Care Quality Commission

Quadrant

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

Quadrant provides health visiting and school nursing services for children, young people, and families who live in North Tyneside.

We regulate independent healthcare services but we do not currently have a legal duty to rate them.

We found the following areas of good practice:

- Staff protected children and young people from avoidable harm and abuse, and they followed appropriate processes and procedures to keep them safe. The lead safeguarding nurse advisor had good oversight of the concerns raised by staff and actively shared information and learning across the service.
- The vision, strategy, leadership, governance, and culture promoted the delivery of high quality person-centred care. A dynamic team of directors, supported by a proactive senior manager professional lead, area leads and lead safeguarding nurse advisor had good oversight of risks, which they monitored and reviewed regularly.
- Managers and staff managed caseloads well, and there were effective handovers between health visitors and school nurses to keep children safe at all times. On a day-to-day basis, staff assessed, monitored, and managed risks to children and young people. This included risks to children who were subject to a child protection plan or who had complex health needs.
- Children, young people, and families felt staff communicated with them effectively, kept them involved and informed about care and treatment, promoted the values of dignity and respect, and were kind and compassionate.
- Services were organised to meet the needs of children and young people. Managers and practitioners worked collaboratively with partner organisations and other agencies to ensure services provided choice, flexibility, and continuity of care.

Summary of findings

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Summary of this inspection

Background to Quadrant

Quadrant provides health visiting and school nursing services to children and young people from 0-19 years old across North Tyneside.

Practitioners deliver care and treatment to children, young people, and families in their own home, in schools, and in children's centres across the local area.

Health visiting and school nursing is part of the Health, Education, Care and Safeguarding (HECS) department of North Tyneside Council and sits within the Public Health team, under the leadership of the Director of Public Health. The service is closely aligned with Children's Services. Practitioners are based in four localities across North Tyneside and work together in integrated teams, each one led by an area lead.

Quadrant registered with CQC in March 2017 and the registered manager is the Director of Public Health. Health visiting and school nursing in North Tyneside was previously provided by Northumbria Healthcare NHS Foundation Trust.

This is the first inspection following registration. The service is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury

Our inspection team

Our inspection team was led by:

Angie Brown, CQC Inspector, with oversight from Sandra Sutton, CQC Head of Hospitals Inspection.

The team that inspected this service comprised of two CQC inspectors and specialists in health visiting, school nursing and safeguarding.

Why we carried out this inspection

We inspected this service as part of our on-going comprehensive independent health inspection programme.

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?

We regulate independent healthcare services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Before the inspection visit, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed service-specific information provided by the organisation, and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive, and well-led.

Summary of this inspection

We carried out the announced visit from 06 to 07 March 2018. We did not undertake an unannounced visit.

During the inspection visit, the inspection team:

- Visited all four localities across the borough of North Tyneside (central, coastal, north west, and south west).
- Spoke with 13 children, young people, and families.
- Spoke with the registered manager and senior managers from the service and local authority.
- Spoke with 26 health visitors, school nurses, staff nurses, nursery nurses, and administrative staff.
- Attended and observed five home visits, two school drop-ins, and five clinics and appointments.
- Looked at 10 care records.

What people who use the service say

- Children, young people, and families we spoke with were unanimously positive in their feedback about the health visiting and school nursing service.
- Families felt they could engage safely in open and honest discussions with practitioners. For example, one parent said, 'I feel I can talk freely about anything'.
- Families spoke positively about the accessibility of the health visiting service. One parent told us, 'I can just pick up the phone or text whenever I want' and said they always received a prompt response.
- One parent described the health visiting service as 'outstanding' and spoke of supportive staff who all provided good advice.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- Staff protected children and young people from avoidable harm and abuse.
- Staff understood their responsibilities in relation to incident reporting, learning, and improvement. All practitioners knew how to report incidents and North Tyneside Council had developed a bespoke electronic reporting system to meet the needs and requirements of the service. We saw evidence of lessons learned and this was shared at team and management meetings.
- Safeguarding children and young people had a high priority and staff knew what to do if they had a concern. The lead safeguarding nurse advisor had good oversight of the cases within the service and actively shared information and learning with staff. All practitioners had completed Signs of Safety training and we found robust evidence of engagement with the multi-agency safeguarding hub (MASH), which involved other agencies such as the police, housing, and social services.
- The quality of care records was good and practitioners completed electronic records in line with national guidance.
- Staff managed caseloads well, and there were effective handovers between health visitors and school nurses to keep children safe at all times. On a day-to-day basis, staff assessed, monitored, and managed risks to children and young people. This included risks to children who were subject to a child protection plan or who had complex health needs.
- Although the service had experienced an increase in staff turnover immediately following the transition from the NHS to local authority, managers had recruited new staff to fill the vacancies. There was good skill mix within each team. Compliance with mandatory training was good and the service had implemented a system to ensure there was sufficient oversight of training requirements.

Are services effective?

- Policies and guidelines were evidence-based, and there were good examples of multidisciplinary and multi-agency working and collaboration.
- Staff completed comprehensive assessments, which took into consideration the physical and mental health needs of children, young people, and families.

Summary of this inspection

- The care and treatment of children and young people achieved good outcomes and promoted a good quality of life.
- Health visitors and school nurses delivered the Healthy Child Programme and managers routinely collected and monitored the data using a performance dashboard. Performance was good and practitioners delivered all mandated contacts in the pre-school years.
- The service had achieved full accreditation with the UNICEF Baby Friendly Initiative and breastfeeding rates showed continuous improvement.
- Managers encouraged staff to develop their professional skills and practitioners took ownership of their own performance. All staff had received an annual appraisal and there was a good preceptorship programme for new staff joining the service. The management team had also prioritised the recruitment and retention of staff through the introduction of developmental staff nurse posts.
- Practitioners exercised good practice in relation to consent and confidentiality, and appropriately applied Fraser guidelines and Gillick competency when offering treatment to children less than 16 years old.

Are services caring?

- Staff created a strong, visible, person-centred culture. Practitioners were highly motivated and inspired to offer the best possible care to children, young people, and families, including meeting their emotional needs.
- All staff we spoke with were passionate about their roles and were dedicated to making sure children, young people and families received the best patient-centred care possible.
- Throughout our inspection, we observed staff delivering compassionate and sensitive care that met the needs of children, young people, and families.
- Staff treated children, young people, and families with dignity and respect and involved them in their care.
- We observed members of staff who had a positive and friendly approach towards children and parents. Staff explained what they were doing and took the time to speak with them at an appropriate level of understanding.
- Families spoke positively about the health visiting and school nursing service. Feedback from surveys indicated 99% of respondents would recommend the service to family and friends and 100% said they felt practitioners listened to them.

