Northamptonshire Healthcare NHS Foundation Trust

RP1

Community health services for children, young people and families

Quality Report

CQC Registered Location
Trust Headquarters RP1X1
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This report describes our judgement of the quality of care provided within this core service by Northamptonshire Healthcare 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 Northamptonshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Northamptonshire Healthcare NHS Foundation Trust

Summary of findings

Ratings

Overall rating for Community health services for children, young people and families	Requires Improvement
Are Community health services for children, young people and families safe?	Requires Improvement
Are Community health services for children, young people and families effective?	Requires Improvement
Are Community health services for children, young people and families caring?	Good
Are Community health services for children, young people and families responsive?	Requires Improvement
Are Community health services for children, young people and families well-led?	Requires Improvement

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Requires Improvement

Overall this core service was rated as Requires Improvement. We found that community health services for children, young people and families in caring was good, but in safe, responsive, effective and well-led requires improvement.

We rated the service as required improvement overall because:

- There were not always reliable systems, processes and practices in place to keep people safe and safeguarded from abuse.
- Gaps were identified in the health visitor caseload, regarding the frequency of contact by health visitors for children with a child protection plan.
- Staffing caseloads did not always have a consistent approach to planning and team capacity.
- Staff said all professionals, including trust staff, needed a better understanding and awareness of the referrals process and the thresholds criteria being used to trigger a safeguarding response for referrals to the Multi-Agency safeguarding Hub (MASH).
- There was no integrated electronic records system to share information about vulnerable children who accessed the Integrated Sexual Health Service, or identify if young people using the service had a child protection plan with other children's teams, however the trust had a number of systems in place to mitigate this risk.
- There was variation in record keeping across the service with some records not being updated regularly or containing appropriate information in accordance with trust procedures.
- Not all of the centres we visited had appropriate hand washing facilities; we saw staff using hand-sanitising gel as they could not wash their hands. The trust told us that not all centres or buildings were owned by the trust, for example village halls and schools and that the use of hand- sanitising gel was an appropriate action and was in line with the trust's infection control policy.
- There was not always effective communication, appropriate information sharing and decision-making about children and young people's care across all the services involved both internal and external to the organisation.
- Multiagency working within the teams that worked within the service had a focus on meeting the child or young person's needs. Working with social care partners was identified as being difficult, contributed to by the high number of agency social workers which impacted on continuity.
- Parents we spoke with told us that they were not always able to have continuity from the same health visitor at each key contact of the Healthy Child Programme (HCP) 0 to 5 years.
- Antenatal contacts were not being undertaken in all areas by health visitors which impacted on the equity of access.
- There was variation in appropriate levels of supervision and appraisal of all staff.
- The provider engaged with commissioners of services, local authorities, other providers, but not always with people who use services and those close to them to provide coordinated and integrated pathways of care that meet people's needs and to provide comprehensive universal services and health and wellbeing programmes.
- Parents told us there had been no consultation with parents about the rationalisation and the changing model of child health clinics. The trust told us that formal consultation was not required because there was no fundamental change to the model of child health clinics merely an enhanced offering of extending hours based on informal engagement with the families. One clinic was affected by long term sickness and appropriate action was taken to ensure contact with the parents were in place.
- Most parents had to travel outside of the county for the treatment of tongue tie. There was a referral pathway for staff to refer parents directly to Milton Keynes or Bedford for treatment, although there was the facility to provide the service at Kettering Hospital.

Summary of findings

- Therapy services at one location we visited had no clear database of scheduled appointments, non-attendance could be missed.
- Within school nursing staff shortages in some teams had resulted in prioritising service provision for child protection, Children in Need, immunisations and screening. One school nursing team had to decrease pupil 'drop in' sessions in schools.
- Although some staff knew about the trust vision, staff did not consistently demonstrate knowledge of the goals and values of the service.
- Systems were not in place to audit the effectiveness and quality of the referral process, caseloads, supervision and risk assessment across all teams.
- Governance arrangements were not always consistent in oversight of quality and performance across all teams.
- Management changes had impacted on leadership and the way staff felt connected, respected valued and safe. Not all staff felt senior managers were visible.
- There was a culture of staff working long hours to cover for staff absence in most teams.

However,

- There was an action plan in place to ensure that staff compliance rates for safeguarding training at Level 2 and Level 3 were at 80% by February 2015.
- Electronic records completed by school nurses, had care plans with specific outcomes, referrals and evidence of multiagency working.
- Systems were in place to report incidents and to share learning from incidents.
- The service had, were required, appropriate systems in-place for the storage and administration of medicines.
- Staffing establishments (levels and skill mix) were set and reviewed to keep people safe and meet their needs.
- There was evidence of good practice seen in the Integrated Sexual Health Service (HIV, GUM and family planning); specialist school nurses had developed training packages to deliver training to school staff. There were only three key performance indicators in school health.
- The Integrated Sexual Health Team had incorporated the Fraser Competency within the Child Sex Exploitation (CSE) best practice protocol.
- The specialist school nursing team were responsive to the needs of children and used safe systems for training, care planning, documentation, with good multi-agency working.
- A school nurse competency framework had been developed within the last year; the purpose was to help develop and support new staff in developing the service.
- Parents had been extremely positive about the support they had received from the specialist infant feeding team. Funding for the team had been secured until the end of March 2015.
- A range of comprehensive Standard Operating Procedures (SOP) had been developed for the health visiting service.
- Parents who used the service felt supported and that their children were well-cared for by staff, which were kind and had a caring compassionate attitude.
- Children and their families were treated with respect and dignity by staff which was observed during the inspection.
- Parents were positive in the feedback they gave about staff.
- An effective translation service was provided by the trust.
- Health visitors offered home visits to parents to meet specific needs, if they could not be met during a child health clinic contact.
- A new initiative that had been introduced for parents and babies was a 'Healthy Day' session at a children's centre. Mothers could attend on a drop in basis without an appointment.
- The ISHS was accessible and flexible.
- The service had an effective system in place to seek feedback from parents and young people and that complaints were handling in accordance with trust procedures.

Summary of findings

- Staff we spoke with were supportive of one another, there was a willingness of people working together to provide a good service to children and young people.
- Staff felt able to raise problems and concerns to senior managers and generally were positive about their local leadership.

Summary of findings

Background to the service

Background to the service

Northamptonshire Healthcare NHS Foundation Trust (NHFT) integrated both physical and mental health community services in July 2011.

Northamptonshire Healthcare NHS Foundation Trust delivers community based services to children and young people and their families providing health visiting, breast feeding support, school nursing, and children's specialist service and looked after children and safeguarding children services. The services are aimed at promoting and supporting positive health. Services are provided in a wide range of community settings including home visits, in schools and at health and children's centres. Health visiting and school nursing teams work to deliver the Healthy Child Programme (HCP) across Northamptonshire from birth to 19 years. The HCP is delivered through a team comprised of staff with mixed skills which follow guidance outlined by the Department of Health for children aged 0 to 19 years old. Universal children's services also provided the family nurse partnership (FNP) programme for those aged 18 years and under who were expecting their first baby.

