity services was the benchmark for the way services were delivered.
- The trust had a number of policies and procedures in place which were based on NICE (National Institute for Health and Clinical Excellence) or other nationally or internationally recognised guidelines.
- All health visitors, specialist health visitors, school nurses and staff nurses we spoke with were aware of the guidelines relevant to their practice and said they were well supported.
- Most services had standard operating procedures in place and new pathways had been developed to ensure that services were effective. These were still at the draft stage. Staff told us they were not yet embedded within normal practice although each pathway did include current methods.
- Staff from the community children's nursing team told us they did not have any standard operating procedures
- The trust followed the national initiative called the Healthy Child Programme (HCP). This is a Department of Health programme of early intervention and prevention for health visitor contacts with babies and children. It offers regular contact with every family and includes a programme of screening tests, immunisations and vaccinations, development reviews and information, plus guidance and support for parents.
- The HCP was delivered across the 0-19 age range by health visitors, specialist health visitors, school nurses, community children's staff nurses and nursery nurses.
- Health visiting staff reported they used 'Ages and Stages Questionnaire's' (ASQs) as part of their assessment of children. This is an evidence based tool to identify a child's developmental progress, and provide support to parents in areas of need.
- The FNP team worked with young people in Stockton and Hartlepool. The service provided evidence to show they followed the national programme, including meeting targets and achieving key milestones with participants of the project.

Requires improvement

Are services effective?

- There were policies and standard operating procedures in place to ensure that looked after children and children with long term and complex needs had their needs met in suitable ways.
- There were systems in place to ensure the emotional needs of children looked after were addressed and met. The LAC team used 'Strengths and Difficulties Questionnaires' (SDQs) as a monitoring tool to identify any concerns around the emotional health of a child. Completed scores were analysed for themes and trends. 37.4% of responses from children looked after in Stockton and 36% of those in Hartlepool indicated there was cause for concern. Individual cases were discussed with the relevant social worker to ensure the health plan reflected ongoing plans and referrals.

Nutrition and hydration

- The trust had an Infant Feeding policy however progress towards the United Nations Children's Fund (UNICEF) Baby Friendly Initiative (BFI) was not robustly adopted within the trust. Some staff we spoke with were very unclear about plans to achieve any level of accreditation.
- There were breastfeeding support groups in place across Stockton and Hartlepool localities.
- We observed a weaning group session and a baby clinic led by health visitors and nursery nurses. The information and advice provided was in line with national guidance, for example, not introducing solid foods until 6 months of age.

Technology and telemedicine

- Staff showed us laptops that had been issued to individual workers to enable them to have more access to the network when working in the community. One member of staff told us that it saved time being able to complete notes when away from their base of work. Several people raised concerns about the availability of the 3G network and the inconsistency of being able to access it.
- There were plans within the school nursing service to introduce a texting service so children and young people could source information and advice directly from a nurse.

Patient outcomes

- Paediatric therapy services adopted goal-based pathways to achieve the desired outcomes of treatment. Patients, families and carers were involved in deciding what those outcomes and goals should be. They had developed a smiley face parental audit to monitor the effectiveness of the service.
- We saw evidence that patients' needs were thoroughly assessed before care and treatment started and there was evidence of care planning. This meant that children and young people received the care and treatment they needed.
- The immunisation rate for the measles mumps and rubella (MMR) vaccine (children aged two) was 89.2% in Hartlepool which was just under the England average of 92.3%. The rate in Stockton was better than the England average at 94.1%.
- The immunisation rates for children in care were 88.9% in Stockton and 100% in Hartlepool. This was better than the England average of 83.2%.
- The health visiting service did not meet the antenatal contact target. This was the percentage of women who received a first face to face antenatal contact with a health visitor at 28 weeks or above. The target in quarter one was 25% and the service achieved 2.4%. The target in quarter four was 95% and the service achieved 48.5%. Each quarter did demonstrate an upward trend towards achieving the agreed targets and evidence presented to us by the trust suggested that this would improve once a full complement of staff was achieved.
- Health visitors in Hartlepool told us they were not delivering 3-4 month contact assessments. Although they were commissioned to do so as part of the HCP delivery, staff we spoke to said this work was not being undertaken due to staffing capacity issues. We were told an action plan had recently been developed to address the issue and had been submitted to the community services general manager.
- 96% of families received new birth visits from health visitors. 76% occurred within 14 days of birth. 74% of children received a 12 month review in the month of their 1st birthday and 86% of children had a review by the time they were 2.5 years old. There was no data available to compare these statistics against the England average.
- FNP outcomes were robustly monitored and measured through the 'Open Exeter' information system. The FNP service specification included a set of fidelity goals. The stretch target for expected visits during pregnancy was

80% and the service achieved 89%. The targets for expected visits during infancy and toddlerhood were also achieved, reaching 70% (target 65%) and 71% (target 60%) respectively.