Summary of this inspection

Are services responsive?

- Managers and staff planned and delivered services to meet the needs of children and young people and worked in partnership with families, partner organisations, and other agencies.
- The service prioritised the needs of the most vulnerable children and families. Practitioners worked collaboratively with other agencies to deliver joined up care for young parents and for vulnerable families who had experienced domestic abuse.
- Families had access to the right care at the right time, taking into account children and young people who were vulnerable or those with urgent or complex needs. School-aged children could access timely advice and information from a school nurse via the Chat Health text messaging service.
- Staff actively promoted involvement from children, young people and families, and the individual needs and preferences of children and young people were central to the planning and delivery of services.
- Staff proactively looked at different ways to address and manage public health needs, such as managing obesity. The service provided a dedicated Healthy 4 Life nurse to deliver an evidence-based intervention programme designed to encourage and support behaviour changes and help facilitate long term health benefits.
- There was an open and transparent approach to handling complaints. Information about how to make a complaint was available and we found evidence of lessons learned.

Are services well-led?

- The leadership, governance, and culture promoted the delivery of high-quality, person-centred care.
- There was a good strategy, designed to meet the needs of children, young people, and families and deliver a high quality service. Managers had proactively engaged with staff and other stakeholders.
- Managers created a culture of openness and transparency with a clear focus on putting children and young people at the centre of their care. Staff displayed integrity in their work and communication was very good.
- There was strong collaboration and a culture of collective responsibility amongst practitioners and managers, with a common focus on improving quality of care and the patient experience.

Summary of this inspection

- Managers had an inspired shared purpose and strived to deliver, and leadership was good across the service. There was a clear management structure, and line managers were visible and involved in the day-to-day running of services.
- There was a good governance structure. Monthly operational and governance meetings provided opportunities to discuss regular agenda items such as risk, incidents, and safeguarding.
- Risks were reviewed at local and senior management meetings, and appropriate timescales and mitigation was in place.
- Staff were very positive about working for North Tyneside Council. They felt respected and valued by managers at all levels and described them as approachable and supportive.
- Managers and staff gathered feedback from children, young people, and families. They listened to suggestions and incorporated the feedback into their list of priorities. There was a collective focus on continuous improvement. Staff felt empowered to raise concerns and offer innovative suggestions to improve service delivery, quality, and care.

Detailed findings from this inspection

Community health services for children, young people and families

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Incident reporting, learning and improvement

- Health visitors and school nurses reported incidents on an electronic reporting system and followed guidance produced by North Tyneside Council. The Council developed a bespoke system, tailored to meet the requirements of the 0-19 children's public health service. The system was integrated into the Council's overarching incident reporting system, which meant there was corporate oversight of incidents across the organisation. Staff told us they had received training in the use of the new system.
- When incidents occurred, staff told us they were open with children, young people, and families. Staff we spoke with understood the duty of candour requirements. The incident reporting system took into account the requirements of the duty of candour, which 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 provide reasonable support to those persons.
- Managers received an email notification of every incident. Area leads responded to the initial incident and instigated investigative action. All incidents were escalated to the senior manager.
- Between 01 April and 31 December 2017, staff reported 21 incidents. The majority (76%) related to information and communication. All incidents were categorised as low risk and causing no harm, and did not require the application of duty of candour.
- There were no serious incidents reported between 01 April and 31 December 2017.
- 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. No never events had been reported in this service.
- Managers had good oversight of incidents raised across the service. The service had produced an incident report that documented emerging themes and actions taken. The main theme related to information technology (IT), including connectivity issues and the electronic records system. Managers described positive outcomes in relation to both and staff we spoke with could explain the actions taken, demonstrating good communication in relation to managing incidents.
- Staff discussed incidents and lessons learned regularly at a weekly meeting attended by the senior manager, matron, and area leads, and at monthly clinical governance meetings.

Safeguarding

- The service had safeguarding children policy. Every member of staff we spoke with told us they felt confident about keeping children safe. Staff knew whom to contact for advice and told us they would speak to their line manager or the children's safeguarding team. Practitioners were able to describe to us actions they would take if they had any safeguarding concerns.
- The service had a dedicated lead safeguarding nurse advisor and safeguarding nurse advisor.
- The lead nurse represented the 0-19 children's public health service on the Local Safeguarding Children's Board (LSCB) Case Review Sub Group. The designated nurse for North Tyneside Clinical Commissioning Group chaired the meetings, which took place every two months. The group made recommendations to the chair

of the LSCB on cases that met the serious case review (SCR) criteria. The safeguarding nurse advisor was responsible for ensuring the implementation of any resulting action plan within the 0-19 service.

- Between 01 April and 31 December there had been one serious case review (SCR), which was identified in November 2017 and was currently on going.
- Within the same period, the service identified two other safeguarding incidents and instigated a significant learning event (SLE) process. One of the actions following an SLE was an audit of the 'Supporting Families' meetings across the Borough. The purpose was to identify if such meetings were happening, the frequency, and the quality of communication between relevant healthcare professionals. The audit outcomes demonstrated clear evidence of regular meetings and recognised the need to strengthen communication between GPs and public health school nurses.
- We reviewed evidence demonstrating the service had proactively engaged in learning from serious incidents. For example, ensuring practitioners regularly asked the question about domestic violence at different visits and, if not, documenting the reason why. Practitioners also now included the father's name on a child's record.
- The safeguarding team shared learning from SCRs and SLEs through email, and attendance at locality and multi-agency meetings. Practitioners spoke positively about their level of contact with the safeguarding nurse advisors.
- There were systems in place to check if a child was subject to a protection plan. We saw evidence within patient records of detailed information recorded about vulnerable children and families, as well as details of how they were being supported by other agencies. Practitioners completed a monthly return form which was sent to the children's safeguarding team with details of all current children who were looked after, subject to a protection plan, or who were classified as a child in need.
- Practitioners had received training to the appropriate safeguarding level. Information provided to us by the service showed compliance with safeguarding level three training was 91%. The lead nurse told us they had completed level four training.
- All staff had completed Signs of Safety training. The Signs of Safety model is a tool intended to help practitioners with risk assessment and safety planning in child protection cases. The lead safeguarding nurse advisor explained the service now used the child-focused Signs of Safety action plan and staff spoke positively about the tool.
- A recent audit of child protection reports led to the introduction of improved pathways and flow charts that incorporated Signs of Safety methodology. This meant reports were more concise, and tailored to meet the individual needs of each child.
- There were safeguarding champions in each team. The service had also developed practitioner 'champion' roles to assist the safeguarding team in providing specialist support and advice to frontline staff around issues such as MARAC (multi-agency risk assessment conferences) and MSET (missing, sexually exploited or trafficked).
- The service was proactively engaged with the multi-agency safeguarding hub (MASH). Other agencies represented within MASH included the police, independent domestic abuse advisors, housing, early help, youth offending, and social services. The safeguarding team maintained a regular daily presence within the hub and other agencies within MASH spoke positively about their level of involvement.
- The lead safeguarding nurse advisor received clinical supervision from a senior safeguarding manager within the Council. Both safeguarding nurse advisers led individual supervision sessions with practitioners across the service every six months. This was in line with the service guidelines. If there were any significant safeguarding concerns in a case, the safeguarding nurse advisor and practitioner engaged in more frequent, enhanced supervision sessions. The safeguarding lead monitored safeguarding supervision attendance and the overall rate of compliance (April to December 2017) was 95%. Staff spoke positively about the quality of the supervision.

