Northumbria Healthcare NHS Foundation Trust

RTF

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RTFFS	North Tyneside General Hospital	Wansbeck General Hospital	NE63 9JJ
RTFFS	North Tyneside General Hospital	Langdale Centre, Wallsend	NE28 0HG
RTFFS	North Tyneside General Hospital	Shiremoor Resource Centre	NE27 0HJ
RTFFS	North Tyneside General Hospital	One to One Centre, Shiremoor	NE27 0HJ
RTFFS	North Tyneside General Hospital	Albion Road Clinic, North Shields	NE29 0HG
RTFFS	North Tyneside General Hospital	Riverside Children's Centre, North Shields	NE29 0HG
RTFFS	North Tyneside General Hospital	Amble Health Centre	NE65 0HD
RTFFS	North Tyneside General Hospital	The Gables Health Centre, Bedlington	NE22 7DU
RTFFS	North Tyneside General Hospital	Alnwick Consulting Rooms	NE66 2NR

This report describes our judgement of the quality of care provided within this core service by Northumbria 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 Northumbria Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Northumbria Healthcare NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Outstanding ☆
Are services safe?	**Outstanding** ☆
Are services effective?	**Outstanding** ☆
Are services caring?	**Outstanding** ☆
Are services responsive?	**Outstanding** ☆
Are services well-led?	**Outstanding** ☆

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Overall summary

Overall, we rated community health services for children, young people and families as outstanding because:

Managers and staff created a strong, visible, person-centred culture and were highly motivated and inspired to offer the best possible care to children and young people, including meeting their emotional needs. Staff were very passionate about their role and, in some cases, went beyond the call of duty to provide care and support to families. There was respect for the different personal, cultural, social and religious needs of the children and young people they cared for, and care and treatment was focussed on the individual person rather than the condition or service.

Families were very positive about the service they received. They described staff as being very caring, compassionate, understanding and supportive. Children and young people were able to see a healthcare professional when they needed to and received the right care at the right time. Services were flexible, provided choice and ensured continuity of care. The care and treatment of children and young people achieved good outcomes and promoted a good quality of life. Staff proactively collected and monitored this data and used the information to improve the care they delivered.

The culture was open and transparent with a clear focus on putting children and young people at the centre of their care. Services had good strategies and plans, each with service-specific objectives and goals to meet the needs of children and young people and deliver a high quality service. These plans directly linked with the overarching trust vision and goals.

Staff protected children and young people from avoidable harm and abuse. Managers and staff discussed incidents regularly at monthly meetings and took appropriate action to prevent them from happening again. Staff regularly received safeguarding supervision from managers and the trust safeguarding children team, who also kept services updated on outcomes and learning from serious case reviews. The clinics, health centres, children's centres and school premises we visited were clean and staff followed national guidance in relation to hand hygiene and infection prevention and control. Staff managed medicines safely and the quality of healthcare records was good. Clinical leads and service managers audited records annually and outcomes shared with individuals and the wider team.

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 and this included risks to children who were subject to a child protection plan or who had complex health needs.

Staff were very positive about working for the trust and leadership was excellent across all services. There was a clear management structure and managers were visible and involved in the day-to-day running of services. Staff could contact them whenever they needed to and received regular supervision from line managers and clinical leads. The trust provided opportunities for training and development and staff were well trained and highly motivated to offer the best possible care to children and young people.

Summary of findings

Background to the service

Northumbria Healthcare NHS Foundation Trust provides services to children and young people up to the age of 19 across Northumberland and North Tyneside. Services include health visiting, school nursing, community children's nursing, looked after children, the family nurse partnership, physiotherapy, occupational therapy, speech and language therapy and sexual health services. Services are provided to people in their own homes, in schools and in clinics across all the local area.

Children and young people under the age of 20 years made up 21% of the population in Northumberland and 22% in North Tyneside. 5% of school children in Northumberland were from a minority ethnic group. The figure was slightly greater in North Tyneside at 7%.

The health and wellbeing of children living in Northumberland and North Tyneside was mixed compared with the England average. Infant and child mortality rates were similar to the England average in Northumberland however, child mortality rates in North Tyneside were better. The level of child poverty was better than the England average in Northumberland and the same as in North Tyneside, with 17% and 19% respectively of children under 16 years living in poverty. The rate of family homelessness was better than the England average in both areas.

With the school nursing team, we visited three schools in Berwick, Bedlington and Ashington plus two special schools in Hexham and Wallsend. We also attended three baby clinics and accompanied health visitors, the family nurse partnership and paediatric therapists on five home visits and one appointment held in a local school.

We spoke with 10 managers and clinical leads, 10 therapists, 14 health visitors, 12 school nurses, 10 other nursing and clinical staff, five administrative staff and nine families. We observed staff practice in clinics and, with the consent of parents, in patient homes. We looked at 15 care records. Prior to and following our inspection we analysed information sent to us by a number of organisations such as the local commissioners, Healthwatch and the trust.

Our inspection team

Our inspection team was led by:

Chair: Dr Linda Patterson OBE , Consultant Physician.

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

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

Why we carried out this inspection

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

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Summary of findings

Is it responsive to people's needs?

Is it well-led?

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and 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. We carried out the announced visit from 9 to 13 November 2015.

What people who use the provider say

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

- Families spoke very positively about the help and support they had received from health visitors. One parent told us she was encouraged to attend baby massage classes and received twice-daily visits when her baby was suffering from colic. A father was very happy with the service and said staff were friendly and trustworthy.
- A teenage mother described the care she had received from the family nurse partnership: 'they have been really good and helpful. I have had lots of advice about my housing problems and some good parenting tips'. Another young mum said she had really benefitted from the service and had a much broader knowledge about what to expect and do when her baby arrived.
- During a speech and language therapy session, a four-year-old child told us his therapist was 'nice' and had enjoyed playing with the interactive toys and games she had brought.
- Following a home therapy session, a mother told us she was very happy with the service. She felt listened to and involved in her childs care and treatment.

Good practice

- Patient outcomes were consistently high and better than the England average. For example, the immunisation rate for measles, mumps and rubella (MMR) vaccine in children aged two was 96% in Northumberland and 95% in North Tyneside, both better than the national average of 92%. The health visiting service ensured all new mothers received a Maternal Mood review and the family nurse partnership exceeded their fidelity stretch goals.
- There were excellent arrangements to support young people with complex needs and learning disabilities transitioning to adult services. Specialist school nurses supported the transition process for 17 to 19 year olds and the trust had recently appointed a dedicated specialist nurse to review current practice and identify any gaps in the service.
- Staff from all community services for children and young people went beyond the call of duty to provide compassionate care and emotional support. Parents were unanimously positive about the care they and their children received. We heard and observed examples of outstanding practice that demonstrated staff were caring, compassionate, understanding and supportive.
- Community services for children and young people had proactively participated in the You're Welcome toolkit, which was a quality criteria highlighted in the National Service Framework for Children. The toolkit sets out a number of principles to ensure young people aged 11 to 19 (including vulnerable groups) were able to access services better suited to their needs. The toolkit covered 10 key areas assessed, including accessibility, publicity, confidentiality/ consent, the environment, staff training, skills, attitudes and values.
- Services contributed to addressing the public health needs of children and young people. For example, the family nurse partnership had identified an increase in the number of teenage mothers who had returned to smoking once they had given birth. The team sought support from the trust's Stop Smoking Team who, in turn, trained the nurses to identify triggers and deliver

appropriate intermediate care and treatment. This included the use of smoking monoxide monitors and prescribing patches to help sustain the level of reduction.

