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

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

Where applicable, we have reported on each core service provided by Wye Valley NHS Trust and these are brought together to inform our overall judgement of Wye Valley NHS Trust.
## Summary of findings

### Ratings

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<td>Are Community health services for children, young people and families safe?</td>
<td>Good</td>
</tr>
<tr>
<td>Are Community health services for children, young people and families effective?</td>
<td>Good</td>
</tr>
<tr>
<td>Are Community health services for children, young people and families caring?</td>
<td>Good</td>
</tr>
<tr>
<td>Are Community health services for children, young people and families responsive?</td>
<td>Good</td>
</tr>
<tr>
<td>Are Community health services for children, young people and families well-led?</td>
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## Summary of findings

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3 Community health services for children, young people and families Quality Report 14 October 2014
Overall summary

Community children, young people and family services provided safe, effective, caring and responsive services. Safeguarding training and safeguarding supervisions ensured staff could recognise and deal with issues effectively. Staff received training to help keep them safe.

Care and support were based on sound assessments and clinical good practice.

Staff were enthusiastic and caring and often went far beyond what might be expected of them to ensure people using the service received the best service they were able to provide. Working practices in different departments were centred on providing individual care and support.

Not all staffed received one-to-one supervisions with their managers. Although there was a close working relationship, the absence of regular confidential meetings meant staff might be identified if they tried to raise concerns because they had to ask to speak privately and this would be seen as unusual.

Risks were acknowledged and on the risk register, but staff felt issues were not addressed. The executive team was not visible in the community children’s and young people’s services. Nursery nurses at Ross Road had no manager on site. A member of the team visited with and reported to their manager regularly at the Kite Centre, but staff told us that the manager did not visit the service and left the team member to report back to their peers.
**Summary of findings**

**Background to the service**

Wye Valley NHS Trust formed in April 2011 by the merger of acute, community health and adult social services in Herefordshire. In September 2013 adult social services became the responsibility of Herefordshire Council. The trust provides services to 180,000 people in Herefordshire and to 40,000 people in Powys, Mid Wales. The catchment area is rural and remote. More than 80% of the people using the services live five miles or more from Hereford city or a market town.

We inspected the service because it is an example of a high risk trust and has had a rapid response review in the Autumn of 2013.

Community children, young people and family services are part of the Wye Valley NHS Trust. The trust provides a diverse range of services to the local community including: health visitor; school nurse; community children’s nurses; occupational and physical therapy; child development centres; ‘looked after’ children’s services; and respite services.

**Our inspection team**

Our inspection team was led by:

**Chair:** Andrea Gordon, Deputy Chief Inspector (Hospitals) Care Quality Commission.

**Team Leader:** Tim Cooper, Head of Hospital Inspections, Care Quality Commission.

The children’s community services inspection team included: CQC inspectors, school nurse; health visitor; and a retired executive officer.

**Why we carried out this inspection**

We carried out this scheduled inspection because Wye Valley NHS Trust had been identified by CQC Intelligent Monitoring as a risk, additionally; the trust was subject to a rapid response review by NHS England in autumn 2013 and so considered a high risk trust.

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

**How we carried out this inspection**

We visited community bases for the teams, the child development centre and respite centre. We also accompanied health visitors, school nurses and community nurses on clinic and home visits.

The inspection team included two inspectors and three specialist advisors.

We spoke with 16 people who used services or their families.

We spoke to 43 staff.

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 4 and 5 June 2014. During the visit we
Summary of findings

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 met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

Comments from parents and carers included:
- “Staff are lovely.”
- “They are brilliant.”
- “They are great and not at all judgemental.”
- “The respite centre has been a lifeline for us.”
- “The only problem I’ve had has been trying to get in touch with them on their mobile.”

- “Staff very good at picking up new concerns and things to be tried.”
- “X enjoys going to Ledbury Road and smiles when going and claps when brought in.”
- “Trips are fun and well organised.”

Good practice

Our inspection team highlighted the following areas of good practice:

The enthusiasm and dedication of staff was outstanding. Observed interaction with children and families was excellent.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The service should ensure that senior management are more visible to staff. Buddy systems have recently been put in place that identify board members with specific departments. This has not yet provided a measurable increase in visibility from the perspective of staff, who feel isolated and the ‘poor relations’.

The service should ensure that risk register issues are addressed in a timely manner. For example, the school nurse safeguarding levels that had been on the register for two years.

The service should ensure that completing business cases is not complex, time-consuming or an added pressure for the department concerned, and that feedback is provided to staff.

These inadequacies would not constitute a breach of regulations.
The five questions we ask about core services and what we found

Are Community health services for children, young people and families safe?

By safe, we mean that people are protected from abuse

**Summary**

Children and family services were safe because there were robust systems to monitor and report incidents and concerns. There were good arrangements to protect children from abuse. All staff we spoke with knew the safeguarding procedures and the systems they would use to ensure action was taken where required.

Some school nurses felt their ability to identify early signs of potential abuse were compromised by the large number of safeguarding cases they carry. This prevented them from undertaking their core role of health promotion, and reduced contact with children and families not already identified as having additional needs. Reviews had been conducted into the high volume of safeguarding reports both by the trust and by social services departments of the local authorities. No reasons for the higher than average number of reports had been identified.