All children in Northamptonshire would be allocated a health visitor. The health visiting service's aim is to help give children the best start in life by offering a review of their growth, emotional and physical development at regular intervals. NHFT offers breastfeeding support and information for mothers experiencing breastfeeding difficulties. This is offered either in the home, a clinic or drop-in setting. The team is made of senior health visitors and health professionals led by a lactation consultant. Children and young people in Northamptonshire have an allocated school nurse team led by a specialist school nurse. The school nurses provide care and assessments for children enrolled at school. School nurses work in partnership with schools, families, care givers and other health and social care services to advise, educate and provide health interventions. As part of children's and young people's services there was an integrated sexual health service that provided sexual health screening, treatment and contraceptive needs.

Our inspection team

The team who inspected this service were three CQC inspectors, three specialist advisors with specialist knowledge of children's and young people's community services.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive community health 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?

Summary of findings

Before visiting Northamptonshire Healthcare NHS Foundation Trust, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We carried out an announced visit on 3 and 6 February 2015. We visited health centres, schools and clinics and went on home visits with health visitors. During the visit we held focus groups with a range of staff who worked within the service, including doctors, school nurses, health visitors and their teams, community nurses and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records.

We visited ten health visiting teams and five school nursing teams, attended clinics and home visits, visited the Multi Agency Safeguarding Hub (MASH), children's safeguarding team, Looked After Children's team and the Integrated Sexual Heath Team. We spoke with 82 staff, 23 parents and children and looked at the care records for 20 children.

What people who use the provider say

People who used the children, young people and families' service were positive about their experiences. Mothers told us that they received good support from staff that were helpful and approachable. They also commented that they did not always see health visitors in clinics.

Parents told us that accessing the service was a chance to meet other mothers and share experiences, there was a nice informal atmosphere, and friendships are formed. Mothers who had used the breast feeding service were extremely positive about the report they had received and the quick response.

Parents told us 'It's about building trust and confidence', They told us that the service 'It's local', and 'Nice for mums to share experience'.

Good practice

The Integrated Sexual Health Service was innovative, open and transparent. There was good provision for service users with learning disabilities inclusive service. The team utilised text messaging for service users to access their test results if they were negative. If results were positive staff would telephone service users directly. ISHS assessed all service users, all those under 18 years assessed for competence to consent (only required for those less than 16 years); however in addition all service users under 16 years were seen by two practitioners to share decision making regarding capacity to consent.

The Care assessment treatment for children at home team (CATCH) worked closely with GP's to promote early intervention aiming to prevent hospital attendance and admission for children and young people. The team offered home visits and telephone advice to parents.

Therapists from the children's therapy team used therapy plans that were recorded on electronic records and the documentation method employed was written as a SOAP format which stood for Subjective, Objective, Assessment, and Plan. This was good practice which ensured a structured format for documenting the children's progress.

The specialist school nursing team were responsive to the needs of children and used safe systems for training, care planning, documentation, with good multi agency working. All training was evidenced based and service delivery reflected government guidelines for children with complex needs.

We saw a CAF assessment that had been completed to a high standard for a child with complex needs as concerns had been identified by the child's parents. Working with the parents the health visitor had completed a CAF and arranged an initial team around the child (TAC) meeting. The completed CAF was detailed, the information signed by parents, and there was evidence of multiagency involvement with clear planning, including timescales and future appointments. This meant that the needs of the child had been met and planned interventions and

Summary of findings

support was in place to meet them. We attended the TAC meeting and observed how the CAF was used to highlight the voice of the child, with collaborative multiagency and parent's involvement in meeting the needs of the child. There was clear forward planning, with ownership of actions and timeframes for them to be completed by.

The Looked After Children's and Child and Adolescent Mental Health teams facilitated a six week programme for parents and carers. The purpose of the programme was to help parents/carers to understand complex behaviour issues that relate to emotional and physical attachment. The programme helped parents and carers to be able to support children to help them feel safe and to contain risk and behavioural issues through interventions and coping strategies. Parents were positive about being able to use strategies that they had learnt on the programme to support their parenting, allowing their children to feel safe and supported.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure that safeguarding children policies and procedures are fully understood and implemented by staff to ensure that all children and young people were protected from the risk of abuse.
- The trust must ensure that effective audit and governance process are in place to monitor the delivery of health visitor contacts to the agreed frequency of the service.

Action the provider SHOULD take to improve

- Review the quality assurance process for the RMC to ensure effective oversight for the safety of the referral handling process is monitored
- The trust should consider a review of the tongue-tie service as parents with new babies were travelling outside of the county to access an appropriate service.
- The trust should ensure there is a robust audit and governance system and that learning from the audit process is effectively shared across all teams

Northamptonshire Healthcare NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

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

Requires Improvement

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

By safe, we mean that people are protected from abuse

Summary

We rated this domain as required improvement because:

- There were not always reliable systems, processes and practices in place to keep people safe and safeguarded from abuse.
- Gaps were identified in the health visitor caseload, regarding the frequency of contact by health visitors for children with a child protection plan.
- Staffing caseloads did not always have a consistent approach to planning and team capacity.
- Staff said all professionals, including trust staff, needed a better understanding and awareness of the referrals process and the thresholds criteria being used to trigger a safeguarding response for referrals to the Multi-Agency safeguarding Hub (MASH).
- There was no integrated electronic records system to share information about vulnerable children who accessed the Integrated Sexual Health Service, or identify if young people using the service had a child protection plan with other children's teams, however the trust had a number of systems in place to mitigate this risk.

- There was variation in record keeping across the service with some records not being updated regularly or containing appropriate information in accordance with trust procedures.
- Not all of the centres we visited had appropriate hand washing facilities; we saw staff using hand-sanitising gel as they could not wash their hands. The trust told us that not all centres or buildings were owned by the trust, for example village halls and schools and that the use of hand- sanitising gel was an appropriate action and was in line with the trust's infection control policy.

However,

- There was an action plan in place to ensure that staff compliance rates for safeguarding training at Level 2 and Level 3 were at 80% by February 2015.
- Electronic records completed by school nurses, had care plans with specific outcomes, referrals and evidence of multiagency working.
- Systems were in place to report incidents and to share learning from incidents.
- The service had, were required, appropriate systems in-place for the storage and administration of medicines.
- Staffing establishments (levels and skill mix) were set and reviewed to keep people safe and meet their needs.

