

Virgin Care Limited

1-653464011

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)
1-673822558	Capital Court		EX2 7FE
1-673142083	Springfield Court		EX31 3UD
1-673933279	Lescaze Court		TQ9 6JE

This report describes our judgement of the quality of care provided within this core service by Virgin Care Limited. 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 Virgin Care Limited and these are brought together to inform our overall judgement of Virgin Care Limited, Integrated Children's Services Devon.

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	5
Background to the service	6
Our inspection team	7
Why we carried out this inspection	7
How we carried out this inspection	7
What people who use the provider say	8
Good practice	9
Areas for improvement	10

Detailed findings from this inspection

The five questions we ask about core services and what we found	11
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Summary of findings

Overall summary

We rated community health services for children and young people as good because:

- Staff demonstrated a good awareness of their responsibilities around safeguarding young people. Procedures for supporting staff around safeguarding were robust and effective.
- Staff received regular appraisals and supervision and said they felt well supported in their roles.
- Effective multi agency working was embedded in practice and provided positive outcomes for children.
- Staff demonstrated care and compassion at all times during our inspection. We saw staff treating parents, children and carers with dignity and respect.
- It was fully embedded for services and staff to recognise the different needs and cultures of children and their families. This allowed support to be provided in an appropriate way and reasonable adjustments to be made. Staff demonstrated their knowledge and skills around consent consistently. We saw that staff always asked for the consent of the child or young person they were seeing, and where appropriate, documented this consent. This also applied when parents had given consent.
- The risk registers of individual services reflected the concerns of the staff we spoke to. Whilst risks could not always be mitigated they were discussed and staff were confident their managers were aware of the challenges they faced
- Care and treatment was delivered in line with the National Institute for Health and Care Excellence

(NICE) guidelines, with a system in place to ensure this guidance was communicated with staff. We also saw this information being shared with parents and carers.

- Staff described an open culture, where they felt confident to raise issues, and in the response they would receive. Achievements were recognised, and staff felt valued for the work they did.

However:

- Front line staff and managers did not demonstrate a full awareness of the presence of the standard operating procedures regarding enteral feeding tubes which underpinned their work.
- Vaccines were not always managed in a way which ensured they were fit for use. The storage temperature of vaccinations was not monitored when vaccinations were being transported.
- The Public Health Nursing service was performing below national averages within the Healthy Child Programme; namely for new born and six week checks of babies.
- The organisation did not always have a clear oversight of the numbers of children who were at various levels of the safeguarding process. Although processes were in place, these were not always followed in a timely manner or correctly to ensure staff had access to the most up to date information about children's safeguarding statuses.
- Infection prevention and control processes were not followed by all staff. We saw examples of poor IPC practice.

Summary of findings

Background to the service

Virgin Care Limited took over the provision of integrated children and young people's services in Devon in 2013 as part of a five year NHS contract. At the time of inspection they were in year four of the contract. Virgin Care Devon provides a range of community based services for children, young people and their families across Devon. Each team has a manager with overall management responsibility being provided by six Heads of Service and the Head of Operations.

The service works with infants, children and young people predominantly aged 0 to 19 years of age, their parents, carers and a range of other agencies to provide care, support and treatment. In exceptional circumstances, on a case by case basis, young adults up to 25 years continue to receive care, support and treatment if already known to the service and on a transition plan.

The population includes 160,000 0-19 year olds, with over 7,000 births per year, 5,000 children with a disability and 700 children in care.

The services provided and teams inspected include:

Public Health Nursing Service:

- Public Health Nursing Teams – 17 teams working across 38 office bases, providing a public health nursing service based on the 0 – 19 years healthy child programme.
- Children in Care Team – assess, interpret and identify health needs, both met and unmet, of children and young people in care.
- Immunisation Team – delivering three vaccination programmes in schools and community clinics.
- New born Hearing Screening – identifying permanent deafness and hearing impairment in new born babies.

Family Support Services:

- Enabling – engaging children and young people in community activities

- Multisensory impairment – working one to one with children and young people who have a dual sensory loss.

Children with Additional Needs Service:

- Speech and Language Therapy – therapy for specific speech and language problems.
- Specialist Children Assessment Centres – a multidisciplinary team providing specialist developmental assessment, diagnosis and treatment for children under five.
- Occupational Therapy – helping children, young people, and their families adapt to the challenges of everyday life as a result of a condition or disability.
- Special School Nursing – delivering nursing care, health care training and advice in schools.
- Community Children's Nursing – supporting children with a wide range of conditions requiring expert nursing and therapy input, advice and support.
- Complex Healthcare Home Team – deliver care at home to children and young people who meet the criteria for continuing healthcare funding due to significant health needs and/or complex disability.
- Palliative Care – nursing care and support for children and young people with life-limiting and life-threatening conditions.

Strategic Business Development:

- Single Point of Access Team – office based team who receive and process all referrals (with the exception of the public health nursing) and are the main point of contact for the organisation.

We also visited the Rehabilitation Officers for Visually Impaired Children (ROVIC) and Portage services and spoke with staff and service users. ROVIC is a rehabilitation service which works with visually impaired children on orientation and mobility at home, school and in their local environment. Portage is a home-visiting educational service for pre-school children with additional supportive needs such as significant disability

Summary of findings

or delayed development. Both services do not undertake CQC regulated activities and so our findings from these visits are included as information only and do not inform the ratings.

During our inspection, we visited clinics, staff bases, schools, children's centres and children's homes. We accompanied health visitors, school nurses and other staff members on community visits and in clinics. We met with the safeguarding lead for children and child protection supervisors.

Virgin Care Devon also provide care and services in four children's homes. We visited and spoke to staff employed by Virgin Care Limited within the children's homes, however, these were not inspected by the CQC as they are inspected and regulated by Ofsted.

We had planned to visit the Eastern Activity scheme during the inspection, however at the time of the inspection this service had been suspended due to lack of staff being available to run the scheme safely. We were informed the scheme would be stopped and families were being supported to find alternative arrangements.

During our inspection, we spoke with 136 staff, 68 parents/relatives/carers and 20 children and young people. We observed how children and young people were cared for, held focus groups for staff and children, and looked at 30 sets of care and treatment records.

Our inspection team

Our inspection team was led by:

Chair: Graham Nice, Independent Healthcare Management Consultancy

Team Leader: Helen Rawlings, Care Quality Commission

The team included CQC inspectors and an assistant inspector. We were joined by the following specialist advisors: specialist children's community nurse,

children's physiotherapist, consultant paediatrician, school nurse, children's end of life nurse, children and adolescent mental health practitioners, learning disability practitioners, psychologist, and a director of human resources. An expert by experience who had experience of caring for children and adults with complex needs spoke with children, young people and families who use the services to gain their views.

Why we carried out this inspection

We inspected Virgin Care Limited – Integrated Children's Services Devon as part of our comprehensive independent 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?
- Is it responsive to people's needs?

- Is it well-led?

Before visiting, we reviewed a range of information we hold about the organisation and core services and asked other organisations to share what they knew. We requested and reviewed a wide-range of evidence from the provider. We carried out an announced visit on 16-19 January 2017. During the visit we held focus groups and drop in sessions with a range of staff who worked within

Summary of findings

the service, such as nurses, therapists, health care professionals, and administrators. We interviewed staff working in the community teams, staff at the headquarters including then senior management team, and some executives who work at a national level for Virgin Care and contribute to Virgin Care Limited in Devon.

We talked with children and young people who use services, our expert by experience telephoned a group of children and young people and their families who were

receiving, or had received care and support. We observed how children and young people were being cared for and talked with carers and/or family members and reviewed care or treatment records of children and young people who use services. We met with children and young people who use services and carers, who shared their views and experiences of the core service. We further visited on 1 February 2017 for an arranged staff focus group.

What people who use the provider say

We received feedback from people who used the services provided by the organisation. This was received via comment cards, and through conversations with people who use services and their families and / or carers. We received 17 comment cards, and spoke with 68 parents or carers of children and young people. Across the services people said they felt children and young people were safe. Parents said behaviour and actions of their children was evidence of this. People who were happy with the service said care was co-ordinated with other professionals. People said:

- “The therapist was really lovely and really listened to what I had to say. She didn’t make me feel my questions were stupid. We have come three times and my little boy’s speech is coming on a lot since we started coming here. Everyone says they understand him more and has been a lot less frustrated. Thank you.”
- “Professional specialist assessment was extremely helpful in identifying my daughter’s specific difficulties and following this up through direct communication with education and further assessment. Therapist was professional and we were treated with patience and respect, and listened to.”
- ‘He likes going there’ (SALT);
- ‘I completely trust her and I know he feels safe with her’
- ‘I worried at the beginning as I am an over-protective parent and if I was not comfortable I would not leave [my daughter].’

