Northamptonshire Healthcare NHS Foundation Trust

RP1

Community health services for children, young people and families

Quality Report

Sudborough House
St Mary's Hospital
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Kettering
NN15 7PW
Tel: 01536 410141
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Date of inspection visit: 23 to 27 January 2017
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RP1X1	Trust Headquarters, Sudborough House	Community health services for children, young people and families	NN15 7PW
RP1J6	Danetre Hospital	Community health services for children, young people and families	NN11 4DY
RP1A1	St Mary's Hospital	Community health services for children, young people and families	NN15 7PW
RP1JG	John Greenwood Shipman Centre	Community health services for children, young people and families	NN3 8UW
RP1NR	Short Breaks Unit, 82 Northampton road	Community health services for children, young people and families	NN8 3HT
RP1X3	Isebrook Health Campus	Community health services for children, young people and families	NN8 1LP

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 NHS Foundation Trust and these are brought together to inform our overall judgement of Northamptonshire NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Good

Overall, we rated the children, young people and family service as good. We found that:

- Despite staffing pressures due to vacancies, staffing levels generally met patients' needs at the time of the inspection.
- Staff understood their responsibilities to raise concerns and record and report safety incidents, concerns and near misses and adhered to safeguarding policies and procedures.
- For staff training, the overall compliance rate was 88% and this was comparable to the trust target of 90%.
- Individual care records were written in a way that kept patients safe from avoidable harm. For example, records were maintained on the trust's electronic record system and staff were able to access the system and update records.
- Generally, arrangements for the handling of medicines kept people safe from avoidable harm. The servicing arrangements for equipment were generally effective.
- There were reliable systems in place to prevent and protect patients from healthcare associated infection.
- Care and treatment were planned and delivered in line with current evidence based guidelines, standards, best practice, and legislation.
- Clinical audits were undertaken and outcomes used to drive improvements in the service.
- The service delivered all aspects of NHS England's Healthy Child Programme and had Baby Friendly Initiative breastfeeding stage 2 accreditation.
- Staff had the skills, knowledge, and experience to deliver effective care and treatment.
- There were suitable arrangements in place to enable staff to receive professional development, supervision and appraisal. Multiagency working across teams was positive and effective.
- Staff worked together to assess and plan ongoing care and treatment in a timely way when patients moved between teams or services, including referral, discharge and transition.
- Consent was obtained in line with legislation.
- Staff involved children, young people and those close to them in all aspects of their care and treatment.
- Staff were committed to empowering young people and provided them with appropriate information and support to enable them to make decisions around the care they received.
- The service reflected the needs of the local population and provided flexibility, choice and continuity of care to meet needs of the local community.
- Generally, patients had timely access to initial assessment, diagnosis or urgent treatment.
- There were positive adjustments in place when monitoring and responding to patients with a learning disability.
- Complaints' processes were effective.
- Front line staff described their senior managers as being supportive, visible and approachable and provided an open door policy.
- Staff were aware of the vision and strategy for children and young people's services and supported the changes to provide a more child centred service.

However, we also found that:

- Arrangements for storing some medicines, such as vaccines storage in cool boxes, did not always keep people safe. Staff took immediate action to address this concern.
- The service undertook child protection medical assessments but had no standard operating procedure for these assessments.

There were 233 children waiting on the attention deficit hyperactivity disorder waiting list and 127 patients on the

autism spectrum disorder waiting list. However, the number of children on the waiting list had reduced and there was an action plan in place to monitor the waiting list.

Summary of findings

Background to the service

Information about the service

Northamptonshire Healthcare NHS Foundation Trust delivers community based services to children, young people, and their families. It provides health visiting, breast-feeding support, school nursing, a children's specialist service, support for looked after children and safeguarding children's 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 follows guidance outlined by the Department of Health, for children aged 0 to 19 years old. The Universal children's service also provides the family nurse partnership programme for those aged 18 years and under, and who are expecting their first baby.

We carried out an announced visit from the 23 to 27 January 2017. We visited health centres and clinics where children, young people and family (CYPF) services are delivered. We visited St Mary's Hospital, Danetre Hospital, Weston Favell Health Centre, Upton Children's Centre, Campbell House, Northampton integrated sexual health service, Isebrook Hospital, Northampton Central Library, John Greenwood Shipman Centre, respite unit at 82 Northampton Road and Towcester Health Centre. We also went on home visits with health visitors.

During the inspection 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
- observed how people were cared for, talked with carers and family members, and reviewed care or treatment records
- visited health visiting and school nursing teams, attended clinics, and visited the Multi-Agency Safeguarding Hub (called the MASH), the children's safeguarding team, the integrated sexual health team, the attention deficit hyperactivity disorder team and the dietetic team
- spoke with 81 staff members including managers, team leaders and staff working within the following services; health visiting, school nursing, physiotherapy, occupational therapy, speech and language therapy, community nursing, family support, looked after children,integrated sexual health team and dietetics, and
- spoke with 20 parents and children and looked at 24 care records and four medication records.

We last inspected this core service in February 2015 and rated this service as requires improvement. Following the inspection we told the trust to take the following actions:

- 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.
- The trust should review the quality assurance process for the RMC to ensure effective oversight for the safety of the referral handling process is monitored. (Referral Management Centre (RMC) is a base for processing and screening all referrals for specific children and young people's services)
- 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.

On examination of data provided by the trust and on evidence collected during the inspection we found that the trust has achieved all of these actions.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Mark Hindle, Chief Operating Officer, Merseycare NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection CQC

The team included three inspectors, a variety of specialist advisors, which included nurses and an expert by experience who had experience of using or caring for someone who uses the type of services we were inspecting.

Why we carried out this inspection

We inspected this core service as a follow up comprehensive inspection.

How we carried out this inspection

To fully understand the experience of people who use services, 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 the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- Inspected 11 locations where services were provided for children, young people and their families and looked at the quality of the environment.
- Observed how staff were caring for people.
- Spoke with 15 young people who were using the service.
- Spoke with five parents of young people using the service.
- Spoke with 12 managers and the service manager.
- Spoke with 69 other staff members; including paediatricians, school nurses, health visitors, family therapists, receptionists, occupational therapists, and clinical psychologists
- Attended and observed two hand-over meetings, three home visits, an early health assessment meeting and the multi-agency safeguarding hub (MASH) meeting.
- Looked at 24 care and treatment records of young people.
- Carried out a specific check of four medication charts.

Looked at a range of policies, procedures and other documents relating to the running of the service.

Good practice

- The children and young people's community health services' newsletter, issued in July 2016, showed that the bid to Health Education England's innovation fund had been successful. The grant was used to develop and implement an online live chat, telephone support and facilitated self-referral facility for emotional well-being and mental health support specifically for young people aged 13 to18 years and their parents/carers.

Summary of findings

- Health visitors had developed a social media page for children's services at the trust, which provided advice and guidance to parents and service users.

School nursing had implemented a confidential helpline texting service for young people in schools to enable them to raise issues and concerns which they did not want to discuss in person.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should consider development of a policy governing child protection medical assessments
- The trust should review the storage of vaccines to ensure they are fit for use.
- The trust should consider ways in which the potential deterioration of patients on the and autism spectrum disorder waiting lists can be monitored.
- The trust should consider provision of staff training for major incidents.
- The trust should review the risk register to include those services where patients are waiting over 18 weeks.

Northamptonshire Healthcare NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the service as good for safe because:

- Despite staffing pressures due to vacancies, staffing levels generally met patients' needs at the time of the inspection.
- Staff understood their responsibilities to raise concerns and record and report safety incidents, concerns and near misses.
- Staff understood their responsibilities and adhered to safeguarding policies and procedures.
- For staff training, the overall compliance rate was 88% and this was comparable to the trust target of 90%.
- Generally, arrangements for the handling of medicines kept people safe from avoidable harm.
- The servicing arrangements for equipment were generally effective.
- Individual care records were written and managed in a way that kept patients safe from avoidable harm.
- There were reliable systems in place to prevent and protect patients from healthcare associated infection.
- Staff generally had an understanding of what to do in a major incident.

However, we also found that:

- Arrangements for storing some medicines, such as vaccines, were not stored at the correct temperature. Senior managers took immediate action to address this concern.
- The service undertook child protection medical assessments but had no standard operating procedure for these assessments.

Good

Are services safe?

The service did not have a clear oversight of the potential deterioration of the 233 patients waiting on the attention deficit hyperactivity disorder waiting list.

Safety performance

- Quality and safety data about the service was collected and included on the trust's central dashboard. Staff were aware of this performance and safety information and it was discussed at staff meetings to identify areas for improvement.
- There were no reported never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Three serious incidents (SIs) were reported by the children, young people and families' (CYPF) service from October 2015 to September 2016. Two incidents were related to a leak of confidential information through theft of patients' records from staff vehicles, which occurred in two separate teams. One incident was related to the failure to recognise a deteriorating patient. This was discussed during team meetings and, as a result, the service adopted a paperless approach to record keeping by health visitors and school nurses.
- From October 2015 to September 2016, 159 low or no harm incidents had been reported, with the main theme of minor accidental injury.