Medicines

- The service did not deliver an immunisation programme and did not handle medicines directly.

Environment and equipment

- We found all the equipment in use was visibly clean and had been tested and serviced where required. Weighing equipment was calibrated annually, and practitioners were aware of the process to follow if they needed to report any faults.

- Practitioners told us they had enough equipment to deliver safe care and had no problems ordering additional supplies when required.
- We visited a number of locations where clinics were held, including children's centres and local leisure centres. We found the clinic environments were clean and tidy and suitable for children and their families. The service carried out appropriate risk assessments and documented existing control measures to mitigate any environmental risks, such as slips, trips, and falls.

Quality of records

- The service used an electronic records system. Practitioners were generally positive when describing the benefits of the tool, specifically the ability to see updates from other services about children in their care.
- We looked at 10 care records and saw they were comprehensive, and included all relevant information. Practitioners documented all risks, family dynamics, relevant assessments, development reviews, and safeguarding. Information was clearly recorded, and each record was dated and did not include any unnecessary abbreviations, jargon, or speculation.
- The service completed an inaugural audit of 208 records in December 2017 to review compliance with the service's own record keeping standards and with those of the Nursing and Midwifery Council (NMC). Compliance was very good and demonstrated practitioners maintained a high standard of record keeping. In conclusion, managers made four recommendations for improvement. These included the asking of a question about domestic abuse and that practitioners scan the (paper-based) health needs assessment tool to the child's record at the primary visit. All of the recommendations were captured in an action plan that also identified the level of risk (which was low in all cases).
- NMC guidelines state practitioners should complete nursing records within 24 hours of patient contact. Practitioners did not report problems in completing contemporaneous notes and clinical leads confirmed they reviewed and discussed records at one-to-one meetings with staff. The records we looked at showed practitioners had completed their notes within the required period.

Cleanliness, infection control and hygiene

- Practitioners were aware of safe infection prevention and control (IPC) measures and knew how to access the IPC guidelines on the local shared drive. The service had recently published additional guidance specifically in relation to good hand hygiene and this included a competency assessment. The service had not completed any hand hygiene audits to date although one was scheduled to commence in April 2018.
- The clinics we visited were visibly clean and tidy. We observed practitioners using hand gel to clean their hands and adhering to the bare below the elbows guidance, in line with national good hygiene practice.
- We saw personal protective equipment was readily available for staff to use and we observed practitioners using it appropriately.
- In baby clinics, practitioners cleaned the equipment after every use using antibacterial cleaning wipes. Practitioners also used a paper roll to line the baby scales and replaced it for each new patient.
- Practitioners used appropriate toys and games to engage and interact with children. Practitioners cleaned toys using antibacterial sanitary wipes, adhering to guidance outlined in the toy cleaning practitioner guide.
- The majority of staff had undergone infection control training in the last 12 months. The level of compliance was 93%.

Mandatory training

- Prior to the transition of the service from the NHS to local authority, managers completed a training need analysis to identify the key mandatory training requirements for staff. This included the development of a bespoke public health training package for information governance, the inclusion of safeguarding modules from the Local Safeguarding Children Board (LSCB), and infant feeding.
- The service manager worked closely with the council's workforce development team to create a training dashboard, which detailed the requirements for every member of staff. This meant managers and area leads had good oversight of mandatory training compliance.
- Compliance was above 90% for information governance, fire safety, infection control, and safeguarding level three. Just over 75% of staff had completed equality and diversity, and CPR (cardio-pulmonary resuscitation) training while compliance was just below 50% for the completion of the health and safety module. Managers explained

modules with low compliance were prioritised and gave assurance all staff would complete the required training once the service had recruited the full complement of staff.

- Staff told us managers discussed mandatory training requirements with them at supervision and locality meetings. Staff did not report any problems accessing the required training.

Assessing and responding to patient risk

- In the 10 records we reviewed, we saw practitioners had completed patient risk assessments appropriately and documented all related entries clearly.
- Practitioners told us they reviewed all GP, out of hours, and A&E attendances to monitor the children on their caseload. Practitioners and area leads also reviewed workload and caseloads weekly to ensure they prioritised vulnerable children.
- Health visitors completed maternal mood assessments in the antenatal period as well as the postnatal period, and made appropriate referrals for additional support when required.
- Practitioners completed a robust health needs assessment to identify and assess patient risk. Integration with the Early Help service and weekly meetings with other agencies such as housing, the police, schools, and the child and adolescent mental health service (CAMHS) meant risks were shared and discussed by multi-agency teams.
- The service was in the process of introducing a child sexual exploitation sub-group, as part of the wider local authority safeguarding governance remit.
- There were arrangements in place to support timely information sharing between practitioners when children transitioned from one service to another. For example, when transferring a vulnerable child to the care of school nursing service, health visitors would either remain the named practitioner until the end of the episode of care, or complete a verbal handover. In some cases, health visitors undertook a joint visit with the receiving school nurse.
- Health visitors worked closely with local community midwives to assess and respond to patient risk. We observed a regular meeting between two practitioners during which they discussed substance abuse issues concerning one client.
- The Child Health Information System sent electronic notifications to the service for all new births. The health visitor would then contact the family to arrange a primary visit. If there were new or known concerns about the baby or family, the midwife and health visitor would liaise with each other directly. Practitioners told us they would agree a care plan with the midwife and joint visits were undertaken when appropriate.
- Practitioners were able to check each other's tasks on the electronic records system, and provide cover for urgent issues if their colleagues were absent.