A small number of staff in the respite centre had not received safeguarding training in line with national guidelines. However, all staff had a good understanding of safeguarding issues, knew who to approach for advice and guidance and how to protect and promote the health of people in their care.

Services overall were well managed, monitored, and staff were well trained and supported to provide safe services.

Staff resources were allocated to meet the needs of families and children.
Are Community health services for children, young people and families safe?

Incidents, reporting and learning

- There had been no recent never events (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers) reported in the children's community teams, children and family locations.
- All staff we spoke with stated that they were encouraged to report incidents and received direct feedback from their managers or supervisors. Issues arising from incidents were investigated and analysed, learning was shared within teams. However, it was not clear if learning and best practice was shared across other departments to avoid similar situations arising with other staff. In more serious incidents we saw that learning was shared. We could not be confident that learning was shared effectively either from or to the children’s services from other core areas. We did see that incidents and news were circulated by email to all staff in the ‘team brief’. However, staff told us that the onus was on the individual to read this and not all staff did. We did see some examples of the team brief being discussed within team meetings. A large number of staff told us that they received no feedback from incidents they had reported on the electronic system.
- Serious case reviews resulted in root cause analysis. Incidents not reaching the level of a serious case review were subject to a serious incident learning programme (SILP). In either case, learning points were shared with all staff at team meetings.

Cleanliness, infection control and hygiene

- Personal protective equipment was available for all staff in clinical areas.
- Cleaning regimes included cleaning toys and equipment.
- Equipment was marked to show when it had been cleaned and by whom.
- Hand hygiene was not always adhered to by all staff. We saw evidence of staff not using gel or washing their hands prior to and following examination or assessment of children. We observed a nursery nurse on a home visit and school nurse during a school visit. Neither event involved personal examination, but simple precautions might prevent the spread of infection between homes, clinics and individuals.

Maintenance of environment and equipment

- The community bases, centres and clinics we visited were fit-for-purpose and there were effective infection control procedures in place. Although some bases and clinics were located in old buildings, they appeared well maintained. Administrative staff told us that maintenance requests were responded to quickly.

Medicines management

- Medicines were kept securely and handled safely.
- Temperature-sensitive medicines were kept refrigerated and temperature checks were completed and recorded.
- Equipment was well maintained so medicines were safe for use.
- Children using the respite centre brought their own prescription medicines from home. Changes to medication or dosages since their last stay were discussed and documented with parents each time a period of respite was offered.

Safeguarding

- There was a clear safeguarding policy in place. Staff we spoke with in all children’s services teams were able to state who the trust safeguarding lead person was. Staff provided examples of when and how they had raised alerts. Staff told us they felt supported by their immediate line managers with safeguarding issues.
- Staff were clear about the reporting information system they would use, the lead officer or manager they could discuss issues when needed, and the multi-agency safeguarding hub they would contact to record concerns.
- Safeguarding supervision took two forms. Group sessions were held with some teams, while those areas where staff carried high numbers of safeguarding cases received individual supervision. This meant that staff were able to discuss issues openly and appropriate procedures were being followed.
- We did speak with some staff who had not received their annual safeguarding training. However, they were able to describe the different types of abuse and the systems in place to report any concerns.
- People we spoke with told us they felt safe and had confidence in staff who they dealt with.
Are Community health services for children, young people and families safe?

Records systems and management
- We saw records that demonstrated how staff had managed care and treatment plans well, escalated concerns and safeguarded children and families in their care.
- Patient records were updated regularly and reflected the care and support that people required. Risk assessments had been completed to ensure people’s safety.
- The services were heavily reliant on paper record systems that meant there could be updating delays because community staff often carried notes with them, which they updated when they reached one of their bases. We did not see any evidence of where patient safety had been compromised by this system, although staff told us they would prefer mobile working, using tablet computers that would mean records could be updated more quickly.
- Other records relating to training, meetings and general maintenance were kept and filed appropriately.
- Audits of individual departments were completed regularly and copies showed how they had been analysed.
- Records were kept securely, and there were systems to transfer confidential documents such as patient notes between sites where this was necessary.

Lone and remote working
- Lone workers used buddy systems to ensure they were safe. Staff told us that they often had difficulty when away from their base because of poor mobile phone reception. We were told that a programme of replacements had begun to provide more reliable coverage. Staff who worked in the Vaughan Building at Belmont Clinic in Hereford complained of feeling isolated and vulnerable. The building had been without a receptionist for a considerable period of time. Some patients who used services sometimes became upset and potentially violent because of their condition unless they were given reassurance about where to go and waiting times. Staff described how one patient who was blind had been dropped off by a taxi, and when they entered the building became very distressed because there was no receptionist and had been unable to read signs about where to go. We saw that there was a receptionist on duty during our inspection but understand this was not a permanent position.

Assessing and responding to patient risk
- Risk assessments had been completed when patients first started to use services. These formed part of people’s care records and detailed risks to the patient, but also to advise staff on mitigating risk to themselves such as guidance on using hoists.
- Occupational therapists provided direction for families and assisted them with applications to local authorities where equipment or modifications were required to assist with people’s care or improve their quality of life.
- Policies were available to guide staff on their personal safety, and additional training in managing actual and potential aggression was given to vulnerable staff groups.