Incident reporting, learning and improvement

- Staff understood their responsibilities to raise concerns and record and report safety incidents, concerns and near misses. Systems were in place to report incidents and to share learning from incidents.
- Incidents were reported using an electronic system and staff knew how to use the system. Staff felt supported by their team leaders and managers to do this. They received feedback when incidents were reported. Staff received regular feedback and learning from incidents. Feedback and learning was shared through team meetings and newsletters.
- There were reliable systems, processes and practices in place to keep people safe from avoidable harm. Following a serious incident involving a child, group feedback sessions for staff were held within the service. This led to health visitors raising awareness of safety issues for families and carers through localised additions to the personal child health record (also known as the PCHR or 'red book'). The PCHR is a national standard health and development record given to parents/carers at a child's birth. More questions to raise awareness to parents and carers about potential risks were added to the PCHR.
- Thorough and robust reviews or investigations were carried out when things went wrong. Staff and people who used services were involved in the review or investigation. Staff were actively involved in the reviews of SIs. Recommendations and outcomes from SIs and recently published serious case reviews (SCRs) were discussed during team 'cluster' meetings.
- Reviews from safety events involving the service fed into service improvement. For example, following an incident involving an underage pregnancy, staff learned that sexual health was not always discussed with staff in wards settings. This led to the introduction of discussions around sexual health with young teenagers through the programme 'Voice of the child' in records.
- Mechanisms to report incidents were used appropriately where care was provided in people's homes or clinics. For example, the system in place for lone workers to raise an alarm was by making a call through a mobile phone. Staff were competent and knew when to seek help. However, following an incident, staff were told they would get smart phones with an emergency alert mechanism to improve on incident reporting for lone workers.
- Staff were confident in describing the process of learning from incidents shared in monthly multidisciplinary team meetings and this learning was available on 'the staff room' located on the intranet page.

Duty of Candour

- From November 2014, NHS providers were required to comply with the duty of candour regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and

requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.

- Duty of candour was included within the reporting and management of serious incidents policy and in the serious incident and clinical review investigation template documents. Once an investigation had commenced, the appointed staff engaged with the patient, carer and family in line with the duty of candour process. The investigator continued to work with the individuals throughout the investigation period and fed back any outcomes to the patient, carer and family in a way that was suitable to them. For example, we observed an early help assessment meeting with a health visitor. The team openly discussed concerns raised regarding the safety of the child in question and went through an action plan, which identified the health needs of the child.
- The trust monitored duty of candour as part of the weekly incident reporting schedule, with duty of candour statistics reported to trust board every two weeks.
- The trust had a duty of candour e-learning training package available to all qualified clinical staff: a key part of this referred to 'raising concerns.' 'Freedom to Speak Up' training was also a mandatory requirement for all staff to further support the duty of candour training.
- Staff were confident on the processes and levels at which duty of candour was required for escalation. Staff gave examples of when a failure to escalate a medical review led to the need for duty of candour. Staff followed the duty of candour process and kept the complainant informed at all the stages while the investigation took place.
- Staff told us they were encouraged to raise any concerns they may have about care provided or to escalate problems that could prevent them from working safely.

Safeguarding

- There were arrangements in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Staff understood their responsibilities and adhered to safeguarding policies and procedures.
- 366 child safeguarding referrals were made by the service to the local safeguarding authority from 1 October 2015 to 30 September 2016. We saw that the health visiting team made 309 referrals. Nine adult safeguarding referrals were made by the service from 1 October 2015 to 30 September 2016.
- Community paediatricians undertook child protection medical assessments in the local acute trust between the hours of 9am to 5pm from Monday to Friday. Out of hours, this was undertaken by the paediatricians employed by the acute trust. Staff were unable to show us the flow chart for this process or the trust's standard operating procedure (SOP) for child abuse medical examinations and it was not documented in the trust safeguarding policy. This meant that concerns may not have been evaluated in a consistent and effective manner.
- We saw health visitors and school nurses were routinely notified when a child or young person had attended the emergency department and minor injury units at the local hospitals. They were responsible for assessing the information and ensuring that any required action was taken. The trust had named nurses, consultant paediatricians and a named midwife for safeguarding children.
- Staff were able to recognise safeguarding concerns for children and young people and showed strong knowledge and awareness of the safeguarding processes and their responsibility in protecting children from harm. All staff we spoke with told us they were able to access the safeguarding policies and safeguarding advice as required.
- Staff were able to describe who their safeguarding lead was and knew when to escalate a safeguarding concern. Staff knew who their regional and local safeguarding leads were and who to contact during out of hours.
- The trust had a child protection policy in place. The policy had links with related policies. Examples included the identification and prevention of child sexual exploitation, female genital mutilation and the policy for those children not brought to outpatient appointments.
- Staff had regular planned safeguarding supervision. Supervision varied across the disciplines from once a month to every two months.

Good

Are services safe?

- Safeguarding information leaflets were readily available for patients.
- We looked at three records of children with a child protection plan who were on the health visitor caseload. We found that all children had the frequency of contact with the health visitor as required by the child protection plan. This had been an area of concern at the last inspection but we saw the service had taken steps to ensure these visits were recorded, audited, and monitored effectively. We saw evidence of how alerts were displayed on electronic patient records if the patient was on a child protection plan.
- Members of the safeguarding health team worked on a rota basis with the multiagency safeguarding hub (MASH). Staff working in the community would contact the hub when required. Information from the monthly multiagency meetings, which involved children, was shared with health visitors and school nurses and was accessible via the electronic records' management system. This ensured that staff working with children and young people were aware of any risks of serious harm.
- Across the trust, safeguarding training (adults and children) at level 1 was completed by 92% of those staff requiring it, level 2 (adults and children) by 94% of staff needing this training. For those requiring level 3 safeguarding children's training, 89% had completed it. This was in line with the expected target of 90% compliance.
- In April 2015, the safeguarding team made significant changes to the level 3 training, which had developed from a three-hour training session to an all-day event. The safeguarding team developed a level 2 e-learning package last year, which had been well received by staff, as uptake had been positive. This, in line with the variety of bespoke training packages, was linked to an increase in the number of staff trained.
- The mandatory safeguarding Prevent health 'WRAP' course did not have a compliance target and was classed as a 'one off'. The current compliance rate for this programme was 33%. Further sessions were being arranged.
- The service had a "did not attend" (DNA) policy, which stated that staff members had individual professional responsibility to respond to failure to attend an appointment in a manner based on an assessment of the service user's risk. Repeated or persistent DNAs were seen as an indicator of safeguarding issues and staff were advised to follow this in conjunction with the trust policy on safeguarding children. Health visitors would contact the family in the event of non-attendance and would check with the GP.

Medicines

- Generally, arrangements for the handling of medicines kept people safe from avoidable harm.
- However, arrangements for storing some medicines, such as vaccines, were not kept at the right temperature. For example, we found boxes of vaccines stored in a cool box with cool packs and no thermometer was in the box. Staff said vaccines were stored for up to four to five hours in cool boxes without appropriate thermometers. One of the vaccines we found was used to prevent infection caused by According to the Green Book 2013 (which , temperatures of cool boxes should be monitored when in use, using maximum and minimum thermometers. This meant that the use of a vaccine that had not been stored correctly was outside of the licensed use of the vaccine and therefore could not be used. We raised this with school nursing staff at St Mary's Hospital during our inspection who took actions to address this concern immediately.
- We also found some medicines (BCG vaccination) that had expired in June 2016 in Isebrook Hospital (Castle ward). We raised this with senior managers at the time of inspection who removed the medication.
- Children and young people in special educational schools (SED) were supported by school nurses in the administration of their medicines. Each child had a care plan and their medications were stored in a locked cupboard. Children and young people who required emergency medication had an individual care plan, which identified who could administer the medication. Parents, teachers, and school nurses had been trained and attended annual updates.
- Within the integrated sexual health service there was a dedicated pharmacist. This 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 to meet their health needs.

- Fridge temperature monitoring in two school nurse team's bases (St Mary's Hospital and Towcester Health Centre) had been completed everyday as per policy requirement, to monitor correct temperature ranges for the storage of vaccinations.
- The team discussed medication plans with both the parent and the child. Teenagers were risk assessed and encouraged to take medication breaks in line with their care and treatment plans.
- The dietetics team had written prescribing guidelines for protein cow's milk allergy. The guideline was used by GPs and was under revision at the time of the inspection.