Staffing levels and caseload

- Within the 0-19 children's public health service, there were 40 health visitors, four school nurses, six staff nurses, 12 community nursery nurses, one public health midwife, two healthcare assistants, one vision screener, and four administrative staff.
- Managers and staff acknowledged the turnover of staff immediately following the transition from the NHS to local authority had been challenging. However, the service had recruited staff to fill the small number of vacancies remaining and managers advised they would have a full complement of staff by May 2018.
- In addition, the service provided five developmental staff nurse posts. Individuals were currently studying the Specialist Community Public Health Nursing (SCPHN) programme at a local university and were due to qualify in September 2018. This would create an additional four health visiting posts and one public health school nurse post.
- Four area leads (one of whom was also the service matron) managed staff within each locality and the whole service was led by a senior manager professional lead.
- According to guidance produced by the Community Practitioners and Health Visitors Association, caseloads should be, on average, 300 children per one WTE health visitor. This should vary according to deprivation indicators, with a maximum of 400 in the most affluent areas and less than 200 in the most deprived areas.
- Health visitor caseloads within the service reflected this guidance. Caseloads per WTE health visitor ranged from 277 to 461 depending upon the locality in which they were based. Practitioners working in the more deprived areas of North Tyneside supported a higher number of vulnerable children and had a lower caseload overall compared to colleagues based in a more affluent area. Practitioners described their caseloads as manageable.

Community health services for children, young people and families

- Area leads regularly reviewed health visitor caseloads. Practitioners held weekly allocation of work meetings to discuss new births and current priorities. Health visitors maintained overall responsibility for their own caseload and delegated specific tasks to other members of the team as appropriate. For example, nursery nurses supported health visitors by completing the two-year assessment reviews.
- Nursery nurses also supported the visual screener to deliver the vison screening service across the Borough. Four of the current 12 nursery nurses had received the relevant training so far and managers planned to extend this across the whole team.
- Between April and December 2017, the sickness absence rate for the whole of the public health department was 3.9%.
- The service did not use agency or bank staff.

Managing anticipated risks

- Managers and staff told us they undertook risk assessments when appropriate when visiting families. For example, if the service had received intelligence which identified a cause for concern, practitioners would visit in pairs or not visit the family home at all. In such cases, practitioners would arrange to meet with the family at a mutually agreed alternative venue.
- The service had developed a standard operating procedure in the event of the loss of the electronic records system. Practitioners would complete documentation on a Word document and attach to the electronic record.

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

(for example, treatment is effective)

Evidence based care and treatment

- Children and young people's needs were assessed and treatment was delivered in line with current legislation, standards, and recognised evidence based guidance. Policies and procedures were based on guidance produced by Public Health England, the National Institute for Health and Clinical Excellence (NICE), and other nationally recognised guidelines.
- The service was based on the nationally recognised 4-5-6 delivery model and practitioners delivered the Healthy Child Programme. This is a Department of Health programme of early intervention and prevention for health visitor contacts with babies and children. It offers regular contact with every family and includes a programme of screening tests, development reviews, and information, guidance, and support for parents. The programme was delivered across the 0-19 age range.
- We saw evidence of a wide range of policies, standard operating procedures (SOP) and pathways across health visiting and school nursing to ensure service delivery was effective. This included evidence-based enuresis (bed-wetting), vision screening pathways, and the national child measurement programme SOP. Practitioners could access all guidance on a shared drive, accessible via their laptop.
- The matron and area leads received appropriate updates and alerts in relation to national guidelines. The matron was responsible for ensuring new guidelines were disseminated to staff. All of the policies and guidelines we reviewed were up to date.
- All practitioners we spoke with knew all of the guidelines relevant to their practice and said they were embedded within their service.
- Health visitors used Ages and Stages Questionnaires (ASQs) as part of their assessment of children. This is an evidence-based tool to identify a child's developmental progress and readiness for school, and to provide support to parents in areas of need.
- The health visiting service held full accreditation with the Baby Friendly Initiative. This is a global programme of the World Health Organisation and UNICEF, which encourages health services to improve the care provided to mothers and babies so that they are able to start and continue breastfeeding for as long as they wish.

Nutrition and hydration

- The service had an infant feeding policy. This included support and care for breastfeeding mothers and Department of Health recommendations.
- During home visits and at baby clinics, we observed practitioners providing appropriate information and advice to support breastfeeding mothers.

Community health services for children, young people and families

- We observed a nursery nurse providing supportive advice to a parent concerned about the quantity of formula milk for their infant. We also observed practitioners providing evidence-based NICE guidance in relation to weaning.

Technology and telemedicine

- The service had introduced an SMS messaging service called Chat Health. This enabled children and young people to use familiar technology to contact a nurse to seek help, advice, or information.

Patient outcomes

- We saw evidence demonstrating health visitors and school nurses assessed patient needs before care and treatment started and there was evidence of care planning. This meant children and young people received the care and treatment they needed.
- The service had a clear approach to monitoring and auditing the quality of the service, and outcomes to improve care and treatment.
- The health visiting service used a dashboard to record and monitor patient outcomes. We reviewed data between April and December 2017.
- In quarter one (April to June 2017), 87% of mothers received a first contact with a health visitor when they were 28 weeks pregnant or later, before they gave birth. This dropped to 52% in quarter two (July to September 2017) and rose to 57% in quarter three (October to December 2017). Within the same period, 90% of mothers received a maternal mood review. Managers explained this dip in performance was a result of the loss of staff following the transition from the NHS to local authority. Managers had prepared for this by prioritising the most vulnerable families, and allocated resources appropriately to ensure those mothers received a pre-birth visit
- In quarter one, 88% of families received a visit from a health visitor within 14 days of the baby's birth. Although the rate dropped slightly to 87% in quarter two, performance improved to 90% in quarter three, exceeding the tolerance target of 85%.
- The service exceeded the tolerance target of 85% in all three quarters in relation to the six to eight week review. Over 90% of infants received a visit from a health visitor when they were six to eight weeks old.
- The average percentage of mothers who were continuing to breastfeed at 6-8 weeks was 41% across all three quarters. The rate had improved since the service had transitioned from the NHS to local authority and demonstrated a very good performance when compared nationally.
- The average percentage of infants receiving their 12-month review (by the age of 15 months) was 91%.
- Over 85% of children received their two-year review by the time they were two and a half years old, exceeding the tolerance target. At that review, practitioners completed an 'ages and stages questionnaires' (ASQ) with 98% of children.
- School nurses, with support from nursery nurses, delivered the National Child Measurement Programme (NCMP). Staff visited school age children in Reception and Year 6 to record their height and weight during the first term of the new school year. The most current data showed performance was very good and better than the regional and national average. School nurses delivered the NCMP to 97% of all Reception children and 96% of Year 6 children.
- Although the service did not deliver the school vaccination programme, practitioners contributed to the education of children and families about the health benefits. Vaccination coverage in North Tyneside exceeded the national average in all vaccine and booster programmes for children under five years of age with over 95% in all categories (with the exception of MMR, which was just below at 93% but still better than the national average). The vaccine and booster programme for children in Year 9 and Year 10 also exceeded the national average.