Detailed findings

Incident reporting, learning and improvement

- There were 75 incidents reported from services relevant to children, young people and families between 1 December 2013 and 30 November 2014.
- We reviewed one Serious Incident that had occurred in 2014. The findings from the incident concluded that the health visiting service had responded appropriately with the information that was available to them. Lessons learnt were also identified which included improving working between midwifery and health visiting services through pathways and formal communication systems.
- Other areas of learning included how information was recorded on electronic records, with templates changed to gather more information about family members.
- A Serious Case Review that was still in progress made initial recommendations which included additional risk assessments being added to the electronic records template for each health visitor contact. External training had been commissioned.
- Health visitors that we spoke with told us that issues remained with the transition of children from midwifery to health visiting services, which could be from changes about birth notifications not yet being embedded into clinical practice. There had been a re-launch of a working group to introduce a new pathway for transition from midwifery to health visiting services.
- Feedback from staff from both health visitors and school health showed that there appeared to be a culture were staff would choose whether or not to report an incident based on capacity at that time; but never at the expense of parents or children.
- School health staff shared an example of raising an incident report using the trust's electronic incident reporting procedure for ordering a specialist piece of equipment that had not been available. As a result of raising this incident a response was actioned within 24 hours, and this ensured that the child needing this device had their needs met in a timely way.
- One operations manager told us that every incident record was reviewed, and feedback and lessons learnt were given at the monthly team meeting.

Safeguarding

- We reviewed 20 records of children with a child protection plan from the health visitor caseload, and the frequency of contact with the child and family by the health visitor. We found that some children had not had the frequency of contact with the health visitor as required by the child protection plan. We escalated this concern and an audit of the records of 312 children was undertaken by service managers and health visitors from the children's services on the 5 February 2015.
- The outcome of the records audit identified two children with a child protection plan who were not compliant where a timeframe for health visitor contact was specified. Learning from the audit was identified and an action plan put in place with time scales for completion of actions and named leads to oversee the process.
- The aim of the Multi-agency Safeguarding Hub (MASH) was to provide an assessment and information sharing to improve the outcomes for children and young people. School health and health visiting reported variable experiences with MASH.
- The MASH team said that there needed to be better clarity from all health and social care professionals, including trust staff, regarding referrals to ensure that

they were relevant to people's needs. Staff said due to variable quality of information on the referrals, some referrals were not accepted by the MASH. Staff said all professionals, including trust staff, needed a better understanding and awareness of the referrals process and the thresholds criteria being used to trigger a safeguarding response.

- Within the Integrated Sexual Health Service the Child Sexual Exploitation (CSE) best practice protocol was used, a comprehensive assessment tool used for all young people under 18 years to identify and analyse risks around CSE.
- We were told of a child who had been referred to the MASH on 8th September 2014 but had not been followed up until the 15th October 2014. The child had not been registered on the electronic records system and had no liaison with either health visitors or school nurses. There was no process in place if a child's details were not on the records system.
- Some staff expressed frustration about the response from MASH when reporting a safeguarding concern, and they were unclear about how additional incidents were logged or handled.
- We were told that health visitors always prioritise attendance at case conferences, and that school health staff attended initial case conferences and would not attend reviews routinely unless there was an identified health need. There was no process in place apart from safeguarding supervision to audit attendance at the Initial Core Group meeting held 10 days after the initial case conference.
- Health visitors and school nurses told us they would always submit a written report for case conferences. Minutes from case conferences could be late arriving, so health visitors told us they take their own notes to document actions. We were told of one incident of a health visitor not being invited to an initial case conference, this was due to an administration mix-up where two teams were based at the same location.
- School health staff told us they could find out by chance that a child was subject to a child protection plan (CPP) and that communication with schools could be challenging; health visiting shared similar experiences about children in need (CIN).
- Working with other agencies partners also proved challenging; we were told there was poor communication with the local authority and that there were concerns regarding effective sharing of information.
- Continuity of working with the same social workers was difficult due to use of agency social workers, as was time pressures and not working to the same agenda. This was not recorded on the Children's and Ambulatory risk register, how this was managed locally was unclear.
- There was an action plan in place for the promotion of both Level 2 and Level 3 safeguarding adults and children's training. The outcome of the plan was to ensure that compliance levels exceeded 80% of staff being up to date with the required training by February 2015.
- The service was supported by a safeguarding children's team which provided an effective and timely response to any concerns raised by staff, as well as providing regular safeguarding supervisions sessions to staff. Workload in this team had increased and the service had plans in place to increase the size of the team, to reflect the role it had in providing staff for the MASH.

Medicines management

- All staff were aware of the trust's policy for safer handling of medicines and appropriate training was provided. The service had, were required, appropriate systems in-place for the storage and administration of medicines.
- Within the Integrated Sexual Health Service there was a dedicated pharmacist for the service, which ensured that people using the service had access to specialised drugs in a timely manner. Contraceptive medication was dispensed in the service, which enabled people access to meet their health needs.
- The Specialist children's community nursing team's medication was kept in children's/families homes, no drugs were kept at bases. For children requiring intravenous (IV) medication, including booked intravenous or post discharge from hospital; there was a two person checking system, whereby all medicines were checked by two staff in accordance with trust procedures.
- Fridge temperature monitoring in two school nurse team's bases had not been completed everyday as per

policy requirement, to monitor correct temperature ranges for the storage of vaccinations. This meant there was a risk that medicines were not being stored at the right temperature.

Safety of equipment

- Health visitors had their own individual weighing scales that were calibrated and checked as per trust policy.

Records and management

- Records were maintained on the trust electronic record system, and staff were able to access the system and update records. Prior to an attending a home visit we reviewed the child's record, we identified with the staff member information that was not consistent. We asked for clarification and the process to follow for erroneous details. The member of staff did not immediately initiate following the process to correct the information.
- We reviewed three personal child health records (PCHR) the national standard health and development record given to parents and carers at a child's birth. The PCHR's were variable to the standard that they had been completed; all had contacts with professionals recorded for each time they had been seen. The health visitor contact details and clinic information had not been completed consistently.
- We spoke with therapists from the children's therapy team; therapy plans were recorded on electronic records and the documentation method employed was written as a SOAP format which stood for Subjective, Objective, Assessment, and Plan. This was good practice which ensured a structured format for documenting the children's progress.
- The community children's nursing teams within schools were still providing intervention plans and trying to implement Education Health Care Plans and training and competency agenda. EHCPs refocused school nursing interventions onto vulnerable children, joint care plans and seamless working.
- The health visitors used a holistic family needs assessment at all contacts with children, young people and their families. An element of the assessment was the 'voice of the child'; HV used this observation at the new birth visit to assess 'how the baby appears. A task and finish group were reviewing new guidance on how to capture new observational evidence for 'voice of the child'.
- The Integrated Sexual Health Service used a different closed electronic recording system from school nurses who used different electronic records. The service did not have access to the system, and were unable to access GP records and also were not able to identify if a child or young person had a child protection plan in place or was a child in need or a looked after child.
- There was no timeline as to when there would be access to the system for the Integrated Sexual Health Service.
- The trust told us that to mitigate this risk and to integrate care a number of strategies were employed including where all children and young people open to the Reducing Incidence of Sexual Exploitation (RISE) forum were notified to ISHS and this database was updated on a monthly basis, that all children on a child protection plan were flagged on the bespoke ISHS system and all Looked After Children were notified monthly to the ISHS service and the clinical system was updated accordingly.
- School nurses were not completing their caseload management effectively, closing episodes of care or recording changes in the level of interventions. Data cleansing and management was completed by the electronic records lead.
- We looked at three children's records on the electronic records system and found that they were reviewed and completed by school nurses; all of the records had care plans demonstrating outcomes, appropriate referrals appointments and communication with other agencies.
- We reviewed ten Looked after Children's electronic records, all of the records had consent documented; the review assessments were completed and recorded on British for Adoption Agencies and Fostering (BAAF) forms with comprehensive information about the children.