Environment and equipment

- The servicing arrangements for equipment were generally effective. All equipment looked at during our inspection was well maintained and fit for use.
- At the time of our inspection, the community paediatric service at Sudborough House had 13 items of equipment and we found all was in date for servicing. Equipment used within the sexual health clinic was service tested and up-to-date. For example, portable oxygen cylinders were checked daily and scales and portable suction machines had all been service tested.
- A log of the scales held by health visitors in the service was available. All the scales on this log were in date for servicing and calibration.
- Weekly equipment checks were undertaken in most of the areas accessed by children and young people across community care settings and we saw documentary evidence of this. We observed resuscitation equipment was in place in the short breaks' service, SED schools and clinics. For example, defibrillators, oxygen and suction equipment were maintained and clean. Service testing of equipment had been completed in 2016. This demonstrated emergency equipment had been appropriately tested and maintained and was deemed fit for purpose.
- Health visitors told us that equipment used, such as scales, were annually checked and calibrated through the trust's medical equipment maintenance programme. Stickers on equipment confirmed this.
- The service maintained an equipment database so equipment coming up for a service could be identified.
- The design and use of facilities and premises kept patients safe from avoidable harm. For example, alarms were activated and tailored for each service user's bedroom and were linked to the doors in one of the respite units we visited. This was put in place in order to manage risks at night-time and to keep service users safe.

Quality of records

- Individual care records were written and managed in a way that kept patients safe from avoidable harm. Records were maintained on the trust's electronic record system and staff were able to access the system and update records. Some services also used paper records.
- We looked at eight patients' electronic care records within the short break service, which provided a short break service to patients with autism. The records were accurate, legible, and up to date. For example, risk assessments were all current, consent forms were up to date, and dietary requirements were recorded for each patient. Patients and families completed the risk assessments for their child prior to admission.
- We also reviewed four paper patient records. The records held appropriate information about the child or young person. For example, risk assessments and risk reduction plans, development checks, consent and person centred profiles were completed. There was a personal evacuation plan in place for each child or young person. The records were accurate, complete, legible and signed.
- We reviewed two PCHRs. This is the national standard health and development record given to parents and carers at a child's birth, also known as the 'red book'. The PCHRs were completed to a high standard; all had contacts with professionals recorded for each time they had been seen. The health visitor's contact details and clinic information had been completed consistently.

Good

Are services safe?

- For the school nursing service, we reviewed four children's records on the electronic record system and found they were reviewed and completed appropriately. All of the records had care plans demonstrating desired outcomes and appropriate referrals, appointments and communication with other agencies.
- We observed staff from the speech and language therapy (SALT) service accessing and updating two electronic

Cleanliness, infection control and hygiene

- Generally, there were reliable systems in place to prevent and protect patients from healthcare associated infections.
- We observed staff cleaning their hands by using hand sanitiser between contacts with different patients. All areas we visited appeared visibly clean. Cleaning schedules were up to date and clearly documented.
- Arrangements were in place for the handling, storage and disposal of clinical waste including sharp items.
- Personal protective equipment was available for staff such as aprons and gloves as required. There were safe systems for the disposal of waste such as nappies.
- When visiting children at home staff carried suitable supplies, which included hand sanitiser and anti-bacterial wipes.
- The short break service had environmental cleaning audits, which staff regularly signed and checked daily. It had six bedrooms, which we saw staff had maintained and cleaned them to a high standard.
- Staff within the SALT teams for children's services regularly wiped down the toys for children. Staff told us that there were no audits to monitor the daily cleaning for the infection control of the toys. When we visited the health visitor service in Weston Favell Health Centre, they had a cleaning audit for toys in the clinic room. However, it was last cleaned on the 19 January 2017, which was six days before our inspection.
- Housekeeping cleaning audits were carried out monthly at Sudborough house. These showed high levels of compliance (94% to 98%) with cleaning routines. Where concerns were found, actions plans with dates to achieve compliance were recorded and signed off when completed.
- We observed that the scales were cleaned between patients during our inspection to the drop-in clinics at the central library, home visits, and Towcester children's centre. Health visitors used hand sanitiser to clean their hands between patients.
- The service carried out four audits of hand hygiene from October 2015 to September 2016. The audits looked at provision of basins, soap, sanitizer and moisturiser, hand hygiene practice and staff knowledge. One audit scored a 100% compliance rates in all areas. The remaining three audits scored between 66% and 86%. Three of the audits had inconsistent dates recorded. None of the audits gave any recommendations for actions taken or target dates for completion. This meant that we could not tell if any actions were taken because of the findings or if any lessons learned were disseminated to staff.

Mandatory training

- Staff were required do mandatory training which included equality, diversity and human rights, fire safety, infection prevention and control ,information governance, manual handling , resuscitation (basic life support), safeguarding adult and children, conflict resolution, health, safety and welfare. The service kept detailed information on compliance rates by the course name for all teams. The service provided us with training information for the period 1 October 2015 to 30 September 2016. The overall compliance rate was 88% and this was comparable to the trust target of 90%.
- There were 15 mandatory training courses (excluding the one off safeguarding Prevent health course) and, overall, staff had met or very nearly met the trust target of 90% compliance for 12 of the 15 training courses as of September 2016. The courses that were below the trust's target for 90% compliance were manual handling level 2 at 55%, clinical staff infection control at 80%, and resuscitation level 2 at 77%. Further training courses had been arranged.
- Health visitors, school nurses and the short break service reported that access to training was easy, and they had found the training useful in their role. Paediatricians told us they had easy access to training and this was documented in their job plans.
- Training was a mixture of online and classroom learning. Staff told us they were given time and encouraged to

complete all required training. Compliance with training was discussed at staff appraisals. Each staff member could access their personal record of training, which included attendance and renewal dates. We saw an example of this and how to book onto update training courses.

Assessing and responding to patient risk

- Comprehensive risk assessments were not always carried out for children and young people who used services.
- There were 233 patients on the children and young people ADHD waiting list, who had been waiting for an appointment for over 18 weeks. There was no system in place to monitor the deterioration of these children on the waiting list in the service; however, parents had been advised to speak to their children's GPs in the event of any changes. Referrals came through professionals and the special educational needs co-ordinators (SENCOs) who could provide feedback to children and their families. However, they were based in schools and staff reported that communication between services was not always timely. The ADHD/ASD team had an action plan in place to reduce the waiting list. They planned to run extra sessions on two Saturdays per month commencing in February 2017. There had been no reported patient harm of people on the waiting list.
- The children and young people's ADHD/ASD team also had 127 patients on the autism spectrum disorder (ASD) waiting list, who required an educational psychologist assessment for autism. The waiting time ranged from between six to12 months depending on the area. Parents had been advised to speak to their children's GPs in the event of any changes. This concern had been raised with the educational psychologist team during the last meeting. This was not on the risk register for this service.
- In the standards of operational practice, an antenatal contact for health visitors should occur from 28 to 32 weeks during pregnancy. Staff we spoke with reported not being able to achieve this contact in all cases due to the high volume of new referrals.
- Figures provided by the service for families that received a face-to-face new birth visit within 14 days by a health visitor was from 92% to 95%, which was above the trust target of 90%.
- We reviewed the care of a child with a complex clinical condition supported by the short breaks' service. Risks were managed positively to enable the child to live as full a life as possible within the constraints of their medical condition. The child was able to attend full time education in a special education department school and participated in outdoor activities and outings at the home.
- Registered children's nurses and registered learning disability nurses provided 24-hour nursing cover at respite care units and had undertaken appropriate clinical competency training programmes. An emergency pathway was in place in the event of a medical emergency.
- Staff spoken with described how they would respond to identifying a child with deteriorating health. This ranged from arranging an appointment or visit from their GP to dialling 999.
- Ninety nine per cent of staff had resuscitation level one training and 100% of staff had resuscitation level 3 training (intermediate life support).
- We observed health visitors discussing accident prevention and managing minor illnesses with parents. The health visitors used an assessment tool with pregnant women to help prepare support they might need to look after their mental health, acknowledging it can be a time when women can experience changes in their emotional health.
- Nurses in the short breaks service were trained to deliver specialist skills to children and young people. These included managing feeding tubes, suction, oxygen and care of tracheostomies. A tracheostomy is an incision in the windpipe made to relieve an obstruction to breathing.
- The school nurses had clear protocols in place, which identified the actions to be taken if children or young people were at risk.

Good

Are services safe?

