Belmont House, Guisborough

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

Belmont House provided health visiting and school nursing services for children, young people, and families who lived in the Redcar and Cleveland area.

We found the following areas of good practice:

- The strategy, leadership, governance, and culture promoted the delivery of high quality person-centred care. A strong, cohesive senior management team, supported by a proactive service manager had good oversight of risks, which they monitored and reviewed regularly.
- Staff protected children and young people from avoidable harm and abuse, and they followed appropriate processes and procedures to keep them safe. There was a robust safeguarding supervision model to facilitate learning and reflection, and share good practice. The named nurse for safeguarding children had good oversight of the concerns raised by staff and actively shared information and learning across the service.
- 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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Community health services for children, young people and families

Summary of this inspection

Background to Belmont House, Guisborough

Belmont House registered with CQC in September 2015 and has a registered manager. This was the first inspection following registration. The service is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Diagnostic and screening processes

Belmont House provides health visiting and school nursing services to children and young people from 0-19 years old across Redcar and Cleveland (and up to 25 years for SEND, young people with special educational needs and disability).

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

Health visiting and school nursing in Redcar and Cleveland was previously provided by South Tees NHS Foundation Trust until April 2015. The school nursing service transitioned from the NHS to Redcar and Cleveland Borough Council in September 2015, and health visiting followed in April 2016.

Health visitors and school nurses sit within the Children and Families Directorate of the Borough Council. Practitioners work together in integrated teams, each led by a health clinical lead, and are based in the three localities of Redcar and Cleveland.

Our inspection team

Team leader: Angie Brown (CQC Inspector)

The team that inspected this service comprised of two CQC inspectors and a specialist in health visiting 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?

CQC regulates independent healthcare services but does 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 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 10 to 11 October 2017. We did not undertake an unannounced visit.

During the inspection visit, the inspection team:

- Visited all three localities across Redcar and Cleveland: West, Central and East.
- Spoke with 12 children, young people and families
- Spoke with senior managers and the registered manager, and the lead member for children.
- Spoke with 21 other staff members; including health visitors, school nurses and administrative staff.
- Attended and observed four home visits, two school drop-ins, a baby clinic, a breastfeeding support group, and an allocation of work meeting (accompanied by health visitors and school nurses).
- Looked at four 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.
- We spoke with new mothers who told us they would not have continued breastfeeding their babies had it not been for the support they received from the infant feeding lead.
- Feedback from a school nurse survey showed children and young people thought practitioners were kind and understanding, listened to them, and made them feel comfortable.
- Feedback from health visitor surveys indicated families thought practitioners were very helpful and approachable, an excellent source of information, reassuring and kind, and always available to give advice.
- Families told us practitioners provided good emotional support and they felt safe to share their concerns and anxieties with them.

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 knew how to report incidents and learning was shared at team and management meetings. Although numbers were low, we saw evidence of lessons learned and staff were clear about their responsibilities.
- There was a proactive safeguarding children team and a robust safeguarding supervision model. Safeguarding children and young people was given sufficient priority and staff knew what to do if they had a concern. The named nurse for safeguarding children had good oversight of the concerns raised by staff and actively shared information and learning across the service.
- Health visitors and school nurses followed national guidance in relation to hand hygiene and infection prevention and control. Results from hand hygiene audits were good.
- Practitioners completed contemporaneous notes, in line with national guidance, and the quality of care records was good.
- Health visiting and school nursing had a full complement of staff and there was good skill mix within each service. Compliance with mandatory training was good and the service had implemented a system to ensure there was sufficient oversight of training requirements.
- 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.

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.
- The care and treatment of children and young people achieved good outcomes and promoted a good quality of life.

Summary of this inspection

- Health visitors and school nurses delivered the Healthy Child Programme and managers routinely collected and monitored the data using a performance scorecard. Performance was very 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 staff took ownership of their own performance. Appraisals and one-to-one meetings were regularly undertaken and there was a good preceptorship programme for new staff joining the service.
- 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 and other correspondence highlighted the care and commitment practitioners showed towards the children and families in their care.

Are services responsive?

- Managers and staff planned and delivered services to meet the needs of children and young people and worked collaboratively with families, partner organisations, and other agencies.

Summary of this inspection

- 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 managing obesity. The service had implemented HENRY, an evidence-based programme to protect young children from the physical and emotional consequences of obesity. Practitioners provided families with information and helped facilitate behaviour change.
- There were integrated person-centred pathways that involved other service providers and agencies. 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.
- 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, young people and families who had moved into the area from another country or who had different cultural backgrounds.
- There was an open and transparent approach to handling complaints. Information about how to make a complaint was available and families tended to contact the service directly.
- Practitioners accessed interpreters to support families where English was not their first language, however a small minority of staff acknowledged they had also used a family member or an internet translation function.

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. Staff could contact them whenever they needed to and received regular supervision.
- 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 senior management meetings, and appropriate timescales and mitigation was in place.
- Staff were very positive about working for the local authority. They felt respected and valued by managers at all levels and described them as approachable and supportive.
- Managers and staff gathered regular feedback from children, young people, and families. They listened to suggestions and made changes as a result. 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	

Information about the service

Belmont House provided health visiting and school nursing services for children, young people, and families who lived in the Redcar and Cleveland area.