Staffing levels and caseloads
- Staffing levels and skill mix supported safe practice in all the areas we inspected.
- Issues about the high volume of safeguarding incidents carried by each school nurse had been reviewed by the trust and with partner agencies.
- Practice and assessments were found to be in line with national guidelines. There were pockets of high deprivation in some areas of the county, but no direct cause for the high volume of cases was identified.
- The department head had submitted a business plan to justify increased funding for additional staff, but this had yet to be progressed. School nurses and their manager told us that as a result of this high workload, the school nurses could not devote sufficient time to their core work of promoting health and wellbeing in the wider school community. Many activities that they wanted to undertake could not be achieved because of insufficient time. One school nurse complained that they were concerned that the lack of contact with other children and families in the school could result in some cases of abuse not being recognised until they reached crisis. Staff could not provide examples where earlier intervention could have been identified but emphasised they saw preventative interventions as a key function of their role and did not feel they were fulfilling this.
- Looked after children staff demonstrated how they had managed to maintain their service levels and stay within statutory targets by working outside their normal hours of duty. We were told that on the days when they
Are Community health services for children, young people and families safe?

worked early or late they still tended to work their normal hours either before or after the additional hours. This had not been imposed on them by managers but had become a normal work pattern.
• Health visitors told us that following implementation of national guidelines they had sufficient staff and facilities to provide a good service. People who used the service were complimentary and they told us that there was no waiting time and that staff always had time for them.
• No formal on-call arrangements were in place for the respite centre. Management support was provided by the acute trust on-call manager at Hereford County Hospital, but staff acknowledged that they did not always have a full understanding of the respite centre and its operational procedures. In reality staff sought assistance from off duty colleagues or the unit manager when they were off duty.

Deprivation of Liberty safeguards (optional)
• Deprivation of Liberty Safeguards do not apply to services for children and young people.

Assess, monitor and react to risk
• Risk assessments had been completed to ensure staff and patient safety. Staff were clear of the systems in place to monitor and escalate risks. We noted that issues regarding the high volume of safeguarding incidents carried by each school nurse had been on the risk register for two years.
• Staff in the looked after children unit demonstrated how they had met national statutory requirements for assessments of children. The paediatrician produced audits and analysis of the department’s work. Staff had a very high workload and met targets by demonstrating good will and working additional hours for no reward. Staff explained how they completed assessments before or after school hours to prevent embarrassment to children. These assessments were often in addition to their normal working hours. One member of staff was employed on a temporary basis as a bank (staff who work overtime at the trust) employee. This employment had continued for three years. The department had submitted a business plan to increase the bank workers hours and to make the position permanent. This was submitted 12 months ago and had yet to be progressed.
• Respite centre staff levels were monitored to ensure the individual needs of children using the service could be met. We saw how additional staff had been brought on duty when two children with complex needs had been admitted to the unit. Staff had reported one adverse incident when two members of staff had been committed to working in one area of the unit, which meant one care worker was left alone to deal with six children in the two remaining units for over an hour.
• We spoke with health visitors, community nurses, looked after children staff and school nurses about working in people’s homes and the community. All staff confirmed they had clear procedures to follow for lone working, which meant the provider had made effective arrangements to protect the safety of staff.

Managing anticipated risks
• Individual risk assessments informed staff and helped with planning when children were due to come into the respite centre.
• Lone worker arrangements were in place to protect staff. The systems relied heavily on the use of mobile telephones. Staff told us that the reception particularly in rural areas was very sporadic. This made it difficult for staff to make contact even when using the buddy system. This had been recognised by the trust and new phones were being distributed using a more reliable service. We did not see a target for completion of the replacement phones but were assured that the most vulnerable staff had already received replacements.

Major incident awareness and training (optional)
• Staff we spoke with were not aware of major incident training or trust policies and procedures relating to this. However, they were able to tell us how in times of crisis staff were contacted by text message and asked to work in the acute settings. For example, when there had been an outbreak of illness, staff said this had worked well but were unsure of how and by whom this was coordinated.
Are Community health services for children, young people and families effective?

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

Summary
The service was effective. Services were targeted at particular groups to ensure children in vulnerable or minority groups were well supported.

Services were targeted at key outcomes such as breast feeding rates, developmental checks and uptake of vaccinations.

We found there was effective multidisciplinary working that included GPs, social workers and community paediatric services. Some staff reported problems with information technology that was used to support their work or records.

Evidence based care and treatment
- Throughout children's community services care provided was evidence based and followed recognised and approved national guidance. Staff understood their roles, and clinicians worked within their scope of practice in accordance with their professional governing bodies.
- Health visitor team’s ensured new born children received appropriate assessment and parents received support. Children also received developmental assessment at the expected stages. Looked after Children (LAC) team audits were based on National Institute for Health and Care Excellence (NICE) guidelines. Audits were used to identify targets and direct staff.
- Medicine and Healthcare products Regulation Agency (MHRA) alerts were in place. We saw evidence of this in the respite centre for nasogastric feed alerts.