- ‘I completely trust her with his life. She has been with him through seizures and knows his medications’ (Complex Care Team);
- ‘There is a good open line of communication between the school nurse and myself. The school nurse has been very supportive of transport because we had a big issue and concern with safety’ and that any changes (e.g. to diet) ‘are written and signed so mistakes can’t happen’.(Special School Nurse Team)
- ‘We all know what is going on and what is happening’ (SALT);
- ‘..at school it is co-ordinated well with teachers and then there are visiting advisory professionals’ (MSI);
- ‘everything is co-ordinated, everyone knows what they have to do’ (OT)
- ‘The spirit with which they tackle the task of looking after [my daughter] is really good. They really care about her” (MSI)
- ‘Staff are incredible - they are well trained and fit in well with our family. They are fantastic and really good for her. It is an invaluable service, we rely on their support’ (MSI)
- ‘I can’t fault the Children’s Community Nurses at all...they are amazing - the care, the quality. Even if I am having a bad day I can phone up and have a cry. They are a big part of [our] life...Nothing is too much trouble for any of them. They keep us out of hospital so many times’ (Children's Community Nurses)

The palliative care team undertook a bereavement survey, the results of which were collated in October

Summary of findings

2016. The survey was sent to parents and families whose children passed away over the previous 12 months. The team received four responses but all of them said they would be very likely to recommend the palliative care service to family and friends. The survey results also included comments which were really positive:

- “We cannot rate the palliative care team enough. Our situation would have been extremely different had we not had the support from the team. From diagnosis to end of life we felt entirely supported. In fact the team was paramount in not only our child’s needs but our needs as parents.”
- “Our experience of the palliative care team was solely positive and therefore do not have suggestions on how this service could be improved.”
- “We did not feel that they rushed their visits despite their busy caseload. The care and compassion given to [child] and sister as well as us was exceptional and we will never forget their kindness to us during [child’s] illness and after death. Thank you .”
- ‘Our CCN was our ‘rock’ during our child’s end of life care and the weeks beyond her death. We found that it took weeks (approx. 7) for our child to receive a

consensus amongst her paediatricians and surgeons that she was in her end of life phase. This lack of joined up care was particularly difficult, because as parents we knew our child was seriously declining. Once we were given the support and expertise of the palliative care team, our child’s pain and distress were eased and eventually eliminated. She had a very peaceful death at home, which is a lasting memory.’

However, some feedback we received was not positive. Some people were concerned about continuity of care and the impact that this has. People said:

- ‘How can I trust them if I don’t know them.....over the years they have been an amazing support’ but this has changed in the last 6 months and now there are no full-time staff, only part-time, it is a problem: too many staff makes continuity difficult.’
- ‘very disappointed’ with the response from OT with respect to difficulty contacting, information not being shared and still no assessment or equipment that they need.
- ‘People need to listen to parents. We are the experts about our children.’

Good practice

- Multidisciplinary working was embedded within the service and provided positive outcomes for children and young people. We saw effective and committed multidisciplinary working both within and outside of the organisation, and this was consistent across teams.
- We saw examples where outcomes for children and young people were greatly improved due to the joined up and holistic working of both educational and health services provided by the organisation.
- Adherence to guidance and best practice was monitored through clinical supervision, appraisals and team meetings. Staff told us they were proactive in ensuring they were up to date with the latest

guidance. We saw evidence of best practice being discussed during one-to-one meetings and appraisals following review of employee supervision records.

- The use of a data reporting system provided managers with real time bespoke reports on service outcomes. Managers reported how it was easy to use, provided them with comparison and tracking reports for their services, and immediately highlighted areas they needed to focus on.
- The palliative care team assisted with planning of patient funerals at the request of patient families.
- The culture within the palliative care team encouraged staff to openly support and challenge each other.

Summary of findings

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

Action the provider **SHOULD** take to improve:

- Ensure all staff follow infection, prevention and control procedures.
- Standardise incident reporting procedures across teams in terms of the nature of incidents reported.
- Review processes for recording children's safeguarding status. Ensuring this information is available to all staff on the systems they are using, identified correctly and with accurate up to date information. Ensuring full oversight on the numbers of children they work with on all stages of the safeguarding process.
- Ensure that staff record the temperatures when vaccines are stored outside the refrigerators during transport and immunisation sessions to ensure the cool chain is maintained and the vaccines are fit for use.
- Improve performance in relation to the Healthy Child Programme to meet or exceed national averages – in particular with regards to new born and six week checks.
- Ensure that practitioners and managers have an awareness of the procedures that support them in their roles in relation to clinical procedures such as the management of enteral feeding tubes.
- Provide easy access to leaflets displayed in clinics for people with visual impairment and in easy read format.
- Improve performance in relation to the safety of staff who lone work. This should include addressing risks of staff working across a 24 hour shift pattern.
- Improve local oversight of the management of complaints and concerns. Including improving response times for complaints and communication with national complaints management processes.
- Ensure efficient and effective management of waiting lists that ensures risks to patients are minimised.

Virgin Care Limited

Community health services for children, young people and families

Detailed findings from this inspection

Good



Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the safety of the children and young people's services as good because:

- There were arrangements in place to safeguard children from abuse that reflected the relevant legislation and local requirements. Staff understood their responsibilities and were aware of the provider's policies and procedures.
- We saw positive examples of how risks were anticipated and responded to, particularly within services supporting children and young people with complex health needs.
- At the clinics we visited we saw that safe and child friendly environments and equipment were maintained.

- Records were written and managed in a way that kept people safe and protected confidentiality. They were regularly audited and where required, improvements made.
- There was a proactive and flexible approach to managing caseloads, with staff having autonomy to make decisions about the way they managed their work.

However:

- We observed that not all staff followed infection control procedures in line with the organisation's policy and national guidelines. Weighing scales were not always cleaned between babies, and there were inconsistencies in toy cleaning practices.

Are services safe?

- Staff were not always aware of children at various levels of the safeguarding process. There were not always robust systems in place that assured the communication of important information about children.
- Temperatures for vaccinations transported in cool bags were not recorded, and so the service could not be assured that the cool chain had been maintained.

Detailed findings

Safety performance

- The services were monitoring safety effectively and we saw evidence learning occurred when things went wrong. A range of safety information was being monitored and fed into service improvement. This included the monitoring of incidents including medication errors.
 - There had been no serious incidents (SI) reported in respect of the children and young people's services during the year preceding our inspection – between January 2016 and January 2017.
 - In the year prior to our inspection, between January 2016 and January 2017 there had been no never events in respect of the children and young people's service. A never event is a serious, largely preventable patient safety incident, which should not occur if the available preventative measures have been implemented correctly.
 - Health visitors and school nurses told us they received regular updates on safety performance through team meetings and supervisions. This was in relation to themes emerging from incidents reported across services.
- the electronic adverse incident reporting system. Some staff said they were less confident to report incidents as they didn't do it very often, but would be supported by their line manager should the need arise.
- Between January and December 2016 there were 938 incidents reported across the entirety of Virgin Care services Devon, the main types of incidents were medication (59), breaches of confidentiality (45) and communication (63).
 - There was an inconsistency across different teams of the nature of incidents that were reported. For example not all teams reported as an incident, where a child or young person had a scheduled appointment cancelled due to staff sickness. The lack of this consistency meant the service could not monitor occurrences of this nature. We did not see clear guidance to support staff to ensure they reported events consistently. Staff in some services felt there was not a culture of incident reporting and it was a time consuming process, which put staff off reporting. Other staff told us the nature of incidents they reported was common sense.
 - Managers were confident they had oversight of all incidents that were reported. The registered managers received details of all incidents reported within the organisation and they therefore had sight of all such events.
 - Learning from incidents was shared across the service with reported incidents being discussed at managers meetings and information being disseminated throughout the different services. The learning from reported incidents was part of the monthly team meeting agenda. Staff told us relevant information was cascaded to them as a team by their managers, when learning or changes to practice had been identified through the investigation of incidents. We also saw evidence of learning from incidents being discussed at the monthly Service Governance meetings.
 - We saw examples where learning from an incident had led to a change of system for one team. An error in home storage of equipment at a child's home had led to a mistake occurring with a procedure carried out by a parent. Following this, the team introduced a new storage system for equipment for all children cared for by the team to mitigate further events occurring.

Incident reporting, learning and improvement

- There was not a consistent culture of incident reporting amongst all teams and there was inconsistent understanding among staff about what should be reported.
- Staff reported incidents within an electronic incident reporting system. Managers had responsibility for investigating incidents and developing action plans. Staff were aware of how to use and report incidents on

Are services safe?

- The immunisation team discussed an issue with the delivery of vaccines to its base. As the team were out for a large part of the day, deliveries of vaccines had not been completed as there was nobody available to receive them. This had caused issues with supply that posed a risk to the service. Through conversations with the supplier, amendments were made to the delivery schedule that had resolved the issue.
- We saw there had been a rise in incident reporting around information governance. The total number of incidents reported for the year prior to the inspection had increased by 30% from the year before, from 200 incidents to 260 year on year. Information governance describes the process of ensuring confidential information is kept secure. We were told there had been a focus on this subject as a service, and subsequently the numbers of such incidents had risen due to an increased awareness of staff.

Duty of Candour

- There was knowledge and understanding of the Duty of Candour by staff and managers.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This Regulation requires a provider to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. The provider had a policy in place in respect of this regulation which outlined steps which should be taken, by which member of staff, and the timeframes.
- The managers of the different services we spoke with were aware of this regulation and could explain their responsibilities in relation to it.
- Staff were knowledgeable and aware of the requirements of the Duty of Candour legislation. They were also provided with a staff guide which supported them as an aide memoire in their work. They spoke of their practice of being open and transparent with the families they worked with when things went wrong.
- The immunisation team gave an example of when they had apologised for incidents in which children had been incorrectly vaccinated. They were also able to demonstrate how they had investigated these incidents and discovered how the incidents had occurred.

Safeguarding

- There were arrangements in place to safeguard adults and children from abuse. Staff understood their responsibility to report safeguarding concerns and adhered to local policies and procedures. There were not always robust systems in place that assured the communication of important safeguarding information about specific children.
- Staff were well supported in safeguarding adults and children from abuse. Support was available from the safeguarding team on an on-going basis and policies which reflected relevant legislation, were accessible. Staff had access to the south west child protection document to direct them to the correct place to send referrals. Staff were confident in identifying safeguarding concerns and making safeguarding referrals. Representatives from different services were assigned as safeguarding champions, they attended quarterly safeguarding meetings and were the main source to cascade information to teams.
- There was evidence of inter-agency working to safeguard and promote the welfare of children in line with the government's Working Together to Safeguard Children 2015 document. We were told there had been an increase in early help, providing support as soon as a problem emerges, identified across Devon. The regional manager attended the local safeguarding children's board, and the safeguarding named nurse and professional lead sat on the learning and improvements board.
- Staff demonstrated a sound knowledge of safeguarding procedures and multiagency working with social care colleagues. Staff described how safeguarding was regularly discussed at team meetings and learning from serious case reviews could be discussed. One team gave an example where they provided social care colleagues with evidence in relation to a child living in a situation of chronic neglect. Social care services were then able to intervene and provide the child with the care they

Are services safe?

needed to thrive. Where risk or vulnerabilities were identified, we saw that the public health nursing team made appropriate referrals to the multi-agency safeguarding hub, and this was embedded in practice.