CQC regulates independent healthcare services but does not currently have a legal duty to rate them.

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 Redcar and Cleveland Borough Council. The relevant team clinical lead and service manager received an email notification of every incident and took appropriate investigative action.
- Staff told us the system was robust but the majority of people we spoke with had not recently reported an incident.
- We reviewed incidents reported between April 2016 and September 2017. Health visitors and school nurses had reported 20 incidents. The types of incidents included verbal abuse and aggressions towards staff, families not offered a new birth visit and loss of staff smart cards. In respect of the latter, lessons were learned and managers took appropriate action to prevent future loss.
- In the event of a 'near miss' incident (defined as an unplanned event that did not result in injury, or damage – but had the potential to do so), staff completed a proforma which identified the level of risk. We reviewed one report that demonstrated the service had taken appropriate action to prevent the reoccurrence of further incidents.
- Managers shared feedback from incidents with staff at team meetings and via memo or email when appropriate. For example, following an investigation, the service manager updated staff on the reasons why new birth visits had not been completed within the required time frame, and advised what action staff should take to prevent it from happening again.
- 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 service had a 'Being Open' policy and we reviewed two examples that demonstrated staff had appropriately applied the principles. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to those persons.
- There were no serious incidents (SI) reported between August 2016 and July 2017. The service manager had worked with the NHS England patient safety manager and the local Clinical Commissioning Group (CCG) to develop a procedure to mirror the NHS SI framework. Although the service had not reported any SIs to date, managers felt the process was sufficiently robust.
- 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.

Safeguarding

- The named nurse safeguarding children and safeguarding children advisors were employed by the local NHS acute hospital trust. The team had continued to deliver the provision to health visitors and school

nurses following the transition to local authority in 2015. Managers and practitioners spoke positively about the seamless continuity and felt the processes they followed were embedded in the service.

- The service had safeguarding children and safeguarding supervision policies. 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.
- Practitioners were very clear about their level of involvement in safeguarding cases. For example, school nurses followed a specific process in relation to child protection cases and only attended review case conferences if there was an identified health need that they could support.
- Staff told us they had received training to the appropriate safeguarding level. Information provided to us by the service showed all administrative staff had completed Level 1 training and all school nurse assistants had completed Level 3 training. Compliance for advanced Level 3+ training for health visitors, school nurses, school nurse staff nurses, and early years senior practitioners was currently 92%. The named nurse explained the gap was due to sickness absence. The named nurse and all safeguarding children advisors had completed Level 4 training.
- The named nurse and service manager maintained oversight of all training requirements for staff. Staff described the quality of safeguarding training as very good. Practitioners were able to access regular additional training provided by the Local Safeguarding Children Board (LSCB).
- Practitioners received safeguarding supervision every three months, in line with the service guidelines, and could access additional support upon request. Practitioners were encouraged to bring cases to each session for discussion. The safeguarding children team monitored attendance at supervision. Compliance in quarter one (April to June 2017) and quarter two (July to September 2017) was 100%. Staff spoke positively about the quality of the supervision.
- The named nurse also provided supervision for the three clinical leads and school nursing professional lead. Although this was not part of the contract with the local authority, the group met every three months to discuss themes and trends from individual practitioner supervision sessions. This meant the service could take appropriate action when there was an issue or cause for concern.
- To maintain their visibility and accessibility to support practitioners, the safeguarding children team held monthly drop-in sessions at each locality base.
- The named nurse attended safeguarding governance meetings every six weeks with the service manager. The service manager shared quarterly governance reports with practitioners and the directorate management team. The report included updates about supervision, training, audits and serious case reviews.
- We saw evidence of safeguarding children audits and the service had a process of quality assuring all safeguarding referrals. The named nurse had received eight social care referrals from the service to audit during quarter two (July to September 2017) and there was concern that this number was low. It was clarified during the inspection that the service had made a significant number of referrals that were made directly to other appropriate early help services.
- The service manager attended LSCB meetings and was a member of various sub-groups, including VEMT (vulnerable, exploited, missing, and trafficked). The named nurse also attended these meetings but as a representative of the local NHS acute hospital trust.
- Health visitors and school nurses had not been involved in any serious incidents or serious case reviews (SCR) since transferring to the local authority. However, we reviewed previous SCRs and found evidence lessons had been learned and appropriate actions delivered. For example, recommendations from one SCR proposed the inclusion of child sexual exploitation training for practitioners requiring Level 3+. Managers and practitioners confirmed delivery of this action.
- There were pathways to support practitioners when referring cases to MARAC (multi-agency risk assessment conference) and VEMT meetings. A clinical lead represented the service at each meeting.
- Practitioners and managers spoke positively about partnerships with external agencies including the NHS and local commissioners. For example, the named nurse safeguarding children explained practitioners and the local acute hospital trust frequently shared

information about children and young people in their care. This meant any safeguarding problems or concerns could be identified and managed or resolved quickly.

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.