Cleanliness, infection control and hygiene

- The clinics and children centres that we visited were visibly clean apart from one clinic; there were differences in the venues where child health clinics were held. The quality of the environments varied, dependent on the age of the building.
- In one clinic the floor covering did not look clean; staff used a knitted blanket on the floor for children and parents to sit on and had toys for the children to play with. The blanket was not waterproof and could pose an infection risk.

- We completed home visits with health visitors and observed child health clinics. Not all of the centres we visited had hand washing facilities; we saw staff using hand-sanitising gel as they could not wash their hands. The trust told us that not all centres or buildings were owned by the trust, for example village halls and schools and that the use of hand- sanitising gel was an appropriate action and was in line with the trust's infection control policy.
- Equipment was cleaned appropriately, after each child had been weighed.
- We reviewed two cleanliness and infection control audits that had been completed in November 2014; one was a health visiting team the other for a school nursing team both at the same locality. One service had been rated as "requires improvement" and the other as "inadequate". Action plans had been put into place, regarding staff ensuring they were adhering to the trust policy of being bare below the elbows in clinical areas, and completion dates to review compliance and re-audit the teams.
- We were told that infection control training specific to the needs of the health visitor team was arranged by the operations manager for one location. As a result of learning from the training, health visitors carried infection control hand cleaning kits.

Mandatory training

- We reviewed 20 mandatory training records of health visitors and found that 14 of the records had a compliance rate of 90%. Learning and development records were often not up to date in the management reports on the trust's computer; this had been identified as an issue in management meetings.
- We were told that at one health visitor base, it was felt that the mandatory cardio-pulmonary resuscitation (CPR) was not sufficient for paediatric CPR. Local training was then arranged for the health visiting team for CPR for babies and children.

Assessing and responding to patient risk

- In the standards of operational practice the antenatal contact should occur from 28 to 32 weeks. Staff we spoke with reported not being able to achieve this contact in all cases. This was reflected in the services that we visited, with some not being able to meet this outcome.
- At child health clinics there was not always a health visitor present, and community nursery nurses provided the service, and we asked staff how concerns or risks would be escalated. Staff told us they would either advise the parents or pass onto the health visitor to review. There was a risk that staff could be working at a level beyond there competency.
- The Integrated Sexual Health Service used a proforma for all young people under 18 years of age, which included questions related to lifestyle choices such as drugs, and alcohol and also about self-esteem issues.

Staffing levels and caseload

- There were a 160 health visitors in post, the equivalent of 130 WTE. The final number being planned for was 133 WTE by the end of March 2015. We were told that there had been an increase in the numbers of children at risk including those on a child protection plan, and that the number of safeguarding referrals had increased but that the WTE numbers for health visitors had been decided four years ago and did not reflect this increase in vulnerability in the local community. There were five operational managers for the HV and SN teams.
- We reviewed six health visitor teams caseload sizes by location, the range of the caseload sizes ranged from 908 to 1915. We then looked at the health visitor to caseload ratio, the results showed a range of 1: 346 to 1: 437 across the six locations.
- The care assessment treatment for children at home team (CATCH) had 4.8 WTE staff. The school nurses had a current establishment of 16 WTE, with plans and funding to recruit band 5 nurses to developmental posts. The NHFT call to action for school nurses programme over a four year cycle would aim to achieve 46 WTE school nurses in post.
- The skill mix for the Multi Agency Safety Hub (MASH) consisted of a health visitor, school nurse, mental
- Health practitioners and a midwife who worked from 0.2 to 0.6 whole time equivalent (WTE).
- The allocation of work was different across the trust and this was due to the number of different bases. Managers told us that there would be a weekly allocation meeting using electronic records systems and diaries. However, health visitors told us, their allocation of work was not consistent across the trust and that teams had different allocation systems.

- It was acknowledged that 'Call to Action' had left senior health visitors exhausted, the service was working towards developing a cluster model to increase support for staff.
- The deputy director told us that there had been recent organisational changes with newly appointed operational managers with specialist clinical backgrounds as the trust's chosen model to oversee the transition of managing school nurses and health visitors together for the 0-19 year's pathway.
- The Integrated Sexual Health Service team had three consultants, 22 nurses and ten healthcare assistants; there was a consultant psychologist available 12 hours per week.

Managing anticipated risks

- There were eight Standards of Operational Practice (SOP) for the health visiting service with addition of local pathways of care. The SOPs were developed and cascaded to all staff via email and development days that took place quarterly.
- Any health visitor cases that were deemed to be level 3 or 4 were reviewed monthly, and any child under the age of two years subject to a Child Protection Plan, would have joint visits between a social worker and health visitor once per month. This practice was implemented as a recommendation following two serious case reviews that took place in 2014.
- All staff had been trained on the Northamptonshire Thresholds Pathways. This approach standardised how all agencies worked across the county to assess risk and level of need for children and provided an evidenced based tool to base judgements on. Health visitors were trained on this in level 3 safeguarding training and common assessment framework (CAF) training as part of their mandatory training.

Requires Improvement

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

We rated this domain as required improvement because:

- There was not always effective communication, appropriate information sharing and decision-making about children and young people's care across all the services involved both internal and external to the organisation.
- Multiagency working within the teams that worked within the service had a focus on meeting the child or young person's needs. Working with social care partners was identified as being difficult, contributed to by the high number of agency social workers which impacted on continuity.
- Parents we spoke with told us that they were not always able to have continuity from the same health visitor at each key contact of the Healthy Child Programme (HCP) 0 to 5 years.
- Antenatal contacts were not being undertaken in all areas by health visitors which impacted on the equity of access.
- There was variation in appropriate levels of supervision and appraisal of all staff.

However:

- There was evidence of good practice seen in the Integrated Sexual Health Service (HIV, GUM and family planning); specialist school nurses had developed training packages to deliver training to school staff. There were only three key performance indicators in school health.
- The Integrated Sexual Health Team had incorporated the Fraser Competency within the Child Sex Exploitation (CSE) best practice protocol.
- The specialist school nursing team were responsive to the needs of children and used safe systems for training, care planning, documentation, with good multi-agency working.
- A school nurse competency framework had been developed within the last year; the purpose was to help develop and support new staff in developing the service.
- Parents had been extremely positive about the support they had received from the specialist infant feeding team. Funding for the team had been secured until the end of March 2015.
- A range of comprehensive Standard Operating Procedures (SOP) had been developed for the health visiting service.