- Training records showed staff were compliant with safeguarding training. Training levels reported excluded staff that were on long term sick leave or on maternity leave. This included safeguarding children level one (100%), level two (98%) and level three (95%), and safeguarding adults level one (100%) and level two (96%). The safeguarding named nurse and professional lead for the organisation was appropriately trained in level four safeguarding children. During induction all staff received safeguarding training and this was renewed three yearly as part of a mandatory training cycle. The level of safeguarding training was in line with guidance from the Safeguarding Children and Young People Intercollegiate document 2014. This document describes the required training for staff in differing roles and levels of contact with children and young people. Opportunities were given for staff to attend additional safeguarding training.
- Local leadership in safeguarding had been strengthened through the establishment of a named nurse professional lead and an associate named nurse. Organisational safeguarding infrastructure was clear, accessible and well understood across the organisation. Line managers had received training on delivering safeguarding supervision and this was routinely addressed in practitioners' supervisions.
- Staff were supported through a structured approach to safeguarding supervision which occurred, on average, every three months. In addition staff were able to request additional supervision and support when required; either from their team leaders or from the safeguarding team. We were told by staff they felt confident both in their ability to recognise and report safeguarding concerns, and also in the support they were offered. Safeguarding was discussed within six weekly supervision meetings with their manager as a standing agenda item.
- The staff we spoke to had good understanding of the guidance, recognising and reporting of abuse, female genital mutilation (FGM), child sex exploitation (CSE), PREVENT and trafficking. Prevent focused on all forms of terrorism in a pre-criminal space, and provided support and re-direction to vulnerable individuals at risk of being groomed into terrorist activity before any crimes were committed. We were told of a situation where a staff member had suspected the risk of FGM and had worked with a forensic team to confirm this. Staff were given support from their team leaders as well as the safeguarding team in this situation.
- Information was displayed within the waiting rooms in the form of leaflets and posters to alert patients to recognising and reporting of concerns relating to physical and sexual abuse and support.
- We saw a safeguarding chronology form in use within the electronic system. This allowed all staff involved in the care of the child to input their interventions onto the form, and allowed for an instant analysis of this information by professionals involved in the care of the child. The single point of access team received information from the police surrounding domestic abuse and these could be added to the care record systems to alert staff. Similarly, any multi-agency risk assessment conference (MARAC), high risk domestic abuse cases, were received and shared with the relevant public health nursing teams.
- Where risk or vulnerabilities were identified, public health nursing practitioners made appropriate referrals to the multi-agency safeguarding hub (MASH). We saw an example where a health visitor referred to MASH a family where domestic violence was a concern. This was done with an appropriate referral, with the mother being appropriately supported by the health visitor. This resulted in interventions which mitigated the risks to the family and produced positive outcomes.
- The computer system highlighted to staff those children who may be a safeguarding risk. However, systems did not interface and thus this information was not always shared in a timely manner to ensure information of child safeguarding status was accurate. We observed a staff member only being informed of a potential safeguarding risk in regards to the home they were visiting due to another staff member, from a different service, overhearing their conversation. This did not provide assurance of an effective system that kept staff informed of the situations they may be going into.
- Children who may be subject to a child protection plan had this information flagged on their record within the

Are services safe?

electronic reporting system. However the staff using this system were dependent on staff within the Single Point of Access finding this information on a system used by social care teams, and placing this manually onto the system. This information was then collated on the referral recording form and made available to clinicians who screen the referral. There was no central process to check whether children were subject to a child protection plan, teams managed this locally. However, systems did not interface between different services and therefore there is a risk if a child or young person moves between services that this information is not conveyed. It had been agreed with the local authority this information would be shared and subsequently added to all care record systems by the single point of access team to ensure staff were aware of any children or young people on a child protection plan.

- Electronic records management systems were used by the organisation providing key information about the children in their care. Different services used different care records systems. Case recording regarding the status and known risks to children was robust in most services, with good use of chronologies and alerts. There was variable recording in the community children's nursing service in the alert pop-up box on the electronic system which appeared when the case record was first accessed. The alerts identified safeguarding, but were not always specific about what the status of the child was or what level of safeguarding the child was subject to. Terminology for key documentation was imprecise with administrative staff responsible for inputting the data onto the system in this service misidentifying child protection plans as social work plans and the status of the child was not up to date on all cases. As a result of this lack of accurate identification, key information that should be guiding day to day practice with the child was not easily accessible to practitioners and managers in this service. This increased the risk that key actions and risk management would not be effectively carried out by the practitioner, and did not facilitate good caseload management or workforce planning.

Medicines

- Arrangements for managing medicines were usually safe however; there were not always reliable processes in place for the storage and transport of medicines.

- There were management and administration of medicines and controlled drugs policies; these were available on the intranet and staff told us they were aware of where to find them. Standard operating procedures were in place for controlled drugs and also other aspects of medicines management.
- Nurses had medicines management training at induction. In the six months prior to our inspection, a new medicines training system had been rolled out. Module one was completed by all staff who handled medicines. Module two contained specialist modules which included PGDs, administration of vaccines, maintenance of the cold chain, and syringe drivers.
- Medicines management arrangements were adapted where staff provided care at home. We saw evidence of standard operating procedures for medication administration. Staff told us within a group setting parents had responsibility to administer medication to their own children. These medicines were prescribed by GPs, and then dispensed by local pharmacies to be administered at home.
- The provider had a small number of patient group directions (PGDs) which are written instructions, providing a legal framework to allow clinicians who have completed appropriate additional training and signed the PGD, to supply or administer medicines to patients. We reviewed PGDs which were up to date and had been signed off.
- The PGD in use by school nurses pertained to the supply of emergency hormonal contraception (EHC) during the drop in sessions in schools. All nurses had been authorised to use them by their line managers.
- Nurses within the immunisation team were trained in the use of PGDs. PGDs related to three vaccines that were in use: Meningitis, human papilloma virus and low dose diphtheria/tetanus/inactivated polio. All were produced by Public Health England and ratified by a local PGD group. Staff were able to explain the guidelines they were to follow to ensure the safety of children receiving vaccines.
- Anaphylaxis kits were available at each immunisation session in line with Resuscitation Council guidelines.

Are services safe?

- We observed safe systems around the storage, administration and disposal of medication. Drugs given were clearly recorded including the batch number and site of infection. Each record was signed, dated with the time of administration stated.
- The security and safety of medicines was good. All medicines checked were in date. Keys were held securely and routine access was restricted to trained nurses. FP10 prescription forms were stored securely. There was a robust process for the non-medical prescribers to obtain prescription pads via a central ordering point within the organisation. The staff members either picked up their prescription pads in person and signed for them, or their manager did so.
- The number of medication incidents in the organisation was low, approximately six per month, the largest group of incidents were about communication. These included changes in medicines not being communicated by parents, parent authorisation for medicines administration within the respite units, and medicines not being brought into the service by parents, or being left at school in error.
- The medicines management committee met every three months. The service level agreement pharmacists also attended. It reviewed medicine incidents and adverse events, and also reviewed National Institute for Care and Excellence (NICE) guidance that had been issued.
- Staff said there was an open culture for reporting medicine incidents. They used a computer programme to report. All incidents involving medicines were also sent to the corporate medicines team for review. The corporate medicines team reviewed incidents involving medicines, adverse events and non-medical prescribing. All such incidents were also reviewed locally within the service.
- We saw good practice where vaccines and anaphylaxis kits were stored in medicine refrigerators which were monitored continuously. This system sent an e-mail if the temperature deviated from the required range for more than ten minutes. Paper records were also kept of the minimum, maximum and current temperatures which were manually checked on a daily basis. All recorded were within range. There was guidance for the action to be taken if the temperatures were outside the required temperature range.
- When vaccines were removed from the refrigerators for use in immunisation sessions, and transported using cool bags, the temperatures were not recorded and therefore the cool chain could not be validated. The medicines policy stated that vaccines that had been kept between two and eight degrees Celsius could be marked and returned to the refrigerators and then were to be used first. Any vaccines outside this temperature range had to be destroyed. Staff were not recording the temperatures and thus the policy was not being followed. All vaccines were marked and returned to the refrigerators for use at the next clinic even though they could not give assurance they had been stored at the correct temperature. This issue had been reported in the vaccine audit completed in January 2017 and a risk assessment had been completed. This was not in accordance with the medicines policy and meant staff could not give assurance that unused vaccines from these cool bags returned to the refrigerator for use at future sessions would be safe and effective. This issue was raised with the provider at the time of the inspection and action was taken to ensure vaccine temperatures were continually monitored when transported.
- Within the palliative care service, medication audits at the family home were undertaken to ensure all medications were accounted for. If there were any discrepancies they were reported as an incident and investigated accordingly. However, the audit trail broke down after the child's death as checks were not carried out to record if control drugs were returned to a pharmacy for destruction. Following death, all prescribed medicines, including controlled drugs, were to be returned to the pharmacy that supplied them for disposal. We saw evidence of risk assessments being completed when this process had not been followed.
- There were three independent prescribers and 20 non-medical prescribers working for the service in the community who had completed the required course. The use of these prescribers was being reviewed as they were not prescribing regularly.