Competent staff

- The majority of staff had attended a corporate induction followed by a local induction within the service.
- All staff had received an appraisal. Managers explained they had adopted the previous provider's documentation for this first year, underpinned by the local authority pledges, competencies, and values. Staff spoke positively about the quality of the appraisal process.
- Staff spoke positively about the Borough Council's commitment to staff training and development. Practitioners were proactive in identifying their training needs and the service provided opportunities for additional learning and development. Managers explained there were pathways to support the

development of nursery nurses to gain registered nurse status and the service was planning to introduce apprenticeship schemes. Practitioners also had the opportunity to apply for post-graduate degree courses.
- The management team had developed a succession plan to develop and retain staff within the service through the recruitment of developmental staff nurse posts. Individuals were currently studying the Specialist Community Public Health Nursing (SCPHN) programme at a local university. Upon graduation, students were guaranteed a job as a health visitor or school nurse within the service.
- The service had a health visiting preceptorship programme, which included relevant competencies to support newly qualified or returning health visitors. We spoke with a staff nurse currently undertaking the SCPHN programme who described the support they received as 'fantastic'.
- Managers adhered to the local authority's policy for managing poor performance and sickness absence and gave practical examples of application.
- Community practice teachers supported health visitors and school nurses. Practitioners also had opportunities to develop specialist interests, such as domestic violence and breastfeeding, and shared their knowledge and learning with the wider team.
- Practitioners told us they received regular informal supervision from line managers and peers. This was in addition to the annual appraisal. Managers explained the service was developing a framework to ensure all staff received a minimum of two formal one-to-one meetings with their line manager a year.

Multi-disciplinary working and coordinated care pathways

- Health visitors and school nurses worked collaboratively with each other, with 'family partner' colleagues from the early help and prevention team, with colleagues from the local NHS trust provider, and with external agencies to assess, plan, and co-ordinate the delivery of care. Staff described a patient-centred approach and included parents where appropriate, as well as all healthcare professionals involved in a child or young person's care.
- Staff spoke positively about relationships with social workers. The safeguarding children team worked collaboratively with them as part of the mutli-agency safeguarding hub (MASH) and practitioners spoke of the benefits of regular and accessible information sharing about children and young people.
- Staff demonstrated a good awareness of the services available to children and contacted other teams for advice, and made referrals when necessary. This meant staff from all services shared information appropriately and cross-agency working ensured concerns about vulnerable children were shared and managed.
- Health visitors and GPs we spoke with described positive working relationships. We observed two regular meetings between health visitors and GP practices during which practitioners shared health, development, and safeguarding concerns about children and families under their respective care.
- School nurses had good links with their school nurse colleagues from the local NHS trust who supported specialist schools attended by children with special educational needs and/or disabilities. A nurse told us about one case where an NHS colleague shared some tools to enable them to effectively support a child with communication difficulties.
- Health visitors maintained good links with midwives from local NHS trust providers. We observed two meetings between health visitors and community midwives. Practitioners regularly met every month to discuss concerns and new referrals.

Referral, transfer, discharge and transition

- Heath visitors arranged the handover of the continuous child health record by the September of each year for those children entering Reception. Practitioners completed a standard form with basic information about each child, including the new school. This information was shared with the relevant public health school nurse.
- Health visitors and school nurses told us they worked closely with each other to discuss and share important information about children with additional health needs. Children with special or complex needs, or those subject to a child protection plan were handed over in a face-to-face discussion. Health visitors completed a more detailed form that included the details of all health and social care professionals involved in the child's care

Access to information

Community health services for children, young people and families

- Staff we spoke with told us they were able to access the information they needed to ensure they provided safe and effective care to children and young people. This included policies, templates, standard operating procedures, and best practice guidance.
- The service stored all current guidelines, policies, and procedures on a shared drive. This meant practitioners could access advice and guidance easily. All staff we spoke with knew how to access the shared drive and the information contained within.
- Staff spoke positively about the electronic patient record and their access to the summary care record. This meant practitioners had oversight of the care children received from other services such as therapy services.

Consent

- The service had clear guidelines about consent in relation to children, young people, and families. Practitioners had access to further guidance produced by the North Tyneside Local Safeguarding Children's Board about information sharing processes.
- Health visitors and school nurses we spoke with understood the Fraser guidelines and Gillick competency. Fraser guidelines and Gillick competency must be considered when offering treatment to children less than 16 years old, to decide whether a child is mature enough to make decisions about their own care.
- School nurses were clear about obtaining consent. Practitioners explained they always ensured parents had consented to them speaking with their child before they met, unless the child was Gillick competent and they had requested to see the school nurse unaccompanied.
- We observed staff obtaining verbal consent during a home visit and at baby clinics.