Staffing levels and caseload

- Despite staffing pressures due to vacancies in some teams, staffing levels generally met patients' needs at the time of the inspection. Actual staffing levels generally met the planned levels.
- From information provided by the trust for September 2016, 422 substantive staff were employed by this service. In the staffing establishment for the service, there were 221.5 whole time equivalent (WTE) qualified nurse posts and 106.34 WTE nursing assistant posts.
- Total vacant posts overall (excluding seconded staff) were 62 (around 13%) which was lower than the trust average vacancy rate of 16%. The vacancy rate for qualified nurses was 13% and for nursing assistants was 11%
- A total of 34 substantive staff had left from 1 October 2015 to 30 September 2016 (8% turnover). This was reflected in the risk register, which stated that there had been a reduction in staff and actions were being taken to recruit more health visitors.
- A total of 1,967 qualified nurse shifts were reported to have been filled by bank staff by the service from 1 October 2015 to 30 September 2016, with the Northampton central health visiting team reporting the highest number of qualified nurse shifts filled by bank staff (708).
- 1,012 nursing assistant shifts were filled by bank staff over the year period with Kettering children's continuing care team reporting the highest number of shifts filled (488).
- A total of 606 shifts were filled by agency staff over the year period. The service used bank staff to cover sickness, absence or vacancies, to also provide support with the delivery of the flu vaccination and to meet the immunisation demand. Bank and agency staff received local inductions as per the trust policy.
- There were 308 unfilled shifts from March to September 2016 in health visiting. Staff said they had to prioritise workloads in the event of staff shortages. New birth visits and children transferring to the area were prioritised. Staff felt that although they were dealing with a large volume of work, they worked as a team to work around the increased activity of work and this did not impact on safe care.
- **Ten out of 17 of the teams in this service reported an overall vacancy level that was higher than the trust average. Nine teams out of 17 teams exceeded the service average for qualified nurse vacancy rates for September 2016.**
- In mid and east Northamptonshire, health visiting and school nursing were managed across three clusters and were moving into postcode areas. We saw that two health visiting vacancies were being actively recruited to and there were two school nursing vacancies.
- Sickness rates for permanent staff was 4%, which was in line with the trust average sickness rate of 4%.
- Caseloads were based on the dependency tool outlined in the national universal framework for health visiting. The clinical leads constantly scrutinised and challenged the caseload management in discussion with each health visitor. Health visitors told us their caseloads were manageable but said there were times when the two yearly checks for children were difficult to achieve. The teams used bank health visitors who were known to the service and who had received the appropriate training to care for children and young people.
- **The actual average caseload per staff member in the service increased between 01 0ctober 2015 and 30 September 2016 for health visiting and school nursing but fell for specialist school nursing. Family nurse practitioners caseload was a maximum of 25 per whole time equivalent as per national guidance and was dependent upon complexity.**
- Health visiting caseloads varied between 250 and 450 patients for each WTE health visitor. We were told caseloads would be more balanced when the locality model was in place, as this would ensure similar levels of complexity across the clusters. However, the risk register reflected current average caseloads in Abington at 590 per WTE due to a reduction in heath visitors. High caseloads could have an impact on delivery of care and the service had noted recruitment of health visitors as an urgent action to mitigate risks.
- The five nurse prescribers in the children and young people's ADHD/ASD service had approximately 130 to 150 patients on their caseload and had a six monthly review of caseloads.

Good

Are services safe?

- In the north Northamptonshire children's community team, there was one WTE school nurse in the team. The team had a band 5 school nurse undertaking the school nurse development programme, two band 3 support workers and a nursery nurse. There was one WTE school nurse vacancy at the time of the inspection and one school nurse on long term sick. The service had responded to the national 'Call to Action', the School Nursing Implementation Plan (2012), in line with the expected increases in workforce. The team had student school nurses and had plans to recruit two school nurses from the current student cohort. We observed staff working creatively to ensure children and young people's care and support needs were being met at times of staff shortages. For example, nursery nurses who were trained to care for children up to eight years supported the school nursing service.
- The school nursing service recruited bank staff to provide support with the delivery of the flu vaccination and to meet the immunisation demand.
- The John Greenwood Shipman Centre reported daytime care staff fill rates of less than 90% between March and June 2016 and night time care staff fills of less than 90% for the entire period covered. This was due to having daytime registered nurse fill rates of 120% and night time registered nurse fill rates greater than 125% for six of the months in total.
- The service had a breastfeeding team of one whole time equivalent (WTE) health visitor, one lactation consultant and three part time nursery nurses who were allocated across the three clusters. The team provided support to the health visitors through joint visits and ran drop in clinics for parents in the Northamptonshire centre area.
- Community paediatrics consultant-led clinics were provided Monday to Friday from 9am to 5pm via a referral service. All doctors were paediatric trained and there were no staff grade doctors. The cover was arranged across a normal working week for a clinic service

Managing anticipated risks

- Clinical leads for health visiting, school nursing and the short breaks service told us there were contingency plans in place to manage seasonal fluctuations in demand due to adverse weather conditions or disruption to staffing.
- The trust had a lone working policy, staff updated diaries to reflect their location, and staff attended home visits in pairs when a safety risk was identified.
- On a daily basis, health visitors and school nurses used a white board in their offices to indicate where they were visiting and their schedule for the day. Staff were required to maintain their diary on the electronic record management system. Each member of staff working in the community had a mobile phone. Staff were required to report in at the end of their community visits to ensure their location was known to the service. Staff told us there were connectivity problems in some areas of the community, which meant they were unable to make telephone calls, which could put them at potential risk in an emergency.
- The trust maintained a risk register of current risks to the service provision.

Major incident awareness and training (only include at core service level if variation or specific concerns)

- Staff described how to respond to a major incident by following the organisational response. Staff said that they did not undertake any training in major incident awareness.
- Clinical leads were aware of the trust's major incident policy but had not received training on their roles and responsibilities in the community in the light of a major incident occurring.
- Staff had fire safety and health and safety training provided and compliance was above the 90% trust target.

Good

Are services effective?

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

Summary

We rated the service as good for effective because:

- Care and treatment were planned and delivered in line with current evidence based guidelines, standards, best practice, and legislation.
- Clinical audits were undertaken and outcomes used to drive improvements in the service.
- The service delivered all aspects of NHS England's Healthy Child Programme (HCP).
- The health visiting service had achieved the United Nations International Children's Emergency Fund (UNICEF) and World Health Organisation (WHO) stage 1 and stage 2 Baby Friendly Initiative breastfeeding accreditation and were planning to undertake stage 3.
- Outcomes were measured and generally met service targets.
- Staff had the skills, knowledge, and experience to deliver effective care and treatment.
- There were suitable arrangements in place to enable staff to receive professional development, supervision and appraisal.
- Multiagency working across teams was positive and effective.
- Staff worked together to assess and plan ongoing care and treatment in a timely way when patients moved between teams or services, including referral, discharge and transition.
- Patients' nutrition and hydration needs were assessed and managed effectively.
- Consent was obtained in line with legislation.

Evidence based care and treatment

- The service delivered all aspects of NHS England's HCP. This provided families with a programme of screening, immunisation, health and development reviews, and advice about health, well-being, and parenting. Health visitors undertook antenatal visits at 28 weeks of pregnancy, a new birth visit between 10 and 14 days postnatally, a six to eight week postnatal review with a maternal mood review, a three to four month review, a 12-month review, and a two and a half year review.
- The health visiting service had achieved the UNICEF and WHO stage 1 and stage 2 Baby Friendly Initiative breastfeeding accreditation and were planning to undertake stage 3. The Baby Friendly Initiative is a worldwide programme of the WHO and UNICEF. It was established in 1992 to encourage maternity hospitals to implement the 'Ten Steps to Successful Breastfeeding' and to practise in accordance with the 'International Code of Marketing of Breastmilk Substitutes'. This is an evidence-based approach to support breastfeeding by improving standards of care and support.
- The integrated sexual health service had incorporated the Fraser guidelines within the child sexual 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 school nurses delivered the routine school immunisation programme as set out by Public Health England and the Department of Health. The service also delivered the National Child Measurement Programme, which consisted of measuring the weight and height of children in reception class (age four to five years) and year six (aged 10 to 11 years) to assess overweight and obesity levels. School nurses told us this provided them with an opportunity to engage with children and families about healthy lifestyles.
- Children with long-term conditions and complex care needs who used the short breaks (respite) service had clear personalised care plans, which were in line with relevant best practice guidance and set out clear goals for each child.

Good

Are services effective?

- The occupational therapy team developed a modified constraint induced movement therapy for children with hemiplegia (. The team received positive feedback from this six-week family involvement course.
- The integrated sexual health service used a proforma in line with national guidance for all young people under 18 years of age, which included questions related to lifestyle choices such as drugs, and alcohol and about self-esteem issues.
- The service carried out three clinical audits from October 2015 to September 2016 and two of the audits related to multidisciplinary team working. Findings of handover from midwives to health visitors concluded that the expected handover written and verbal processes were not always completed in a format recommended within the agreed handover pathway. The service took action by simplifying handover sheets for both health visitors and midwives.
- The second audit on joint visits for health visitors and social workers was completed in January 2016. This audit showed that 22 of the 23 cases recorded the health visiting holistic family assessment (HVHFA) and identified that the HVHFA reflected the level of work being provided by the health visiting team. The audit revealed that three cases did not comply with the child protection plan in place, because either the visit was carried out but the records did not evidence the contact or that the contact did not occur. The service took action to ensure that a joint visit between health visitors and social workers was documented as part of the child protection plan.
- The third audit (in May 2016) showed that out of 130 sets of health visiting records from around the county, 93% had the voice of the child recorded and 88% had parenting observations recorded. This was a significant improvement from a previous audit in 2013. Following this audit, a 'Practitioners Best Practice Guidance' manual had been compiled and disseminated to all health visiting teams in locality meetings.
- The community paediatricians told us they had undertaken a review of their caseloads and audit in 2016. The audit had identified that 30% of the children and young people seen had a medical problem and 70% had behavioural issues associated with a learning disability, the majority of which did not have a mental health condition. The findings had identified the lack of appropriate resources for these children and young people in the local community and there were actions in place to address this.
- The physiotherapist service had implemented standardized assessment tools. For example, , , and Bailey's infant assessment.