Environment and equipment

- Equipment was observed to be fit for purpose and supported safe care and treatment. Equipment was

Are services safe?

available for staff when needed and maintained in good working order. The environment in some community clinics was not always appropriate; however this was identified and managed.

- Where services were delivered from premises, these were secure and maintained ensuring the safety of children and young people using the service. There were systems to ensure staff and visitors signed in and out when entering and leaving the premises.
- The environment and facilities we visited were tidy, clean and well maintained. They were suitable for children and young people with toys which could be wiped clean. We saw toy cleaning schedules that had been completed; this was in line with organisation's toy cleaning policy.
- The public health nursing service provided mother and baby clinics at children's centres or local facilities in the area. In some cases these environments were not designed for the purpose and posed difficulties for parents and staff alike. For example, at one clinic, the changing stations for babies sat approximately two feet off the wooden floor, on a stage, with no physical barriers to protect from falling. This had been risk assessed by the team using the facility, and mitigation that identified the parent/carer of the child being responsible for their safety.
- Therapy staff had access to equipment required for children and young people, to help improve their function or mobility, or support parents, with activities such as sitting and walking. We observed equipment within a child's home which was in date and stored appropriately. Staff told us there were no issues with delivery of equipment and ordering was easy to do. In addition, any faulty equipment was repaired quickly, and the company responsible for this was responsive. All equipment provided to patients was serviced and repaired by an external company for which there was a service level agreement. Any defects or issues were reported as incidents and escalated accordingly.
- Parents reported differences in the ease at which this equipment could be obtained. One parent reported they had access to specialist equipment straight away with

clear help, guidance and support on how it should be used. However, another parent said they had found it hard to get the right equipment and their child could not access education without it.

- Equipment used by the teams was calibrated in accordance with schedules to ensure effectiveness of their use, for example weighing scales, syringe drivers and hearing screening equipment. We saw records that confirmed this had occurred.
- Syringe drivers, used to deliver a steady flow of injected medication, were maintained and used in accordance with professional recommendations. We saw evidence of a syringe driver policy covering education, training, equipment, medicines, carriage of medicines, disposal of medicines, disposal of clinical waste and processes following death. Although no syringe drivers were in use during our inspection, staff were aware of the policy, knew where to find it and told us they would refer to it if they had any queries. The syringe drivers were secure when in use as they were kept in locked boxes which prevented tampering.
- All equipment and stock, which was temperature sensitive, was kept in a lockable cabinet and the temperature was monitored and recorded. We saw that all perishable equipment was in date.
- Any unused patient equipment was taken by the palliative care staff from one of the children's homes to be disposed of, after a patient's death.
- During our inspection we reviewed the team's stock, systems and storage, which was safe and appropriate. Once a patient's needs were assessed orders for appropriate supplies would be placed. With the parents' consent, appropriate equipment and stock were kept in patient homes.

Quality of records

- Records were written and managed in a way that kept people safe and protected confidentiality. We saw evidence of when records were regularly audited and where required, improvements made.
- Records were audited annually as part of an ongoing programme. Audits that we viewed showed generally good compliance with overarching principles of access

Are services safe?

to records. Samples looked at during audits showed varying compliance with recording of specific details such as times of treatment, and the recording of NHS numbers.

- We looked at a sample of 30 records across the full range of services. We looked at the recording and care planning completed by staff and also spoke with clinicians providing care. Case records were well structured and recording templates prompted practitioners to record detailed observations, analyse risk and formulate clear plans for future work with the individual family. All individual entries were clearly signed by the practitioner with their role identified resulting in a good audit trail for entries and practitioner actions. When cases were discussed in supervision, this was entered in to the case record in line with best practice. The views of parents and the child were recorded when appropriate. A mixture of electronic and paper records were in use depending on the service. Paper records we saw were stored securely.
- The teams we visited within the additional needs service were currently undergoing a transition from paper based to electronic records. This meant at the time of inspection each child had a set of paper records which were scanned and then stored electronically. Paper patient records were secured within filing cabinets in office bases. These were locked at night and not accessible by anyone other than staff members. Staff told us they were able to access records when needed and had a good understanding of data protection and confidentiality requirements. However, we saw some incidences where the quality of scanned records was poor.
- Health visiting teams had moved to an electronic mobile working system during the three months prior to our inspection. Paper records were now only kept for the Child Health Record (Red Book) that was left with families at their home. All plans, assessments and other documentation were recorded electronically.
- There was a proactive approach to the risks of information being lost between systems. In order to safeguard against any loss of information, children who were subject to safeguarding interventions, had their

records maintained as paper documents. We were told this meant teams could be assured information was available during the initial period of mobile working while systems bedded in.

- The speech and language therapy team maintained detailed records regarding the care and treatment they provided to children and their families as well as the child's medical history.
- There was evidence of multi-disciplinary working with therapists inputting their notes within the same recording system. Staff recorded additional information such as allergies of children within care records. Support and outcome plans were reviewed annually as well as updated when changes occurred.
- Within the palliative care team, the electronic patient recording system supported mobile working as staff had access to the system at office bases, patient homes, hospices and hospitals, as long as wireless internet access was available. If any paper records were produced the information was uploaded to the electronic patient recording system, after which the paper records were destroyed.

Cleanliness, infection control and hygiene

- Infection prevention and control (IPC) was seen to be everyone's responsibility. There were individuals who led on IPC locally with accountability corporately and a clear governance structure to ensure IPC was discussed and information cascaded. IPC champions represented services and attended the local IPC group meetings, we reviewed the meeting minutes for August and November 2016 which evidenced clear discussions, learning and actions.
- Staff received annual IPC training with compliance at 95% for the total workforce in the organisation Virgin Care Limited. Support was available to the provider and staff through a service level agreement from the local acute trust's IPC team. Staff also had access to infection control policies. Local procedures were developed where necessary, for example child tracheostomy individualised care plan for cleaning.
- We did not observe all staff following infection prevention and control guidance. Staff wore appropriate protective equipment such as gloves and aprons when providing care and this equipment was available to

Are services safe?

prevent the spread of infections. However, not all staff were washing their hands or using sanitiser gel immediately before and after contact with a child or young person.

- Infection prevention and control could not be assured within the public health nursing service. We did not observe the consistent cleaning of equipment between patients. On numerous occasions across various health visiting teams, weighing scales were not cleaned between babies. On one occasion, a baby with a cold had their bedding used to line the scales. The scales were not then cleaned before being put away. This presented an infection risk to children being placed in the scales.
- Deep cleans of premises were carried out quarterly and we saw cleaning logs to confirm this.
- Waiting area furniture was clean and in good condition, fully wipe able and fully compliant with the Health Building Note (HBN) 00-09: Infection control in the built environment.
- Hand hygiene audits were completed every six months and submitted for most teams. The recent compliance audits between April and September 2016 showed 100% compliance in hand hygiene for the special school nursing, multi-sensory impairment, enabling, palliative care team and Honeylands specialist children's assessment centre. The complex care team had 95% compliance. Some teams, to include the community children's nurses, continuing health care, palliative care and specialist children's assessment units, involved families to assess compliance with the five moments of hand hygiene.
- Annually an IPC audit was completed and formed part of the corporate clinical governance RAG (red, amber, green) score card. Key clinical sites which included four children's homes and two assessment centres were subject to an annual environmental audit completed as part of a service level agreement.
- The organisation had a toy cleaning policy, with clear guidance. However, services could not be assured of consistent practices around the cleaning of toys. There were inconsistent practices in some teams around the cleaning of toys. Some staff members were observed to clean toys after use when working with children by wiping over them with appropriate antibacterial wipes.

Specialist children's assessment team staff had their own toy supplies and were individually responsible for ensuring the toys were clean and in good working order. A sheet was ticked at the base office when cleaning had taken place. However, some staff told us that soft toys were wiped over just the same as plastic toys and others said that they would be taken home by staff members to wash in a washing machine on an adhoc basis. In another service, we were informed that soft toys were machine washed at a centre after they had been used. Therefore, we did not see consistent recording or auditing of toy cleaning practices across the services we visited.

- At children's centres, responsibility for the cleaning of toys lay with the centre. The organisation Virgin Care had a toy cleaning policy, however, this does not mention areas where Virgin patients are using toys for which others are responsible. In these situations, staff could not be assured of the cleanliness of the toys the children and young people they worked with, were using.
- Families informed us that they saw staff wiping down equipment after their child has used the service and that the environment was always clean and tidy.
- In some places we visited, there was a named individual responsible for ensuring therapy rooms were cleaned each day and we saw evidence of checklists on the door of rooms to confirm that this had taken place as well as archive folders of these checklists.
- The arrangements for managing waste and clinical specimens kept patients safe. Arrangements were in place for the collection of clinical waste from patient homes. Staff did not take any clinical waste away from the home with the exception of sharps bins. We saw they were correctly filled, labelled and securely fastened.

Mandatory training

- Training was provided for all staff to ensure they were competent to perform in their roles. There was a designated list of mandatory training. The organisation's target for mandatory training was 85%. Training compliance against total work force overall was 93.9% compliant. Training below 85% compliance was limited to basic life support which was only just below compliance level at 84.7%.

Are services safe?