- Breastfeeding initiation rates in Stockton and Hartlepool were 53.9% and 43.9% respectively. This was worse than the England average of 73.9%.
- The 6-8 week breastfeeding prevalence rate was 24.6% in Stockton which was worse than the England average of 47.2%. There was no published data for Hartlepool.
- Children's community nurses told us they were unaware of any key performance indicators (KPI) for the service. They were also unsure of a community nursing service specification.
- Community nurses completed activity sheets every month which were fed into a database but told us they did not receive any information about outcomes. Staff also felt the data collected did not represent a true reflection of their levels of activity. When we spoke with the assistant director of performance, planning and development, they confirmed their team was responsible for producing the performance dashboards. They were not aware of any data being collected from the children's community nursing team.
- The lead nurse for children's community nursing told us she monitored performance using the monthly activity sheets. This was fed into monthly team meetings however there was no evidence the information was shared with all staff.

Competent staff

- All staff new to the trust underwent a corporate induction in addition to a local induction.
- Staff and managers told us most staff other than new starters had had an annual appraisal. Evidence provided to us by the trust showed some teams did not achieve the 100% appraisal target by the end of March 2015. Most services still achieved above 90% however there were several staff groups below this. They included: child health (30% compliance); children's safeguarding (88%); health visiting Hartlepool additional clinical services (80%); administration (50%); health visiting Stockton additional clinical services (63%); students (80%); and school nursing Hartlepool additional clinical services (50%).
- Staff told us they received regular formal and informal supervision from line managers and peers.
- Staff told us informal supervision occurred on a daily basis. Formal supervision varied from service to service. For example, FNP nurses had weekly supervision meetings with the FNP supervisor and 3-monthly face to face supervision which included a senior nurse from the safeguarding children team. Health visitors and school nurses received formal supervision every three months, in line with the trust policy. Information provided to us by the organisation showed compliance for school nurses, between April and June 2015, was 73%. Some school nurses told us they did not always receive supervision due to workload and time constraints. Other evidence provided to us by the organisation, however, stated non-compliance was due to annual leave or training and sessions were never cancelled, only rearranged.
- Most of the staff we spoke with told us that they had regular 1:1 meetings with their managers and generally felt well supported.
- The trust safeguarding team ran complete training programmes for all staff across all services to promote key messages about keeping children safe. These included professional challenge courses aimed at raising awareness of how to challenge other agencies in the case of child protection.
- According to the national NHS staff survey 2014, the percentage of staff receiving job-relevant training, learning or development in the last 12 months was 80%. This was just under that the national average of 81%. This information was not available specifically for children and young people's services.
- Staff from community services for children and young people told us they felt there were many opportunities for personal development and training. They had received training about female genital mutilation (FGM), child sexual exploitation (CSE), CAMHS (child and adolescent mental health) and Solihull Behaviour Management. We were told there were also opportunities to progress academic learning to further develop skills and competencies. This included specialist community public health nurses (SCPHN) and Master level degree courses.
- The health visiting service had recently strengthened its preceptorship programme. New members of staff were supported through the development of a bespoke preceptorship pack in line with national guidelines. We were told preceptorship guidance for school nursing was in development.

Requires improvement

Are services effective?

- We spoke with two newly qualified health visitors who both told us they felt supported by the preceptorship process, their mentors and the wider team. They also felt they had opportunities for professional development.