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

Compassionate care

- All of the staff we spoke with were dedicated to making sure children, young people and families received the best patient-centred care possible.
- Practitioners and managers were very passionate about their respective role in delivering compassionate care and spoke about the importance of capturing the voice of the child in their work.
- Staff showed respect for the personal, cultural, social, and religious needs of children and young people.
- We observed the way staff treated children, young people, and families in their homes and in the school environment. Practitioners were kind, sensitive, supportive, and compassionate, and treated parents, carers, children, and young people as individuals. For example, one parent told us how they appreciated their health visitor always bringing a set of scales with them to home visits. As a parent of twins, they felt supported by the practitioner who recognised the demands of visiting a well-baby clinic with two infants.
- Practitioners showed respect for privacy and dignity. We heard examples about the support health visitors and school nurses provided for children suffering from enuresis (bed-wetting) and observed two clinic appointments. Both practitioners demonstrated compassionate care and sensitivity towards the families, using appropriate language without any healthcare 'jargon'

Understanding and involvement of patients and those close to them

- The service gathered feedback from children, young people, and families to seek their views about their experience of health visiting and school nursing. A 'two minutes of your time' survey was undertaken between 20 November and 03 December 2017. Staff asked children and families attending drop-ins or well-baby clinics to complete the short questionnaire.
- The survey generated over 300 responses from which 99% said they were likely or very likely to recommend the health visiting and school nursing service to family and friends. In relation to the suitability of the venue and the convenience of the time children and families saw a practitioner, 99% of respondents were satisfied with the current arrangements.
- Practitioners listened to children, young people, and families and involved them in managing their own care. For example, a school nurse supported a child with autism to prepare for mainstream school. The nurse supplied the family with a DVD and appropriate reading materials for them to review in their own time.

Community health services for children, young people and families

- We heard and observed examples of good practice where practitioners actively listened to families and empowered them to seek solutions. Results from the recent survey showed 100% of children and families felt practitioners listened to them. Comments from families praised staff, describing them as 'lovely and friendly'; 'always helpful' and 'informative'. The service had produced bright posters with the results from the survey, which we saw displayed within locality offices and in all of the well-baby clinics we attended.
- Practitioners provided information in suitable formats, such as leaflets and booklets. The service had created an enuresis infographics poster, which was displayed in clinics and children's centres. However, managers and staff acknowledged there were differences in what information practitioners shared with children and families, and when. Managers explained a new project had been initiated to standardise information and correspondence across the whole service.

Emotional support

- Staff understood the impact conditions and their treatment had on children and young people, and this was embedded in their care. One health visitor spoke about the emotional support they provided to a teenage mother who was suffering from anxiety following the birth of her baby.
- We observed health visitors and nursery nurses interacting with children and parents at well-baby clinics and in family homes. Staff created a warm and caring environment, and we observed them positioning themselves in a way that was unthreatening and promoted open communication with the family (by sitting on the floor with them and using clear, non-jargon language). Practitioners also gave parents the opportunity to ask questions and were very patient, giving parents enough time to talk about concerns or queries.
- Health visitors promoted empowerment to support and enable parents to care for their newborn babies and young children in a way that felt right for them. For example, during a home visit, we observed the practitioner reassure one parent about choice in relation to breastfeeding by offering their continued support whatever decision the mother made. The practitioner then provided evidence-based advice and guidance to help the mother make an informed choice.
- All of the practitioners we observed during home visits, school drop-ins, and well-baby clinics encouraged children and families the opportunity to ask questions. Practitioners recognised anxieties and provided appropriate emotional support and guidance.
- Breast-feeding peer support groups provided families with emotional support, advice, and encouragement to enable every mother to continue to breast-feed their babies for as long as they felt able. There were currently four groups and staff spoke positively about the attendance at each one.

Are community health services for children, young people and families responsive to people's needs?
(for example, to feedback?)

Planning and delivering services which meet people's needs

- To ensure the health visiting and school nursing service met the needs of the population, North Tyneside Borough Council proactively engaged with key stakeholders as part of the commissioning review for the health visiting and school nursing service. During the 12 months prior to the procurement of the service, the council sought views from head teachers, parents, carers and guardians, and GPs. In addition, the council held focus groups with young people to seek their views about the school nursing service.
- Feedback from schools indicated head teachers felt the school nursing service provided a key link between a school and the health needs of a child, and that the service had a positive impact on all children's health. Young people gave feedback about their preferred access route to a school nurse and what qualities a school nurse should have.
- The health visiting and school nursing service was embedded within the 0-19 children's public health service within North Tyneside Metropolitan Borough Council. The service worked collaboratively with the wider council and other partner agencies to plan and deliver service to meet the needs of children and young people. The service supported the priorities outlined in the Borough Council's strategy. These included health and well-being, and children and young people's mental health.

Community health services for children, young people and families

- Health visitors and nursery nurses ran well-baby clinics and breast-feeding support groups in accessible venues across the local area, such as children's centres. Although the service did not have a specific infant feeding lead, one of the area leads, supported by a practitioner with a specialist interest in infant feeding, co-ordinated breast-feeding peer support group meetings. The staff nurse practitioner was also leading the work for the re-accreditation of UNICEF baby friendly initiative.
- To ensure the services met the needs of young people, the service invited a young person to join the recruitment panel for a public health staff nurse. The young person asked a specific question to assess how the interviewee would make them feel at ease to discuss their worries with them.
- The 0-19 Children's Public Health Service had a policy that outlined the duties, responsibilities, and implementation of non-medical prescribing. Information provided by the service showed 33 practitioners had completed the Nursing and Midwifery Council (NMC) Community Practitioner Nurse Prescribing course (also known as V100). This meant children and young people had timely access to medicines and treatment. Practitioners attended non-medical prescriber workshops, led by a senior pharmacist, for updates about the latest developments and current practice.
- The service contributed to addressing the public health needs of children and young people. According to the Public Health England Child Health Profile (March 2017), the percentage of children aged between four and five years and between 10 and 11 years who were obese, was about the same as the England average. To ensure overweight children and their families received appropriate care and support, the service provided a 'Healthy 4 Life' nurse. Healthy 4 Life is a direct intervention programme designed to encourage behaviour changes and help facilitate long term health benefits. Such benefits include reduction in weight, improvement in eating habits, and increased physical activity.
- The Healthy 4 Life nurse worked collaboratively with public health nurse colleagues, a dietician from the local NHS trust provider, and exercise and health professionals from North Tyneside Council. Together, they formed the Children's Health and Activity team (CHAT), and worked with children aged between four and seven years old (The Minis programme) and with those between eight and 17 years. Practitioners could refer children directly to the relevant programme and outcomes from 2016-17 were good. For example, 85% of children had reduced their sugar intake following the programme, 85% had maintained or improved their self-esteem while 75% had maintained or improved their intake of fruit and vegetables.
- The school nursing service did not directly support schools to deliver the Healthy Schools Standard. This is a national programme focused on the personal, social, and health education (PHSE), healthy eating, physical activity, and emotional health and well-being of primary and secondary school children. However, school nurses did support and train teachers to care for children with chronic health conditions such as asthma and epilepsy.
- Although the service delivered two targeted drop-ins each one at a secondary school located within an area if high deprivation, school nurses did not routinely hold drop-in sessions, hold clinics, or lead classroom discussions with children covering topics such as contraception or puberty and growth anywhere else. However, to coincide with the national 'No Smoking' day, we observed two smoking-cessation drop-ins at local secondary schools. Held over a lunch period, the session attracted large numbers of children and we observed very good examples of engagement.