- The trust involved and engaged with local communities in planning services for children and young people. Community services in Northumberland had developed a participation strategy and were actively training young people as part of the reaccreditation programme for the You're Welcome initiative. There were also two participation groups: the Northumbria Healthcare Young Apprentices gathered feedback about services for children and young people provided by the trust while the Northumberland College Partnership Health Reference Group offered consultation on literature, materials and resources to ensure they were age appropriate and met the needs of children and young people.
- Young people were an integrated part of the sexual health service. The service had a very proactive health promotion team who involved young people to promote the delivery of sexual health messages. For example, young people from the YMCA Young Health Champions and the Young People's Health and Wellbeing Group worked with the health promotion specialist to develop a 'One2One DVD'. The aim of the DVD was to inform and encourage young people to access appropriate services when they needed to.

Northumbria Healthcare NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Outstanding ☆

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as outstanding because:

Staff protected children and young people from avoidable harm and abuse. There was a genuine culture of openness and transparency and all safety concerns raised by staff or families were highly valued as integral to learning and improvement. Managers and staff discussed incidents regularly at monthly meetings and took appropriate action to prevent them from happening again. Learning was based on a thorough analysis and investigation and managers encouraged all staff to participate in this learning to improve safety.

Staff from all services showed commitment to ensuring there were robust safeguarding systems to protect children and young people from harm and managers encouraged innovation to achieve sustained improvements in safety.

Staff regularly received safeguarding supervision from managers and the trust safeguarding children team, who also kept services updated on outcomes and learning from serious case reviews.

The clinics, health centres, children's centres and school premises we visited were clean and staff followed national guidance in relation to hand hygiene and infection prevention and control. Staff managed medicines safely and the quality of healthcare records was good. Clinical leads and service managers formally audited healthcare records annually, peer reviews were undertaken periodically, and outcomes shared with individuals and the wider team.

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 and this included risks to children who were subject to a child protection plan or who had complex health needs.

Safety performance

- Safety was managed through the effective reporting of incidents. The trust had an incident reporting and investigation policy and this was embedded within the trust. The trust used an electronic reporting system (Datix) to record all incidents.
- Every member of staff we spoke with, at all levels and grades, could explain the reporting process and felt confident incidents were dealt with robustly and in a timely way.
- Senior managers from community services for children and young people were members of the trust-wide safety and quality committee where safety performance was routinely discussed. At a local level, incidents were a standard agenda item at locality and clinical governance meetings.
- According to the national NHS staff survey 2014, 100% of staff from community services for children and young people said they had reported errors, near misses or incidents witnessed in the last month. This was better than the national average of 91%.

Incident reporting, learning and improvement

- We reviewed incidents reported between 1 July 2014 and 21 July 2015. Staff from all services and localities across Northumberland and North Tyneside had reported over 250 incidents. The severity of each incident was recorded appropriately and indicated the level of harm caused by the incident. The majority of incidents (86%) were categorised as causing no harm.
- Themes and trends resulting from incidents were monitored and appropriate action was taken. For example, the children's community nursing team had reported a number of incidents related to discharge notifications from a nearby hospital providing tertiary care for children. Work was currently in progress by senior nurses and paediatricians from both organisations to improve practice.
- Staff told us they felt confident lessons were learned from incidents and were aware of what incidents had been raised within their own service and, in some cases, other services. For example, a member for staff from the speech and language therapy team told us about an incident raised by a health visitor. A member of the public had gained access to a restricted area of a shared building. A new system was implemented to prevent this from happening again and the information communicated to all teams.
- Staff from all services told us information and learning was shared about serious cases reviews. We spoke to a member of staff from the speech and language therapy team who had been involved in a child death review. Outcomes were shared with the wider team and changes to practice were implemented. This included the amendment of a question in the initial assessment form to confirm whether a therapist had already seen a child. This ensured a child with higher priority or special needs could be seen sooner by the relevant healthcare professional.
- We also saw evidence detailing robust action the trust had taken, through root cause analysis, following a serious incident involving physical harm to a child. A health visitor had taken appropriate steps and referred a baby to children's social care services after noticing bruising on the baby's face. A thorough investigation report was published and included a list of recommendations, each with an initial risk rating of low, moderate or high. When we spoke with health visitors and school nurses across different localities, they were aware of the incident and of the lessons learned as a result.
- When incidents occurred, staff told us they were open with patients. Every member of staff we spoke with was aware of the duty of candour requirements and could explain the principles of being open and transparent with patients, families and carers. At clinical governance meetings, discussions about duty of candour included how to apply it in practice and examples of application. A recently appointed member of staff told us they had received information about duty of candour as part of the trust induction programme.

Safeguarding

- The trust had a safeguarding policy and procedures in place and every member of staff we spoke with told us they felt confident about keeping children safe. Staff knew who to contact for advice and told us they would

speak to their line manager or the children's safeguarding team. Staff were able to describe to us in detail actions they would take if they had any safeguarding concerns.

- Staff told us they were trained to the relevant safeguarding level. Information provided to us by the trust showed the majority of services and staff groups who worked directly with children and young people had achieved the 85% target for level three training.
- Health visitors, school nurses and looked after children nurses received one-to-one child protection supervision sessions from the safeguarding team at least every six months, complying with trust policy. Most staff told us these sessions often took place more frequently, around every three months. Outcomes from each session were recorded on SystmOne, the trust's electronic records system, so staff could easily access the advice and feedback for future reference. Compliance was measured using a performance dashboard and when we reviewed this data, we saw 100% of staff had received the required supervision by 30 June 2015.
- Staff also told us safeguarding was a standard agenda item at regular clinical supervision meetings with line managers. This included staff who did not hold caseloads, such as speech and language therapists and occupational therapists.
- The safeguarding children named nurse and senior nurses had a high profile across the community children and young people's services. All of the staff we spoke with knew their named nurse and told us they could seek advice and support whenever they felt it was necessary. Everyone we spoke with was very positive about the safeguarding team.
- The safeguarding children's named nurse attended the Local Safeguarding Children Board. The Family Nurse Partnership (FNP) service lead had also attended the Board on occasions in order to provide updates about the FNP programme. FNP is a voluntary programme for first-time young mothers, underpinned by internationally recognised, evidence-based guidelines. It replaces the health visitor service for the first two years of the child's life. The FNP supervisor also met with the safeguarding children named nurse on a monthly basis to share information, discuss new clients and individual cases plus any issues.
- There were systems in place to check if a child was subject to a child 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 such as the local authority. Health visitors completed a monthly return form which was sent to the children's safeguarding lead and locality lead with details of all current children who were looked after, subject to a protection plan or who were classified as a child in need.
- All of the staff we spoke with were aware of female genital mutilation and child sexual exploitation and told us a new training package was in development. Staff could explain what action they would take if they identified a child at risk. There was also a multi-agency pathway to support staff. Nursing leads from health visiting, school nursing, the family nurse partnership, sexual health services and the looked after children team were also part of a sexual exploitation task group. The purpose of this group was to ensure staff across the trust were aware of child sexual exploitation, recognise children who may be at risk and know how to respond to concerns.
- There was a designated doctor and designated nurse for looked after children. The named nurse attended monthly safeguarding meetings, run by the local authority, to discuss cases and issues involving missing, sexually exploited and trafficked children and young people.