Pain relief

- The nursing team in the short breaks' service included pain as part of their nursing assessment and used tools appropriate to the child's age and medical condition to assess pain. Records seen demonstrated effective pain assessment and management.

Nutrition and hydration

- Patient's nutrition and hydration needs were assessed and managed effectively. We observed that health visitors advised parents on feeding programmes during our inspection. For example, during developmental reviews for two and a half year old children, nursery nurses discussed the advantages of a healthy diet and considering introduction of vitamin supplements.
- Free healthy start vitamin coupons were available every six weeks for pregnant women and babies under one year (from six months). Posters with advice on where to pick up free healthy start vitamins in local areas were readily available. Free milk, fruit, and vegetables vouchers were available for women whose children were under four years old and we saw posters informing service users about how to access them.
- School nurses offered advice on healthy eating through school drop in sessions.
- A youth worker in the mid and east Northamptonshire children's community service worked closely with children in local schools where concerns had been raised around their nutritional status. Children assessed as 'fussy eaters' were supported by the youth worker to complete workbooks and set their own goals around trying new foods. Staff said children and their families had benefitted from this approach, which had helped to establish better dietary intake in children.
- Babies with tongue-tie were referred to the breastfeeding team via the referral management

system. The outcome was documented on the electronic recording system and could be viewed by the referrer. The service had an appropriate care pathway in place for tongue-tie.

Technology and telemedicine

- Staff were able to work remotely with computer tablet devices. The electronic recording system had better connectivity and made services more responsive to meeting service user's needs. All information technology equipment was password protected.
- The school nursing service had implemented a confidential and anonymous texting helpline for young people. The aim of the service was to support vulnerable young people who could be at risk. Nurses monitored and responded to automated text messages signposting to alternative out of hours personalised support available.
- Northamptonshire health visitors had a social media page with links to the child health drop-in clinics across Northamptonshire. Parents were advised to visit the social media page for information about services offered in their area. We looked at the social media page and saw that parents used this and staff responded to their queries on the page.

Patient outcomes

- Information about the outcomes of people's care and treatment were collected and routinely monitored.
- Over the six month period from April to September 2016, 45% of infants were breastfeeding at six to eight weeks after birth, which was below the trust target of 50%. There was an action plan in place to improve these outcomes for infants.
- Over the same period, the
- In September 2016, the number of infants who turned 30 days who received a face-to-face new birth visit within 14 days of birth, by a health visitor with mother (and ideally father), was 95%. This was better than the trust target of 90%.
- Hearing test clinics were held once a month for the academic year 2015/16. Out of 70 children seen, 16 were referred for audiology appointments.
- The school nursing team delivered influenza vaccinations to 58% of schoolchildren and this was within the trust target of between 40 and 60%.

Competent staff

- Staff had the skills, knowledge, and experience to deliver effective care and treatment.
- Staff had the right qualifications, skills, knowledge, and experience to do their job when they started their employment and took on new responsibilities. Preceptorship programmes with set meetings and guidance were in place for newly qualified health visitors and school nurses. Newly qualified health visitors told us they felt well supported. Health visitors reported positive support for training and development.
- Learning needs of staff were identified through 1:1 meetings and staff appraisals. All staff we spoke with told us they had had appraisal within the last 12 months, or had dates to attend. Data provided by the trust supported this with 80% to 100% of staff having recorded appraisals against the trust target of 90%. Staff told us agreed objectives where meaningful and achievable.
- The eating disorder service scored 80% for appraisals and the short breaks (The Squirrels) had overall appraisal rates of 85%. Senior staff told us that they had made a corporate decision to focus on achieving a higher level of appraisal. Operational managers would identify where there were low percentage figures and would work with teams to improve compliance rates.
- A trust clinical supervision policy was available on the intranet. Clinical supervision is a formal process of professional support and learning that enables individual practitioners to develop knowledge and competence, be responsible for their own practice, and enable patient protection and safety of care in a wide range of situations.
- Staff told us they had one to one meetings with their supervisors and regular team meetings included sharing and learning specific to their specialities. However data provided by the trust showed a varied rate of health centre based clinical supervision from 100% in some teams to as low as 25% in one. However, some of the teams consisted of three members of staff, which would account for the high percentage. There was an action plan in place to increase compliance.

Good

Are services effective?

- Nurses, health visitors, doctors, and support staff told us they had easy access to training and had regular clinical supervision and team meetings.
- Within the new integrated pathway for children and young people aged zero to19 years, the service appointed eight practice educators to support the five service teams. This demonstrated that the service supported the ongoing education and training needs of staff, particularly at times of change. Staff told us that training and appraisals were identified through the electronic training system.
- Paediatricians told us they had signed and appraised job plans and were able to access peer support and guidance from consultant colleagues. All medical staff had had revalidation.
- Health visitors and school nurses spoke highly of having access to strong peer support. Nurses undertaking their professional registration revalidation had found the process to be highly beneficial as they were able to feedback to each other in team meetings from learning in practice.
- The children and young people ADHD/ASD service had five nurse prescribers who had monthly supervision and peer supervision.
- We saw training competencies completed by nurses in the short breaks' unit, which were up to date and clearly documented. Staff had been trained and were able to deliver the appropriate care to children and young people.
- There was evidence of positive practice seen in the integrated sexual health service (human immunodeficiency virus, genitourinary medicine and family planning); specialist school nurses had developed training packages to deliver training to school staff.

Multi-disciplinary working and coordinated care pathways

- All necessary staff, including those in different teams and services, were involved in assessing, planning, and delivering patients' care and treatment. We saw excellent examples of multidisciplinary team (MDT) working throughout services. For example, we saw the children speech and language therapy (SALT) team working jointly with the adult SALT team and dietitians. MDT working with health visitors, physiotherapy, and occupational therapists was effective.
- Referrals to the service were handled effectively with clear criteria and a multi-agency approach to ensure timely assessment. We attended a meeting of the multiagency safeguarding hub (MASH) attended by healthcare professionals from across the trust and representatives from social care, the police service and drug and alcohol services. The purpose of the hub was to share information and safeguarding issues and concerns and to focus on early coordinated interventions to support both children and young people and vulnerable adults.
- There was a single point of access system called the referral management centre (RMC). Managers and clinical leads told us the RMC was working well. Paediatricians attended weekly referral review meetings to discuss individual case reviews. They explored care options for children and young people with complex conditions to ensure they were referred to the most appropriate clinical professional for their condition.
- MDT working supported effective care planning and delivery for children and young people, particularly those with long-term conditions, complex needs, and a disability. Parents told us nurses, doctors and other health care professionals worked together to provide coordinated care and support services for children and young people. They told us health professionals knew their child or young person and care, information and support was coordinated around the child and their family.
- We saw that there was an increased incidence of child sexual exploitation with 65 active cases. Monthly MDT meetings were held with the police and other agencies to discuss.
- Staff described a weekly MDT integrated screening panel, which discussed complex cases. Staff explained how they attended and had an input within this weekly integrated panel. Service leads described how this system had a few teething problems before, however, by the time of our inspection, it operated smoothly as a 'one stop shop' for allocating patient referrals to whichever service needed.

Good

Are services effective?

Referral, transfer, discharge and transition

- Staff worked together to assess and plan ongoing care and treatment in a timely way when patients moved between teams or services, including referral, discharge and transition. When families moved into an area and registered with a GP, there was an effective system of notifying the health visitor and an agreed process and timescale in which to make contact with the family and assess their needs. Families were invited to a child health clinic and if the family came from out of area, they were also offered a home visit.
- Health visitors and school nurses had clear referral processes to other disciplines. When families or children transferred out of area or moved to a new school, the health visitor would inform the new practitioner. School nurses offered school entry checks to those children starting school in reception class.
- The RMC provided a single point of access for professional wishing to make referrals for children and young people in the county. A screening process was
- The RMC processed and screened all referrals for children's specialist services. Where appointments had been cancelled, some staff said they were not always informed in a timely manner.
- We looked at the children and young people's ADHD/ ASD operational policy and saw all referrals were paper screened by a senior nurse or psychologist daily, where decisions were made at the point of screening regarding the need for treatment or assessment. Referrals could be made by any professional working with a child, young person and family.
- We reviewed minutes of a team meeting and saw that special school nurses (SSN) felt they did not receive enough information about a child before they started primary school. The possibility of the community children nurse offering an annual meeting with the SSNs to share relevant information was discussed during the meeting
- Health visitors and school nurses were unclear about transition arrangements for young people. Community paediatricians told us there were limited opportunities in the community for children and young people with a learning disability who presented with challenging behaviours, but did not have mental health needs.
- The physiotherapist service had a transition pathway for pupils aged 14 to18 years old and staff attended transition meetings.
- When patients were discharged from services, GPs were notified using the electronic recording system.
- The children's SALT team benefitted from a positive MDT working set up, where they were able to exchange and learn information from the adult SALT team when making a transition.