Equality and diversity

- According to the Public Health England Child Health Profile (March 2017), children and young people (under the age of 20 years) made up 22.1% of the population in North Tyneside. Only 7.9% of school children were from a minority ethnic group.
- Staff could describe the ethnic and religious diversity of the people who used their services and explained how they could make modifications to ensure they were culturally sensitive.
- Practitioners could access interpreting services and had not experienced any problems when they needed to book an interpreter to attend an appointment.

Meeting the needs of people in vulnerable circumstances

- Practitioners proactively engaged with children, young people, and families in vulnerable circumstances. For example, when a young teenage mother and her child became homeless, a health visitor and nursery nurse

worked closely with the family to seek temporary accommodation and find an appropriate nursery placement for the toddler. The health visitor also enlisted support from housing and other agencies to provide financial support.

- The service was developing a 'vulnerable pathway' to define the core offer for the most vulnerable families and children.
- The health visiting and school nursing service was accessible to vulnerable children and families. For example, practitioners supported families living in a local women's refuge, which provided a safe haven for women and children from domestic violence. Practitioners maintained regular contact with families based there and worked closely with staff to ensure children and families received the support they needed. Health visitors could also refer families to the refuge when required.
- The service provided a dedicated teenage pregnancy midwife to support young mothers. The midwife explained the majority of young people she worked with had varying needs and the majority were vulnerable. The midwife maintained regular contact with the teenagers and provided support and advice in relation mental health, domestic violence, and healthy relationships. The midwife worked with colleagues from the perinatal mental health team, local NHS obstetric units and, in some cases, initiated joint visits and attended appointments to ensure vulnerable young mothers received the right level of support. In addition, the teenage pregnancy midwife ran a group for young parents-to-be, which included contributions from mental health practitioners and dieticians.
- Practitioners worked collaboratively with the New Beginnings Young Parents Scheme, to meet the needs of teenage parents. The scheme provides supported accommodation from six months to two years. Health visitors played a pivotal role in co-working cases with key workers from the Scheme. One of the key workers spoke positively about the referral arrangements and the support from health visitors. We also spoke with a young family during our visit who described the health visiting team as 'great'. The young parents told us practitioners gave a lot of advice and support without judgement.

Access to the right care at the right time

- Health visitors offered all of the five mandated Healthy Child Programme contacts. The majority of local families received antenatal and new birth visits, and development reviews. Although performance in one of the contacts dipped slightly following the immediate transition of the service from NHS to local authority, performance was consistently good overall.
- The service provided 44 child health clinics every month and venues included children's centres, local leisure centres, and libraries. Nursery nurses supported health visitors to run the regular clinics.
- Results from the recent health visiting and school nursing 'two minutes of your time' survey showed 99% of children and families said the time at which they saw a health visitor or school nurse was convenient. However, some parents suggested holding additional well-baby clinics (including evening sessions). In response to the feedback, the service was establishing a working group to review the current provision.
- School nurses delivered the National Child Measurement Programme (NCMP) to Reception and Year 6 children within the first three months of the new school year. Following the outcome, practitioners proactively contacted families where results indicated a potential cause for concern and offered appropriate support and advice. Support included a referral to the Healthy 4 Life nurse and the offer of an 'Ease' card, a card which provided discounted access to local leisure centres.
- To ensure children and young people could access timely support and advice from a school nurse, the service provided an SMS messaging service called Chat Health. School nurses monitored incoming texts on a daily basis. Texts received out of hours generated an automated reply confirming the hours within which they would receive a reply from a nurse. The out-of-hours message also included information advising how the child or young person could access urgent help. School nurses told us the service was very popular. Between April and December 2017, 334 messages had been received by the service, 424 messages sent, and 67 conversations initiated.
- Families always received a second visit from their health visitor if they were unavailable at the first pre-arranged meeting. If the second attempt to meet failed, the practitioner left a contact card with a new appointment

scheduled for two to five days later. Following a third and final attempt, the health visitor wrote to the family and GP, and social worker if there were safeguarding concerns.

Learning from complaints and concerns

- Between April and December 2017, the service reported one complaint from a parent about the manner and behaviour of a health visitor. We reviewed the response letter to the family and noted the inclusion of a sincere apology and an action plan to facilitate learning.
- Practitioners and managers proactively worked in partnership with children, young people, and families, which minimised the number of formal complaints. If there were complaints, staff knew what to do and how to signpost people to the complaints procedure if they could not resolve concerns locally.
- Managers shared information and feedback from complaints and concerns at team meetings. Staff told us they discussed the issues and identified areas of learning at these meetings.

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

Leadership of this service

- There was very good leadership at all levels. Managers worked closely and collaboratively with colleagues from the local council cabinet and with other services within the 0-19 children's public health service.
- Staff spoke positively about local leadership, and at senior and executive management level. When health visitors and school nurses joined the local authority from the NHS, they received a personal welcome letter from the chief executive. Practitioners spoke about the visibility of senior managers who they described as having a 'hands on' approach.
- Staff felt well supported by their line managers. There was a clear management structure and staff described area leads and senior managers as very approachable. Managers were also visible, and staff felt connected to their wider team.
- We heard and saw examples of proactive, supportive leadership across the service. The managers and area leads we spoke with were very passionate about delivering an excellent service and ensuring care was patient-centred.
- Senior managers and area leads had an inspired and shared purpose. They clearly strived to deliver and motivate staff to succeed, and there were strategies in place to support them in this purpose.