Detailed findings

Evidence based care and treatment

- A Common Assessment Framework (CAF) was used by practitioners and completed for children or young people when concerns or more complex needs were identified. We saw a CAF assessment that had been completed for a child with complex needs as concerns had been identified by the child's parents. Working with the parents the health visitor had completed a CAF and arranged an initial team around the child (TAC) meeting. The completed CAF was detailed, the information signed by parents, and there was evidence of multiagency involvement with clear planning, including timescales and future appointments. This meant that the needs of the child had been met and planned interventions and support were in place to meet them.
- Specialist school nurses had developed evidenced based training packages to deliver training to school staff; an example was teachers being able to deliver medication in the school setting. This ensured children received their medications at the correct time to meet their health needs and decreased the disruption time to their learning.
- The school health service had a specialist bariatric practitioner to develop the 'Alive 'N' Kicking' evidenced based programme for weight loss for children aged between 2 – 4 years. The purpose of the program was to work with children to raise their self-esteem first before starting weight loss work. Future planning includes introducing the programme for 7 to 11 years and adolescents.

Requires Improvement

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

- Health visitors used the 'Five to Thrive' programme which was to help support healthy personal, social and emotional development in children less than one year of age to encourage positive parenting to deliver messages to all families.
- The Integrated Sexual Health Service (ISHS) had incorporated the Fraser Competency within the Child Sex Exploitation (CSE) best practice protocol, when they spoke with young people. The national CSE risk assessment toolkit was used with all young people under 18 years. The purpose of the assessment toolkit was to enable professionals to assess a child or young person's level of risk of child sexual exploitation.
- The specialist school nursing team were responsive to the needs of children and used safe systems for training, care planning, documentation, with good multi agency working. All training was evidenced based and service delivery reflected government guidelines for children with complex needs.
- During the observation of a home visit with a health visitor, we saw how a mother's request for breast feeding support was assessed. Staff gave evidenced based advice and identified that the baby had tongue tie. The family were referred to the breast feeding support team for further assessment.

Use of technology and telemedicine

- The ISHS utilised text messaging for service users to access their test results if they were negative. If results were positive staff would telephone service users directly.
- Staff told us they would be able to work remotely with the new computer tablet devices and that the new system would have better connectivity and make services more responsive to meeting service user's needs.

Approach to monitoring quality and people's outcomes

- In January 2015 the trust achieved the United Nations Children's Fund Baby Friendly Initiative level 1. NHFT had a breast feeding support team that worked with mothers offering one to one support to those that experienced difficulties. There was a referral pathway for either parent to self-refer to the service or via health professionals. The breast feeding support team offered parents support with home visiting, 'drop in' breast feeding clinics in Northampton, Wellingborough and Corby to maximise accessibility to the service for parents across the county.
- Breast feeding champions had been identified and eight were trained to act as a link and create a network of support for staff within local GP surgeries and visit children's centres and be a link for the specialist team in the locality.
- There were three clinical key performance indicators (KPI'S) in school health; vaccinations for Meningitis C and Human papilloma virus vaccinations, National Child Measurement Programme and personal health and social education.
- The BST monitored feedback from service users through parents completing an 'I want great care' evaluation survey. Every week at the 'drop in' sessions and at each contact with parents they are offered the opportunity to complete a questionnaire.
- We reviewed seven completed questionnaires from mothers who had used the BST service although there was no date to identify when they had been completed. All of the responses were positive, about the support they received and involvement with the decision making process with their care.
- Staff told us that 90% of babies seen by the breastfeeding support team with feeding difficulties had some degree of tongue tie, and of those 50%-75% went on to have treatment. Mothers travelled outside of the county; there was a direct referral template on electronic records.

Competent staff

- In the breastfeeding support team there was an Infant Feeding Lead who was also a qualified Lactation Consultant, who was supported by a health visitor and four support workers.
- Safeguarding supervision for all children's universal services was changing to multidisciplinary group supervision between services; the process had not yet been embedded in practice.
- Clinical supervision should happen ten times per year. We were told that this was not currently happening within school nursing. Senior members of the team were having restorative supervision, to realise the needs of the team to restore morale and support junior staff. The purpose was to ensure all teams are working in the same way across the service.

Requires Improvement

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

- A clinical lead for children's universal services worked with the HV and SN teams as a link to clinical practice. The purpose was to ensure that the standards of clinical practice were consistent, to embed and maintain the quality of evidenced based practice.
- Different types of supervision that were delivered included safeguarding, clinical and management supervision. In January 2015 a new model of integrated safeguarding supervision groups was launched. All trust staff were to be engaged in this process, and there were plans to have 80 supervisors in total.
- Staff that we had spoken with hadn't been able to describe a model of management supervision. We spoke with a senior member of staff who was surprised that practitioners reported they had not had management supervision; one reason for this was due to the number of new operational managers in post learning and embedding organisational priorities and overseeing their new teams.
- Newly qualified health visitors had a preceptorship programme which was part of post qualification support transitioning into their new roles. Newly qualified health visitor's response differently as to how they perceived the quality of the preceptorship programme; we were told that some staff felt the programme was not structured and the transition as a newly qualified health visitor had not met expectation. We also had some positive comments from newly qualified health visitors based other locations.
- The ISHS had three consultants, with expertise in genitourinary medicine (GUM), HIV or sexual and reproductive health (SRH). All staff had knowledge of both GUM and SRH, but currently delivered their own main area of expertise and were gradually accessing training for all staff to do both.
- A school nurse competency framework had been developed within the last year; the purpose was to help develop and support new staff in developing the service.
- We spoke with one operational manager who was overseeing 90 members of staff; we reviewed the appraisal rate of staff from the end of June 2014 to January 2015. The target rate for compliance was 90%; in June 2014 the rate was 85%. In January 2015 the figure was 72%, time constraints to complete appraisals was identified as a contributory factor by managers.

Multi-disciplinary working and coordination of care pathways

- The ISHS worked with partner agencies and, they were part of the Reducing Incidence Sexual Exploitation working forum. The working forum held monthly meetings which were attended by the manager; new cases were identified from missing reports.
- The Integrated Sexual Health Service linked with Looked after Children paediatricians, who at children's review meetings asked about sexual health and recorded information on the assessment forms developed by the genitourinary medicine and sexual and reproductive health service.
- Working with social care partners was identified as being difficult due to the high number of agency social workers being used. Health visitors rang social workers to liaise about children on their caseload and found that the social workers had left. Staff told us this impacted on the continuity of care for children and their families. One operations manager told us that five episodes had been escalated to a senior social worker, but the operations manager did not monitor the outcomes of the escalations as the safeguarding team was also contacted.
- The Looked after Children and Child and Adolescent Mental Health Service team held a weekly multi-disciplinary meeting called the Atlas Panel with representatives from education, local authority and social services. The team had case discussions to review children who had been referred through the referral management centre which screened referrals to children's specialist services, for mental health and emotional difficulties. The team discussed the appropriate interventions to meet children and young people's needs.
- Health visitors demonstrated effective partnership working with children's centres and link workers who liaised with the health visiting service for each of the centres. There was evidence of multiagency working at the "team around the child meetings", with effective sharing of information and detailed planning to meet the child's needs.
- To improve communication between the midwifery and health visiting service the clinical lead for children's universal services showed us evidence of minutes of meetings that had taken place. There were three documents that advised about the referral process; a community flow chart, notification of pregnancy form and a standard for postnatal handover.