Access to information

- All the information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- The community service for children, young people and families had access to laptops and their own electronic record system. Staff said that the electronic record system worked well and was in the majority of GP surgeries. We observed that staff were able to access the system and they told us it enabled them to deliver effective care and monitor the care and support of children on their caseload. However, there were intermittent issues with connectivity in parts of the community, which was being considered by the service.
- The systems that managed information and electronic care records supported staff to deliver effective care and treatment. The trust's intranet held the trust's current policies but some staff told us and we observed it was difficult to navigate.
- Staff used an electronic recording system to manage care records and mobile staff could access care records through password-protected tablets. These systems were monitored and staff could download up-to-date care records onto the tablets.
- Some of the GP practices did not use the same electronic recording system and staff said this made MDT working difficult as health records could not be seen and health visitors were unable to send requests or referrals to GPs if required.
- Parents and carers were given information and signposted to information sources relevant to any queries they may had.

Good

Are services effective?

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. The trust's policy included guidelines relating to consent for children. Consent to care and treatment was obtained in line with legislation and guidance, including the Children's Acts 1989 and 2004.
- Staff were confident in explaining the process when getting informed consent for a patient who lacked capacity.
- All service users under the age of 16 were assessed following the Gillick competency guidelines. The Gillick competency guidelines were formed because of a legal judgment on young people under 16 accessing health services. It stated that a child under 16 can consent to a procedure, without parental knowledge or consent, if they meet the criteria of sufficient maturity.
- Service users under the age of 16 who required contraceptive advice were assessed in accordance with the Fraser guidelines. The Fraser guidelines
- The integrated sexual health team included an assessment in under 18s using a vulnerable person proforma, based on spotting the signs of child sexual exploitation. All staff used "spotting the signs" documentation to access level of concern with young people. This framework reflected the Gillick competencies and was used when deciding whether a child or young person was mature enough to make decisions without parental consent.
- There were protocols for gaining parental consent for school checks. Procedures were in place for gaining immunisation consent. Observations of practice within the services showed staff asked for people's consent before any interventions of care.
- 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.
- We saw consent for an alarm process in one of the short breaks' units was available in each patient's record, which was signed by parents and families.

Good

Are services caring?

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

Summary

We rated caring as good because:

- When speaking with children, parents and carers, they were continually positive about the care that was provided and the way that staff treated them. People told us and we saw that staff went an extra mile when they provided care.
- Staff were committed to empowering young people and provided them with appropriate information and support to enable them to make decisions around the care they received.
- People were treated respectfully and their privacy was maintained in person and through the actions of staff to maintain confidentiality and dignity.
- Patients we spoke with during our inspection were very positive about the way they were treated.
- All staff were sensitive to the needs of all patients and were skilled in supporting children and young people with disabilities and complex needs.

Compassionate care

- Staff understood and respected children and young people's personal needs. Children and young people told us they felt respected and listened to in a non-judgmental way. During the inspection, we saw several instances of positive interactions, which were both age and language appropriate.
- We observed receptionists, nurses, health care professionals and support staff interactions with children and young people as being friendly and welcoming.
- Nurses and health visitors went out of their way to be child centred and we observed examples of where trusting relationships had been developed with the child and their family.
- 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.
- Staff described respecting patients cultural beliefs. Health visitors said they took their shoes off when entering a patient's family home as a form of respect.
- Parents spoke in glowing terms about the short breaks' service, the health visitors, school nurses, paediatricians and the breastfeeding service.
- A parent attending the short break service said "the nurses and support staff always go the extra mile and I know my child is safe and well cared for". The parent and child were regular uses of the short break service and without regular support; they would be unable to continue to care for their child at home.
- A parent attending the child development centre said "the doctor is really empathetic and what I really like is that the doctor remembers what we discussed at the last appointment and thinks about me as well as my child".
- We observed a health visitor undertaking home visits to carry out six weekly checks with mothers and their babies. The health visitor took the time to listen to each mother and addressed any concerns with breastfeeding. One mother, who spoke good English, was from a different ethnic group. The health visitor checked the mother had understood the information to ensure understanding.
- We listened to telephone conversations made to service users by health visitors. Health visitors were professional, courteous and offered advice over the phone.
- Mothers said "how helpful the information was" and how "helpful and caring" the heath visitors had been.
- Patients and their families were given opportunities to describe their good or bad experiences involved in their care. The 'I want great care' results across the children and young people's service was positive with the majority of patients, relatives and families recommending the service.
- Information provided by the trust showed the NHS Family and Friends Test to be positive for whether

service users would recommend the service at 88% to 89%, which was better than the national average of 88%. Patients and families who would recommend the service averaged 96% in August 2016.

- Results of local patient survey from March to August 2016 for children and young people showed that 67% to 100% of patients would like recommend the service.

Understanding and involvement of patients and those close to them

- Staff communicated with children and young people so that they understood their care, treatment and condition. Children told us that they had felt involved with their care and staff made things clear for them during appointments.
- Staff took the time to talk to children in an age appropriate manner about what was going to happen and encouraged them to ask questions about the treatment. We observed interactions with health visitors and school nurses being parent led. This meant that the needs of parents were identified and were listened and responded to. Future care and support was always jointly agreed.
- We observed a development check which showed that the parent was 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.
- Parents and young people (where it was appropriate) were fully involved in multi-agency meetings at the short breaks service and were encouraged to think about what support would help them and the planning and scheduling of it.
- Children and young people were involved in the planning of activities and trips and their personal choices were taken into account, whenever it was possible to do so. We observed staff provided information in various formats and used different styles of body language to aid communication. For example, photographs, diagrams, communication boards and electronic tablets were used to aid communication with children and young people. Staff had recorded in children's care plans the preferred style of communication for each child and young person.
- Children were involved in consultations. For example, person-centred individualised care planning was embedded in practice and ensured service user involvement at all times.
- During the observation of a home visit with a health visitor, we saw how a parent's request for support around managing their child's behaviour was assessed. Staff gave evidenced based advice and identified that the child needed a referral. The child was referred to a family support worker for further support.
- We saw that staff set goals with children and young people, and their families, when attending the short breaks service as part of their plans of care. For example, helping a child to develop greater independence with washing and dressing and participating in activities outside of the home.

Emotional support

- Staff understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them both emotionally and socially.
- Staff recognised and supported the broader emotional wellbeing of children and young people with long term or complex needs, their carers and those close to them. Children and their relatives told us the clinical staff were approachable and they could talk to staff about their fears and anxieties.
- Staff were aware of the emotional and mental health needs of patients and were able to refer patients for specialist support if required. Assessments tools for anxiety, depression and well-being were available for staff to use when required.
- We observed children and their families were supported emotionally.
- Mothers we spoke with described discussions about their emotional wellbeing and how they had been supported. At the antenatal contact, health visitors asked women to think about the support they may need to look after their mental health and wellbeing.
- At the six weekly development checks, we observed the health visitor asked questions around the mood of the

mothers since the birth of their child. A mother told us "the emotional support from the health visitor has been really helpful and I know I can talk to them if I have concerns about myself or my child".

- School nurses provided emotional support to young people through a dedicated and confidential help line accessed through texting. We observed a number of 'chat' conversations undertaken with young people and the advice and support that was provided to them. Responses received from young people to the advice they had received said "thank you for the support, it has been really helpful and I am continuing to use the self-help techniques (for anxiety) you suggested" and "thank you so much, so good to know you are there" and "this has been the most helpful advice anyone has ever given me".

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- The service reflected the needs of the local population and provided flexibility, choice and continuity of care to meet needs of the local community.
- The range of services offered and way that the services were being delivered contributed to addressing the health needs of local children and young people.
- The service was planned to take account of the needs of different people from diverse backgrounds.
- Generally, patients had timely access to initial assessment, diagnosis or urgent treatment.
- There were positive adjustments in place when monitoring and responding to patients with a learning disability.
- Nursery nurses and health visitors facilitated breastfeeding support groups and drop in sessions to provide support to families.
- Complaints' processes were effective.

However, we also found that:

- There were 233 children waiting on the attention deficit hyperactivity disorder (ADHD) waiting list and 127 patients on the autism spectrum disorder (ASD) waiting list. Some of these children waited over 18 weeks. However, the number of children on the waiting list had reduced and there was an action plan in place to monitor the waiting list.

Planning and delivering services which meet people's needs

- The service reflected the needs of the local population and provided flexibility, choice and continuity of care to meet needs of the local community.
- The trust was working with the clinical commissioning group and local partners across the NHS, local authority public health, children's services, education and the voluntary and community sectors to develop local transformation plans for children and young people over the next five years.
- Children, young people and family services were undergoing a radical service redesign to improve services for children and young people. This was being achieved through the implementation of the zero to19 integrated pathway for children's services. The new approach had been a result of a large public engagement event led by the Northampton County Council.
- Heath visitors, school nurses, nursery nurses, support workers and breastfeeding services were being relocated into clusters and where possible, based in shared locations to facilitate a joined up approach to the care of children and young people. Five clinical team leaders were now in place and the emotional wellbeing of children and young people was integral to the pathway approach to children's services.
- Caseloads for health visitors and school nurses were becoming locality based and staff were able to be utilised in different ways. For example, nursery nurses supported immunisation clinics as they were trained to care and support children up to eight years of age.
- Children and adolescent mental health services worked closely with school nurses. They met monthly to discuss the needs of children and young people, for example, the use of appropriate mental health tools to aid in the assessment of young people. Plans were in place to involve health visitors in the future.
- School nurses told us there was less support for children aged between two and five years around developing emotional resilience in younger children. Plans were in place to work more closely with maternal mental health (perinatal) services.
- An administrative hub for children's services was implemented in December 2016. The hub had brought together all the administrative systems and processes for children's services in one location. We were told there was now better communication across all children's services and unnecessary duplication of GP and mental health referrals was being avoided. Families were able to access the hub and book their children's development checks around their family commitments.