Service vision and strategy

- North Tyneside Metropolitan Borough Council had a clear service vision and strategy, 'Our North Tyneside' (ONT) plan, which outlined three key elements: 'Our People', 'Our Place', and 'Our Economy'.
- The 0-19 children's public health service had its own service aim and objectives. The service's strategic context was linked with the ONT plan with specific goals to ensure children and young people were ready for school and ready for work and life.
- There were four service improvement plans for children and young people, two of those plans focused on specific actions related to the 0-5 and 5-19 age groups. The service captured developments for safeguarding children and young people in a third plan while the final plan related to general issues such as IT, training needs, and estates. Each plan included clear actions, an identified lead, timescales, and risk identification where appropriate.
- Managers worked collaboratively with staff to identify current priorities and practitioners spoke positively about their contributions to service development and improvement.
- Staff we spoke with were very clear in their understanding of the Borough Council's organisational vison and values. The appraisal process included individual staff objectives, which linked with both the service and organisational goals.

Governance, risk management and quality measurement

- Health visiting and school nursing was part of the children's services directorate within North Tyneside Borough Council. There was a governance structure with clear lines of responsibility and accountability. We

reviewed the 0-19 Children's Public Health Governance Framework, which comprehensively outlined the vision and strategy, governance arrangements, leadership accountability, and management of the service.

- Four area leads line-managed staff working within each locality team. The senior manager professional lead reported to the director of public health, and the director of children's services maintained executive level management oversight of the service. The senior manager professional lead and director of public health worked collaboratively with the assistant director for early help and development.
- Quality and safety had a high priority within the service. Practitioners and managers attended regular team and governance meetings and spoke positively about the flow of information. All staff felt assured issues that arose from the frontline were escalated to senior managers. We spoke with senior managers who gave examples of this in practice. Frontline staff described the governance arrangements as 'robust'.
- The 0-19 children's public health service had a risk register and risks were aligned with the four service improvement plans. Current risks included the IT provision, workforce, and the transfer to a resident-based population. There were relevant action plans in place. Managers reviewed and monitored risks at service-level team and management meetings, and at directorate and executive meetings
- Managers had good oversight of performance within the service. There was a quality assurance system, and the service captured performance and safeguarding information in a quality dashboard. Staff we spoke with understood the outcomes they were measured against and told us they were discussed in team meetings.
- We saw evidence of an internal quality audit programme. Audits included care records and safeguarding reports.
- There were systems in place to review National Institute for Health and Clinical Excellence (NICE) guidelines and other nationally recognised guidance. Managers and area leads reviewed new guidelines at, and shared the information with staff through, the team meeting structure.

Culture within this service

- All staff spoke positively about the culture within the service and managers acknowledged that the culture had improved since the initial transition from the NHS to the local authority.
- Staff told us they felt valued and respected by local and senior managers from the 0-19 children's public health service and across the wider children's services directorate. Everyone we spoke with told us local and senior managers promoted an 'open door' policy, which meant they encouraged staff to speak with them about anything at any time.
- Practitioners followed the Borough Council's lone-working policy however, teams also had local arrangements in place. All staff carried a mobile phone. Staff we spoke with told us they always told a colleague where they were going and used electronic diaries. There were no reported problems.
- Staff described a culture of openness and honesty, and told us they felt safe to challenge senior members of the team and express their own opinion. Everyone we spoke with was aware of duty of candour and practitioners were encouraged to highlight any concerns and report incidents. Staff felt confident that if they raised a concern, managers would take appropriate action and we heard examples when this had happened and what improvements had been made.
- Staff described their morale as good with one member of staff describing themselves as 'happy and settled'. Managers monitored staff morale through staff surveys. The first survey was completed six months following the transition of the service from the NHS to the local authority. Feedback overall was generally positive, particularly around the strength of leadership. Managers planned a further survey later in the year.
- The director of public health was the Council's lead for health and well-being, which currently held the highest award for Better Health at Work. The priorities for supporting and maintaining good health and well-being of staff were identified from staff surveys. These included mental health, promoting healthy weight, and procuring fit for purpose occupational health. Managers and staff spoke positively about the support they received at service level. For example, following a recent tragic event, which had an impact upon practitioners from the service, staff received a personal message of support from senior and executive managers.

Public engagement

Community health services for children, young people and families

- The service developed a survey to gather the views of children, young people, and families. Staff encouraged people to complete the survey at drop-ins and well-baby clinics to seek their views about the current health visiting and school nursing provision. The feedback was very positive.
- Prior to the implementation of the SMS messaging service Chat Health, the service held drop-in sessions with children and young people to seek their views.
- The service engaged with the local Youth Council to invite one of the members to join the recruitment panel for staff nurse posts. They were given the opportunity to devise a specific question and, at the end of each interview, the young person was given the opportunity to share their feedback about the candidate based on their responses to the interview questions.

Staff engagement

- All staff spoke positively about the engagement undertaken in the lead up to the transition of the service from the NHS to local authority. Following the transfer, managers proactively kept staff informed of subsequent updates through staff development days, management meetings, team meetings, and local and executive management briefings.
- Following the first six months of operational activity, managers invited staff to participate in a survey to gather views about a range of topics, which included motivation and morale, work/life balance, and line management. This enabled managers and staff to identify strengths and areas for development. Staff felt motivated and valued, and felt communication was good. However, practitioners also identified a need to improve their understanding of the Council's operating model and values.
- Everyone we spoke with told us they felt communication from managers and senior managers was good. Weekly emails included updates from service across the Borough Council and the chief executive led Big Team Briefs, a face-to-face event held every three months.

Innovation, improvement and sustainability

- The service worked in partnership with a local university and young people in North Tyneside on a project to reduce obesity for future generations. This included developing specialist training for school nurses to equip them with the relevant skills and knowledge to support young people to achieve healthy lifestyles and promote healthy eating.
- The service had procured a multi-use licence for Solihull Approach online antenatal, postnatal, and parenting courses. This meant practitioners could increase the accessibility of the services to the families they supported. The Solihull Approach aims to increase emotional health and well-being through both practitioners and parents.

Outstanding practice and areas for improvement

Outstanding practice

- Despite having only transitioned from the NHS to North Tyneside Metropolitan Borough Council 12 month ago, managers and staff had managed the change seamlessly and maintained high standards of care.
- The service prioritised vulnerable children and families appropriately to ensure any short-term shortfalls in staffing, because of the transition, did not have a detrimental impact on patient safety and high quality care.
- The Chat Health SMS messaging service meant children and young people could access immediate support and advice from a school nurse. The two-way communication platform allowed direct and confidential contact between children and young people and the healthcare professional.
- Managers and staff demonstrated high levels of integrity, drove continuous improvement, and held themselves accountable for delivering change.

Areas for improvement

Action the provider SHOULD take to improve

- The service should ensure all staff complete mandatory training within the required period.