Nutrition and hydration (optional)
- Staff who worked in the respite centre were required to complete food hygiene training. Staff described the training they had undertaken and records confirmed what we had been told.
- The kitchen areas had provision for storing food safely and fridge and freezer temperatures were checked daily and recorded. Action was taken promptly when the temperature was not at a safe level. We saw reference made in a staff communication book that one fridge was not working at a safe temperature and food was moved immediately to another fridge while it was repaired.
- Detailed care planning was evident in the respite centre and included information on children’s diets, preferences and choices and feeding regimes for tube feeds.
- Community nursery nurses worked with parents in the community on healthy eating and developing diets. School nurses provided dietary advice and associated safety advice about drugs and alcohol during drop in sessions.

Patient outcomes
- The trust had service user and carer feedback systems that demonstrated that they took account of people’s comments and concerns these included children and young person’s services. Some health visitors told us that they only collected patient or family satisfaction levels on discharge. This meant opportunities to improve services during a person’s treatment could be missed. Staff stated that they took continual verbal feedback throughout their involvement with families and any issues were addressed or reported on as they occurred, however, general feedback was not routinely requested and could therefore not be assessed by managers.
- Feedback from parents and children was requested through comment cards in the child development centre and when possible their views were acted on. For
Are Community health services for children, young people and families effective?

example, a small area for older children to wait for appointments was in place so that they did not have to sit with younger children. The signage had also been made more user-friendly and age-appropriate.

- We saw patient survey questionnaires in relation to the respite centre that unfortunately had not been dated. Staff told us they had been completed in the previous three weeks. Surveys showed positive comments including “improvement noted in child’s behaviour since using respite centre”, and “sleeping at home had improved”.
- Parents commented: “Staff are very good at picking up new concerns and things to be tried”; “X enjoys going to Ledbury Road, they smile when going and clap when brought in”; “Trips are fun and well organised.” Suggestions had been made by parents including “I would like better flexibility”. One parent commented they were grateful for a period of emergency respite that the unit had been able to provide.
- Children had been asked to complete surveys on the things they enjoyed at the respite centre and what they would like to be able to do in the future. We saw from the completed surveys their feedback had been considered when planning activities and outings.
- Teenage looked after children had been canvassed about engagement in the service and involved in producing a website to meet their needs.
- Discussions with parents about the Ledbury Road Respite Centre in Hereford were all positive and they told us the staff were excellent, flexible, welcoming and brilliant with their child. Two parents said there was nowhere else for their child to go to spend time away from the family in a fun homely environment. We heard how the support from Ledbury Road had a positive impact on their whole family relationships, including with siblings, because there was time to spend with them rather than focusing on their child with additional needs.
- Health visitors completed a satisfaction survey with families at the end of the service provision. We saw that comments from families were all complimentary about the support and guidance provided and the manner of staff. Staff said they received constant verbal feedback from families and this was generally very good, but there was no formal way to capture this information. Staff told us that if concerns were raised they were dealt with there and then.

Performance information

- Audits were a regular feature of the service. Monthly paediatric team meetings were attended by consultant paediatricians, the service lead and administration staff. At this monthly meeting auditing was a standard agenda item. Issues from audits and associated learning was fed back into this monthly meeting and disseminated among relevant staff.
- The most recent audit undertaken by the LAC team was based on the NICE health and wellbeing standards and demonstrated associated learning. For example, the attendance rate to health appointments had been low at 50%, but had increased to 90% as LAC nurses went to homes to do assessment rather than children coming into clinics.
- It had been established the biggest issue was regarding young people aged 16 years plus who were just coming into care and looking at ways in moving them into adult services. The trust had invested money into LAC health assessments by funding another doctor. Children were offered an out patients department appointment, if needed, within a month of the trust receiving a referral.
- Other audits had taken place in the trust. For example, an audit reviewing autism referral pathways against NICE guidelines that had ensured that late referrals did not occur.
- The administration staff at the Child Development Centre based at the Ross Road Health Clinic had carried out an audit of non-attendance at clinics. The findings from the audit had instigated telephone reminder calls two days before, follow up letters and letters for separate appointments sent individually to each family. Improvements had been identified in the increase in attendance in 2013 and 2014.

Competent staff

- The trust maintained an electronic overview of training. If staff did not book onto and update the system, it would send alerts to their manager.
- Staff had to attend mandatory training two days every year that included: infection control; moving and handling; medication; gastrostomy care; food hygiene; first aid; and safeguarding. Paediatric resuscitation training was provided annually. Level 3 safeguarding had to be completed by staff every three years. Staff were responsible for monitoring and booking their training. Staff told us that the mandatory training had
Are Community health services for children, young people and families effective?

previously been managed by an external company and during that period staff had found the system to book training confusing and difficult. This had resulted in many staff falling behind. Training had been brought back into the trust, which had resulted in an increase in attendance. Some content of mandatory training sessions did not always reflect the needs of staff who attended, although they accepted that it would not be possible to tailor the training to individual specialities.

• In addition to mandatory training staff received training appropriate to their roles. For example, management of actual and potential aggression for staff who might have to restrain patients to prevent them hurting themselves or others. Other staff had attended autism awareness and sensory processing. Staff were supported by portage workers (home-visiting educational service for pre-school children with additional support needs such as developmental, learning disability or physical disabilities) from the community to deal with the care needs of individual children.