Multi-disciplinary working and coordinated care pathways

- There was an emphasis on multi-disciplinary and multi-agency working within the trust. Staff had a good awareness of the services that were available to children in the area they worked and were able to contact other teams for advice and make referrals when necessary. This meant information was shared readily and cross-agency working ensured that where there were concerns about vulnerable children, these were shared and managed.
- We observed staff working jointly with parents and other agencies to provide the relevant care and support for children and their families. During a CAF (common assessment framework) meeting at a local primary school, which included a school nurse and staff from education and the local authority, we saw a full assessment had been completed of the child's needs and relevant referrals had been made.
- School nurses told us they had very good links with their local schools. We saw evidence of this during the CAF meeting and when we observed staff at a drop in clinic at a secondary school.
- Paediatric therapy services told us they work closely with school nurses and health visitors when caring for children with complex needs.
- FNP nurses gave us an example of the support they provided to a young person who had been a victim of honour-based violence in another part of the country and who was seeking asylum. The nurse worked with various partner agencies to ensure continuity of care and the sharing of best practice. This extended beyond the geographical boundaries of the trust.
- Informal communication between children and young people's services and GPs was good. Staff told us if they needed to speak to a GP about a child in their care they could contact them by telephone in the first instance and talk to them directly. The organisation operated a flagging system, which identified children at risk. This arrangement incorporated GPs and was centrally controlled by the local safeguarding unit.
- The LAC team told us they had good working relationships with social services, community agencies, non-statutory bodies and departments within the trust. A&E, for example, would contact the LAC team if they had any concerns about a child and also informed them of any A&E attendances.
- Children's community nursing staff told us the paediatric consultants they worked with were 'excellent'. Although based at the acute hospital sites, staff felt they took a very keen interest in community work and were the driving force behind developing the service.

Referral, transfer, discharge and transition

- Both health visitors and school nurses told us they worked closely with each other to make sure vulnerable children and their families were discussed and important information relayed.
- Staff informed us all safeguarding graded level 3 (children with special needs) and 4 (children with a child protection plan) were handed over in a face to face discussion. Parents were involved in the handover if appropriate.
- We saw evidence that the health visiting service was 98% compliant with the CQUIN (Commissioning for Quality and Innovation) standard for transferring a child's health record when they moved out of the area. The service transferred the record to the health visiting service in the new area within two weeks of notification and made direct contact when handing over all child protection cases.
- Community nursing did not have any formal transition clinics however when children reached the age of 16 they were asked if they wanted to be referred to adult services. Staff we spoke with told us there were no standard operating procedures and it was often dependent upon GPs making the relevant referral. As this did not always happen, the team continued to care for the patient until they were confident the transition process had been completed.
- The process for children with complex needs was more gradual. Children's community nurses would work jointly with adult services and district nurses. The process would include home visits as appropriate.
- Paediatric therapy teams told us they supported young people when they moved from secondary education to college. They visited the new environment with the young person to ensure that they felt comfortable and that their needs were assessed and met.

Requires improvement

Are services effective?

Access to information

- The intranet was available to all staff and contained links to current guidelines, policies, procedures and standard operating procedures and contact details for colleagues and key contacts. This meant that staff could access advice and guidance easily. All staff we spoke with knew how to access the intranet and the information contained within it.
- Health promotion information was available as well as information about services. This included leaflets in other languages. The school nursing team told us they were able to hand out cards with their contact details on them however they were also planning to create leaflets to provide more detailed information for children and families.

Consent

- Staff from paediatric therapy services told us consent was obtained from parents and children at the initial assessment stage. School nurses worked within Fraser guidelines to make decisions about whether young people had the maturity, capacity and competence to give consent themselves. Staff from all services told us they took in to consideration the voice of children and young people when obtaining consent.
- If partner agencies such as social services requested information from the school nursing service about a child, the information would not be shared unless the service was in receipt of a signed parental consent form.
- Staff from all services told us information would only be shared without consent if it was in the best interests of the child. For example, if they were subject to a child protection plan or it was a safeguarding issue.
- We saw evidence of correctly completed consent forms and we observed staff obtaining verbal consent correctly prior to a home visit
- The LAC team told us consent was sought at every stage of the process. Where possible, they asked the child themselves to write their own name on the form as a means of helping them to understand that they were consenting to their own care.
- The LAC team sometimes had issues obtaining consent when parents were unwilling to provide it. This would involve working with social services to obtain a court order.
- We observed that completed consent forms were not always included in patients' care records.
- School nursing and health visiting teams asked parents to opt out of participation in the national child measurement programme if they did not wish their child to be measured and weighed.