Good

Are services responsive to people's needs?

- Non-medication based focus groups and workshops were planned following a diagnosis ofADHD. These groups were open to everyone. The team received feedback from the adult ADHD/ ASD team and used this feedback to support young children.
- The range of services offered and way that the services were being delivered contributed to addressing the health needs of local children and young people.
- 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.
- Regular child health clinics were held across the area for parents to access advice and monitor the growth and development of their young children. Parents were also signposted to regular baby weaning groups.
- The school nurses provided termly meetings with schools and regular drop-in sessions for students in schools.
- Children's occupational therapy services had been actively engaged in special educational needs (SEND) reforms within Northamptonshire. For lower levels of need, occupational therapists developed and circulated printable advice packs for schools (and parents), giving information/advice for school staff to follow with children with poor motor coordination, functional difficulties, table top skill problems and sensory issues.
- Targeted and specialist provision was provided by supporting parents and young people and advising of the nature, causes and likely outcomes for children with SEND. Where there were identified needs for occupational therapy, referred children were offered on-going support in the form of advice, reviews and direct therapy. Levels of involvement responsively fluctuated and varied depending on changing needs of the child.
- The physiotherapy service had initiated arrangements to ensure that the assessment and educational needs of the child were met including improved care using a person-centred approach, joint goal setting between therapists, child/family and education and improved access to therapy services within local areas.

Equality and diversity

- The service was planned to take account of the needs of different people, for example on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.
- The service had an in date interpreting and translation policy. Interpreters were available through a local agency and telephone line. Staff described using the service and arranged for interpreters to attend face to face. If they were not available, they had access to the telephone translation line. The health visitors at the Danetre Hospital described using internet services to translate appointment letters and any other form of communication according to a patient's language requirement.
- Staff told us interpreters were available if they were able to pre-book. However, difficulties were encountered due to the wide range of languages and their associated dialects within Northamptonshire.
- Leaflets were available for patients about the services and the care they were receiving. Staff described having access to an online system to order any leaflets in order languages for patients. CYPF teams could print information in non-English languages if required although these were not readily available in patient waiting areas.
- Health visitors supported parents from ethnic minority groups to access and attend child health clinics and to engage with the service. This gave them the opportunity to meet other parents and promoted
- Health visiting teams signposted service users to the NHS immunisation website to access a range of languages to understand immunisation information.
- Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment and enabled them to access language interpreters. For example, we listened to a telephone conversation from a health visitor to a parent. The health visitor checked their preferred language and offered to involve an interpreter.

Good

Are services responsive to people's needs?

Meeting the needs of people in vulnerable circumstances

- Staff described how patients with complex needs were discussed in the referral management centre. The multi-disciplinary team held weekly meetings to discuss the planning and arrangements of placing vulnerable patients, living with disability, in the right service appropriate to meet their needs.
- The respite location which was an autism speciality service, had a system in place of using 'place mats' which highlighted if a patient had dietary requirements or other additional needs such as hearing impairments. By having this system in place, staff were made aware of additional needs if it affected communication with patients.
- Staff from the children's speech and language therapy (SALT) team described the management of patients with a learning disability using a bespoke home visit programme. This saw patients with significant needs such as a physical impairment or those requiring wheelchairs within their home environment.
- Additional psychological support had recently been secured to support the ASD assessment service.
- We looked at the pathway for response to domestic violence for health visitors, family nurses and school nurses. From October 2015, the police introduced a system of informing health agencies about domestic abuse incidents where a child or young person was known to live in the household. The aim of the system was to improve information sharing between professionals where a domestic abuse incident had occurred, and therefore to better protect and support children, young people and families in these situations. Health visitors, family nurse and school nurses followed this pathway to mitigate risks.
- Safety guidance was given around babies travelling in cars and mothers were directed to the health visiting social media page for information on local children's services. For example, dates and times of breastfeeding clinics were published on the page.
- We observed that clinical areas we visited were accessible to people with disabilities. Staff received equality and diversity training as part of their mandatory training. Staff at the short breaks service were able to do a report with pictures for children and young people with a learning disability and had made videos for those who were unable to read.

Access to the right care at the right time

- Generally, patients had timely access to initial assessment, diagnosis or urgent treatment. However, there were waiting lists for two services. Waiting times for children and young people's ADHD/ASD services including the time to first assessment was over 18 weeks. There was a backlog of 233 patients on this waiting list and 127 patients on the ASD waiting list.
- Community paediatricians worked closely with the children and young people's ADHD/ASD, and Asperger's team and made the final diagnosis of children and young people suffering from these disorders. The wait for an assessment by a clinical or educational psychologist was between six to eight months. This had reduced from a12 month wait reported a year ago. The team had 127 patients on the ASD waiting list, who required an educational psychologist assessment for autism.
- Staff within health visiting teams prioritised care and treatment for people with the most urgent needs. For example, they prioritised new birth visits and transfers into the area over antenatal contacts. Parents we spoke with said they had no problem assessing the service. There was no waiting list for sexual health services.
- New-born babies and new mothers were seen by a health visitor between 10 to14 days post-partum (after birth). We observed a new birth home visit and staff provided evidence based information to the new mother and carried out a maternal mental health assessment.
- We were told that performance measures for the Healthy Child Programme showed that babies and children received regular development checks. The proportion of infants who turned 30 days and received a face-to-face new birth visit within 14 days of birth exceed the trust target (90%) and was greater than 90% across all of the reported months.
- However, some health visitors told us they were not always able to complete the two and a half yearly reviews as parents had often gone back to work, moved

house or did not see the importance of the development checks. The health visitors had undertaken caseload reviews to prioritise the needs of children who may be at risk and had followed this up with targeted visits. Parents were contacted and offered an appointment at a time to suit them to enable the development check to be undertaken.

- The trust target for feeding status being recorded at the 6 to 8 week check was 98% and the trust's performance fell slightly below this target at between two and six percentage points lower throughout the six months provided.
- The trust target for infants being breastfed at six to eight weeks is 50% and the trust was only marginally below this target in May (49%), June (48%) and July (47%) 2016. The trust was between six and nine percentage points below the target in April, August and September 2016.
- School nursing had the highest average days from referral to initial assessment (42 days) followed by children's continence services (25 days).
- Community paediatricians met the national target of 18 weeks from referral to initial assessment for children and young people, reporting an average time of 12 weeks from referral to assessment.
- The children's centre at St Mary's hospital had nine consultation rooms, which were used by the SLT team, ADHD/ASD, paediatricians and other teams. There was a room request process in place and this process was coordinated by administrative staff. There were sometimes difficulties in booking rooms.
- Health visitors had weekly drop-in clinics in the library from 1.30pm to 3.30pm. During this drop-in session, we saw mothers who had their babies weighed and we observed health visitors giving feeding and developmental advice.
- The service provided breastfeeding support drop-in sessions, which were led by health visitors and nursery nurses. We observed an interactive drop-in session at the Upton children's centre and this was well attended by mothers and babies.
- Figures provided by the trust for health visiting universal contact "did not attend" (DNAs) showed that from October 2015 to September 2016, there were 114 DNAs in antenatal care, 233 DNAs for new birth visit, 401 DNAs for the six week examination, 1,882 DNAs for the eight to nine month examination and 2,690 DNAs for the two and a half years examination. The total figures for DNAs was 5,320. During our inspection, we spoke to health visitors who said they would ring families through to confirm appointment order to reduce DNA rates.

Learning from complaints and concerns

- Parents we spoke with knew how to make a complaint or raise concerns, and were encouraged to do.
- Staff told us that complaints were handled effectively and confidentially, with regular updates for the complainant with a formal record kept.
- Staff said lessons were learned from concerns and complaints, and actions taken as a result to improve the quality of care when required.
- The children and young people's services were effective at making patients aware on how to make a complaint. We saw patient advice and liaison service (PALS) leaflets on notice boards around the locations we visited. Staff were also responding to complaints through their 'you said, we did' system, which was then visible on notice boards highlighting how they had responded to any concerns or complaints.
- The sexual health team reported two recorded complaints for this service in 2016. As a result of the complaints made, full training programmes were put in place in order to mitigate future risks.
- New birth visit packs contained information leaflets for parents about local services, including a PALS leaflet.
- A senior member of the children's services described complaints from parents, regarding the long waiting times for an ADHD diagnosis assessment. They described how they learnt from this complaint by including an information leaflet on their referral letter stating that a diagnosis for ADHD assessment can take up to nine months from first initial appointment onwards. This helped to mitigate the parents' expectations

Good

Are services well-led?