Medicines

- The trust had processes and standard operating procedures to manage the ordering, storage, disposal and monitoring of vaccines. Evidence provided to us by the trust also included up-to-date, documented procedures for the safe handling and use of vaccinations, packing and transport of vaccines and monitoring of fridge temperatures. We saw staff following the guidelines appropriately and found evidence of good practice, for example, fridge temperature checks and the administration of vaccines.
- Medicines were securely stored and handled safely. Staff were aware of the trust protocols for handling medicines to ensure the risks to people were minimised and expiry dates were checked monthly.
- School children who suffered from asthma or epilepsy each had a secure box, held in school, which contained

their individualised treatment plan and dosage information. Inhalers were not locked away. We were told this was a recent change, in response to a serious case review involving an asthmatic child.
- Some health visitors and sexual health nurses were independent prescribers. This meant children and young people had timely access to medicines and treatment. Staff were able to access support for this role using the trust's pharmacy department.

Environment and equipment

- We found all the equipment in use was clean and had been safetytested and serviced where required. Weighing equipment was calibrated annually and staff were aware of the process to follow if they needed to report any faults.
- The majority of staff told us they had enough equipment to deliver safe care and had no problems ordering equipment.
- We visited a number of buildings where clinics were held. We found the environments were clean and tidy and suitable for children and their families. Waiting areas were bright and cheerful particularly those catering specifically for children and young people such as the child health centre based at Wansbeck General Hospital.

Quality of records

- We looked at 15 care records across school nursing, health visiting, the family nurse partnership and children's community nursing. We viewed both paper and electronic records. Most of the records we saw were clearly set out, legible, comprehensive, dated and signed. Records also included individualised care plans, risk assessments, action plans and relevant pathways where required. Additions were made in a timely manner.
- Health visitors and school nurses used SystmOne, an electronic records system, and were positive when describing the benefits of the tool. Plans were in place for the transition of therapy services and looked after children records. The children's community nursing team told us the relevant modules were currently being developed in SystmOne to facilitate their transition. Those staff who were currently using SystmOne acknowledged there were challenges in adapting to the new system however they felt very supported if they needed to ask questions or seek help.
- Clinical care records audits took place annually and peer reviews took place periodically throughout the year. Specific outcomes were discussed with individuals, learning was shared across each relevant service and changes were made. For example, the recent audit completed by the speech and language therapy team highlighted the requirement to record a childs NHS number and identified not all records captured the time a therapist saw a child. We also reviewed the health visiting audit report, completed in October 2015. The report was clearly set out and included all of the results plus a list of recommendations with appropriate actions attached to each one.
- Paper records were stored securely in locked cabinets within an office environment. We saw patient notes being safely transferred from community visits back to the staff base in sealed bags.

Cleanliness, infection control and hygiene

- Staff were aware of safe infection prevention and control (IPC) measures and knew how to access the IPC policy on the intranet.
- The clinics we visited were visibly clean and tidy. We observed staff using hand gel to clean their hands and adhering to the bare below the elbows guidance, in line with national good hygiene practice. We reviewed an analysis of hand hygiene audits carried out across Northumberland and North Tyneside and noted the compliance target of 98% was exceeded across all services.
- We also saw personal protective equipment was readily available for staff to use and we observed staff using it appropriately.
- In baby clinics, the equipment was cleaned after every use using cleaning wipes. The paper roll, used to line the baby scales, was also replaced for each new patient.
- Staff from all services used toys and games to engage and interact with children. Toys were cleaned using antibacterial sanitary wipes after every use.
- The majority of staff had undergone infection control training in the last 12 months. The level of compliance across all services was above the 85% target set by the trust.

Mandatory training

Are services safe?

- Staff told us the trust placed a high importance on training. Individual members of staff were responsible for making sure they were up to date with all of their own training, however, they also received notifications from line managers.
- Training resources were accessible and available face-to-face or online using an e-learning package. At a focus group with health visiting staff, they told us some training was tailored towards their specific needs as a community service and was not primarily aimed at acute services.
- Staff told us they were fully compliant with all of their mandatory training requirements. Evidence provided to us from the trust demonstrated compliance levels were good across all services. For example, all staff had achieved the training target for paediatric life support and health and safety.

Assessing and responding to patient risk

- In the 15 sets of records, we observed patient risk assessments were completed appropriately and updated as required.
- Staff across all services told us assessing risk was a standard part of their role. For example, risks within the family nurse partnership were identified through various means including DANCE (Dyadic Assessment of the Naturalistic Caregiver Experience) assessments. DANCE helps to enhance the relationship between the parent and child and educates the parent on the benefits of reciprocal interaction. It is also a means to identify risk in the relationship between the new mother and her baby. The health visiting service also used the Tynedale Assessment Tool to identify potential risks they may have missed during previous visits such as, for example, deep parental psychological issues. The tool also encouraged parents to see things through the childs eyes.
- In the children's community nursing team, daily handovers took place at 9.00am. Based on the SBAR principle (situation; background; assessment and recommendation), one purpose of the meeting was to highlight any risks and allocate resources appropriately. To ensure the team was accessible, one qualified nurse was responsible for the team mobile telephone each day to ensure urgent cases were triaged and prioritised accordingly.
- Standards were in place to support timely information sharing between health visitors and public health school nurse. Health visitors we spoke with told us handover arrangements with midwives and school nurses were good. When we spoke with school nurses, they told us a face-to-face meeting took place with the respective health visitor if a child leaving the service had complex needs or was subject to a child protection plan.
- Young people under the age of 16 who accessed sexual health services initially had a one-hour appointment to allow an in-depth assessment. The clinical lead told us this enabled staff to identify any risks or concerns, particularly in relation to safeguarding. To mitigate further risk, the service also had a system to feedback results or outcomes following an appointment. The service would telephone the young person three times (on an agreed contact number), and then text if there was still no response. If the young person remained uncontactable, a meeting was held to discuss any potential risk and the team would seek further support from the school nursing service to contact the young person where appropriate.
- We saw evidence of the systems to monitor and track looked after children. Once the local authority notified the team of a new child, an appointment was made for the initial health assessment. This took place within 28 days. All new notifications were discussed at the weekly team meeting. Daily business reports were also produced to ensure all children were accounted for and appropriate action had been taken.

Staffing levels and caseload

- Overall, staffing levels across community services for children and young people were safe. Caseloads were managed well and there was a good skill mix within each team and across each locality.
- In Northumberland, there were 73 whole time equivalent (WTE) health visitors, 17 WTE nursery nurses and two WTE staff nurses serving a population of approximately 16,500 children under five years of age. In North Tyneside, there were 51 WTE health visitors and seven WTE nursery nurses providing services to approximately 12,500 children.
- Information provided to us by the trust showed there were two whole time equivalent (WTE) vacant health visitor posts in North Tyneside and six WTE vacant posts in Northumberland. This constituted 4.% and 8% of the

health visitor workforce respectively. Four vacant posts had recently been appointed to in Northumberland. Staff told us vacancies were reviewed regularly and there were on-going recruitment plans in place.