Good

Are services caring?

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

Summary

Services for children, young people and families were very caring. People told us they were treated with compassion, dignity and respect. They were involved in discussions about treatment and care options and able to make decisions. Information was provided in a number of formats to enable young people to understand the care available to them and help them to make decisions about the care they wanted to receive.

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

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

Detailed findings

Compassionate care

- All staff we spoke with were very passionate about their roles and were very dedicated to making sure the children and young people they cared for were provided with the best care possible.
- Staff showed respect for the personal, cultural, social and religious needs of children and young people. For example, during a school immunisation session, nurses protected the privacy and dignity of Muslim children by offering to vaccinate them first or last.
- The LAC team gave us an example of working closely with the local authority to ensure that two children from the Gypsy/Traveller community were provided with a placement on a local farm with horses and other animals, to support them to feel happy and secure in their new environment.
- Community nurses told us they often worked above their contracted hours to make sure patients received the care and treatment they needed. Families with children who had complex needs or who were receiving palliative care could contact staff during an evening or on a weekend.
- We observed the way children and their parents were treated both in their homes and in clinic settings. Staff were kind, patient, empathetic and informative.
- Patients were treated as individuals and we saw that staff and patients had built up good working relationships.
- Parents told us they had confidence in the staff they saw and the advice they received.

Understanding and involvement of patients and those close to them

- We observed a formal supervision meeting and saw evidence of individualised care planning, ongoing engagement with the patient and an action plan relating to the young person's needs.
- The LAC team told us they always involved children in the completion of their health assessment. If a child was unable or unwilling to participate, this was made clear on the form. They would also meet with children in the child's own environment wherever possible.
- Parents and carers of children told us staff focussed on the needs of the child and their family.
- Parents and carers felt involved in discussions about care and treatment options and told us they felt confident to ask questions about the care and treatment they were receiving and make decisions based on the information they received.
- During a home visit, we observed staff position themselves in a way which was unthreatening and promoted open communication with the family (by sitting on the floor with them and using clear, and plain language).
- Staff told us they supported children and their parents or carers to manage their own treatment needs, whenever possible. Staff told us they discussed goals with families and gave them advice about how they could make progress towards achieving those goals.
- The health visiting service designed a questionnaire to capture patient experience feedback from families and carers. 84% of those surveyed said the health visitor always listened to them; 87% felt they were treated with kindness and understanding and 82% said the health visitor involved them as much as they wanted in decisions about their baby's care.

Good

Are services caring?

- We observed health visitors and nursery nurses interact with children and parents at a baby clinic in a local children's centre. Staff created a warm and caring environment and greeted every individual by name.
- We observed school nursing staff deliver a presentation to children in Year 6 (aged 10-11 years) about the national child measurement programme and its purpose. They explained about privacy in a style that was open, engaging, caring and supportive.

Emotional support

- Children, young people, their families and carers were supported by staff from the trust in the first instance. Should further more specialised support be needed, staff could make referrals to other services such as CAMHS, psychologists, GPs and counselling services.
- Staff in health visiting teams managed their own caseload. This meant that mothers met the same health visitor at each appointment in their home. Consistency meant that health visitors built up relationships with mothers and children, and we saw evidence of this during home visits.
- The LAC team told us they always ensured professional boundaries were maintained with the children they cared for as vulnerable children can often become very attached to them. They recognised that this could sometimes be difficult, especially in the case of providing emotional support.
- During a very busy baby clinic, we observed staff spending time with individual parents, discussing their concerns in a manner that was not rushed or hurried.
- The health visiting team had a lead for refugee and asylum seeking families in Stockton. They supported adults to enable social integration and prevent parental isolation. This minimised the potential risk of depression impacting upon the mental health of the children. The health visiting lead was very knowledgeable and had an in-depth understanding of the issues facing families and was dedicated to ensuring they received the right level of care and emotional support.

Good

Are services responsive to people's needs?

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

Summary

Services for children, young people and families were responsive. Care was provided to people in their home and also in local clinics, treatment centres, through drop in sessions and also timed appointments as and when required.

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

There were policies and procedures in place to ensure that people in vulnerable circumstances were able to access the services they needed in a timely manner. There were no significant delays in waiting times within the paediatric therapy services teams.