Quality of records

- Health visitors and school nurses 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 four care records and saw they were clearly set out and comprehensive, and included all relevant information. Outcomes from a recent audit highlighted a concern about the number of templates practitioners needed to complete to record information about a child. Staff told us the streamlining of these templates had improved their ability to complete records within the required timescale.
- Nursing and Midwifery Council (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.
- We reviewed recent audit and assurance activity and there were no significant concerns. In one audit, only two practitioners had not completed their notes following home visits. Clinical leads addressed this with the relevant staff. Each audit identified areas for learning, actions, and good practice.

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 and local shared drive.
- The service had a bespoke IPC training package. Not all staff had undergone the training in the preceding 12 months. The current level of compliance was 70%. However, further training was in progress for staff who had not completed this post-service transfer. The service manager was confident all staff would complete IPC training before the end of the current year.
- 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 also observed staff practice good hand hygiene within family homes.
- Health visitors and school nurses adhered to the Borough Council's hand hygiene competency guidance, and we reviewed hand hygiene compliance audits. Outcomes from an audit conducted at health drop-ins showed staff were compliant against all indicators.
- We saw personal protective equipment was readily available for staff to use and we observed staff using it appropriately.
- In baby clinics, practitioners cleaned the equipment after every use using antibacterial cleaning wipes. Staff also used a paper roll to line the baby scales and replaced it for each new patient.
- Practitioners used toys and games to engage and interact with children. Staff cleaned toys using antibacterial sanitary wipes, adhering to guidance outlined in the toy cleaning practitioner guide.

Mandatory training

- Although there was no formal target for the completion of mandatory training, the service manager expected all staff to comply with the requirements. Mandatory training courses for staff included Safeguarding Children, Prevent, Looked After Children, Infection Prevention and Control, Basic Life Support and Equality and Diversity.
- Compliance was above 90% in all modules except Looked After Children (which was only introduced as mandatory three months prior to this inspection), Infection Prevention and Control, and Basic life Support. All staff who had not yet attended training had been booked to attend the next available course.

- Following the transition of services from the NHS to local authority, managers had explored ways to record staff attendance at mandatory training. The system in use by the Borough Council was not able to provide the service with compliance data therefore the service manager developed a separate spreadsheet to capture this data This not only captured the training staff had attended, but also the level of compliance to provide management oversight.
- Work was currently underway to develop the Borough Council's electronic workforce management system to capture the full range of training data, and managers expected this to be operational within the coming months.
- Staff were aware of what training they needed to complete and when it was next due. The business support team updated practitioners via email and clinical leads reminded staff at one-to-one meetings.

Assessing and responding to patient risk

- In the four records we reviewed, we saw practitioners completed patient risk assessments appropriately and updated them as required.
- Practitioners told us they reviewed all GP, out of hours, and A&E attendances to monitor the children on their caseload. Practitioners and clinical leads also reviewed workload and caseloads weekly to ensure they prioritised vulnerable children.
- Practitioners told us assessing risk was a standard part of their role. The service manager explained risk assessment and analysis was embedded within the service clinical assessment tool. Audit outcomes showed practitioners completed risk assessments to a good standard.
- Health visitors told us they completed maternal mood assessments during post-birth visits with new mothers. During an antenatal home visit, we observed a practitioner explain what this was and what support they could provide.
- Standards were in place to support timely information sharing between practitioners. We reviewed transfer of care pathways and spoke with practitioners who described the action they took. 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 could undertake a joint visit with the receiving school nurse.
- Midwives from local NHS trusts notified the service of new births via an electronic referral process. The health visitor would then contact the family to arrange a primary visit. If there were new or known concerns about the baby, 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.
- The business support team notified school nurses about children and young people requiring standard levels of care via an electronic referral. Practitioners confirmed they discussed any child or young person who was vulnerable, or who had more complex health needs, in a face-to-face meeting with the relevant health visitor.
- Health visitors 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

- Belmont House had a full complement of staff and no vacancies. There were 28.70 whole time equivalent (WTE) health visitors, and 8.20 WTE early years senior practitioners (formerly known as nursery nurses). There were 6.09 WTE school nurses and 5.64 staff nurses, plus 3.05 school nurse assistants.
- There was good skill mix within each service, including a school nurse professional lead, an infant feeding lead, plus school nurse and health visitor practice teachers, and early years practitioners.
- According to guidance produced by the Community Practitioners and Health Visitors Association, caseloads should be, on average, 250 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.
- Managers told us practitioners usually had approximately 270 children in their caseload at any one time. This included a mix of 'universal' and 'universal plus' children. Universal plus described those children who were vulnerable or where there were safeguarding concerns, such as a child in need, looked after children and those subject to a child protection plan. Health visitors described their caseloads as manageable.