Requires Improvement

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

- There was a pathway for health visitor management of Looked After Children, which had been developed within the standards of operational practice of health visiting. We were told that there could be delays in the local authority notifying the trust that a child had come into care.
- The Care assessment treatment for children at home team worked closely with GP's with early intervention to prevent hospital attendance and admission. The team offered home visits and telephone advice to parents.
- School nurses building team capacity using training toolkits e.g. self-harm, speech and language; sharing across teams and schools to enable them to do interventions.

Referral, transfer, discharge and transition

- The Referral Management Centre (RMC) was single point of access for referrals of children and young people;staff told us referrals were only accepted from the north locality of the trust. The trust told us the Referral Management Centre takes referrals from the North and South of the county for all services delivered by the Trust.
- The screening panel for referral was staffed on a rota basis from specialist teams.
- The RMC processed and screened all referrals for children's specialist services. The RMC referral process had not always been effective for the Looked After Children and Child and Adolescent Mental Health Service team; one referrals had been delayed through not being passed to the team which had risk elements for child not being picked up by the service. The incident was reported; learning outcomes were that the team put extra checks in place ensuring children were not missed.
- The LAC team had a transition co coordinator who was looking at improving multiagency approach to leaving care pathway for young people aged 17 to 17.5 years.
- Children leaving care had a county health care assessment; there were two health assessors who completed health assists for LAC including those placed out of county. No one had overall responsibility for ensuring health assessments and pathway plans were completed.

Availability of information

- Health visiting teams signposted service users to the NHS immunisation website to access a range of languages to understand immunisation information.
- New birth visit packs contained information leaflets for parents about local services, including a PALS leaflet.

Consent

- Health visitors talked with parents at the new birth visit about immunisations, and consent was presumed across Northamptonshire; if parents did not want their child to be immunised they had to sign a disclaimer form to withdraw consent.
- The Integrated Sexual Health Service assessed all service users, and all those under 18 years were assessed for competence to consent (only required for those less than 16 years); in addition all service users under 16 years were seen by two practitioners to share decision making regarding capacity to consent. We reviewed the consent policy for ISHS which included the Fraser competency.

Good

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 rated this domain as good because:

- Parents who used the service felt supported and that their children were well-cared for by staff, which were kind and had a caring compassionate attitude.
- Children and their families were treated with respect and dignity by staff which was observed during the inspection.
- Parents were positive in the feedback they gave about staff.
- Interactions observed during the inspection with parents and children showed kindness, dignity and involvement as partners in care and emotional support.
- The Looked After Children's and Child and Adolescent Mental Health teams facilitated a six week programme for parents and carers. The purpose of the programme was to help parents/carers to understand complex behaviour issues that relate to emotional and physical attachment.

Detailed findings

Dignity, respect and compassionate care

- Children and their families were treated with respect and dignity by staff which was observed during the inspection.
- Staff we observed in the child health clinics was enthusiastic and committed to getting to know parents and their babies, making themselves known and approachable.
- Staff that we saw demonstrated a caring approach and were passionate about the service they were aligned with in the CYP service.
- A child health clinic we observed being held at Brixworth Children's Centre, offered babies and their parents the opportunity to be seen by the health visitor in a consulting room. By being able to access a separate consultation area with the health visitor. This offered parents and children privacy and maintained their confidentiality.
- In child health clinics without the provision of a separate consulting room to see parents privately, discussions or advice being given could be at risk of being overheard and not maintain the confidentiality of the child and parents.

Patient understanding and involvement

- Staff we observed during home visits and in child health clinics were seen to positively engage with children and their families. Parents told us that any questions or concerns they had they could talk to staff that listened and offered support.
- We observed a development check which showed that the child and parent were given a clear introduction to the purpose of the development assessment. The mother had been asked to complete an ages and stages questionnaire prior to the visit, to review her child's social, emotional, behavioural and language development. Assessing children's development is a key feature of the Healthy Child Programme.
- We spoke with a mother who had been involved with her health visitor to complete a CAF for her child. The mother was extremely positive at how supportive and responsive the health visitor had been and said they will always call back and respond. The parent had felt involved in the decision making process and engaged with the service.
- The specialist children's community service empowered parents in the decision making process to meet the health needs of their children.
- We looked at the results of a patient satisfaction survey that was undertaken by the Integrated Sexual Health Service in September 2014. The response rate was 470 questionnaires returned, just over 1% was under 16 years and 21.3% aged 16-20 years. The results showed that 97% of all patients who returned the questionnaire were able to access the service. Patients felt that they were involved in decisions about their care, treated with dignity and respect.

Emotional support

- The Looked After Children's and Child and Adolescent Mental Health teams facilitated a six week programme

Good

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

for parents and carers. The purpose of the programme was to help parents/carers to understand complex behaviour issues that relate to emotional and physical attachment.

- The programme helped parents and carers to be able to support children to help them feel safe and to contain risk and behavioural issues through interventions and coping strategies. Feedback from parents and carers was through completion of questionnaires at the start and at the end of the course, 200 responses had been audited.
- We were told by parents about the support that health visitors gave to fathers, in the transition after the arrival of a new baby they felt this was very helpful.

Promotion of self-care

- Health visitors gave clear messages to parents about how to give positive re-enforcement for their children's positive behaviours.

Requires Improvement

Are Community health services for children, young people and families responsive to people's needs?

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

Summary

We rated this domain as requires improvement because:

- The provider engaged with commissioners of services, local authorities, other providers, but not frequently with people who used services and those close to them to provide coordinated and integrated pathways of care that meet people's needs and to provide comprehensive universal services and health and wellbeing programmes.
- Parents told us there had been no consultation with parents about the rationalisation and the changing model of child health clinics. The trust told us that formal consultation was not required because there was no fundamental change to the model of child health clinics merely an enhanced offering of extending hours based on informal engagement with the families. One clinic was affected by long term sickness and appropriate action was taken to ensure contact with the parents were in place.
- Most parents had to travel outside of the county for the treatment of tongue tie. There was a referral pathway for staff to refer parents directly to Milton Keynes or Bedford for treatment, although there was the facility to provide the service at Kettering Hospital.
- Therapy services at one location we visited had no clear database of scheduled appointments, non-attendance could be missed.
- Within school nursing staff shortages in some teams had resulted in prioritising service provision for child protection, Children in Need, immunisations and screening. One school nursing team had to decrease pupil 'drop in' sessions in schools.