Services were tailored to the needs of local populations and most staff were able to access training specific to the needs of the children and young people they supported.

The care provided to refugee and asylum seeking families was outstanding. The specialist health visitor had extensive knowledge about the key issues and delivered tailored advice and support to families upon arrival in Stockton.

Detailed findings

Planning and delivering services which meet people's needs

- We found services were accessible to children, young people and their families. For example, the school nursing team had a single point of access for parents to contact if they had any questions or requests for information. Outside of normal working hours, messages could be left which would be picked up the following working day.
- School nurses found it challenging to promote good health in more deprived areas. The level of children under 16 years living in poverty in Stockton was 22.5% and in Hartlepool was 30.6%. This was worse than the England average of 20.6%. 11.1% of children aged 4-5 years and 21.1% aged 10-11 years in Hartlepool were classed as obese. This was worse than the England average of 9.3% and 18.9% respectively.
- School nursing teams worked closely with schools to identify children who required extra support and included relevant advice during assessments about diet and aimed to include parents wherever possible.
- The Stockton school nursing team were working with 'More Life', a family weight management service, to develop and provide a tailored obesity programme aimed at children in primary and secondary schools.
- The school nursing team in Hartlepool were developing a healthy weight strategy in partnership with the local authority and voluntary sector.
- Staff told us they actively involved children and families when planning and delivering services. For example, school nurses ran an engagement event with local youth groups and asked them what they expected from the service and how it should be promoted to young people. School children also had the opportunity to design a poster and were asked if they thought school nurses should wear a uniform to distinguish themselves from school staff and visitors. The consensus of opinion from school children was 'yes' and a uniform pilot was due to commence at the beginning of the following term.
- We saw a complete list identifying all nurse prescribers. There was a prescribing lead within the trust who offered support to staff. We spoke with a number of staff across different services who actively prescribed medication to children and young people. One member of staff we spoke with told us that she did not prescribe and that was a personal choice.
- Most staff had a good knowledge of the people they had on their caseload, or who attended the schools they looked after. They were aware of the needs of the population and the type of support they needed.
- The health visiting team lead for refugee and asylum seeking families in Stockton had developed a project called the 'Olive Branch'. The project aim was to develop and promote independent living for families to meet their physical and mental health needs whilst

empowering and enabling them to integrate socially within the community. The service ran weekly clinics and offered an appointment system for individual private consultation with the health visitor.
- Staff were able to access interpreters for people whose first language was not English or who had a sensory disability. However, some staff we spoke with also said they sometimes asked siblings to act as an interpreter when English was not the first language of their parent which is not best practice.

Equality and diversity

- According to the national NHS staff survey 2014, 44% trust of staff had received equality and diversity training in the last 12 months compared to the national average of 63%.
- This information was not available specifically for children and young people's services where we saw evidence of good practice, knowledge and understanding.
- Most staff were aware of the ethnic and religious make-up of the people who used their services and were able to describe how they could make modifications to ensure they were culturally sensitive.
- Staff within the school nursing service had attended training about gypsy and traveller communities. Staff told us they were actively looking at ways in which they could support children at school and at home to remove barriers.
- There was equipment available to support people with disabilities.
- People who used the services told us that they were treated as individuals.

Meeting the needs of people in vulnerable circumstances

- Staff we spoke with were aware of female genital mutilation (FGM) and child sexual exploitation (CSE). Some staff had received training although the majority of staff we talked to had no experience of working with victims.
- Within the health visiting service, there were staff leads for the gypsy and traveller community, asylum seekers and domestic violence. Staff had strong links across the wider community and referred families to relevant agencies for further support and guidance as appropriate.
- Refugee and asylum seeking families were offered early support upon arrival in Stockton. The purpose was to build relationships, address minor ailment issues and facilitate contact with other groups and agencies. The key aims included social integration and building trust between health services and families. We were told some women had shown their trust in the service by seeking confirmation from the health visitor that the advice and treatment recommended by their GP was correct.
- We spoke with some of the families who accessed the service. They told us they felt 'safe' and 'happy'. One woman told us she felt able to ask staff anything, even advice about sun cream.
- The lead health visitor for refugee and asylum seeking families retained children above the age of five in their caseload until refugee status had been achieved. Children were handed over to the school nursing team once a permanent home had been established.
- There were very good networks of support in place for looked after children. Health plans were in place. Staff worked closely with young people and built up close working relationships with them.
- Staff were very dedicated to supporting looked after children and even when children moved out of the area, still maintained contact and continued to deliver support as appropriate.