Community health services for children, young people and families

- Clinical leads for each health visiting team held weekly allocation of work meetings to discuss new births or children who had transferred to the area from elsewhere in the country. Every month, practitioners completed a caseload priority document, which was reviewed by their line manager. This ensured managers had clear oversight of individual and team caseloads. Additional support was provided to practitioners who had a higher number of complex cases involving vulnerable children.
- School nurses also completed the caseload priority document and the school nurse professional lead chaired weekly allocation of work meetings.
- Between September 2016 and August 2017, the average sickness absence rate for health visitors and school nurses was 5.6%.
- 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 from colleagues or another agency relating to a family, which identified a cause for concern. Practitioners told us in some cases, staff would visit in pairs, or not visit the family home at all.
- The service followed the major incident plan procedures for the Borough Council. A clinical lead also told us they held their own localised business continuity plans. For example, during incidences of inclement weather, practitioners told us they would work from the closest base and update clients via telephone about any planned visits.

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 the Public Health Nursing Service, the National Institute for Health and Clinical Excellence (NICE) and other nationally recognised guidelines.
- The service manager chaired a meeting at which clinical leads and practitioners reviewed and ratified new evidence-based policies and guidelines. The service was considering establishing a formal practice development group to strengthen the process.
- We saw evidence of a wide range of standard operating procedures and pathways across health visiting and school nursing to ensure service delivery was effective. This included referral pathways for the child and adolescent mental health service (CAMHS), sexual health, and continence services. Practitioners could access all guidance on a shared drive, accessible via their laptop. All of the policies and guidelines we reviewed were up to date.
- All practitioners and clinical leads we spoke with knew all of the guidelines relevant to their practice and said they were embedded within the service.
- 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, and up to 25 years for young people with special educational needs and disability (SEND).
- 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 had achieved 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.
- The service had implemented HENRY, an evidence-based programme to protect young children from the physical and emotional consequences of obesity. Practitioners followed the HENRY three core elements and provided families with information about food and activity; supported parents to develop their parenting skills and helped facilitate behaviour change.

Community health services for children, young people and families

Nutrition and hydration

- The service had an infant feeding policy. This included support and care for breastfeeding mothers and Department of Health recommendations.
- The infant feeding lead had recently achieved a lactation consultant qualification, which meant they could provide expert advice to help manage and resolve breastfeeding issues.
- Breastfeeding pumps were available to enable mothers to feed and care for their babies in line with national best practice. With oversight from the infant feeding co-ordinator, health visitors could complete loan agreements to ensure families received all of the equipment they needed.
- Results from a recent health visitor survey showed 100% (37 responses) of families who needed advice regarding feeding said they had received it.
- During home visits, we also observed practitioners providing appropriate information and advice to support breastfeeding mothers.

Technology and telemedicine

- Although the service did not currently utilise any technology initiatives to enhance the delivery of care, school nurses were investigating the use of social media to connect with children and young people.

Patient outcomes

- We saw evidence demonstrating health visitors and school nurses thoroughly 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. There was also a clear approach to monitoring and auditing the quality of the service and outcomes to improve care and treatment.
- The school nursing team 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. Performance was very good. School nurses delivered the NCMP to 98% of all Reception children and 96% of Year 6 children.
- School nurses completed 100% of the required school entry screenings for four and five years olds starting school in the 21016/17 school year. This included sight and hearing tests to identify any sensory needs.
- The health visiting service used a performance scorecard to record and monitor patient outcomes. We reviewed data from April to July 2017. The service set a target of 95% for four out of the five key indicators. Performance was consistently very good and the service was better than the national and regional averages in all five mandated contacts:
- 90% of families received a face-to-face visit from a health visitor at 10-14 days following birth.
- 94% of families received a face-to-face visit at 6-8 weeks.
- 97% of children received a development review before they were 15 months old.
- 93% of children received a development review when they were two and a half years old.
- 70% of families received an antenatal visit, which was the same as the target set for this indicator.
- Health visitors worked closely with the infant feeding co-ordinator and breastfeeding outcomes were continually improving. In 2016/17, the breast-feeding initiation rate at the start of the year was 47%. By the end of March 2017, this had increased to 55%. Initiation rates had improved again during quarter one (April to June) 2017/18. The service achieved 59%, which was just slightly below the regional average of 60%.
- The percentage of mothers who were continuing to breastfeed at 6-8 weeks also improved throughout the year. In April 2016, the rate was 21% and by March 2017, it had increased to 29%, exceeding the 27% target.

Competent staff

- All staff had attended a corporate induction followed by a local induction within the service.
- Staff 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 managers. External training included child and adolescent mental health and Solihull Behaviour Management. There were also opportunities to progress academic learning to develop skills and competencies. This included specialist community public health nurse (SCPHN) degree courses.
- The infant feeding lead delivered specific infant feeding training for health visitors and facilitated practical skills reviews on a one-to-one basis with practitioners.