- According to guidance produced by the Community Practitioners and Health Visitors Association, caseloads should be, on average, 250 children for 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. We found health visitor caseloads in Northumberland and North Tyneside were managed well and followed this guidance. Health visitors looking after children with a high number of child protection and safeguarding concerns had a lower overall caseload than colleagues who were managing less complex cases. This meant some localities had higher caseloads than others. Staff told us this was reviewed regularly to ensure caseloads were managed safely and teams worked together to ensure the distribution of work was equitable.
- The children's community nursing team covered Northumberland and North Tyneside as one unit. There were 10 WTE qualified nurses and four WTE healthcare assistants. The service was led by a modern matron who had recently appointed a band seven nurse to manage the nursing team led the service, following a service review. Caseloads were managed collectively across the team; however, each child or young person did have a named nurse.
- Family nurse partnership caseloads were below the national recommendation of 25. Supervisors told us this had been planned deliberately to ensure there was some flexibility built into the system. This flexibility enabled the teams to support some young mothers who lived outside of the immediate locality. The limit was set at 23 young mothers for each family nurse and the current staffing levels enabled the service to deliver the healthy child programme and meet its fidelity measures.
- School nurses told us they felt there were resource issues affecting the service in rural areas and this resulted in staff feeling isolated. However, there were plans in place to address the issue, which involved amalgamating teams that currently operated separately from one another.
- Paediatric therapy services formally reviewed caseloads annually however, local assessments were undertaken every three months. Staff we spoke with told us caseloads were manageable and response times were good. Staff explained the service adopted a holistic approach when reviewing caseload numbers and considered a variety of factors including the nature of the case, administrative support and report writing.
- We reviewed sickness absence statistics across all services from data provided to us by the trust. In 2014/15, the majority of services were below the trust 12-month average of 4% as at November 2015. Children's community nursing and the health visiting service sickness rate in North Tyneside was 9%.

Managing anticipated risk

- Staff who were based in rural areas in Northumberland told us they had experienced problems due to extreme winter weather in recent years. Travelling around the local area presented a number of risks in adverse weather conditions. The trust had developed a pathway to support staff and ensure care could continue to be provided to children and young people. For example, staff had access to trust 4x4 vehicles when necessary and could also work from their nearest trust base if their normal access to work was restricted. One member of staff told us 'snow grips' for shoes had also been provided to keep staff safe during icy weather conditions.
- Staff told us they undertook risk assessments when working in the community. For example, when visiting a new family in their home for the first time, health visitors would visit in pairs or gather information from different sources to inform their risk assessment. SystmOne featured an alert to ensure risks were communicated to the wider team.
- Staff from all services told us they had completed, or were in the process of completing, an emergency preparedness plan. The plan documented a list of service contingencies, which, in the event of an emergency, would ensure continuity of service delivery.

Outstanding ☆

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 effective as outstanding because:

Policies and guidelines were all evidence based and we saw excellent examples of multidisciplinary and multi-agency working and collaboration. There was a holistic approach to assessing, planning and delivering care to children, young people and families. Staff consistently sought new evidence based techniques and demonstrated their commitment to work in partnership with others to support the delivery of high quality care.

The care and treatment of children and young people achieved excellent outcomes and promoted a good quality of life. Health visitors, the family nurse partnership and school nurses delivered the full Healthy Child Programme. They routinely collected and monitored the data to maintain the high standard and engaged in activities to improve outcomes where appropriate. Staff from all services proactively pursued opportunities to participate in benchmarking, peer review accreditation and research.

There were effective arrangements for young people transitioning to adult services. Needs were assessed early, with the involvement of all necessary staff, teams and services and staff applied Fraser guidelines appropriately in relation to obtaining consent. Arrangements fully reflected individual circumstances and preferences.

Managers encouraged staff to develop, both personally and professionally, and staff took ownership of their own performance. Appraisals, based on the trust values, and one-to-one meetings were regularly undertaken and there was a good preceptorship programme for new staff joining the service.

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 the National Institute for Health and Clinical Excellence (NICE) or other nationally or internationally recognised guidelines.
- We saw evidence of standard operating procedures and pathways across all services to ensure service delivery was effective. New policies and pathways were introduced where appropriate, for example, a new feeding policy was introduced to provide guidance for staff caring for children with complex needs.
- The sexual health services had introduced a new method of assessing young people under the age of 16 at their first appointment. 'Spotting the Signs' was a national tool and evidence-based framework to support healthcare professionals in the detection of child sexual exploitation (CSE). The service recognised the tool was also appropriate for identifying other safeguarding concerns. In their 2014 annual report, it was reported that 13 young people were referred to the local authority safeguarding service, six of which were unborn babies.
- All health visitors, school nurses and the family nurse partnership nurses we spoke with knew all of the guidelines relevant to their practice and said they were embedded within their service. They followed the national initiative called 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, immunisations and vaccinations, development reviews and information, guidance and support for parents. The programme was delivered across the 0-19 age range.
- Health visitors and the family nurse partnership 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, readiness for school and provide support to parents in areas of need.
- Staff from the health visiting teams in Northumberland and North Tyneside told us they had achieved accreditation from the United Nations Children's Fund (UNICEF) Baby Friendly Initiative and we reviewed supporting documentation.
- The family nurse partnership worked with young people in Northumberland and North Tyneside. The service

provided evidence to demonstrate they followed the national programme, including meeting targets and achieving key milestones with participants of the project.

- There were policies and standard operating procedures to ensure looked after children and those with long term, and complex needs had their needs met in appropriate ways. For example, the looked after children team used Strengths and Difficulties Questionnaires (SDQs) as a monitoring tool to identify any concerns around the emotional health of a child. Completed scores were analysed for themes and trends. Individual cases were discussed with the relevant social worker to ensure the health plan reflected ongoing plans and referrals.
- Staff caring for children and young people with complex needs attended regional clinical excellence network meetings to share and learn from good practice. We heard examples from staff describing how new evidence-based guidance had been adopted and adapted within the trust, including the development of new pathways for dysphagia, stammering and speech-sound disorders. Dedicated staff ensured new research and development initiatives were incorporated into their service and there were robust systems in place to support them.

Nutrition and hydration

- Support was available for children with complex feeding needs. A health visitor explained the system to support children who were adverse to the oral in-take of food. Those over three years of age received support in their transition to school from specialist speech and language therapists and dieticians. There were also pathways providing guidance when managing children with nutrition and hydration based allergies.
- The trust had a Newborn Feeding policy and this included support and care for breastfeeding mothers. There were breastfeeding support groups across Northumberland and North Tyneside.
- We observed baby clinics led by health visitors and nursery nurses. The information and advice provided followed national guidance, for example, not introducing solid foods until six months of age.

Technology and telemedicine

- Services were looking at different ways to use technology effectively. For example, the family nurse partnership was in the process of introducing the 'baby buddy' application (app), designed for parents and parents-to-be with personalised content that spans from pregnancy right through to the first six months after birth. Although this had not been developed by the trust, nurses from the team had researched the benefits and presented a case, which had been approved at a recent governance meeting.

Patient outcomes

- We saw evidence patient needs were thoroughly assessed 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 immunisation rate for the measles mumps and rubella (MMR) vaccine in children aged two was 96% in Northumberland and 95% in North Tyneside, both better the England average of 92%. The immunisation rate for diphtheria, tetanus, polio, pertussis and Hib in children aged two was also better than the England average of 96%. The rate was 97% in Northumberland and 99% in North Tyneside.
- The immunisation rates for children in care were 90% in Northumberland and 92% in North Tyneside. This was better than the England average of 87%.
- The health visiting services used the national Programme Delivery Assurance Tool (quarterly area team dashboard) to record and monitor patient outcomes. The trust provided data recorded in Quarter 1 (April 2015 - June 2015). It showed performance targets were met and some of the key findings are outlined below:

- 91% of mothers received a first face-to-face antenatal visit from a health visitor at 28 weeks or later, before they gave birth.
- 90% of families received a new birth visit, which took place within 14 days of the baby's birth.
- All families were offered a 12-month assessment. 68% of children received a review in the month of their first birthday while 88% received the review by the time they were 15 months old.
- All families were offered a 2-2.5 year assessment. 84% of children received a review by the time they were 30 months and 90% by 36 months.