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

Summary

We rated well-led as good because:

- Staff consistently told us they were proud of working for the family, young people and children's service.
- Front line staff described their senior managers as being supportive, visible, and approachable and provided an open door policy.
- Staff were aware of the vision and strategy for children and young people's services and supported the changes to provide a more child centred service.
- The service leadership was visible and communicated with staff by monthly newsletter. Service managers attended team meetings.
- The health visiting and school nursing teams were undergoing changes with the implementation of the zero to19 integrated pathway for universal children's' services. Staff going through this transition period been consulted and found their team leaders and service managers supportive.
- Staff morale was positive and staff felt well supported, despite the demands and challenges. Managers were said to be available to support staff and to provide advice where needed.

However, we also found that:

- The risk register did not include those services were patients were waiting over 18 weeks

Service vision and strategy

- Staff were aware of the vision and strategy for children and young people's services and supported the changes to provide a more child centred service. Most staff were aware of the wider vision of the trust, with poster displays of the trust's vision and values being evident in all of the areas we visited.
- Staff were able to articulate that the vision of the service was to continuously improve the quality of the services in order to provide the best care and optimise health outcomes for each patient accessing the service.
- Staff were open and honest about not understanding the previous vision and strategy for the service. However, they felt the new leadership for the trust was a positive one moving forward which would shape and improve services for children and young people.
- Staff were very insightful on knowing the strategy of the ''DIGBQ' acronym which was used alongside meetings and incorporated in their appraisals and supervision.
- Children's universal services had implemented the zero to19 year's pathway for children and young people in November 2016. The aim to bring health visiting and school nursing professionals together in designated clusters was still in transition.
- Staff told us they supported this vision but expressed concerns around the shortages of school nurses. Action plans were in place to address staffing concerns within school nursing teams.
- The senior management team was committed to working with staff across all children's universal services to deliver the proposed vision and strategy.

Governance, risk management and quality measurement

- There was a clear structure for clinical governance in the services. The service reported into the service line reporting structure and assurances were made through the various committees into the trust board.
- Managers and clinical leaders attended monthly governance meetings where incidents, accidents, and near misses were discussed and actions agreed and recorded in the minutes.
- There was a directorate service risk register in place, which included the children and young people's service. The service risk register had 13 risks in place and each had been reviewed regularly with details of mitigating actions to reduce the risks were recorded. Key staff were shown as being accountable for the risks on the register and timescales for actions were clearly recorded.

Good

Are services well-led?

- A risk was recorded on the risk register in September 2016 and related to organisational change and moving from locality based administrative support to an integrated single administrative hub. During the transition phase, there was a risk that organisational processes may have lost structure and there was the potential for reduced organisation and an increase in communication errors. An outline plan was in place to help mitigate the risk.
- There were two risks relating to staffing levels within the service. One was a reduction in health visitors and skill mix teams. Health visitor caseloads in Abington were on average at 590 patients per WTE and this was due for review on 30 June 2016. The action described was "recruitment of health visitors". The action due date had passed in June 2016 but the register had not been updated to reflect progress.
- There were children waiting on the attention deficit hyperactivity disorder and autism spectrum disorder waiting lists for over 18 weeks with no clear oversight on the deterioration of those waiting. This risk had not been recorded on the risk register.
- We spoke with nurses, health visitors and doctors who were involved in local audits. Staff told us they audited care records and caseloads and shared the findings in their governance and team meetings.
- Staff described a useful platform regarding 'the staff room' on the intranet page where the governance team gave updates to staff regarding risks

Leadership of this service

- A deputy director, head of universal children's services, head of specialist children's services and service managers led the service.
- Leaders had the skills, knowledge and experience that they needed both when they were appointed and on an ongoing basis. Leaders we spoke with had worked for the organisation for many years and stated that there were opportunities for professional development and career progression across all staff teams.
- Front line staff described their senior managers as being supportive, visible, and approachable and provided an open door policy. Staff also described the leadership from the directors and the chief executive officer (CEO) as positive and child and young person focused, which had helped improve services for children and young people.
- Nurses, health visitors, doctors and support staff were all aware of who their immediate managers were. There were clear lines of responsibility and accountability.
- Staff said the CEO was well known in the organisation and had visited many areas of community children's services.
- Staff told us their line managers and clinical leaders had supported them through the changes associated with the implementation of the zero to 19 integrated pathway for children and young people in the trust.
- Managers and clinical leaders had ensured there were regular team meetings, newsletters and emails circulated regularly so that staff knew about the on going changes to children's services.

Culture within this service

- Staff felt respected, valued and confirmed an open policy regarding the sharing of views in relation to the planned reconfiguration of services. There was an open and transparent culture where staff were encouraged and felt comfortable about reporting incidents.
- Staff were proud to work for the trust; they were enthusiastic about the care and services they provided for patients. They described the trust as a good place to work and some staff we spoke with had worked for the trust for a number of years.
- Teams worked collaboratively, with support and advice provided as necessary. On the wards, we observed senior staff mentoring junior staff in their tasks. Mentoring staff explained processes and procedures to ensure staff to ensure they understood the processes.
- We saw that staff had 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 at these meetings.
- We saw friendly and open engagement between all groups of staff. Nurses, doctors health visitors and support workers we spoke with were proud of the care

and service they provided to children, young people and their families. Managers and clinical leads were clear that staff placed children and young people at the heart of everything they did.

- The culture encouraged the reporting of incidents, concerns and complaints. A nurse said "staff work hard to ensure we give the best care and support we can to the children and young people and their families and we place the child at the heart of everything we do".
- Staff talked positively about a 'no blame' culture in children's services. We were given examples of where staff had raised issues and concerns and how they had been acted upon in an appropriate and timely manner by managers and clinical leads.
- Staff described an open and honest culture from both their senior management and director level. Staff felt they could be open and honest about anything they wanted to discuss whether in supervision or in team meetings.
- 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 and 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.
- Some staff, particularly those working remotely within a respite team, felt disconnected to other teams and sites within their service and to the organisation as a whole.
- Staff showed us on their staff room website how the CEO acknowledged good work on their thank you section. Staff also received a postcard if they had not been off sick for more than a year. Staff who had been long service also received awards and recognition from the CEO.

Public engagement

- We saw positive scores regarding 'I want great care', which allowed children and young people to share their views on the quality of the service. Staff were good at responding to their concerns around the service delivery.
- Children and young people's services used a variety of approaches to gather feedback. A child friendly 'I want great care' questionnaire was in place in the children's development centre. Health visitors were undertaking a survey into the accessibility of children and young people's services out of hours. A staff and user engagement group had recently been established and there were plans to involve children and young people in staff recruitment.
- Key positive themes from feedback comment cards included supportive, caring knowledgeable and professional staff. Waiting times from assessment to appointment and lack of communication was the key negative theme identified.
- 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 services, and healthy day sessions. Families also said 'we want a health visitor in the room', but this had not yet been implemented.
- Health visitors had developed a social media page for children's services at the trust, which provided advice and guidance to parents and service users. A new parent told us "the information provided by the trust was really helpful around diet and alcohol consumption as I was breast feeding my baby over Christmas and was unsure how to manage this".
- School nursing had implemented a confidential helpline texting service for young people in schools to enable them to raise issues and concerns which they did not want to discuss in person. We saw examples of where young people had sought advice. For example, in relation to their sexuality, anxiety issues and changes in appointment times with the school nurse. Themes from the text service were identified and used to support the planning of children's services.

Staff engagement

- The 2015 trust staff survey response rate was 44% and this was higher than the national average response rate of 41%.
- Nurses, doctors, health visitors and support staff told us they were encouraged to share ideas about service improvements and spoke positively about how they were actively involved in service planning.
- All staff told us they attended regular team meetings and participated in clinical supervision.

Good

Are services well-led?

- Staff feedback received on the overarching aim of delivering a zero to19 integrated pathway for universal children's services was very positive. Staff identified a range of benefits for children, young people, families and staff across a range of professions

Innovation, improvement and sustainability

- Health visitors had developed a social media page to help provide up to date information on children and young people's services in Northamptonshire. The health visitors oversaw the management of the website and had been awarded an innovation award by the trust.
- The school nursing service had developed a confidential and anonymous helpline to support vulnerable young people accessed using texting. From August to December 2016, the service had received 279 messages, sent 336 messages and had 53 conversations.
- Staff were proud to be nominated for the 'PRIDE' award 2016 from the autism speciality respite location. They also won team of the year 2016.
- The senior member for the children services discussed of a self-referral service through the referral management centre, which would take effect from April 2017. They spoke highly of this innovative 'CAROL' pathway, which would allow young patients to chat live online interactively to get help and be referred to the right service that they required.
- The children and young people's community health services newsletter issued in July 2016 showed that the bid to health education England's innovation fund had been successful. The grant was used to develop and implement an online live chat, telephone support and facilitated self-referral facility for emotional well-being and mental health specifically for young people aged 13 to18 years and parents/carers.