Access to the right care at the right time

- The paediatric occupational therapy (OT) team told us the waiting time for treatment had previously been 12 months. The service undertook a review of the referral process to make the criteria stricter and more robust to reduce the number of inappropriate referrals. Current waiting times were 10-12 weeks. The service had an action plan in place and we saw this was regularly reviewed at team meetings.
- OT referrals were also triaged and prioritised according to need. For example, children with complex needs were given a higher priority than other cases. This included children and young people with cerebral palsy, autism, neurological conditions and those on a palliative care pathway. New patients who required urgent appointments were seen within one week. Families were also given a choice where they wanted to be seen which reduced the demand on clinic rooms (for example, some families requested to be seen in school

which resulted in 70%-80% of children attending appointments in their local school). The robust triage system also minimised the number of duplicated referrals thus speeding up the whole process.

- The OT team told us they were very open and transparent with parents and carers about the wait for treatment by including this information on patient letters. One parent we spoke with told us she had noticed a significant improvement over the last 12 months.
- OTs had recognised there was a higher than normal 'did not attend' (DNA) rate during the school holidays. To negate any unnecessary cancellations, OTs phoned parents to confirm that they and their child were still planning to attend the appointment. OTs told us they would inform patients' GP and school nurse in the event of a DNA as a standard safeguarding measure.
- We observed a community assessment framework (CAF) meeting and saw evidence that timely referrals had been made to ensure a child would receive continuity of care with the relevant services. We also saw evidence of responsiveness during a home visit where a mother expressed her concerns about her baby's ability to stand.
- Some staff we spoke with in Hartlepool felt they were not as accessible to children and families as they were when they were based in children's centres within the community. Health visitors, community paediatric nurses and school nurses were based in the acute hospital in Hartlepool. Families had to telephone the relevant service or visit staff in a scheduled clinic. When we spoke to parents who used the health visiting service, most of them told us they felt the service was accessible and was easy to contact.
- The waiting time target for children's 'speech and language therapy' (SALT) was 18 weeks. Evidence provided to us by the trust indicated that current waiting times in Hartlepool were 11 weeks and in Stockton, six weeks. The SALT team were also asked to deliver services across County Durham where the target was six weeks - the current waiting time was 18 weeks. We were informed this had been highlighted as a key area for improvement.
- SALT administration staff ran performance reports on waiting times and these were fed back to the team. Staff recognised the 18 week target could be breached and was usually due to staff shortages over holiday periods.
- The SALT team was also part of a multi-agency pilot to develop an autism diagnostic pathway. It was not possible to analyse data specifically relating to the SALT team as the administrative processes were co-ordinated through Tees, Esk and Wear Valley Mental Health Trust. However, we were told the length of time from accepting a referral to reaching a diagnosis was currently at 8-9 months. Within the local pilot, it was agreed that best practice would be to plan the diagnostic discussion for 4-6 months after the initiation of the assessment. Following our inspection, waiting times were discussed at the CCG-led ASD (Autism Spectrum Disorder) Strategy group. Paediatricians agreed to increase the number of clinics per month and SALT confirmed they had the resources to meet this demand. We were told this should improve the overall wait for diagnosis for children and their families.
- School nurses offered regular drop-in sessions for pupils to attend and discuss concerns or questions they had about sexual health, smoking, alcohol consumption, drugs or general health.
- School nurses delivered health promotion in schools, usually at school assemblies. These focussed on topics such as smoking, alcohol and drug taking, sexual health plus information about immunisation and vaccinations.