Are services effective?

- 100% of new mothers received a Maternal Mood review and data taken from an audit showed 10% of women identified as requiring additional support.
- Family nurse partnership recorded and monitored outcomes using the 'Open Exeter' information system. The service specification included a set of fidelity 'stretch' goals. We reviewed evidence that showed the service met its fidelity measures. The percentage of teenage mothers who enrolled in the programme by 16 weeks exceeded the fidelity goal of 60% and the attrition rate (the number of teenage mothers who did not complete the programme) was low. We spoke with one of the supervisors who told us these figures were due to the skills of the nurses and the appropriate caseload-staff ratio.
- Another fidelity stretch goal stated 100% of clients should receive at least 80% of the planned programme visits in pregnancy and 65% in infancy. The team achieved 83% in pregnancy and 90% in infancy, which was a very positive figure, compared to the national averages of 57% and 62% respectively.
- Feeding status data was recorded in SystmOne and we reviewed information collected in Quarter 1 (April 2015-June 2015). At birth, 55% of all new babies were breastfed. At the 6-8 week stage, 79% of these mothers continued to breastfeed their babies. Health visitors and the family nurse partnership worked closely with the trust infant feeding co-ordinators. To improve breastfeeding outcomes amongst the teenage mother population, the service bought teenage-friendly breast pumps to encourage and support young women to breastfeed their babies over a sustained period.

Competent staff

- All staff new to the trust underwent a corporate induction followed by a comprehensive local induction within the relevant service.
- Staff and managers told us they had had an annual appraisal. Staff completed an evidence-based workbook, focused around the trust values. Information provided to us by the trust included statistical evidence and we found the majority of services had achieved 100% compliance. We spoke with one member of staff who voluntarily showed us her appraisal booklet and explained how her objectives were linked to the overall service objectives and values of the trust.
- Nurses, therapists, administrative staff and clinical leads told us they received regular formal and informal supervision from line managers and peers. Informal supervision occurred on a daily basis while formal supervision varied from service to service in line with trust and national guidance. For example, nurses from the family nurse partnership had weekly supervision meetings with their supervisor and three-monthly face-to-face tripartite supervision, which also included a senior nurse from the safeguarding children team. Health visitors and school nurses received formal supervision every three months although most staff told us this often occurred more frequently.
- Staff from community services for children and young people told us they felt there were many opportunities for personal development and training. Additional training needs were identified through supervision and appraisals. Staff we spoke with were encouraged to seek additional training as necessary to develop their roles and they were supported in doing this by the management team. External training included child and adolescent mental health and Solihull Behaviour Management. There were also opportunities to progress academic learning to further develop skills and competencies. This included specialist community public health nurse degree courses and we spoke with health visitors who had recently completed Master level degree courses.
- New or recently qualified members of staff, across all services, told us there was a very good preceptorship programme. New health visitors told us they had many opportunities to shadow and work with more experience staff and time for personal development. A newly appointed senior nurse told us about the recruitment and selection process. She explained the trust vision and values were included in all of the questions. She felt the process was very robust and a manager told us they felt it supported them to select the right people for the right job.

Multi-disciplinary working and coordinated care pathways

- There was an emphasis on multi-disciplinary and multi-agency working within the trust. Staff described a patient-centred approach and included parents where appropriate as well as all other healthcare professionals involved in a childs care.

Outstanding ☆

Are services effective?

- Staff had a good awareness of the services available to children and were able to contact other teams for advice and make referrals when necessary. This meant information was shared readily and cross agency working ensured where there were concerns about vulnerable children, these were shared and managed.
- The looked after children team were part of the local Raising Health and Education for Looked After Children group. The Virtual Head Teacher chaired the RHELAC meetings and other members included educational psychologists, counsellors, drug and alcohol teams, educational welfare officers and teaching staff. Individual children were discussed with the aim of ensuring each child received the appropriate care and support they needed. The named/designated doctor for looked after children, clinical psychologist and named nurse were also members of the Corporate Parenting Board in North Tyneside.
- School nurses and paediatric therapy services told us they had very good links with local schools. We saw evidence of this when we attended a speech and language therapy session, a flu vaccination clinic and a school nurse presentation about puberty to Year 5 children.
- Paediatric therapy services told us they worked closely with specialist school nurses and health visitors when caring for children with complex needs.
- Health visitors had close links with local Children' Centres and utilised the facilities to run weaning support groups, baby play and parent-craft sessions.
- Communication between children and young people's services and GPs was good. Every health visiting team was affiliated with a GP practice and staff reported there were no issues when they needed to speak to one about a child in their care.

Referral, transfer, discharge and transition

- Health visitors and school nurses told us they worked closely with each other to make sure vulnerable school-age children were discussed and important information relayed. Children with special needs or those subject to a child protection plan were handed over in a face-to-face discussion. Parents were involved in the handover if appropriate.
- There were arrangements in place to support young people with complex needs and learning disabilities transitioning to adult services. Paediatric therapy services had a pathway to support young people leaving special school. The community children's nursing team explained their process began when the young person was 14 years old when all medical and nursing documentation was colour-coded according to the childs condition and requirements. Eighteen months before the young person was due to transition, the nursing team involved the relevant adult district nurse and at 12 months before, meetings were arranged with primary and medical care services to discuss the young person's care plan.
- When a child or young person was discharged home following acute care in hospital, the community children's nursing team told us they were not always informed. Nurses should be included in handover discussions, initiated by the trust discharging the patient. When this happened, the team would proactively contact the relevant ward and inform the staff. Managers were working collaboratively with staff within the trust and the local tertiary provider to improve discharge planning and prevent future occurrences.
- The looked after children team told us they supported young people leaving the service by building their confidence and promoting empowerment. Each young person was in possession of his or her own, unique 'passport'. This included details about their full health history and relevant information about their GP and other healthcare services. If a young person had medical problems, the team liaised with acute services or, if the young person was receiving care and treatment from the Child and Adolescent Mental Health Service (CAMHS), staff would support the young person through their transition to the Adult Mental Health team.
- Strategic transition meetings, jointly led by the trust and the local authority, took place every three months. At a recent meeting, the agenda included a new pathway developed by one of the community paediatricians. The community children's nursing team attended this meeting as well as representatives from paediatric therapy services and CAMHS, the child and adolescent mental health service.

Access to information

- 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. There

were systems to manage and monitor care records and we saw this in practice with both paper and electronic patient care records. Information was also shared with families.

- The intranet was available to all staff and contained links to current guidelines, policies, procedures and contact details for colleagues within the trust. This meant staff could access advice and guidance easily. All staff we spoke with knew how to access the intranet and the information contained within.

Consent

- The trust had a consent policy, which included specific references to children and young people.
- Staff we spoke with told us they understood the Fraser guidelines and applied them in practice. Consent was obtained from parents and children at the initial assessment stage. School nurses worked within the guidelines to make decisions about whether young people had the maturity, capacity and competence to give consent themselves. Staff from all services told us they took in to consideration the voice of children and young people when obtaining consent.
- We saw evidence of correctly completed consent forms and we observed staff obtaining verbal consent correctly prior to a home visit.

Outstanding ☆

Are services caring?

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

Summary

We rated caring as outstanding because:

Managers and staff created a strong, visible, person-centred culture and were highly motivated and inspired to offer the best possible care to children and young people, including meeting their emotional needs. Every member of staff we spoke with, across every service, was very passionate about their role and, in some cases, went beyond the call of duty to provide care and support to families. There was respect for the different personal, cultural, social and religious needs of the children and young people they cared for, and care and treatment was focussed on the individual person rather than the condition or service.