- There were electronic systems in place to monitor and remind staff when training was due with each service manager having oversight of their staff members' individual training need.
- Mandatory training was delivered via classroom based learning and electronic learning. Staff reported they were given the time to attend training sessions and since the introduction of electronic based learning it had been easier to complete training and it was engaging and responsive to their needs. However, some staff reported there was lack of classroom based learning available in their localities which meant training was harder to attend due to the impact it had on their time and clinics.
- A corporate induction and local induction policy created a framework in which all staff, whether temporary or permanent, were effectively and appropriately introduced to the organisations culture, environment and ways of working. New members of permanent or temporary staff were invited to attend a corporate induction programme on their first day of employment.
- The biggest risk on the medicines risk register was completion of the new medicines training modules. We were told by staff that the reason for this was due to the availability of computers and staff having the time available to complete the modules. The quizzes at the end of the modules were not being done so it was difficult for the service to pull a report off their computer system to be able to review the uptake of the training. Some staff also commented how this training was above and beyond their role if they were not a registered clinician and therefore proved difficult to complete.
- electronic patient's records to indicate specific risks, which ensured staff were aware of and had speedy access to individual needs and risks. However, not all members of staff used the same computer system, for example staff used a different system for recording notes and alerts for children using the children and adolescents mental health service (CAMHS). This meant these alerts were not always accessible and seen.
- There were systems and processes for staff to follow when children and young people did not attend (DNA) appointments to ensure their safety and welfare. For example, within the speech and language therapy department if a patient failed to attend an appointment they would be telephoned and also contacted by letter. If they felt a child was at risk then contact would be made with the child's General Practitioner and the appropriate safeguarding team.
- Urgent medical attention was accessed, if needed, at different times of the day. Staff told us they always advised the children or young person's families / carers of the correct processes to follow in an emergency. If a child or young person required urgent medical attention when staff were present in a patient's home, their process was to call for a GP or ambulance depending on the severity.
- We reviewed some children's emergency procedure files. All were in date with the exception on one seizure procedure. We were informed this was due to the procedure being written by an acute hospital, an appointment had been booked for the patient to attend to have their epilepsy and seizure emergency procedure reviewed.

Assessing and responding to patient risk

- Risk assessments were carried out to assess and respond positively to risk. Overall staff could identify and respond appropriately to changing risks however, this was not always evident in every service.
- Risk assessments were completed as part of the assessment process for children receiving a service. This would include the environment and any associated risks depending on the service being delivered.
- There were mechanisms in place to identify patients at risk and ensure all staff involved in their care were aware of this. Electronic alerts could be added to the
- Risk assessments within the complex healthcare team were robust. Risks were documented and mitigated with thorough records held within a child's home. We saw examples where risk assessments were completed for a child with complex care needs. The risk management plan highlighted anticipated risks. There were also personalised risk assessments made around the specific circumstances of a child, with equally specific mitigations.
- We saw systems in place that aimed to ensure staff were able to identify and discuss risk. Templates were used by the public health nursing team, which prompted

Are services safe?

clinicians when exploring potential risks to the child. Within the public health nursing team, we were told at meetings and supervisions staff were able to highlight and discuss areas of concern.

- We were not assured of the awareness of standard operating procedures that covered the management of enteral feeding tubes. Enteral feeding tubes are inserted through the nose and provide direct passage to the stomach. The organisation had a clear standard operating procedure for the management of these tubes, however, when talking with a staff member they were not familiar with the detail of the guidance specifically in relation to the management of a tube which was not in the right position. We raised this issue with clinical managers who were not able to confidently site this policy at the time of our inspection. The provider responded to our concerns at the time of the inspection, they investigated and ensured the practice and procedures were safe and the policy fit for purpose.
- Within the palliative care team we observed staff carrying out risk assessments and saw evidence of completed risk assessments on record. These related to falls, mobility, deep vein thrombosis, moving and handling, pressure ulcers, oxygen storage in homes, hazards, medication and fire.
- Staff identified and responded appropriately to changing risks to people who used the palliative care service. Of the three risk assessments we reviewed we saw they were all complete, noted the severity of the risk and actions were taken to mitigate any risks.
- The palliative care team were available to provide advice and support to patients out of hours. However, individual funding for patients at end of life needed to be arranged beforehand. In order to mitigate any risks, patients were assessed in respect of their end of life care needs at the time of their referral and on an ongoing basis to ensure funding was in place at the right time.
- The palliative care team continually assessed patient needs at each visit and would pre-empt whether a patient's needs would increase. Part of this process involved liaising with the patient's GP and/or paediatrician to discuss additional needs and ensuring the appropriate anticipatory prescriptions had been made beforehand.

- The palliative care service provided, reflected the needs of the local population and ensured flexibility, choice and continuity of care. The team held a caseload review meeting every week where capacity, high priority and deteriorating patients were discussed. This was done to discuss prioritisation based on specific patient needs.
- Children and young people approaching the end of life were identified appropriately and in a timely way. As part of the risk assessment process, patients were rated as red, amber or green depending on their status in respect of end of life. Patients assessed as being red were classified as high priority and the commissioners were approached to approve funding for an end of life out of hours care plan. Most patients within the end of life service were assessed as amber but were continuously re-assessed.

Staffing levels and caseload

- Staffing levels, skill mix and caseloads were reviewed and planned taking into account safe care and treatment. Staffing did not always meet the planned levels and in some services there was a difficulty in recruiting, this had been managed using alternative ways of working.
- There were systems in place in the different teams and services to manage and plan caseloads. Whilst there was an increased demand for many services staffing levels were maintained by offering available shifts to current staff who worked part time. Staff we spoke with across the services told us their workloads were generally manageable, although some staff within the public health nursing service said they were busy with little capacity for extra.
- We saw responsive caseload management practices. For example, in the speech and language team the caseloads were managed on a group basis and regularly reviewed by management. If it was deemed a staff member had a large caseload, then this would be shared amongst the other members of staff who had smaller caseloads and greater availability.
- Staff across different teams held allocation meetings on a weekly basis to discuss caseload and allocate work. Staff discussed that they had a good knowledge of the skill mix and specialisms of staff within the team and therefore were able to use this to allocate appropriately.

Are services safe?

Staff told us they had autonomy to be flexible with their caseloads, once they had been allocated. This also included being able to schedule in extra visits if required. No tools were used within this system.

- The school nursing teams were more depleted than health visiting teams, and this was identified on the risk register for the public health nursing service. There had been some success in offering conversion courses to health visitors to convert to school nursing. To manage this shortfall, work had been undertaken to “pool” school nurses in areas in order to provide a more equal service. In addition, team leaders and service leaders were carrying out work aimed at identifying any areas of work that could be undertaken by staff other than school nurses – school based staff for example.
- The high number of vacancies in the school nurse service and difficulty in recruiting was being well supported by health visitors. This was achieved by health visitors retaining cases up to the child being eight years old where they needed ongoing public health nursing intervention and there were younger children in the family.
- In areas where staffing was a particular issue, teams were using a “Caseload Weighting Tool”. This was described as a tool to enable the consistent approach across teams, to prioritising areas of work. Areas prioritised included children for whom there was an open safeguarding referral for example. This tool was being trialled at the time of our inspection, and had not been ratified at executive level. Feedback from staff was positive.
- Within the public health nursing services there had been a move towards “hub” working. This meant staff such as administrators were being moved away from individual team bases to a hub, providing support to a number of teams simultaneously.
- We were told during periods of absence caused by sickness or annual leave, caseloads were managed by remaining staff members. There were a small number of bank staff available, but we were told there were no school nurses available on the bank. Agency staff were not used within the public health nursing service.
- Recently published guidance from the National Institute for Health and Care Excellence (NICE) set out that a specialist paediatric palliative care team should include

at a minimum; a paediatric palliative care consultant. The palliative care team was a nursing team and so was not commissioned to provide a consultant, this had resulted in a gap in the service and was identified as a significant risk by the service lead and as a result was escalated and included on the services’ risk register and classified as a high risk. The risk was mitigated by ensuring each end of life patient’s GP and paediatrician based at the NHS trust was identified. In doing this they were able to closely liaise with GPs and paediatricians to plan and develop their patients’ end of life care, symptom management and prescriptions.

- The lack of specialist paediatric palliative consultant advice from other providers was a recent development as there was previously access at a local hospice until the post became vacant. However, the post was being recruited to at the time of our inspection.

Managing anticipated risks

- Potential risks were taken into account when services were being planned. Staff we spoke with were aware of the plans to be put into place in the event of adverse conditions. These plans were aimed at facilitating staff to provide care, safely, in various types of adverse conditions such as bad weather.
- In premises where Virgin Care Limited were guests providing a service, they carried out their own risk assessment of the area. We saw the immunisation team, carry out a risk assessment at a school, identifying exit routes in the event of fire, and establishing at what times breaks occurred and therefore corridors would be more populated. Where clinics were provided in children’s centres, the teams also carried out risk assessments of the facilities.
- The palliative care team out of hours rota had been risk assessed. In order to maintain a safe workload for staff a maximum of two nights in four could be worked. To ensure safety and efficiency of the day service at least six members of staff available for the on call rota.

Major incident awareness and training

- Business continuity plans existed for the children and young people’s service. These detailed possible interruptions to the service, for example from the loss of power or water and the actions that needed to be taken. For example if there was flooding within the Capital

Are services safe?

Court building then the single point of access would be given priority in relocation due to the fact this service provides the point of contact for advice and help for service users and members of the public.

- The various teams we visited in the children's and young people's services had business contingency plans in

place to respond to emergencies and other major incidents. The plans were specific to the individual services but were all written in conjunction with the organisational procedure. These plans included information about managing the impact of adverse weather conditions.

Are services effective?

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

Summary

We rated the effectiveness of the children and young people's service as good because:

- People's needs were assessed and care and treatment was delivered in line with legislation and evidence based guidance.
- Staff had the right qualifications, experience and knowledge to undertake their roles.
- Staff received regular supervision and appraisals.
- We saw evidence of positive and proactive multidisciplinary working across teams and with other professionals and organisations. We saw care being delivered in a co-ordinated manner and the required services were involved in assessing and planning care and treatment.
- Consent to care and treatment was sought in line with legislation and guidance. We saw consent was clearly recorded, and processes were well embedded in practice.
- Technology and telemedicine had been introduced to improve quality of care, and services were proactive in this.
- We saw effective use of competency frameworks to assure children, young people and their families or carers of the skills of staff.