Learning from complaints and concerns

- The trust had a complaints policy and staff we spoke with knew how to access it. We were told that most complaints were dealt with by the relevant service. Staff felt the process was open and honest.
- Staff told us they knew how to handle complaints and when to escalate a complaint to a manager.
- Evidence provided to us by the trust showed there had been 15 recorded complaints in the last 12 months.
- The paediatric therapy team told us many of their complaints were about the waiting times. Everyone we spoke with was aware of this and of the work involved to reduce those waiting times to improve the services for children and young people.
- The school nursing service told us the majority of complaints about the service were in relation to the National Child Measurement Programme. All complaints were responded to directly and appropriate advice and information was shared with the complainant.
- Complaints and concerns were discussed at team meetings although staff told us they did not often find out about concerns raised about other teams, or share

Good

Are services responsive to people's needs?

learning across teams. Team leaders fed back to staff about complaints and concerns and the outcome of any investigations. They communicated with staff about any learning and any changes which resulted from complaints. Staff confirmed that this was the case although they did not find out about the outcome of an investigation in all cases.

- According to the national NHS staff survey 2014, 54% of staff believed feedback from patients and service users was used to make informed decisions in their directorate or department. This was slightly worse than the national average of 56%. The information was not available specifically for children and young people's services.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

Services for children, young people and families were well-led. Staff were aware of the vision and goals of the wider trust and of those within their own service.

Staff we spoke with told us patients were at the centre of what they do. Staff were positive and proud about working for the trust and felt they contributed to service improvement and development within their own sphere of practice.

The relationship between staff and line managers was good across most services with some exceptions. Children's community nurses in Hartlepool felt disconnected from their line manager due to lack of geographical proximity and communication.

Generally, staff told us they felt valued and respected by managers, who advocated an open and transparent culture across all services.

Detailed findings

Service vision and strategy

- The trust had a business plan outlining the strategic vision for the Out of Hospital Care Directorate. When the health visiting service moves to the local authority later in the year, this included plans for community children and young people's services, such as working in partnership with commissioners to support a seamless transition.
- Most staff we spoke with were aware of the vision and strategy of their own service.
- Staff showed their knowledge and understanding of the trust's corporate strategy as represented by the 'triangle' which identified the six strategic themes. Staff we spoke with showed a good understanding of the core basic values that underpinned the trust's vision, known as the '6 Cs', and the role of 'care makers'.
- Staff told us, within their own service, they had been actively involved in the development of new pathways and standard operating procedures.

Governance, risk management and quality measurement

- The trust provided evidence of the risks identified for each service. Each service had its own risk register. We were told this was discussed at team and business meetings and outcomes were shared with staff. Staffing was identified as a major risk in the immunisation, school nursing and health visiting teams. Actions had been identified to address these issues. Many of the risks were general and included health and safety, lone working and information governance.
- Paediatric therapy services told us one of the ways they identified risk was through the analysis of themes and trends from incidents and complaints. The team patient safety lead had close links with the trust-wide risk management team and worked jointly to put plans in place to mitigate further risk. An example of this was the reduction in waiting times for occupational therapy. Staff told us the action plan was monitored regularly and discussed at team meetings.
- Some staff told us they felt the leadership structure was not as robust as it could be. The senior clinical matron (SCM) had been absent for an extended period of time and staff felt this had a detrimental impact upon the delivery of their own service. We were told a new SCM had been recruited and would be in post within the next month.
- We spoke with the management team of the directorate. They told us they were aware of the issues and limitations of the line management structure across community children and young people's services. We were informed plans were in place to reorganise the leadership team and governance systems.
- There was a process in place to feedback information to staff by newsletters, emails and staff meetings.
- The health visiting service held business meetings which were chaired by the professional lead integrated nurse. The purpose of these meetings was to discuss and share good practice, skill mix, knowledge and experience with a focus on the strategic direction of the service. Staff told us a recent meeting highlighted problems with the handover between midwives and health visitors. This led to the development of a new pathway to improve practice.

Good

Are services well-led?

- We saw evidence of internal quality audits being undertaken routinely across all services and, in some cases, outside the trust to ensure safe and effective care.
- Community nursing was part of a research project comparing the outcomes of three epilepsy drugs. The service was also involved in the Epilepsy 12 Audit to measure and improve the quality of care for children and young people with epilepsy.

Leadership of this service

- Some staff felt uncertain about the future leadership plans for their service however they felt the flow of information between their team leader and senior managers was good.
- Most of the staff we spoke with told us they felt well supported by their immediate line manager. However, children's community nurses in Hartlepool felt disconnected from their line manager due to lack of geographical proximity and communication.
- Staff felt there were clear management structures within the team and managers were very approachable. If there was any conflict within the service, they would go to their line manager and seek support.
- Staff knew who the senior management team of the trust were, but most had never seen them in person. Staff had mixed opinions about the visibility of the chief executive and his management team. Some felt they were not very visible and 'hidden away' while others felt they were both visible and approachable, albeit at the acute hospital site of North Tees.