• The respite centre held an annual team development day that included elements of refresher training. The safeguarding lead for the trust attended this day to ensure all staff were up to date. This annual development day was well attended with only one member of staff absent last year because of sickness. The day was planned well in advance to enable all staff to make arrangements to attend.

• E-learning modules had recently been made available for staff to complete. They included: Mental Capacity Act; safe use of insulin; and Deprivation of Liberty Safeguards. Community-based staff complained that they could not access this system without travelling to one of the office sites. Staff were able to use the computer in the respite centre during their working hours to complete the training. One member of staff we spoke with was positive about this aspect of training and the content.

• Notice boards with information for staff were visible at all of the locations we visited. Details of local training events were on the notice board in the staff room at the respite centre, which included palliative care for paediatrics. Staff confirmed they were supported and encouraged to attend training.

• A newly-appointed epilepsy specialist nurse attended national and regional training outside of the trust for their development. Mentoring support was being provided for this nurse by another specialist nurse in the trust.

• Trainee and newly-appointed health visitors were supported by an in-house academy that focused on learning completed at university. Staff told us this enabled them to bolster understanding and reinforce their learning. On completion of their course they undertook a six month preceptorship (a period of guidance and support for all newly qualified practitioners to make the transition from student so that they can develop their practice further). During the programme they received additional training in core areas such as safeguarding and were continually assessed. Satisfactory completion was required for progression to becoming fully qualified.

• Not all staff had effective supervision of their clinical practice. Formal one-to-one supervision meetings did not take place in all teams. Staff who did not have regular supervisions told us they felt supported and staff and managers had excellent working relationships. However, if staff wished to discuss confidential issues with their manager they had to make a direct approach, which could prevent some people raising issues for fear of being identified. Most staff had regular safeguarding supervision relevant to their role in line with national guidelines; we did speak with some staff who had not received this support.

Telemedicine (optional)

• Telemedicine was not observed to be in use.

Use of equipment and facilities

• Some areas of the Ross Road Child Development Centre were not child-friendly. The outside play area had no provision for shade in the summer. The area was bland and uninspiring, with a dark brown fence and plain brick walls and was tarmacked with a small grass bank. A sensory room in the centre had a broken bubble light and limited equipment.

• Staff raised concerns at the respite centre that not all of the doorways were wide enough to accommodate wheelchairs, which meant some children did not have easy access to all areas.

• Toys were replaced through fundraising and equipment obtained by applying to the NHS charitable fund or local
Community health services for children, young people and families effective?

Some staff had held fundraising events and others described buying books from car boot sales with their own funds. Staff told us there was a lack of investment from the trust.

Multi-disciplinary working and coordination of care pathways

- A single point of referral team (SPORT) meeting took place each week and handled approximately 30 referrals every week. Following an initial assessment, an allocation was made to an appropriate lead professional. For example: portage teams; early year's education; physical therapists; occupational therapist; and school nurses.
- The Ross Road Child Development Centre had systems in place to ensure patients were referred to appropriate professionals following consultations and clinic appointments. Administration staff ensured referrals contained detailed information in a dictated letter to consultants. A record was kept to show when these were completed.
- We observed and were informed about joint working between education, occupational therapists (OTs), physiotherapists and speech and language therapists (SALT) at the child development centre and in the child’s own home. Some delays were reported in accessing SALT and OT services, although parents were very complimentary about the staff and level of service once it was received.
- Staff at the respite centre worked closely with schools, school nurses, health visitors and speech and language therapists when needed. The epilepsy specialist nurse provided training for special schools in administering Midazolam hydrochloride (used in the treatment of convulsions). Support was provided with gastrostomies (artificial external opening into the stomach for nutritional support). Other support included dealing with challenging behaviour and use of nebulisers for the children who required them.
- During times when the respite centre did not have any children staying, for example during school hours, the care staff had development roles supporting health visitors and school nurses while they carried out health checks on children at home or school. It was not suggested that this assistance mitigated the workload caused by the high incidence of safeguarding.
- The post of epilepsy specialist nurse had recently been created and the trust had a nurse who was developing their skills in order to apply for the role. The nurse worked across all paediatric community services. Staff commented on the effectiveness of having access to the specialist.
- Staff throughout children’s community services were knowledgeable about other services in the trust and in the wider health community to which they could refer or signpost parents and children. We received feedback from parents about the assistance they had received from the respite centre.
- We observed the weekly health visitor planning and allocation meeting. We heard staff discuss how other agencies needed to be involved in certain cases; we heard exchanges of contact names and numbers to enable staff to liaise with the most appropriate partners.
- The paediatrics respiratory team delivered training in asthma management to GP practices and practice nurses. The looked after children service introduced a coding system for GPs so that they could clearly identify all looked after children.