Community health services for children, young people and families

- The school nursing team met the Royal College of Nursing guidelines, which state there must be a minimum of one qualified specialist community public health nurse (SCPHN) for each secondary school. All schools had a registered school nurse and five (out of eight) of those nurses held a SCPHN school nurse qualification. The service had a succession plan. One school nurse seconded to do the SCPHN programme this year and another staff nurse was currently acting up into a school nurse post and hoping to apply for the SCPHN programme in the next academic year.
- The service also had a succession plan to develop band 5 nurses to support staff retention. We spoke with a school nurse staff nurse who was currently seconded to a school nurse position and was scheduled to commence her SCPHN course next year.
- Practitioners and clinical leads told us they had received an annual appraisal. We reviewed evidence that showed the current appraisal rate was 93%. Out of 67 staff, only five members of staff had not received one and this figure included two new recruits and staff sickness absence. Staff told us the quality of the appraisal process was good and felt it met their needs appropriately.
- Community practice teachers supported health visitors and school nurses. Practitioners also had opportunities to develop specialist interests and shared their knowledge and learning with the wider team. For example, we spoke with health visitors who maintained portfolios of special interest in mental health, domestic violence, and breastfeeding.
- Practitioners told us they received regular formal and informal supervision from line managers and peers. Informal supervision occurred daily and practitioners received formal supervision at least every three months.
- The service had a public health nursing practitioner guide for preceptorship, outlining roles and responsibilities to support newly qualified or returning health visitors. We spoke with health visitors, both experienced and newly qualified, who told us preceptorship within the service was positive and worked very well.

Multi-disciplinary working and coordinated care pathways

- Health visitors and school nurses worked collaboratively with each other 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 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.
- Since transition from the NHS to local authority, practitioners told us relationships with children's social care had improved. Staff spoke positively about their ability to contact a social worker and their prompt response times.
- The service held an information sharing policy with the local NHS acute hospital trust. Practitioners told us the assessment, planning and delivery of care was very good because information was shared appropriately, and in a timely way.
- Communication between the service and GPs was good. Every health visitor was affiliated with a GP practice and staff reported there were no issues when they needed to discuss a child in their care.
- The service was proactive in identifying areas for improvement such as, strengthening its links with the child and adolescent mental health service (CAMHS). This would lead to improved information sharing arrangements and protocols to support children and young people.

Referral, transfer, discharge and transition

- Health visitors and school nurses told us they worked closely with each other to discuss and share important information about vulnerable school-age children. 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.
- Practitioner supported young people up to the age of 19, or 25 for young adults with SEND (special educational needs and disability) needs. The service was in the process of developing new transition pathways and school nurses worked closely with the local acute hospital's transition team and specialist nurses when appropriate.

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. This included policies, templates, standard operating procedures, and best practice guidance.
- 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.
- NHS trusts shared information about children and young people's A&E attendances with the service. The business support team updated the relevant electronic record to ensure practitioners could access the information.
- Midwives sent notifications of new births electronically, which the business support team also added to the electronic care record. Staff told us they usually received the referrals promptly.
- Practitioners told us they received timely information from schools about children or young people with long-term health conditions such as diabetes or epilepsy. This enabled practitioners to provide timely and appropriate support

Consent

- The service had a consent policy specifically for children and young people.
- 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. School nurses 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 this in practice at school drop-ins.
- We observed staff obtaining verbal consent correctly prior to a home visit and saw evidence of correctly completed consent forms.

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

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. Every member of staff we spoke with told us 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. One example demonstrated how a practitioner had gone beyond the expectations of their role to provide care for an asylum-seeking family who had recently transferred to the area. This included facilitating a process to provide clothing, toys, and books for the children who had arrived in the country with nothing.
- We observed the way staff treated children, young people, and families both in their homes and in the school environment. Staff were kind, sensitive, supportive, and compassionate, and they treated children and young people as individuals. Parents told us they had confidence in the staff they saw and the advice they received.
- We observed one practitioner facilitate a positive change in the demeanour of a young person, attending a school drop-in, through kindness and compassion. Following the discussion, the young person left the meeting with a smile and a sense of purpose.
- Practitioners showed respect for confidentiality. We observed one nurse discuss confidentiality with a young person and explain the reasons why and when they might need to discuss their concerns with other healthcare professionals.

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. For example, school nursing received 53 responses from an

online survey. Of those, 94% said they were treated with kindness and understanding and 85% said they felt the school nurse listened to them and considered their views.

- Feedback from a health visiting survey showed 92% of families would recommend the service and 97% said their health visitor listened to them. All families said they felt their relationship with their health visitor was good, and they were treated with kindness and understanding.
- We heard and observed examples of good practice where practitioners actively listened to families and empowered them to seek solutions. In one example, a practitioner facilitated a discussion between two parents to help them recognise their different parenting styles and how they could adapt them for the benefit of the child.
- The school nursing service worked collaboratively with the local Healthwatch and young people to produce a leaflet about the service. It included ideas and suggestions from young people about what specific information they wanted.
- The school nursing service invited a young person to be part of the interview panel when interviews took place in June 2017 for a staff secondment to undertake the school nurse degree programme at a local university.
- Practitioners involved the whole family in discussions about the care of a child or young person. For example, school nurses visited children at home to encourage full family participation. During a home visit, we also observed a health visitor include the father in the conversation and answer all of his questions.

Emotional support

- Health visitors managed their own caseloads. This meant mothers met the same health visitor at each appointment in their home. Consistency meant health visitors built up relationships with children and families. We saw evidence of this during home visits.
- Staff understood the impact conditions and their treatment had on children and young people, and this was embedded in their care. One practitioner told us they had received positive feedback from a parent who had felt overwhelmed by the level of support they had received.
- We observed good examples of practitioners recognising and supporting anxieties. During a home visit, a health visitor patiently listened to the concerns from a parent, displayed empathy, and sensitively provided appropriate support and advice. During another home visit, a health visitor suggested she visited the family again the following week to offer additional support in relation to concerns about breastfeeding.
- Families spoke positively about the emotional support they received whilst breastfeeding their babies. All of the parents we spoke with were unanimous in their praise and told us the breastfeeding group they attended also provided a peer support network.