However:

- An effective translation service was provided by the trust.
- Health visitors offered home visits to parents to meet specific needs, if they could not be met during a child health clinic contact.
- A new initiative that had been introduced for parents and babies was a 'Healthy Day' session at a children's centre. Mothers could attend on a drop in basis without an appointment.
- The ISHS was accessible and flexible.
- The service had an effective system in place to seek feedback from parents and young people and that complaints were handling in accordance with trust procedures.

Detailed findings

Planning and delivering services which meet people's needs

- Staff told us that 90% of babies seen by the breastfeeding support team with feeding difficulties had some degree of tongue tie. Of those 50%-75% needed to have treatment for the condition. Staff told us that mothers had not had positive experiences with provision of the service within the county. There was a referral pathway for staff to refer parents directly to other NHS trusts outside the county for treatment.
- Distances that parents had to travel to access the service outside of the county was a concern that staff raised; but more evidence was needed to ascertain the impact this had on continuing breast feeding rates and whether many just stopped breast feeding.
- A translation service was available within 24 hours of request. Staff gave us examples of where translation services had been used with children and families and were positive about their use.
- The children's therapy team offered clinics for all specialties throughout the week, occupational therapy and physiotherapy. Neurological development and neuro-muscular clinics were held monthly.
- The trust had set up a short term project with winter pressure funding from NHS England where the health visitors had an out of hour's advice phone line; until the end of March 2015 service users could call and speak with a health visitor from 5pm-8pm Monday to Friday and Saturday mornings from 9am-1pm.
- A new initiative that had been introduced for parents and babies was a 'Healthy Day' session we observed one being held at a children's centre during the

Requires Improvement

Are Community health services for children, young people and families responsive to people's needs?

inspection. Mothers could attend on a drop in basis without an appointment. The session had a rolling programme of topics. When we attended there was a talk on weaning. It offered mothers the chance to meet and share experiences, as well as the option to have their babies weighed.

- The Integrated Sexual Health Team had two main centres in Northampton and Kettering, with provision of services in Rushden, Wellingborough, Corby and Daventry. The service was for young people, who were encouraged to use these for single contraceptive needs and self-referral or referral into hubs if they required seeing a specialist for GUM or SRH.
- Within school nursing we were told that staff shortages in some teams had resulted in prioritising child protection, completion of CAF assessments, seeing vulnerable children (CIN), immunisations and screening. In one school nursing team they had to 'pull back' on drop in's in schools and were not able to provide personal health and social education (PHSE) unless the children were identified as vulnerable group or had an identified health need.
- Parents told us there had been no consultation with parents about the rationalisation and the changing model of child health clinics. The trust told us that formal consultation was not required because there was no fundamental change to the model of child health clinics merely an enhanced offering of extending hours based on informal engagement with the families. One clinic was affected by long term sickness and appropriate action was taken to ensure contact with the parents were in place.

Equality and diversity

- The ISHS was open every day, and either an appointment could be made or people just turned up no one was refused access. The service was accessible and flexible. We were told that the clinics held on Tuesday afternoons were quieter, and tended to see younger service users or people with learning disabilities who could be seen by a nurse advisor and consultant if they required.
- Integrated Sexual Health Service had managed the specific needs of two minority ethnic groups with specific health related issues, showing how the group's accessed care to meet these specific needs. The team also visited people who were in hospital to facilitate their care.
- Health visitors offered home visits to parents to meet specific needs, if they could not be met during a child health clinic contact. Some health visitors that we spoke with offered earlier appointments to facilitate parents being able to access the service.
- We saw during the inspection health visitors supported parents from minority ethnic groups to access and attend a child health clinic, to engage with the service and have the opportunity to meet other parents and promote inclusion within the group.

Meeting the needs of people in vulnerable circumstances

- The ISHS would arrange home visits to see service users with disabilities to ensure they could access the service.
- In the Looked after Children service receiving information from the local authority was down to two to three weeks, notification was not given until consent had been received from parents. There were in excess of 900 looked after children, and nearly 200 were in out of county placements.

Access to the right care at the right time

- Specialist school nurse teams had been reconfigured in line with government legislation to provide the right care at the right time for children with special needs.
- Health visitors identified their concerns about not being able to offer continuity to all of their clients by being able to see them at the antenatal check, through to the new birth and six-week check. We had examples of families that had contact with three different health visitors by the six-week check. For continuity and relationship building with clients this could act as a barrier.
- The process of receiving birth notifications to the health visiting service varied, north of the county birth notifications were sent via child health services part of NHFT; electronically. For the south of the county via child health services at Northampton General Hospital (NGH) could be delayed as notifications come via post.
- Therapy services at one location we visited there was no clear database of scheduled appointments, non-attendance could be missed. There was reliance a diary in the office, hand written and updated by team members. There was an option to flag non-attendance on electronic records, but not being used.

Requires Improvement

Are Community health services for children, young people and families responsive to people's needs?

Complaints handling (for this service) and learning from feedback

- The service had an effective system in place to seek feedback from parents and young people and that complaints were handling in accordance with trust procedures.
- Data submitted by the trust for the last twelve months showed that the Health visiting and school health services had a total of eight complaints within the last twelve months; of these six of the complaints were upheld. Themes arising from complaints were identified and actions taken to resolve the areas of concern.
- For children's therapy services the total number of complaints was six and of these only one was upheld. The community children's nurses and community paediatric services had four complaints; all of these complaints were upheld.
- Staff we spoke with were able to explain about the complaints process and how to advise people using the service. Parents were given a PALS information leaflet at the new birth visit by health visitors.

Requires Improvement

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

We rated this domain as requires improvement because:

- Although some staff knew about the trust vision, staff did not consistently demonstrate knowledge of the goals and values of the service.
- Systems were not in place to audit the effectiveness and quality of the referral process, caseloads, supervision and risk assessment across all teams.
- Governance arrangements were not always consistent in oversight of quality and performance across all teams.
- Management changes had impacted on leadership and the way staff felt connected, respected valued and safe. Not all staff felt senior managers were visible.
- There was a culture of staff working long hours to cover for staff absence in most teams.
- The leadership within the RMC was not effective with a lack of understanding of quality assurance and the effectiveness of the screening process; this included the consistency of the professionals reviewing referrals that may not have been their area of expertise.

However,

- Staff we spoke with were supportive of one another, there was a willingness of people working together to provide a good service to children and young people.
- Staff feel able to raise problems and concerns to senior managers and generally were positive about their local leadership.
- At children's centres visited during the inspection there were 'you said, we did' posters displaying responses to what families had asked for; breast feeding support, out of hours service, Healthy Day sessions. Families also said 'we want a health visitor in the room', but this had not been implemented. There was variation across the county whether a health visitor would be at CHC, or if they were led by nursery nurses.
- The Integrated Sexual Health Service was innovative, open and transparent.