However:

- There was no clear pathway for a referral to external specialist palliative care services as there was no specialist paediatric palliative care consultant available within the Devon region.
- The move towards mobile working, whilst largely successful, caused some issues with regards to access to information for staff where systems did not communicate with each other.

Detailed findings

Evidence based care and treatment

- Policies, guidelines and pathways had been developed in line with national guidance and evidence based guidelines. These included National Institute for Health

and Care Excellence (NICE) guidelines. Oversight of NICE guidelines were reviewed by the Care and Effectiveness Team locally and reviewed nationally by the Virgin Healthcare Governance team to ensure best practice and continuity within each teams and services. If the guidance was service specific, the service developed and submitted its own action plan to the committee on how the guidance was to be implemented. The operational lead for both the children's community nurses and the end of life service sat on the committee. For example the committee was in the process of looking at NICE guidance relating to: spasticity in under 19s, management and end of life care for infants, children and young people with life limiting conditions planning and management, sepsis, and the transition of children and young people into adult services.

- The health visiting service followed guidance from the Healthy Child Programme. The Healthy Child programme focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.
- Staff used evidence-based guidance to assess children's needs. We saw specialist nursery nurses used Mary Sheridan's work on children's developmental stages for the basis of their work and used the National Foundation for Educational Research guidance for teaching talking.
- Adherence to guidance and best practice was monitored through clinical supervision, appraisals and team meetings. Staff told us they were proactive in ensuring they were up to date with the latest guidance. We saw evidence of best practice being discussed during one-to-one meetings and appraisals following review of employee supervision records.
- During our inspection we were told and saw evidence that the palliative care team followed best practice guidance issued by NICE, Together for Short Lives and the Child Death Overview Panel. Best practice was also received and shared following mortality and morbidity meetings attended by the service lead. Senior staff within the palliative care service had recently reviewed



Are services effective?

the recent guidance published by NICE on end of life care for infants, children and young people with life limiting conditions planning and management. They told us they were meeting all elements of the guidance except where it relates to the minimum requirement for a specialist paediatric palliative care consultant.

- The palliative care service lead co-chaired a local palliative care network three times per year. The network hosted palliative care practitioners from across the South West of England. Best practice within palliative care was discussed during the network events which was then shared with the palliative care staff during team meetings and used to improve the service.
- Nationally Virgin Care Limited had been accredited with the Unicef Baby Feeding initiative (Unicef BFI) in September 2015. Unicef BFI accreditation aims to support and enable women to breastfeed and all mothers to make effective attachments with their infants through close and loving relationships. It also follows safe feeding practices in compliance with both national and local policies, guidance and public health nursing high impact areas. There were baby feeding hubs identified across Virgin's geographical area in Devon, and this had been established through effective partnership working. The number of these facilities had expanded to cover four days per week, in various locations. This had been completed through the recruitment of "special interest" health visitors. These were health visitors, already employed by the organisation who had been trained to become consultants in this role. They offered support to families, but also to colleagues who then provided care to breastfeeding mothers. BFI champions, trained by consultants were present in teams. However, this work was completed within the health visitor's normal working week without protected time to provide this support. These health visitors told us it could be a challenge to complete this work within their normal caseload.
- We saw health visitors offering advice to new mothers in line with World Health Organisation guidelines. This was explained to them clearly with explanations of the rationale behind the guidance.
- The team leader of the New born Hearing Screening team had been supported to achieve a masters of science (MSc) module at University. This had been funded by Public Health England, with travel, expenses and accommodation funded by Virgin. This enabled her

to lead the service, with appropriate qualifications, and impart this knowledge to their dedicated team. The hearing screening team provided additional screening to babies who had not achieved clear results when routinely screened by health visitors. They also reported uptake of screening within Virgin services onto a database.

- Within the palliative care team staff followed guidance set out in the Formulary for Association of Paediatric Palliative Medicine Master formulary, the Basic Symptom Control in Paediatric Care and the British National Formulary for Children. The Formulary for Association of Paediatric Palliative Medicine Master formulary provides information on indications, routes and standardised doses for paediatric palliative medicine. The Basic Symptom Control in Paediatric Care provides comprehensive guidelines for treating a wide range of symptoms experienced by children with life-limiting or complex health conditions. The British National Children is the standard UK paediatric reference for prescribing and pharmacology, among others indications, side effects and costs of the prescription. When asked, staff were able to tell us what formulary they use and we saw copies of them within the just in case boxes in patient homes, which would be available to staff.

Pain relief

- Within the palliative care service, children and young people's pain levels were regularly assessed and appropriate pain relief was administered in a timely manner. We saw evidence in patient records that pain assessments had been carried out during visits and medication was administered accordingly. Staff told us they use a range of methods in assessing pain levels by asking children and young people with verbal communication skills to rate their pain using words and pictures. For children who were too young or unable to communicate verbally, their pain was assessed using non-verbal cues, body language and facial expressions.
- Anticipatory medications were prescribed for patients identified as requiring end of life care. We saw evidence in patient records that staff within the team had sought advice and liaised with patients' GPs and paediatricians to prescribe medications for patients when they were

Are services effective?

considered to be at end of life. Staff told us they were in regular contact with GPs and paediatricians to update them on patient conditions and discuss what medications were needed and when.

- We saw evidence of pre-emptive prescribing of pain medication along with a sliding scale, enabling nurses to increase a dose if there was a clinical need to do so.

Nutrition and hydration

- Children and young people's nutrition and hydration needs were assessed and met by the service.
- The speech and language therapy team were observed giving advice to children, young people and their parents, in regards to the importance of hydration in the protection and development of their voice.
- We saw evidence of staff using weight charts effectively in the care of children in the complex health care team. There was a clear feeding regime for a child being fed via a nasal gastric tube.
- Staff within the family support services were supporting children and young people to undertake accredited courses in order to promote the children and young people's independence with healthy eating.
- We saw evidence that a child's daily food intake was recorded in care notes as well as regular checks on weight being completed.
- Children had access to water, juice and snacks at the assessment centres. A separate fridge held food for children and temperatures were recorded. Nurses were aware of allergies of any child they were working with.
- The palliative care team ensured children and young people's needs were addressed at the earliest opportunity by making a referral to a dietician. Information relating to patient needs were recorded in advance care plans.
- Staff completed joint visits with dieticians, who worked for an external healthcare provider, if this was assessed as required to meet the child or young person's need.

Technology and telemedicine

- The organisation Virgin Care Limited were in the process of moving from a paper based system to an electronic notes system. Staff had been provided with portable electronic devices to record their electronic notes on. However, several staff reported they had experienced connectivity problems in certain parts of the locality that could make using the devices difficult at times. The

organisation was aware of these difficulties and had undertaken work and investment to try to overcome them. At the time of our inspection this was being managed through the use of a system which allowed electronic notes to be saved when the device was off-line and automatically uploaded when the device was back online. However, this system was not always reliable as we observed a patient not being able to complete a questionnaire because the device was not online.

- Staff told us the transition to mobile working had not been without difficulties, but effective workarounds had been provided in the meantime. For example, prior to the introduction of mobile working, an electronic system was already in use which held a significant amount of information about patients not available on the mobile working system. This system was continuing to be used alongside the mobile working system. At the time of our inspection, the two systems did not link together. They were however, both accessible on the devices provided to staff and information could be "dragged" between the systems. We were told that work was underway to create an interface for the two systems to communicate with each other.
- The use of mobile text messages reminders had been introduced in response to the friends and family test feedback. During a speech and language therapy assessment we observed consent being gained for this text reminder to be used.
- Within the occupational therapy department they had recently introduced skype assessment sessions to increase the number of patients that could be seen. Staff told us this also made the service more accessible for patients and their families.
- We saw the use of braille computers within school settings which children were supported to use by multi-sensory impairment staff. Microphones were also used to enhance the voices of the worker and teachers.
- Tablet computers were being used by different teams to capture feedback from young people about the service they received. We were told that the levels of feedback had increased since the introduction of the electronic system.

Patient outcomes

- Information about the outcomes of children and young people's care and treatment was routinely collected in most services. For example the speech and language

Are services effective?

therapy team were currently undertaking an audit in to the efficacy of the parent child interaction following treatment, as well as the changes in school practice following the educational workshops provided by the speech and language team to teachers. However, at the time of the inspection, managers within the specialist children's assessment teams did not use a system to measure the effectiveness of recent changes and no audits had taken place. Following the inspection we were provided with a Quality Equality Impact Assessment which was undertaken in November 2016 to assess the potential impact on families. However, the information about measuring the effectiveness of these changes were not described in this document. We were informed that there were plans for a review to take place in December 2017.

- Each service had to carry out five core audits per year. These were audits in to records, safeguarding, infection control, information governance and medicines. The results of these were benchmarked both between services and externally to other Virgin Care business units. One manager informed us they personally audited care record files on a six weekly basis.
- We saw good examples of quality outcomes for families supported by health visitors. The organisation, Virgin Care Limited frontline practitioners were being supported and encouraged to think creatively when working with families likely to disengage from services. This approach was leading to good outcomes for vulnerable children and families and developed skills and confidence in practitioners.
- We saw an example where a child who was on a "Child in Need" plan transferred to a new health visitor. The family was not engaged with services on offer. The health visitor made face to face contact with parents at nursery and quickly built a good relationship with family. At the time of our inspection the child was doing well in school, making friends and attendance was good. The health visitor used text appointment reminders to the family who then improved their engagement with services. The child was then "stepped down" from a child in need plan. This demonstrated innovative and creative working by the health visitor, who had been given the autonomy to work effectively.
- The public health nursing service had completed an audit on the use of a sepsis management leaflet provided to parents by health visitors. This leaflet had been designed by a member of the public health

nursing team, following the death of a child from sepsis. The audit showed positive results – both for the dissemination of the literature, but also for the effectiveness for parents. Ninety- Six percent of parents had found the leaflet helpful, with 16% having used the information it contained.