Culture within this service

- Most of the staff we spoke with told us they felt valued and respected by their immediate and senior managers.
- During the previous winter, some staff supported colleagues in acute services to assist with the pressures caused by an increase in the number of patients admitted to hospital. Although they were not expected to work outside of their competencies, staff felt it impacted upon their ability to do their own jobs. As a team, they spoke with the community services general manager. Although no reassurances were given that this would not happen again, staff felt comfortable that the manager had listened to and understood their concerns.
- Within the community nursing team, some staff felt isolated from the wider trust and not recognised for the work they did. When this issue was raised at the community forum, representatives from the senior management team responded by visiting the team and spending time with the service.
- Staff felt the culture within their own services was open and transparent. Staff met regularly to attend team meetings and informal supervision took place on a daily basis.
- We found staff were very supportive of each other and there was a very strong sense of joint team work across all services.
- Overall, staff felt they were encouraged to report to the trust: incidents and near misses; concerns from patients; and identify risks. Staff were confident action would be taken if concerns were raised in relation to patient safety.
- According to the national NHS survey of 2014, 9% of trust staff experienced discrimination at work, compared to the national average of 11%.

Public engagement

- The trust was planning to roll out the 'Friends and Family Test' (FFT) in relation to children and young people's services later in the year. The FFT is a single question survey which asks patients whether they would recommend the NHS service they had received to friends and family who needed similar treatment or care.
- Other services within the directorate had developed other mechanisms to capture patient feedback. The health visiting service surveyed 237 families to capture their thoughts and feedback about the service. 80% said they would recommend the service to friends and family.
- Services were also involved in a project called 'A Fairer Start' in which the aim was to ensure every child in Stockton had the best start in life. This involved engaging with local families to seek their views with regards to pregnancy and early years.

Staff engagement

- The senior management team, led by the chief executive, held a group meeting every quarter for all community-based staff. We spoke with a number of staff who had attended at least one and they told us they found them both useful and informative.
- Staff had taken part in the national NHS staff survey in 2014. The results were not available specifically for

Good

Are services well-led?

children and young people's services. The national staff survey showed that on a scale of one to five, with five representing highly engaged staff and one being completely disengaged, the trust scored 3.64. This score was worse than the national average of 3.74.

- As part of the 'A Fairer Start' project, a staff skills audit was undertaken to develop a competency framework and inform workforce development. This involved health visitors, community nursery nurses and FNP nurses who provided information about personal levels of competence and confidence, plus training and development. The majority of responses indicated that staff felt their level of competence was good or high. Staff also felt very passionate about their role, had a positive attitude to enable them to fulfil their role and felt they made a difference to children and families.
- The trust produced regular instalments of 'Community Focus', a newsletter which was primarily focused upon community initiatives across all services. Staff we spoke with made reference to the newsletter and told us they felt it was a useful way of receiving information. Staff also told us they received regular communication emails from the senior management team with information relating to the wider trust.

Innovation, improvement and sustainability

- There were plans within the school nursing service to introduce a texting service so children and young people could source information and advice from a nurse directly.
- The FNP were exploring opportunities to meet the needs of their clients more effectively by setting up Twitter and Facebook accounts. They also had support from Public Health England to develop a 'Young Mum's Ambassador' role to offer peer support to other young mothers.
- Staff we spoke with felt they could make suggestions to improve care and share good practice within their respective service. For example, one health visiting team had developed a number system in the baby clinic to ensure the clinics were run in an organised and timely way. Other teams recognised the effectiveness of this and adopted the method within their own clinics. Staff told us they felt encouraged by managers to implement change.
- The SALT team were piloting a joint-funded integrated care approach in special schools across the localities. A member of the team was attached to a school which enabled the service to be more responsive to the needs of the children they cared for.
- We spoke to a community nurse who had helped to develop a care package for end of life patients in the Hartlepool area. She worked with social services and other agencies to ensure that parents had more involvement and control over the care for their child.