Detailed findings

Service vision and strategy

- There was disparity between the vision for the service described by the deputy director of the service and what we heard from frontline staff. We were told that the vision for the service was moving towards integrated children's service with specialisms within it, moving away from silo working but we found that there was some evidence of management clinician divides.
- Although some staff knew about the trust vision, staff did not consistently demonstrate knowledge of the goals and values of the service.

Governance, risk management and quality measurement

- We reviewed 33 referrals that had been screened by the RMC. All had requested more information, 14 were referrals for speech and language therapy (SLT) requesting that a toolkit be completed first.
- There was a referral that had been in the system since June 2014, with evidence that the referral had been passed through several specialities, but was returned with requests for more information. We raised this with the strategic lead for RMC, who confirmed that it should not have happened and would take action to address this concern.
- We were told the RMC had not undertaken an audit to review the effectiveness of the service and evaluate the project's impact. There was no standard for the time referrals take to go through screening process. Trust staff were used to work within the RMC.
- There was a monthly clinical audit and effectiveness committee meeting, we looked at the minutes from three non-consecutive monthly meetings. There were representatives from the children's and young people's service who presented a completed audit at the meeting.
- We looked at one audit of the quality of health records completed by health visitors in relation to the health visitors 'Standards of Operational Practice'. This audit looked at 80 records to see if core contacts when children should be seen by the health visiting service

Requires Improvement

Are Community health services for children, young people and families well-led?

had been embedded in clinical practice in line with best practice. The results from the audit were poor; the plan was for actions to be implemented a further re-audit was to be carried out.

- One audit measuring the trust's health visitor compliance with NICE guidelines had looked at identifying any gaps in clinical delivery. They compared and rated the risks of the NICE guidance against the local service delivery. The results showed that nine of 13 were guidelines were compliant, the remainder had one medium risk and the rest were low risk. To improve the medium risk an immunisation facilitator was put in post.
- We reviewed a Joint multi-agency audit on safeguarding as required by the Local Safeguarding Children's Board Northampton (LSCBN). Each month, the joint team selected at random six to 12 children who had been at risk; every agency audits their own involvement and LSCBN collate the results. There was no formal feedback yet, the tool used for the audit facilitated reviewing local safeguarding as well as from a multi-agency perspective. This helped the operational managers to raise any safeguarding issues with staff.
- We spoke with staff at one base who told us that they were involved with record audits (HV team) every three months, they audited an alternative HV teams records. Learning from the audit was fed back to the operational manager. Findings were discussed at the locality team meeting for all staff within the Kettering team, however there was no written record of this discussion or the findings and whether any actions had been put in place.

Leadership of this service

- The ISHS told us there was effective communication to and from the Board to clinics. The Board attended at the senior management team forum. Consultants from the service met with the medical director at the medical management directors meetings.
- ISHS consultants and the business manager met on a weekly basis to review staffing issues, incidents reported and team planning issues. There was a fortnightly meeting for senior staff, with direct reporting up to Board level.
- We saw that staff did have regular team meetings but there was a variance in the frequency across all teams. There was an opportunity for staff to share concerns or issues they wanted to raise.
- The lone working policy was known by staff, but its interpretation was varied by teams on how they ensured that all staff whereabouts were known at the end of the working day, that all staff was safe. The children's community team ensured that staff 'checked-in' with the team at the end of their working day.

Culture within this service

- Staff we spoke with were supportive of one another, there was a willingness of people working together to provide a good service to children and young people.
- Some operations managers had set up a drop in system for staff to be able to have access to talk about any issues. Emails were sent out with dates and times when operations managers would be available, weekly at different clinics; this was open to school nurses as well as health visitors.
- There were contingency plans in place if a staff member was off sick, the wider team would offer support for short term sickness cover. We were told that all staff often worked extra hours (eight to ten per week). They also did extra work on computers in their own time. This was due to their commitment to the service and the children and young people in their care.

Public and staff engagement

- The deputy director for the service described the processes in place that ensured the health visiting staff were informed and involved in the transition phase to local authority. The health visitors were not transferring employer but funding for the service would be from the public health part of the local authority. There had been a developmental day for health visitors ensuring that they understood the process; there was a newsletter for all staff.
- The deputy director for the service told us staff were listened to and that there would be scheduled visits to teams from the directors to engage with all staff teams.
- Staff we spoke with commented that they did not feel that senior managers had been highly visible.
- In September 2014 a patient survey was undertaken by the Integrated Sexual Health Service, 470 responses were received from across the county. From the survey requests or suggestions that were identified included having TV screens in the waiting area. As a result of this

Requires Improvement

Are Community health services for children, young people and families well-led?

feedback, the trust had purchased TV's for these areas. There were also 'you said, we did' display boards in place. There was a comments book and comment slips for service users to give feedback.

- At children's centres visited during the inspection there were 'you said, we did' posters displaying responses to what families had asked for; breast feeding support, out of hours service, Healthy Day sessions. Families also said 'we want a health visitor in the room', but this had not been implemented. There was variation across the county whether a health visitor would be at CHC, or if they were led by nursery nurses.
- In preparation of the transfer of the health visiting service to local authority funding in October 2015 a development day was held in December 2014, when 120 health visitors attended the event. Operational managers and Board members also attended this event to re enforce the message of sustainability of the health visiting service in transition, not provider change but commissioning.
- We saw two emails from different schools, which gave positive feedback about the training delivered to staff; and the engagement with pupils and the content of the session provided.
- The leadership in the school health service was reported to be good by staff; feel that they were involved had experience of working with the local authority which was positive part of commissioning and shaping services.

Innovation, improvement and sustainability

- Recently the trust had been successful in securing a £1million pound bid from the Nursing Technical Fund; to provide clinical support to front line staff. This funding would also enable health visitors and school nurses to facilitate remote working leading to, better use of staff time and information collection. New equipment had been ordered and the plan going forward was implementation meetings to roll out programme.
- A transition board for the move to the local authority had been established the deputy director of the services attended this meeting. The message to the health visiting service was that in transition there would not be provider change, but changes in funding arrangements for the service.
- The ISHS had identified a need for on line appointments for services, they had a business case for funding approved and the development was planned to happen in 2015 to 2016.
- There had been a £1.3 million investment into a 'Call to Action' transformation programme for the school nursing service. The programme was being over a four year cycle to 2018. The trust was planning to recruit band 5 developmental posts with the aim of practitioners undertaking the Specialist Community Public Health Nurse programme.

Compliance actions

Action we have told the provider to take

The table below shows the regulations that were not being met. The provider must send CQC a report that says what action they are going to take to meet these regulations.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means – (a) taking responsible steps to identify the possibility of abuse and prevent it before it occurs and (b) respond appropriately to any allegation of abuse. Northamptonshire Healthcare NHS Foundation Trust: Children on a protection plan were not always visited at the frequency required and there was not a robust audit and governance system sothat learning from the audit process was effectively shared across all teams