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

- The health visiting and school nursing 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 strategies. These included health and well-being, children and young people's mental health, and well-being transformation plan.
- Health visitors and school nurses delivered the Healthy Child Programme universal offer to identify the needs of children at the earliest opportunity, and target services appropriately. This included five key reviews: antenatal, new baby, 6-8 week assessment, and 1 year and 2-2 ½ year assessments. Health visitors and children's centres worked together to provide a seamless offer.
- The service provided 20 practitioners trained in Neonatal Behaviour Observation (NBO). The NBO is a structured set of observations designed to help the practitioner and parent together, to observe the infant's behavioural capacities and identify the kind of support the infant needs for successful growth and development. Further sessions to train more practitioners in NBO were in the process of being arranged.
- Health visitors and early years senior practitioners delivered the Pregnancy, Birth and Beyond programme providing information, support and advice to families during the antenatal stage of pregnancy.

Community health services for children, young people and families

- Health visitors and early years senior practitioners ran baby clinics and breast-feeding support groups in accessible venues across the local area, such as children's centres. The environment at those we visited allowed mothers and babies to mix and bond as part of the group.
- The service provided a dedicated infant feeding co-ordinator who supported mothers with complex problems and worked alongside practitioners to meet the needs of babies and families.
- All secondary schools in Redcar & Cleveland had a named school nurse and all primary schools had a named school nurse staff nurse and an overseeing named school nurse. The school nurse provided monthly management supervision and oversight of work undertaken by the school nurse staff nurse.
- The school nursing service supported schools to achieve 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. School nurses held weekly drop-ins at all secondary schools in their area.
- School nurses were developing processes to support children aged 16-19 years who were in further education.
- The service had a policy that outlined duties, responsibilities, and implementation of non-medical prescribing. The service provided 35 practitioners who had completed the Nursing and Midwifery Council (NMC) Community Practitioner Nurse Prescribing course (also known as V100). Six practitioners had completed the NMC Nurse Independent Prescribers course (also known as V300). This meant children and young people had timely access to medicines and treatment. Staff attended non-medical prescriber workshops delivered by the pharmacist and clinical lead.
- Health visitors and school nurses used surveys to gather the views of children and young people and took appropriate action in response to the feedback. For example, only 15% of responders said they were given a telephone number for the school nurse. As a result, the service identified the need to create a poster advertising contact details for display at drop-in clinics and a contact card to give to children and young people.
- 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 worse than the England average. One of the health visitors was also a physical activity clinical nurse champion for Public Health England in the North East. There was a plan to deliver training to all practitioners, which would enable them to support children and young people to become active. Practitioners also followed the HENRY programme, holistically supporting children and families and enabling them to manage the physical and emotional consequences of obesity.

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 22.5% of the population in Redcar and Cleveland. Only 4.2% 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. For example, a Traveller family had recently settled into a home in the area. Practitioners arranged additional support to send the young children to pre-school nursery and to book dental appointments. Practitioners also worked closely with the local schools.
- Practitioners could access interpreting services and had not experienced any problems when they needed to book an interpreter to attend an appointment. However, a small number of staff told us they had also accessed an internet translation programme to help scribe a letter or had utilised support from family members, which is not good practice.

Meeting the needs of people in vulnerable circumstances

- The service had developed pathways for families who had experienced domestic abuse or female genital mutilation. During a home visit we observed a practitioner make subtle enquiries about domestic violence in a gentle and sensitive way.
- Staff we spoke with were aware of female genital mutilation (FGM) and child sexual exploitation and practitioners had received specific training provided by the local safeguarding children board (LSCB). One practitioner gave us an example of supporting a family

who had travelled to England to protect the female children. The school nurse demonstrated sensitivity and integrity when describing the actions she had taken to meet the needs of the children and parent.

- The school nursing team completed individual holistic assessments with all children who were identified as vulnerable, such as those subject to child protection procedures, children looked after, a child in need or who have special educational needs. The meant practitioners could develop plans to meet the health needs and ensure those children receive the right care and support.
- School nurses arranged visits with vulnerable children in their home environment. Nurses told us this enabled them to gain an insight into a child's social circumstances as well as the opportunity to address their health needs.
- School nurses used the Strengths and Difficulties Questionnaires (SDQs) to assess the emotional health and well-being of children and young people. If the nurse identified a need, they would discuss the results with the child or young person together with their parent or carer. School nurses would recommend making a referral to another appropriate support service, such as the child and adolescent mental health service (CAMHS) or the specialised crisis team if appropriate.
- Health visitors completed health assessments for looked after children (LAC) and the named nurse safeguarding children told us the quality of the reports was very good. To ensure practitioners met the needs of each child, the safeguarding children team delivered LAC training around the process, the legal system, and the vulnerability of the children.
- We heard examples demonstrating the tenacity of practitioners to ensure they met the needs of vulnerable children and young people. On one occasion, when a practitioner was unable to contact a young person to complete a LAC assessment, they utilised a variety of intelligence to locate the young person. This included contacting the local accident and emergency unit and the social worker.