- The new-born hearing screening programme aimed to identify permanent childhood hearing impairment and provide intervention within the first six months of life. Screening is provided by a New born Hearing Screening team within the organisation Virgin Care Limited, where a baby has not produced a conclusive result to hearing screening carried out by a health visitor after two attempts. The service monitored screen rates and 99.7% of babies received hearing screening within five weeks of birth.
- The organisation had introduced a programme called "Let's Talk More". This was an early language screening tool being used by health visitors to assess potential problems with communication at the two and a half year check of children. The aim of this tool was to identify at the earliest opportunity, potential barriers to communication for a child and refer them to speech and language services, where necessary using a red, amber, green (RAG) rating system. An assessment of red would necessitate a referral to speech and language therapy straight away, and amber would dictate a 12 week period of intervention, prior to a referral being made if it was still needed. A green result meant no intervention was needed. This project had been running since 2014 and had started to collect data to inform and assess the impact of this project from January 2016.
- The palliative care team participated in relevant local audits and benchmarking. One such audit, completed in July and October 2016, examined the prevalence and quality of advance care plans. In order to benchmark the results, the palliative care team used three standards set by Together for Short lives; which produced standards of care for children with life limiting conditions. These were:
 1. 100% of patients, where death is anticipated within 12 months, will have documented discussions introducing the concept of advanced care planning to support decision making for end of life care.
 2. Where a recognised advanced care plan tool is used 90% will include:
 - a) Child and Parents' wishes for life;

Are services effective?

- b) Preference for place of death;
- c) Resuscitation status;
- d) Plan for Anticipated symptoms.

3. 100% of advanced care plans will be shared with relevant partners in care and reviewed within 12 months.

- In order to analyse practice, audits were undertaken in July and October 2016. In respect of the first standard, results from the July audit demonstrated 87% of patients had a recognised advance care plan document but improved by October, scoring 100%.
- In respect of the second standard, in July less than 20% of advance care plans documented the child's wishes, 100% documented the parent's wishes, preference for place of death and resus status but less than 60% included a plan for anticipated symptoms. By October results improved to 20%, 100%, 100%, 100% and 65% respectively.
- The results in July for the third standard demonstrated advance care plans had been shared with GPs and consultants 80% of the time, hospices and family 100% of the time and schools 70% of the time. Results in October were improved with advance care plans being shared with all parties 100% of the time.
- In January 2017 an action plan was developed which included a full review of staff caseloads to identify gaps in documentation, increased use of child and young person's advance care plans, including learning disability nurse input to improve methods in obtaining views from children with communication difficulties.
- Together for Short Lives is a charity for children's palliative care, who hold a national event with parents of end of life patients, hospital representatives, hospice representatives and community representatives in attendance. Feedback on best practice and key themes within end of life care are discussed after which a national report is produced. The service lead regularly attends the conference and told us the palliative care service was benchmarked against the standards set by the charity.

Competent staff

- Staff had the right qualifications, experience and knowledge to undertake their roles and were supported

to undertake further training. Staff were regularly supervised and appraised by their managers. Staff told us they were encouraged to develop their skills and share their learning with colleagues.

- New staff effectively and appropriately introduced them to the organisations culture, environment and ways of working. New members of staff we spoke with reported that the introduction had prepared them well for their role. Staff within the complex health care team would firstly have an induction and then refresher training each year. New starters within the speech and language therapy team received a 'buddy'. This buddy acted as a point of contact to provide support and advice during and beyond the staff members induction phase.
- Competencies were regularly assessed. All staff working in the immunisation team had completed their core immunisation training. This was followed by a competency assessment. Competencies were assessed by the team lead, or by the band six nurse in the team. We saw evidence of completed competency assessment documents and upon review we saw that issues were flagged and detailed feedback was provided by the team lead where appropriate. Staff were prohibited from using syringe drivers until they had passed their competency assessments
- At the time of our inspection 98.4% of staff members within the children with additional needs services and 96.3% within the public health nursing team had received an appraisal within the last 12 months. Staff we spoke with reported they received regular six monthly appraisals which they found to be useful and any training or development needs were discussed and acted on. The appraisals also used feedback from service users and colleagues regarding the care and treatment they had provided as part of this process.
- Staff reported that peer review and clinical supervision were carried out on a regular basis and provided them with a platform to self-reflect and learn from each other. Staff were provided with supervision every 4-6 weeks. In addition to this staff informed us support could be gained on an informal basis and that there was an 'open door' arrangement with the lead professional and managers. Peer supervision, which included reflection, happened on a monthly basis.

Are services effective?

- Staff reported the organisation was a good place for training and development opportunities. Specialist nursery nurses had undergone additional training in communication systems such as Makaton and the picture exchange communication system as well as baby massage. Two members of staff within the specialist children's assessment team were undertaking Level five management training. One member of staff was undertaking a health and social care qualification. Team leaders within the family support services were working towards a level five diploma.
- Poor and variable staff performance within the services were identified and managed. When reviewing employee records we saw evidence of variable performance being identified and plans had been developed to support the staff member to improve. This was done by setting a goal and then arranging dates to review progress.
- In addition to mandatory training, the organisation had a training system whereby staff were expected to complete training specific to their role. This included, for example training around supporting young people with bladder and bowel problems. Community health practitioners were well trained and supported to undertake language assessment in accordance with the "Let's Talk Now" programme.
- School nurses were encouraged to develop leadership skills through attending train the trainer workshops. These workshops train staff to deliver training to other staff so there is a cascade of learning thorough the team. This was working well and practitioners were cascading the learning to colleagues.
- Children in care champions were identified in health visitor teams. These nurses received additional training on completing routine health assessments for children in care and went on to audit the quality of the review health assessments undertaken by other health visitors in the team using a benchmarking tool. In turn, champion health visitors' assessments were audited by specialist children in care nurses. Where review health assessments had been undertaken by health visitors for other local authority looked-after children placed in Devon, none of these had been returned as being of insufficient quality. Collectively this demonstrated that clinicians carrying out these assessments were suitably supported and qualified to do so effectively.

Multi-disciplinary working and coordinated care pathways

- Multi-disciplinary working between services was aided by different services working from the same locations. Staff we spoke with reported that being based from the same building has vastly improved multi-disciplinary working as it was easier to have the clinical discussions and meetings required to improve the journey of the child.
- All staff we spoke with said that multidisciplinary working was an integral part of their work. We heard of numerous examples of multidisciplinary working between teams. For example children being seen by the occupational therapy team would have six monthly meetings where the child, family, portage, occupational therapy and speech and language therapy members would meet to review the child's therapy plan and establish the goals for the next six months. Also within the specialist children's assessment team a range of professionals, including occupational therapists, physiotherapists, specialist nurse nurses, speech and language therapists, and paediatricians worked together to ensure that the assessment of children with possible developmental delay was effective. Psychology support was less available across areas due to a lack of people in post. Where possible, psychology support was also offered.
- A single point of access system had been implemented in February 2016, this aimed to provide a central point to receive referrals for all services with the exception of public health nursing. A non-clinical team was responsible for handling the referrals. The non-clinical team had support from a multi-disciplinary clinical team to review referrals and make a clinical decision on the needs of the child or young person. Any complex cases were taken to the pathway management meetings where the referral was discussed in detail by clinical staff.
- The single point of access service was unable to evidence audit, challenge and learning to confirm referrals were handled effectively and with relevant clinician input.
- Every two weeks an Integrated Children's Services Pathway Management Meeting was held in the North and East. This involved a round table discussion, of complex cases of children and young people referrals, amongst a multidisciplinary team. We observed the



Are services effective?

discussion of four cases in the Eastern meeting, each case was presented in detail and there was participation from the multidisciplinary team, with appropriate challenge of peers, to discuss options and come to an agreement on a pathway decision.

- Multi agency case audits were completed. This involved all relevant practitioners meeting to discuss care and review good practice and areas of learning. Staff agreed this was an effective process which they found very useful, the process was child focussed and the child and their family were involved where relevant.
- There was effective work between services and external organisations. The cleft lip and palate service provided by the speech and language therapy team had close links and worked with an NHS organisation on the cleft lip and palate national pathway. This enabled them team to gain specialist management on cases and caseloads.
- We observed a multidisciplinary team meeting to discuss the treatment plans for a number of patients who were soon to be transferred to the palliative care service caseload. The attendees included the service leads, palliative staff, an oncology nurse from the local acute NHS hospital and a hospice nurse. The details of patient conditions end of life plans, family dynamics and possible deterioration was discussed between all attendees. Conversations were open and attendees challenged each other.
- Special school nurses provided a school nurse passport for children and young people when they were admitted to hospitals. This passport contained information to things clinicians must know about the child, things that are important to the child and the child's likes and dislikes.
- Locality meetings within the specialist children's assessment team were held every two weeks and included all members of the multidisciplinary team.
- Teams worked closely with colleagues within the service and the local hospital. The complex health care team advised that they worked closely with the community nursing team holding three monthly meetings with them and the discharge liaison nurse within the local hospital. Being co-located was also seen as a significant factor in the ability to work alongside the palliative care team within the service.
- Children in care specialist nurses reported good relationships with GPs across Devon. They routinely requested information from the young person's GP in

preparation for the annual children in care review health assessment and this process had been a long established practice, although GP responses varied considerably. The children in care nurses routinely arranged a telephone appointment with the GP to discuss the young person's contact with primary care in advance of the review health assessment. This had proved more effective in securing GP's input into assessments resulting in the health review being more comprehensive.