Feedback from families we spoke with was unanimously positive about all aspects of the care they and their children received. They described staff as being very caring, compassionate, understanding and supportive. Staff worked in partnership with children and young people and promoted empowerment, enabling them to have a voice and realise their own potential. Young people, for example, were supported to develop and maintain relationships within their community to help manage their own health and care and to maintain independence. Managers and staff valued the emotional and social needs to children and young people and this was reflected in their care and treatment.

Compassionate care

- All staff we spoke with were very passionate about their roles and were clearly dedicated to making sure children and young people received the best patient-centred care possible.
- Staff showed respect for the personal, cultural, social and religious needs of children and young people. For example, a paediatric therapist ensured there were no pictures of pigs included in the display tool she used when caring for a young child following a request from his parent.
- We observed the way staff treated children and their parents both in their homes and in clinic settings. Parents told us they had confidence in the staff they saw and the advice they received. Staff were kind, sensitive, supportive and compassionate and they treated children and young people as individuals. For example, we observed a sensitive discussion about a young child's weight. The health visitor and nursery nurse adopted a very non-judgemental approach, gave some initial suggestions along with a food diary and arranged a follow-up visit, all readily accepted by the child's mother.
- We reviewed the results from patient experience surveys and the feedback was very positive. For example, 100% of parents and carers would recommend the paediatric therapy services in Northumberland and North Tyneside. 100% of people also said they were involved in decisions about the care and treatment of their child. One parent commented: 'lovely ladies, my son was assessed and he seemed relaxed and enjoyed the session'.
- Out of a maximum of 10, the health visiting service scored 9.65 when parents were asked if they were as involved as much as they wanted to be in discussions about their family's needs. Parents also gave the service 9.85 out of 10 when asked if they had confidence in their health visitor.

Understanding and involvement of patients and those close to them

- The looked after children team told us they had asked children and young people if they understood the purpose of the letter inviting them to attend their initial health assessment. The responses led to changes, which included a section explaining what to expect from the assessment. The assessment was then explained in further detail at the actual appointment. Young people were also involved in the development of their unique passport, which included their full health history and background. If a child had a learning disability, the information was tailored to meet their individual need and ensure their understanding.
- Services involved children, young people and families in the planning of their own care. For example, teenage mothers were encouraged to talk about any anxieties they had about their pregnancy and a plan was developed to incorporate those into their next visit. During a home visit, the young mother told us she had really benefited from the support she had received from

the family nurse partnership. She felt more confident and prepared for when her baby arrived. When we attended another home visit, we witnessed a health visitor proactively engage with the father about the care of the baby instead of focusing solely on the mother.

- Parents and carers of children told us staff focussed on the needs of the child and their family. They felt involved in discussions about care and treatment options and told us they were confident asking questions. Parents described staff as 'fantastic', 'trustworthy', 'responsive' and 'accessible'.
- Staff told us they supported children and their parents or carers to manage their own treatment needs, whenever possible. Staff told us they discussed goals with families and gave them advice about how they could make progress towards achieving those goals. We heard examples of staff 'going the extra mile' to support families - an occupational therapist ensured relevant equipment and furniture matched the décor in a child's bedroom and health visitors gave additional support to a family during a house-move.
- We observed health visitors and nursery nurses interact with children and parents at a baby clinic in a local children's centre. Staff created a warm and caring environment and greeted children by name. We also observed staff position 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).
- We observed school nursing staff deliver presentations to children in Year 5 (aged 9-10 years) in line with the national PHSE programme. The delivery style in each session was open, caring and supportive. Children had the opportunity to ask questions and the nurses explained some children might have different reactions to a short film explaining the stages of puberty (and gave 'permission' for the children to giggle if they felt they wanted to). All the children engaged with the nurses. When we spoke with some of the children following the presentation, they told us they thought it was 'good' and they understood the content.

Emotional support

- Staff from the trust supported children, young people, their families and carers in the first instance. Referrals to other services such as psychologists, GPs and counselling services could be made if further specialised support was needed.
- Staff understood the impact the condition and treatment had on children and young people and this was embedded in their care. For example, we spoke with a speech and language therapist who had referred a young person to a cleft lip and palate clinic for further treatment. The patient did not attend the appointment due to fears about an operation. The therapist worked with the young person in school to build her confidence and develop more links to ensure she received further support. Once a new appointment was scheduled, the therapist planned to meet with the family in advance. We heard another example from a member of staff who contacted a parent by telephone after a clinic appointment so the child was not upset by the feedback.
- Staff in health visiting teams managed their own caseload. This meant mothers met the same health visitor at each appointment in their home. Consistency meant health visitors built up relationships with mothers and children; we saw evidence of this during home visits. One health visitor also gave us an example of supporting a family during bereavement when a father died.
- During a very busy baby clinic, we observed staff spending time with individual parents, discussing their concerns in a manner that was not rushed or hurried. We also observed a flu vaccination clinic where school nurses offered constant reassurances to some very nervous children.

Outstanding ☆

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 outstanding because:

Staff actively promoted involvement from children, young people and the local community, 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 supporting teenage mums to stop smoking, and services offered a wide range of accessible clinics and appointments across different venues and locations.

There were integrated person-centred pathways that involved other service providers, and services were flexible, provided choice and ensured continuity of care. Families had access to the right care at the right time, taking into account children and young people with urgent or complex needs.

There was a proactive approach to understanding the needs of different groups of children and staff delivered care in a way that promoted equality. This included children and young people who were in vulnerable circumstances and those who had complex needs.

There was an open and transparent approach to handling complaints. Information about how to make a formal complaint was widely available however; families tended to contact the service directly either when they had a concern or sought support from the Patient Advice and Liaison Service (PALS).

Planning and delivering services which meet people's needs

- Staff told us they actively involved children, young people and families when planning, and delivering services. For example, to ensure they met the needs of teenage mothers, the family nurse partnership involved two young mothers, who had previously accessed the service, in its recruitment and selection process for new nurses. The young women, with support from the team supervisor, prepared some questions based upon their expectations of a family partnership nurse and were able to ask them during the interview. Although they did not contribute to the overall scores for the candidates, their comments were taken into consideration.
- Community services for children and young people had proactively participated in the You're Welcome toolkit, which was a quality criteria highlighted in the National Service Framework for Children. The toolkit sets out a number of principles to ensure young people aged 11 to 19 (including vulnerable groups) were able to access services better suited to their needs. The toolkit covered 10 key areas assessed, including accessibility, publicity, confidentiality/consent, the environment, staff training, skills, attitudes and values.
- Staff we spoke with recognised and understood how families could feel overwhelmed by the number of visits they might receive from healthcare professionals, particularly those who had children with complex needs or who were subject to a protection plan. Health visitors and the family nurse partnership told us they would often accompany each other on the same visit, when appropriate, to ensure they met the needs of the family. Paediatric therapists attended appointments led by dieticians or paediatricians to support families and minimise the frequency of visiting professionals.
- We found services contributed to addressing the public health needs of children and young people. For example, the family nurse partnership had identified an increase in the number of teenage mothers who had returned to smoking once they had given birth. The team sought support from the trust's Stop Smoking Team who, in turn, trained the nurses to identify triggers and deliver appropriate intermediate care and treatment. This included the use of smoking monoxide monitors and prescribing patches to help sustain the level of reduction.
- Young people were an integrated part of the sexual health service. The One-to-One Centre in North Tyneside reported a quarter of all attendances were young people under 18 years of age. The service provided was inclusive and young people did not have a separate appointments system or specialist clinics. They did have

Are services responsive to people's needs?

a dedicated waiting area adjacent to the main waiting room. The sexual heath team also had a very proactive health promotion team who focused on ensuring the service met the needs of young people.