Co-ordinated integrated care pathways

- Play team staff worked in the respite centre and provided a weekly plan for children to join in with group sessions together with individualised plans. Records showed the participation of children in activities and associated risk assessments. A play team weekly meeting attended by the unit manager showed a review of activities, future activities and checks that risk assessments and consent were in place for the planned outings in the coming week.
- There were robust transition pathways for children moving between services such as midwife to health visitor and health visitor to school nurse based on national guidance. Support services such as physiotherapy, occupational therapy and looked after children services followed the child through the transitions. Some parents we spoke with found the transition from health visitor to school nurse difficult. They felt that they received less support once the child reached school age. The school nurse manager confirmed such issues had been raised and that it was a natural progression whereby children with less complex needs required less support as they developed. However, this was compounded by the excessive safeguarding workloads carried by school nurses because the nurses had less time to devote to such areas.
Are Community health services for children, young people and families caring?

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

Summary
We observed staff in a variety of settings as they interacted with children and their parents or guardians. We saw in all cases that staff were caring, compassionate and friendly towards the children. The children were genuinely pleased to be in their presence.
Staff were non-judgemental and respectful to people when with them and in conversations to discuss cases with other health professionals and colleagues.
We viewed care records from different services and saw they were centred on, and reflected people’s individual needs and took account of cultural and emotional concerns.
Staff were innovative and put the welfare and care of children before their own needs.

Compassionate care
• We observed staff from different disciplines and in different environments. We accompanied staff on school and home visits and at clinic sessions. We also observed staff in the respite centre and the child development centre. All our observations of care and support found staff were kind and showed empathy and understanding to children and their parents.
• We saw how children of all ages responded positively to staff and how staff interacted with both children and parents or guardians. Families we spoke with described how they had been supported emotionally as well as with the health needs of their child.

Dignity and respect
• Children and parents were observed to be treated with respect by staff in the respite centre and when they worked in the child development centre.
• The respite centre did not have any listening devices for staff to monitor children overnight or call systems available for more able children. This meant that bedroom doors were left open so that staff could hear any activity and also to enable them to visit and observe the children without disturbing them. We did not see any documentation to show what involvement the children or parents had had in agreeing to this practice, which could compromise children’s dignity due to a lack of privacy.

Patient understanding and involvement
• We observed staff as they checked the understanding of parents during their visits to the child development centre and during home visits. Staff reiterated the proposed care plan and the next actions to take. Parents were encouraged to ask questions and take part in sharing information and understanding.
• We saw evidence of records being maintained between home, school and the respite centre. New books were being developed to communicate material that was not relevant to the school, but included information between home and respite centre. This ensured information was shared even where there was no personal contact. For example, using school transport rather than parents picking up the child.
• Parental consent had been sought and recorded for the use of photographs and going on outings. Parents were informed prior to any trip or outing.
• School nurse assessment sessions were communicated to parents by the school.
• Patient surveys based on the Department of Health ‘Friends and Family Test’ that asked whether people would recommend the service to their families were being rolled out across the trust. Staff were aware of the programme, but we had not seen any results at the time of our inspection.

Emotional support
• Parents told us they were able to contact professionals and services when necessary.
• Parents were unanimous in praising the staff they dealt with. Staff were described as “really friendly”, “brilliant”, and “so caring”. Staff we spoke with were always respectful of the families and children they supported during any conversations we had with them.
• Looked after children’s team members described how they had not completed an assessment in a school setting for over 18 months. They changed their work pattern to enable assessments to be done away from
This was to prevent young people having to be absent from school and not identified as ‘different’ by their peers or asked what might be embarrassing questions.

- One parent described the respite centre as “a lifeline” that enabled the family to have time for themselves without feeling guilty about the care of their child.

Promotion of self-care

- Clinics and groups were run through the child development centres to encourage children towards independent skills such as mobility and social skills. The clinics were staffed by nursery nurses, OTs and education staff.

- The respite centre had a three-bedded unit that provided support for older children with challenging behaviour to help them to learn and develop skills in a safe environment.

- School nurses promoted general health and wellbeing in addition to dealing with safeguarding issues. School nurses and their manager expressed concerns about their availability to engage with children about their general health and health risks caused by the amount of time they have to commit to safeguarding issues.
Are Community health services for children, young people and families responsive?

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

Summary
The geographical location of children and family services across the trust made access throughout Herefordshire satisfactory. Staff were also involved in activities to reach out to the local community. Parents or guardians told us in general they had little difficulty travelling to and accessing services when required.

We saw evidence of how staff responded to changes in people’s needs and to national targets to ensure services were relevant.

Many services were provided in people’s homes or children’s centres, which meant there was good access for people in their local community.

Service planning and delivery to meet the needs of different people
- The respite centre had originally catered for children and young people aged 5–18. Within the last year the manager and staff had reviewed the referral criteria and now provide care and support to babies and children under five. This not only extended the service to more patients but also made better use of the staff and facilities by using the centre during the day in term time as well as during holiday periods.

Access to care as close to home as possible
- Outreach clinics took place close to patient’s homes. The single point of referral allocated the appropriate service to the patient and then the most appropriate venue.
- Consultants were allocated to special schools where they held clinics together with the school nurse. This reduced the need for parents to take their children for additional clinic visits. Multidisciplinary team reviews took place every term in special schools.