Access to the right care at the right time

- We reviewed evidence that showed phone calls made to the health visiting service were actioned in a timely way. A duty health visitor handled all calls and distributed messages to the appropriate practitioner. The role rotated on a daily basis.
- 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. Performance was consistently above 90%.
- Early years senior practitioners (formerly known as nursery nurses) supported health visitors to run regular baby clinics in accessible venues such children's centres.
- Health visitors and school nurses had completed the Community Practitioner Nurse Prescriber and Nurse Independent Prescriber courses. This meant children and young people had timely access to medicines and treatment.
- School nurses delivered the national Child Measurement Programme (NMCP) to Reception and year 6 children within the first three months of the new school year. Practitioners also delivered targeted reviews to children aged 12-13 years and at transition to adulthood.
- School nurses supported weekly health drop-in clinics for all secondary schools. This meant children and young people could speak directly with a practitioner for advice and information.
- Families always received a second visit from a practitioner if they were unavailable at the first pre-arranged meeting. If the second attempt to meet failed, the practitioner reviewed the child's record for any new concerns and, in some cases, contacted the family GP. Practitioners would continue to try to make contact if there was cause for concern, and subsequently decide a plan of action. If not, the service wrote to the GP to update them.

Learning from complaints and concerns

- Complaints were managed in line with the children and families directorate complaints, compliments, and comments procedures. Following the transition of the service to the local authority, all complaints were verbal and dealt with by clinical leads at team level. Work was in progress to record all future verbal complaints formally, to ensure the process was consistent across the whole service.

Community health services for children, young people and families

- The service had only received three formal complaints between April 2017 and September 2017. All three were about the health visiting service and we saw managers had taken appropriate action to investigate and resolve the issues.
- Practitioners and clinical leads 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. Service and senior managers worked closely and collaboratively with colleagues from the local council cabinet and Public Health.
- We heard and saw examples of proactive, supportive leadership across the service. The managers and clinical leads we spoke with were very passionate about delivering an excellent service and ensuring care was patient-centred.
- All practitioners we spoke with were very positive about local leadership and senior managers. Staff felt well supported by their line managers. There was a clear management structure and managers were very approachable. Managers were also visible, and staff felt connected to their wider team.
- Clinical leads and managers 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

- There was a comprehensive strategic plan, with a very direct purpose: to give a clear sense of direction for the development and improvement of the service; to set out the key priorities for action; and to monitor the plan and be held accountable for performance.
- The service improvement plan included specific actions linked to the overarching strategy and each section was based on the CQC five key questions (are services safe, effective, caring, responsive and well-led?).
- Managers worked collaboratively with staff and other agencies to develop the strategy. Practitioners spoke positively about their contributions to service development and improvement.
- The service had its own vision, aims, and values. These centred on creating a brighter future for children and young people in the local area, focusing on their physical and mental health and promoting healthy living. We found practitioners, clinical leads, and managers across the service reflected the aims and values in their work ethos.

Governance, risk management and quality measurement

- Health visiting and school nursing was part of the children and families directorate within the Redcar and Cleveland Borough Council. There was a governance structure with clear lines of responsibility and accountability. This was documented in a communications framework, which included the range of meetings at which health visiting and school nursing was discussed Practitioners and managers attended regular team and governance meetings (at all levels) and spoke positively about the flow of information.
- Three clinical leads line-managed staff working within the locality teams. The service manager reported to the head of service for early help and partnerships, and the corporate director for children and families maintained executive level management oversight of the service. They worked closely with the director of public health.
- Within the Borough Council, the lead member for children attended cabinet meetings. They provided strategic leadership at health and well-being, local safeguarding children and corporate parenting boards.
- Practitioners told us they 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.

- There was a robust quality assurance system and performance measures across health visiting and school nursing. Staff we spoke with had a solid understanding of the outcomes they were measured against and told us these were reported and monitored regularly through action plans, performance scorecards. Managers and practitioners also discussed performance at supervision and one-to-one meetings.
- The service had recently completed a self-evaluation of performance, based on the CQC key lines of enquiry. Managers explained the findings from the assessment contributed to the key priorities outlined in the service strategy. The comprehensive document demonstrated clear service management oversight, good governance, and accountability. The service manager explained this was an on-going process of self-assessment and shared updates with the senior management and directorate management teams every three months.
- The children and families directorate had a risk register and managers completed a risk profile proforma for each identified risk. Current risks included recruitment and retention of staff and a lack of clinical expertise at executive level. Risks were reviewed at service-level management meetings and at directorate and executive meetings.
- We reviewed evidence that showed managers had introduced control measures to mitigate current risks and there were appropriate target and review dates. For example, to mitigate the risk of a lack of clinical expertise at executive level, the service manager had developed a support and professional practice network with other local authority-delivered health visitor and school nursing services. There was also a plan to introduce an external assurance audit of the service. In addition, the local authority was in the process of developing a system in which they received clinical oversight and scrutiny from an external source.
- We saw evidence of internal quality audits undertaken routinely across the service to ensure safe and effective care for children and young people. The audits we reviewed included safeguarding supervision and case files. Each audit report highlighted good practice, areas for development and included an action plan.