- School nurses ran drop-in clinics in secondary schools. Any pupil could attend at any point, to discuss anything, including alcohol, drugs, growing up, bullying. Health visitors, nursery nurses and the family nurse partnership also ran clinics across all localities to support new mothers and encourage participation and networking.
- Paediatric therapists ran clinics in local Children's Centres and met children in nurseries and schools. Parents and carers were invited to the initial appointment to meet the therapist and discuss any concerns.
- We saw evidence the trust involved and engaged with local communities in planning services for children and young people. Community services in Northumberland had developed a participation strategy and were actively training young people as part of the reaccreditation programme for the You're Welcome initiative. There were also two participation groups: the Northumbria Healthcare Young Apprentices gathered feedback about services for children and young people provided by the trust while the Northumberland College Partnership Health Reference Group offered consultation on literature, materials and resources to ensure they were age appropriate and met the needs of children and young people.
- The trust also held a series of Young People's Health roadshows in location across South-East Northumberland where there were higher levels of deprivation, teenage pregnancies and mental health issues across the young people demographic. The purpose of the roadshows was to gather feedback from young people about the types of health issues they have and where they find information and advice. Following the events, the trust reported it was updating young people's health information resources and ensuring current approved literature was advertised throughout young people's settings to promote positive Mental Health messages.
- The sexual health promotion team in North Tyneside involved young people to promote the delivery of sexual health messages. For example, young people from the YMCA Young Health Champions and the Young People's Health and Wellbeing Group worked with the health promotion specialist to develop a 'One2One DVD'. The aim of the DVD was to inform and encourage young people to access appropriate services when they needed to.

Equality and diversity

- Staff told us access to interpreting services was good. In many cases, they used the telephone service; however, they had not experienced any problems when they needed to book an interpreter to attend an appointment. Paediatric therapy services used Makaton, a language programme using signs and symbols, enabling them to communicate with children and young people with learning disabilities. The service also included a regional Makaton tutor who provided support and advice to staff.
- The named nurse for looked after children told us about the concerns some children and young people had about being stigmatised as a 'child in care'. To ensure looked after children did not face unnecessary discrimination, the trust ensured children and young people would not be identified as such when presenting at A&E or any other hospital appointment. The decision had been made following discussions with staff from acute services; however, the named nurse acknowledged they were looking at reviewing the current practice. If a looked after child was subject to safeguarding or a child protection plan, the appropriate alert would be included.
- 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.

Meeting the needs of people in vulnerable circumstances

- Staff we spoke with were aware of female genital mutilation and child sexual exploitation and some staff had received specific training. The local safeguarding children board had developed an operational guide for staff about child sexual exploitation, which included a risk assessment tool.
- The named nurse for looked after children in North Tyneside was a member of the Missing, Sexually Exploited and Trafficked group. This was organised by the local authority and included the local police force. The group met monthly. If the named nurse had

Are services responsive to people's needs?

concerns about a child or young person in her care, she could make a referral to the group where a triage discussion would take place and action taken where appropriate.
- Children and young people who attended special schools received care and support from a dedicated team of school nurses and paediatric therapists.
- There were very good networks of support for looked after children. Staff worked closely with them and developed close working relationships to ensure they met their needs. For example, following an assault, one young person felt vulnerable leaving their home therefore the team arranged to meet the young person in a place of their own choosing and ensured they received the right care and support.
- There were dedicated specialist school nurses to support children and young people with complex needs. To strengthen the transition process for 17 to 19 year olds with complex needs and learning disabilities, the trust had recently appointed a specialist nurse to review current practice and identify any gaps in the service. Consideration was being given to the introduction of a hospital passport as well as more involvement with families.

Access to the right care at the right time

- Referrals to paediatric therapy services were triaged and prioritised according to need. For example, children and young people deemed as high priority saw a therapist within 13 weeks while the waiting time for non-urgent cases was the standard 18 weeks. Some referrals received an immediate response, for example, urgent dysphagia referrals were actioned within 10 working days. There were local systems within each service to monitor waiting times. Staff discussed their caseloads and the subsequent impact this had, if any, on waiting times at supervision sessions and at locality meetings. Senior managers within the service and business unit received assurance or were alerted to significant issues at clinical lead management and governance group meetings.
- Managers told us there were no breaches to current waiting time targets. We reviewed data between April 2015 and August 2015. The average wait for a non-urgent occupational therapy appointment within the community was 13 weeks and 10 weeks within education. We also reviewed referral to treatment time data in May and June 2015 for speech and language therapy and saw they achieved 100% compliance against target.
- Paediatric therapy services triaged some referrals as 'routine'. This meant the child did not receive an actual appointment. Instead, the family received a package containing relevant information and advice with an invitation to contact the service again if they did not see any sign of improvement. This was intended to reduce waiting times for complex cases and also to help promote effective parental management.
- The sexual health clinic in North Tyneside was accessible to young people. Appointments were offered at a local higher education college and outreach clinics operated at other health centres. An outreach nurse also offered home visits where appropriate.
- Referrals received by the community children's nursing team were actioned promptly. Children and young people received a visit from a nurse within the service target of three days. The team offered a seven- day service and was accessible between 8:00am and 6.00pm, Monday to Friday, and 9.00am until 5.00pm on weekends.

Learning from complaints and concerns

- The trust had a complaints policy and staff we spoke with knew how to access it. Staff felt the process was open and honest. Staff were aware of actions to take when concerns were raised. This included trying to resolve any problems as they were raised. Staff were proactive in working in partnership with children, young people and their families, which minimised the need for people to raise 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.
- We reviewed complaints made between September 2014 and August 2015. Three complaints had been made about community services for children and young people. There were no discernible themes or trends.
- There was information about how to make a complaint and how to contact the Patient Advice and Liaison Service (PALS) displayed in the clinics and locations we visited.

Outstanding ☆

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 outstanding because:

Managers created a culture of openness and transparency with a clear focus on putting children and young people at the centre of their care. Services had good strategies and plans, each with service-specific objectives and goals, to meet the needs of children and young people and deliver a high quality service. Objectives were stretching, challenging and innovative while remaining achievable. They directly linked with the overarching trust vision and goals and staff knew what these were.

Staff were very positive about working for the trust and leadership was good across every service. Leaders had an inspired shared purpose; they strived to deliver and motivated their staff to succeed. There was a clear management structure and managers were visible and involved in the day-to-day running of services. Staff could contact them whenever they needed to and received regular supervision from line managers and clinical leads. There was strong collaboration and a culture of collective responsibility between teams and services with a common focus on improving quality of care and the patient experience.

Managers and staff used innovative approaches to gather feedback from children, young people and families. They listened to suggestions and made changes as a result. Managers from every service drove continuous improvement and empowered staff to raise concerns and offer innovative suggestions to improve service delivery, quality and care.

There was an effective and comprehensive system to identify, monitor and address current and future risks. Managers had embedded clinical and internal audit processes within services and this had a positive impact in relation to quality governance, with clearly defined outcomes and actions.