Access to the right care at the right time
- Parents of children who received occupational therapy services commented on the excellent service they received but complained about excessive waiting times when they were initially referred. Current targets are no longer than 18 weeks and generally 13 weeks from referral to assessment. Historical evidence showed waiting in one case was 18 months.
- Access to school nurses was limited, staff told us that most of their time was spent completing safeguarding issues. This meant they had less time to spend delivering advice and guidance on health and welfare issues that was their normal practice. Drop-in sessions took place, but staff felt they were not supported to deliver a comprehensive service.

Flexible community services
- Four community workers were managed from the respite centre and provided care to children with complex needs to enable their parents a period of respite. This complemented the service provided in the respite centre where children could spend time when necessary.
- Staff at the looked after children unit ensured that reviews of young people took place by providing an out of school hours service that often extended their working hours without reward
- A school nurse we spoke with had changed her day off in order to support the department.
- Where assessments could not be completed during normal clinic hours we saw how staff had made home visits to accommodate families.

Meeting the needs of individuals
- We observed joint working between two different professionals to address the needs of a patient. The child’s parents were pleased with this approach because it reduced the number of visits.
- The trust provided us with information about working towards being UNICEF baby friendly (the UK Baby Friendly Initiative is based on a global accreditation programme of UNICEF and the World Health Organization to support breastfeeding and parent infant relationships by working with public services to improve standards of care). They had introduced midwife and health visitor leads in line with the UNICEF criteria. Community nursery nurses worked across acute and community services to provide seamless support for
Are Community health services for children, young people and families responsive?

newly breastfeeding mothers. The trust had also implemented a system where midwives work between acute and community services to increase understanding and support.
• Breastfeeding support groups had been introduced, although the loss of a meeting facility in one area had reduced attendance.
• The children's physiotherapy service provided support to parents and carers of pre-school children through weekly group sessions. There were three groups available to children designed to help them develop the skills of sitting through to walking and running. Individualised hydrotherapy sessions were also available to all age groups.
• The school nurse service provided drop in services in secondary schools to advise on children’s health. This allowed children to access sexual health services, stop smoking support, signposting to appropriate services and emotional support at school. Immunisation programmes were also carried out at secondary schools. Staff told us they would like to be able to do more of this type of work had they the opportunity.

Moving between services
• There were robust transition pathways for children moving between services such as midwife to health visitor, and health visitor to school nurse based on national guidance. Support services such as physiotherapy, occupational therapy and looked after children services followed the child through the transitions. Some parents we spoke with found the transition from health visitor to school nurse difficult. They felt that they received less support once the child reached school age. The school nurse manager confirmed that issues had been raised and that it was a natural progression whereby children with less complex needs required less support as they developed. However, this was compounded by the excessive safeguarding workloads carried by school nurses.
• Staff involved in the transition between midwife and health visitor services occasionally encountered minor issues. Guidance to health visitors required them to complete their first visit to a new born baby at 10 to 11 days after birth and after the midwife has discharged the baby; however some midwifery discharges did not take place until 14 days after birth. This meant that there were occasions where the health visitors could not meet their targets. This had an impact on performance data for the service rather than care of the child.

Complaints handling (for this service) and learning from feedback
• The trust had a complaints process in place. Staff understood the system and knew how to help people who wanted to complain. The parent of a child told us they were not clear of the formal process, but had received assistance about an issue they had with a health professional. They said they were satisfied with the outcome of the complaint, but commented on the time taken to resolve the issue and lack of feedback.
• We saw evidence of how issues and complaints were fed back to teams and discussed openly to provide learning and prevent further incidents.
• The trust had a patient advice and liaison service that assisted people with complaints and queries. They referred to themselves as the patient experience team.
Are Community health services for children, young people and families 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
While risks to the service were acknowledged and entered into the trust risk register, staff who raised the issues felt they were not addressed or responded to. A business case in support of additional school nursing staff had been on the trust risk register for over two years. Staff had to complete business case reports for funding at a level which did not justify the effort and expense of completing them.

Staff in community services referred to themselves as the poor relations. They believed that acute services received more funding and were thought of as more important by board members.

The executive team was not visible in the community and what little had been seen of them did not involve interaction with staff about their work or issues.

Local management was mostly good. Staff knew who their managers were and felt supported and valued. Not all staff received formal one-to-one supervision. Although they believed they were well supervised and supported by their managers.

Vision and strategy for this service
- Children’s community services were placed with the integrated family health services. The services were included in the board’s four-year quality and safety strategy and the trusts overall strategy. This included its values and vision statements:
  - Vision: To improve the health and wellbeing of the people we serve in Herefordshire and the surrounding areas.
  - Mission: To provide a quality of care we would want for ourselves, our family and our friends.
- The recent appointment of a paediatrician to the trust board had raised expectations with staff in children’s services that they may become more visible and better represented.
- The service was working towards being UNICEF baby friendly. The baby friendly accreditation is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care.

Guidance, risk management and quality measurement
- Risk registers were in place for individual issues including the respite unit, safeguarding levels and looked after children. Staff demonstrated awareness of the risk assessments and attended divisional risk meetings.
- The level of safeguarding cases carried by school nurses was on the trust risk register, and had been discussed in January and March 2014 at the safeguarding children’s strategy board meetings. The manager had submitted a business case for additional staffing in January 2014, but was waiting for a response.
- The looked after children team had one full time member of staff and allocated 1.5 days’ paediatric consultant cover. A bank (staff who work overtime in the trust) nurse also worked two days a week. We found evidence that all staff worked more hours than they were rewarded for. The paediatrician estimated that they spent double the allocated time in the department because of the high workload and audits. A business case had been submitted over 12 months ago to ask for additional hours for the bank nurse and administrative support. The business case also highlighted that the bank nurse had been in post for three years and should be made permanent. No executive response had been received.