Culture within this service

- Staff told us they felt valued and respected by managers within their own service and by senior managers in the children and families directorate. They described them as approachable and supportive.
- Staff worked well together. We heard positive examples from practitioners and it was evident staff were very supportive of each other. Staff also described a strong team ethos and everyone was very positive about what they did and how they influenced the service. Staff felt empowered and shared ideas with the team and managers at local and senior level.
- The service manager collated feedback from families and published posters to share with practitioners and senior managers. Staff spoke positively about this practice and told us it made them feel valued. One poster also included praise from a senior Public Health manager, acknowledging the positive progress health visiting teams had made supporting mothers to breastfeed their babies.
- Senior managers identified the health and wellbeing of staff as an important priority. One senior manager spoke about the robust supervision process, training and workforce development plans, and the 'better health at work' programme, in which the Borough Council had achieved the highest accolade. Managers and staff told us they discussed personal health and wellbeing during one-to-one meetings and supervision**.** Practitioners spoke positively about restorative group supervision sessions.
- Practitioners followed the Borough Council's lone-working policy however; each locality team also had local procedures in place. All staff carried a mobile phone. Staff we spoke with told us they always told a colleague where they were going, used electronic diaries, and office display boards. 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 told us they could access relevant policies, including whistleblowing. 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 where improvements had been made.
- Staff described their morale as good. Senior managers told us they received updates from practitioner

supervision sessions and used the information to monitor staff morale. Following the transition of the service from the NHS to local authority, the senior management team commissioned an internal audit to assess morale and acknowledged the positive outcome was a result of the determination and commitment shown by everyone involved in the process.

Public engagement

- Health visitors and school nurses used surveys to gather the views of children and young people. Questionnaires were distributed at health drop-ins, breastfeeding support groups, parent forums and through telephone calls. The service manager collated all of the feedback every quarter and shared this with staff and managers. The feedback was very positive.
- The school nurse professional lead had worked collaboratively with the local Healthwatch team to seek young people's views regarding ways to develop the service. This included a workshop at a local college, where students provided feedback on what they wanted from the service, how they would like to access the service and its name.
- Other engagement work included working with children to develop the school nursing information leaflet for secondary school pupils. Children and young people also shared their views in respect of social media and a text messaging service to contact the school nurse.

Staff engagement

- Following transfer to the local authority, the service manager engaged with practitioners to seek their views about what the service does well/not so well, and what opportunities staff felt were available for them. This feedback helped to inform the priorities outlined in the service improvement plan.
- Staff participated in the local authority's 'shaping our future' consultation programme. Outcomes from this saw the introduction of the new early years senior practitioner and early years practitioner roles.
- School nurses recently attended a development day to review the current provision and to generate ideas and suggestions to improve the service. This was followed by a second development day that focused on pathways of care.
- Directorate managers held a children's services roadshow in April 2017 to share feedback with staff from a recent Ofsted inspection. The roadshow encouraged practitioners to share their thoughts about the services they provided and what improvements they could make.
- Staff positively about the level of engagement. Practitioners told us they felt the transition from the NHS to the local authority was, overall, very good. They felt senior managers had listened to them and proactively addressed any concerns.
- The service was in the process of developing a direct observation tool. This involved managers engaging with practitioners by observing and shadowing them during the course their duties. For example, the Borough Council councillor who was the lead for children and young people had met with health visitors, and the service manager had attended local team meetings. Managers and staff both spoke positively about the experience and felt it generated a greater understanding about key issues, roles and responsibilities.

Innovation, improvement and sustainability

- We found there was a culture of continuous learning, improvement, and innovation and all staff we spoke with could demonstrate their commitment.
- The service was in the process of developing an integrated early years' service offer to provide a fully integrated offer between health visiting and children centre services. This meant practitioners could deliver a coordinated seamless service to children and families.
- The Pregnancy Birth and Beyond Parenting programme was in the process of being implemented across all three localities in Redcar & Cleveland. Health visitors, early years senior practitioners, and midwives delivered sessions together and practitioners spoke positively about its success.
- One of the health visitors was also a physical activity clinical nurse champion for Public Health England in the North East. The Burdett Trust for nurses funded the post, and the service supported the practitioner to work their full time hours flexibly so they could fulfil the role in addition to their substantive position.
- School nurses were currently exploring new ways to engage with school children. One such option was the Chat Health SMS messaging service. This enabled children and young people to use familiar technology to contact a nurse to seek help, advice, or information.

Outstanding practice and areas for improvement

Outstanding practice

- Managers, practitioners, and administrative staff had managed the transition from the NHS to local authority seamlessly without detrimental impact upon the children, young people, and families in their care.
- Managers, practitioners, and administrative staff demonstrated high levels of integrity, drove continuous improvement, and held themselves accountable for delivering change.