Service vision and strategy

- The Child Health business unit had a business plan in place and there were direct links to the overarching trust strategy, organisational goals and objectives. Individual services also had strategies in place to deliver high quality care and treatment. For example, the trust had recently won the bid to re-commission its own sexual health service in North Tyneside. A clear and comprehensive three-year strategy was set out outlining the new service delivery model of integrated care.
- Staff we spoke with were very clear in their understanding of the trust's organisational vision and values. The appraisal process included individual staff objectives, which linked with both the service and organisational goals.

Governance, risk management and quality measurement

- There was a very robust governance structure with clear lines of responsibility and accountability. The majority of services for children and young people sat within the Child Health business unit. Paediatric therapy and sexual health services sat within the Community Services business unit. Staff told us how strong they felt the governance structure was. They believed communication was very good and felt, despite the number of different services that made up community services for children and young people, they worked together as one.
- There were systems in place to review National Institute for Health and Clinical Excellence (NICE) guidelines and other nationally recognised guidance. Senior manager and clinical leads reviewed new guidelines at clinical business meetings before sharing the information with staff. We spoke with staff from all services who told us this worked very well in practice.
- There was a robust quality assurance system and performance measures across all services. Staff we spoke with had a solid understanding of the outcomes they were measured against and told us these were reported and measured regularly in team meetings, through action plans, performance dashboards and discussed during supervision and one-to-one meetings.
- The Child Health and Community business units had its own risk register and included all of the risks for each

relevant service. We saw evidence these were reviewed regularly at locality and business unit meetings. We also saw documentation detailing plans to address the risk, for example, health visitor recruitment.

- Regular team meetings took place across all services and localities. The agenda included incidents, risks, staffing, complaints, service developments, best practice plus training and development. Feedback from staff was very positive about the meetings. Many staff told us they welcomed the opportunity to meet with their service leads and colleagues, particularly those who worked remotely from each other and in rural locations.
- We saw evidence of internal quality audits undertaken routinely across all services and, in some cases, across organisational boundaries to ensure safe and effective care for children and young people. The audits we reviewed ranged from monthly meetings between health visitors and midwives to a review of practice against the missed appointment standard for children on a child protection plan. Each audit report included conclusions drawn from the research and recommendations for change or improvements in practice.

Leadership of this service

- Staff we spoke with were very positive about the local leadership across each service and at business unit level. Staff, at all levels, felt very well supported by their line manager. There were clear management structures within each service and managers were very approachable. Managers were also visible and staff told us they felt connected to their wider team, despite some of the challenges presented by the geographical diversity across Northumberland and North Tyneside.
- We heard and saw examples of proactive, supportive leadership within the child health and community business units. The managers and clinical leads we spoke with were very passionate about delivering an excellent service and it was clear the patient was at the very heart of each service.
- Clinical leads and senior managers from every service had an inspired and shared purpose. We spoke with managers who clearly strived to deliver and motivate their staff to succeed and there were strategies in place to support them in this purpose.

Culture within this service

- Staff told us they felt valued and respected by managers within their own service and by senior managers leading the business unit.
- Staff described the culture of community services for children, young people and families as open, transparent dynamic and forward-thinking. Staff met regularly to attend team meetings and informal supervision took place on a daily basis. We found staff were very supportive of each other and was a very strong sense of collaborative team work. The different services worked well together with strong leadership and support from senior managers, all focused on improving health outcomes for children and young people.
- Staff were encouraged to report incidents and highlight any concerns. Staff felt confident that if concerns were raised in relation to patient safety, action would be taken. We also heard examples from staff where action had been taken and improvements made as a result.
- The health and well-being of staff had a high priority within the trust. Staff told us they had received excellent support from the occupational health team and could access physiotherapy or counselling if they needed to. We heard an excellent example from one member of staff describing the support she received when she returned to work following a period of long-term sickness absence. Another person told us their manager visited their base once a week just to check upon the general well-being of the team.

Public engagement

- Capturing the patient experience had a high priority in the trust and across community services for children and young people.
- Services proactively engaged with children, young people and families and took appropriate action based upon the feedback they received. For example, following feedback from a teenage mother, the family nurse partnership was preparing to hold its first client user group meeting. The purpose of the meeting was to encourage peer support and develop relationships amongst the teenage mothers who accessed the service. In addition, the service has identified a number of young women who had requested to participate in 'breastfeeding peer support' training.
- Patient satisfaction surveys were routinely exercised across all services and we saw 'You Said, We Did' notices

in many different locations including the child health unit in Wansbeck Hospitals and the sexual health clinic in North Tyneside. This was a mechanism to capture and display patient feedback and the trust's response to it. For example, one comment on display requested music in the waiting room of the child health unit. During our visit, we heard the evidence of the trust's response and noted the request had been actioned. Other methods of capturing patient feedback included '2 minutes of your time', a real-time survey which asked parents seven questions about their experience of the service. The trust used this survey more prevalently than the national Friends and Family Test and there were many similarities in the questions. All of the scores we reviewed across the different services were very high.

- The looked after children team ran an annual event for children and young people in their care, celebrating their achievements. Children were actively encouraged to participate in the planning and organisation of the celebration.

Staff engagement

- Staff told us they felt encouraged to contribute to service development. For example, the Chief Executive promoted an 'open door' policy where staff could contact him at any time to discuss any concerns they had or suggestions for improvement. We spoke with a member of staff who told me she had emailed the chief executive with an idea to support young people leaving the looked after children service and those who had learning disabilities. She suggested the trust apprenticeship scheme could look at ways to actively recruit those young people and offer them the opportunity to gain sustainable work experience. She received a very prompt response with an assurance her suggestion would be considered.
- Everyone we spoke with told us they felt communication from managers and senior managers was good. The trust communications team sent a weekly bulletin to all staff with general news about the trust and its services, national initiatives, training opportunities and compliments received from patients. Community services also produced a weekly bulletin for all community staff. Information about the trust's business and financial performance was shared with staff every three months.
- Staff from community services for children and young people took part in local trust surveys designed to measure staff satisfaction and gather feedback about services. For example, an equality and diversity perception survey asked staff about their views and experience of equality and diversity in the workplace. Staff also took part in the national staff survey. The latest results were from the 2014 survey in which 80% of staff from the child health business unit reported they were able to contribute towards improvements at work.
- The trust introduced a Friends and Family Test for staff and asked them if they would recommend the organisation to their friends and family if they needed care or treatment and as a place to work. Reponses from staff working in the child health and community business units were positive with over 80% recommending the trust in both categories.

Innovation, improvement and sustainability

- There was a culture of continuous leaning, improvement and innovation across community services for children and young people. Staff told us their managers actively encouraged them to look at different ways to improve their service. For example, paediatric therapy services ran a research and development group chaired by the senior manager. Any member of staff could complete a template plan and present their idea to the group for discussion. Staff told us they felt safe to try something different without fear of recrimination if a project did not achieve the goals it set out to achieve.
- Following a patient satisfaction survey, which indicated patients were dissatisfied with the waiting time for clinics, sexual health services in North Tyneside initiated a three-month pilot study to introduce a new system of booking appointments and to balance the work demands of staff. Outcomes from the review included the implementation of a new booking system to allow patients to self-book and provide new time slots for appointments.
- Staff from paediatric therapy services told us they were encouraged to initiate and participate in group-led service developments. For example, the service received a referral to review a very young child with unclear speech. The therapist realised extra support was required however, due to the unusual nature of the case, there was no clear pathway to follow. The team worked collaboratively to investigate and research national evidence-based guidance in relation to

intervention and treatment and liaised with local universities. A care plan was developed for the child along with a new service pathway to assess very young children.