Leadership of this service
- A buddy system allocated board members a service to champion.
- Leadership in children’s community services was good. Regular meetings were held between department heads where issues raised by staff and board matters were discussed. We saw examples of minutes from the meetings. Many staff were very complimentary about their supervisors and middle management. However, they felt disconnected from the trust and believed that community services took second place to acute services.
- Staff we spoke with described supervision systems. Health visitors had restorative supervision (a system of
Are Community health services for children, young people and families well-led?

one-to-one supervision to support healthcare professionals by using discussion, reflection and challenge, which they said were excellent. For example, a member of staff who had been on long-term sick leave was happily back at work after restorative supervision, and had asked a colleague to tell us how effective it had been. The trust has identified this as good practice and extending its use to other departments including community nursery nurses and school nurses.

- Student health visitors had benefited from the academy, which complemented and supported their university studies. We spoke to two newly-appointed health visitors who described how the academy had helped them develop their skills and understanding. Their support continued through a preceptor programme (a period of guidance and support for all newly qualified practitioners to make the transition from student so that they can develop their practice further).

- Some aspects of local leadership and governance functioned on the goodwill and expertise of staff. Services at the child development centre (CDC) based at the Ross Road Health Clinic in Hereford did not receive direct supervision at management level. It was managed remotely from the Hereford Kite Centre (a project to support children and their families whose lives are affected by disability and/or chronic illness) A member of the nursing team at Ross Road led weekly meetings with colleagues and acted as the go-between with the manager. The team effectively had to manage themselves.

- Respite centre staff made positive comments about the leadership of the service since the appointment of a new manager one year ago. They said the manager was supportive, approachable and willing to listen to suggestions to improve the service.

- The board met regularly with senior nurses and managers throughout the trust. We were told the meetings were mainly focused on adult acute services. Staff in community paediatric services said that although told they would have similar meetings they had not happened yet.

- Staff working in the community were unaware that board members had visited their services. Board members details were displayed on notice boards in community settings, but not all staff knew who they were. We were told that following the appointment of a paediatrician to the board, staff believed children’s services would be better represented in the future.

**Culture within this service**

- We found a very open and supportive culture in children’s community services. Staff at all levels described being able to approach managers or go direct to the children’s services lead.

- The children’s services lead met managers, directors, finance and human resources on weekly basis. This fed into a monthly governance meeting for the family services directorate where team issues and complaints and incidents were discussed.

- Staff knew the trust values and vision statements and believed they played an active part in delivering the goals.

- Restorative supervision (a system of one-to-one supervision to support healthcare professionals by using discussion, reflection and challenge) had become a part of the health visitors’ management role in line with national guidelines. Its success with health visitor teams has meant that it will now be extended to community nursery nurses.

**Public and staff engagement**

- We found inconsistency in how services obtained parent or guardian feedback. For example, questionnaires were generic and not always displayed in prominent locations. Some services only completed exit surveys, and regular verbal feedback was not recorded and could not be assessed.

- Some departments promoted links with local organisations such as breastfeeding clinics, parents and grandparents groups.

- At the time of our inspection we were unable to see any results from the ‘Friends and Family Test’ children’s services patient surveys. Friends and family tests were not compulsory for community services at the time of the inspection. However staff told us that they believed some children’s community services in the trust had started to collect information in that format.

- We saw a full exchange of information, issues and ideas between individual children’s services teams and management when we reviewed their regular meeting records. Minutes of meetings demonstrated how information had been disseminated.

- When we observed health visitors during their weekly allocation meeting we saw how staff were able to discuss cases openly and offered support and advice to
each other. The meeting was held during the lunch break, which we were told was normal practice. This meant that staff did not have the opportunity to escape the work environment and relax while they ate.

**Innovation, improvement and sustainability**

- We saw evidence of good interdepartmental working despite a history of services working independently of each other. Staff described how community services had been aligned geographically with GP services and acute and community staff rotated to get a better understanding of each other’s roles. Joint meetings and visits also now took place, and staff said the new working practices were really helpful and provided a more streamlined care pathway. Families were complementary of all the departments they had contact with.
- Innovation by community children’s services staff was encouraged, but without financial support. For example, although staff were able to change their work pattern such as when school nurses introduced drop-in sessions, they had to do this without incurring additional costs.
- Staff and departments had autonomy to work flexibly and tailor services to meet individual needs. For example, school nurse services introduced drop-in services, and looked after children staff completed assessments before and after school hours.
- Staff used innovative approaches to target groups who are more difficult to communicate with. For example, teenage looked after children were encouraged to get involved in developing a website designed to promote the health and wellbeing of children in care.
- Requests for additional staff or resources had to be made as a business case, but responses were slow even when the request related to an issue on the trust’s risk register.
- Children’s play areas were poorly resourced and uninspiring.