- The handover and transfer of cases from health visitors to school nurses was effective. It was routinely conducted as a face-to-face handover and commonly included a joint visit to introduce the new practitioner to the parent and child.
- Children's community nurses had good links with the children in care specialist nurse team and routinely contributed to the routine health assessments of looked-after children. This had been established practice for the 12 months prior to our inspection.
- We reviewed nine case records in the Public Health Nursing Teams and all demonstrated good liaison by health visitors and school nurses with other professionals working with individual children and families. These included midwives, perinatal mental health practitioners, social workers, nursery staff, dental practitioners and GPs.
- Children and young people approaching end of life were identified and supported to die in their preferred place. Staff within the palliative care team coordinated care between themselves and other providers by ensuring their patients' paediatrician and GP was identified at the earliest opportunity. In order to do this multidisciplinary team meetings were held as soon as it was reasonably appropriate to so. At the meeting attendees would discuss who was best placed to be the lead for the patients' end of life care. Once this was established, staff within the palliative care service contacted the lead to update them on any changes in condition, medication needs, treatment escalation plans (TEP), advance care plans (ACP) or wishes documents. A TEP, ACP or wishes document is a way of recording a patient's individual treatment plan, focusing on which treatments may or may not be most helpful for a patient when they deteriorate or are in the final months of their life.
- The palliative care team developed and used the 'Devon Care Pathway'. We saw evidence of this coordinated care pathway being used and were told by senior staff it was

Are services effective?

based upon the 'Together for short lives' care pathway. Staff told us the pathway was used when a patient referral had been accepted by the team. Staff within different teams told us they would have liked to have been involved when the care plan was developed as they thought they could have contributed valuable input.

- After a child or young person's death the team were involved with the child death review process, mortality and morbidity meetings and de-brief meetings with those involved in the patient's care and treatment.

Referral, transfer, discharge and transition

- There was a central point for referrals to be received via the single point of access referral system, this was introduced in February 2016 and therefore had been in operation for nearly one year. The aim of the system was to provide greater clarity and consistency for members of the public when contacting the service, a single referral form for clinicians, a centralised process with the same thresholds for accessing services, and to ensure all referrals were in one place. For each referral a process of gathering information across different systems was completed before the referral was screened by a clinical specialist. Following this review the referral was either accepted and placed on the waiting list, or rejected and the referrer was signposted elsewhere. This had varying levels of effectiveness across different teams. Some staff reported this had resulted in a disconnect between themselves and the families as they had no overview of where patients were in the referral process waiting list and large amounts of time were being spent chasing referrals and patients.
- Community children's nurses and school nurses reported the single point of access system worked well for them. The single point of access team had a good understanding of what the children's community nursing team offered and referrals coming to community children's nurses via the single point of access were appropriate.
- Self-referral to services was possible and information was available on the website. However, some parents told us this information was not always clear. The organisation told us self-referral rates to the single point of access had increased since advertisement on the website.
- We saw staff worked together to assess and plan ongoing care and treatment when families or children moved between teams or services. Staff were clear about the referral process and how they could advise families to access the different services that were available.
- There were delays in referrals being received and processed. We observed one referral being assessed that was received on the 30 November 2016, nearly two months prior to our inspection. The referral was not initially processed and accepted as it required an assessment by the integrated children's service northern pathway management meeting which occurred fortnightly. Following on from this it was deemed further information was required and additional screening forms needed to be sent. This meant a further delay in the referral being accepted with the time to treatment time not being started until this had been completed. This provided an inaccurate representation of the waiting times experienced by that patient and the effectiveness of the referral process.
- Staff had a good knowledge of the transitioning process from children's services to adult services but were also aware each case should be assessed on an individual basis. Young people within the family support services usually prepared for the transfer to adult care services with staff from the age of 16. We were informed of two young adults that had not been able to transition from the service as expected. This was due to the need for hard to access services not being in place from the adult social care team. The service had supported these individuals and undertook regular meetings to discuss goals the young adult had. Staff continued to support this person but felt that resources were lacking within adult services, which affected their ability to secure appropriate care.
- Children had access to appropriate support at the transition stage within the specialist children's assessment team. Nursery nurses were able to be flexible and stay involved with a child as they were moving to new settings. The service recognised this was a crucial time for the child and the support was provided to enable a smooth transition.
- The transition pathway from nursery into schools and hence into secondary school for children with special

Are services effective?

educational need/disability and specifically autistic spectrum disorder, worked well, with good relationships between SENCOs (special educational need co-ordinators) and public health nursing practitioners.

- There was no clear pathway for a referral to specialist palliative care services as there was no specialist paediatric palliative care consultant available within the Devon region. The team addressed this by obtaining advice, if needed, from a specialist paediatric palliative care consultant based in Bristol, although this consultant only worked three days per week and did not know the patients in question.
- When patients were discharged from a service into the palliative care team's care, this was done at an appropriate time of day and only done when ongoing care was in place. The palliative care team operated an out of hours service and so patients admitted at the local acute NHS hospital could be discharged into their care at any time which meant the team could accommodate patient wishes in terms of place of death. Staff coordinated with the hospital, patient GP and therapy teams to ensure the appropriate care was available upon discharge.

Access to information

- Staff did not always have access to the information they need to deliver safe and effective care. Staff used an electronic recording system, which did not interact with social care systems. The single point of access team were responsible for checking other systems and ensuring information was transferred to all systems used by the organisation, Virgin Care Limited. However, we were told of instances where flags indicating a child had a child protection plan were not raised. We also heard that single point of access referrals could sometimes be slow to be put on the system causing a delay in information being received by teams
- The immunisation team uploaded information about the vaccinations given to young people onto Virgins computer system. However, GPs in the area did not use this system, and so they were not contemporaneously aware of immunisations that had been given. This information was passed to them on a monthly basis. This created a risk to young people of professionals not being aware of their immunisation status for up to a month.
- The way in which records were stored and how available they were varied across the services. Where paper

records were still available, staff reported these were easy to access when necessary. At the time of our inspection, most staff within community young people's teams were using a mobile working system. School nurses were using paper records but this was due to change to mobile working at the beginning of February 2017. Alongside the mobile working system, was another system. This system held more substantial information about patients than the mobile working system. At the time of our inspection the two systems did not interface with each other. Therefore to get complete information about a child, staff would need to access two systems. We were told of workarounds to this issue, whereby information from one system could be "dragged" into a section of the mobile working system. This still depended on the staff member performing this action. And so complete information about a child or young person was not instantly available to staff. At the time of our inspection work was underway to create an interface that allowed the systems to talk to each other and make access to information easier.

- The palliative care team developed patient summary sheets which outlined a patient's most recent care and treatment which meant it was easy for staff to access the most up to date information quickly and easily. Patient summary sheets were uploaded to the electronic patient recording system.
- The palliative care team had access to an electronic register, on which all paediatric end of life patients in the Devon region were listed. The register was accessed by a number of healthcare services. The team was able to upload patient's treatment escalation plans, advance care plans and patient summary sheets onto the register to ensure all those checking the register were able to review the patient's/family's wishes and most recent treatment. We reviewed this register and the information available was comprehensive, clear and effective, enabling those with access to have real time information on the treatment provided.
- If palliative care service staff required specialist paediatric palliative care advice out of hours they were able to access advice 24/7 from a NHS specialist children's hospital advice line.

Consent

- Consent to care and treatment was sought in line with legislation and guidance. Staff were aware of the needs

Are services effective?

to ask for consent and for this to be appropriately recorded. Use of this guidance and compliance was monitored through a consent audit. The organisation had a clear policy and guidelines for use by staff which described how consent should be obtained and the factors to consider.

- Staff spoken with were knowledgeable about the Fraser Guidelines and Gillick competence. Fraser guidelines refer to a legal case which found that doctors and nurses are able to give contraceptive advice or treatment to under 16 year olds without parental consent. The Gillick competence is used in medical law to establish whether a child (16 years or younger) is able to consent to his or her own medical treatment without the need for parental permission or knowledge.
- We saw care plans where consent was clearly recorded. For example in the speech and language therapy service there was clear documentation of the parents' consent in regards to assessments, treatment, sharing of information with other healthcare professionals and the use and sharing of clinical photographs.
- We witnessed consent being obtained during assessments. Consent forms were clearly explained and discussed to ensure parents understood what they were consenting to.
- Staff used various communication techniques to gain consent. The special school nurses used symbols to explain to children that they required an injection and to gain consent from them if this was deemed appropriate.
- Staff were aware of what to do in situations where gaining consent was more challenging. We observed young people being asked for verbal consent on the day of their vaccinations, parental consent having been previously obtained. We discussed with the team variations on this circumstance. We were told of occasions where parents had refused consent, but young people wanting vaccinations. In this situation the team worked with parents and young people together to reach a solution. Where it could still not be resolved, Fraser guidelines were used to establish competency and subsequent actions taken accordingly. The voice of the young person was at the centre of this process.
- Good practice in 'Do not attempt cardiopulmonary resuscitation (DNACPR)' was followed in line with national guidance by the palliative care team. We reviewed a number of DNACPR and each form was completed by an appropriate clinician, decisions were clear, documented and reviewed and all documentation was available to those who needed to know.
- We saw clear consent gained from parents for special school nurses to administer medication. All medical care plans were in date with a clear review date documented.

Are services caring?

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

Summary

We rated the caring of children and young people's services as good because:

- We observed care, support and advice being delivered by a variety of staff in a compassionate and caring manner at all the locations we visited. Feedback and comments from children and families was positive about the staff they received a service from. People told us that staff took the time to explain and ensure they understood the care and treatment they were involved in providing. Patients and their families were kept informed at all times about their treatment and felt included in the decision making process.
- Families and carers were encouraged to ask questions in order to be involved with their child's care. We observed staff giving families and the children time to ask questions and discuss any concerns or feelings they were experiencing.
- Staff were helpful, kind and encouraging to patients and families, providing support whenever required.
- Staff treated and interacted with children in a way that was respectful of their emotional needs.
- The palliative care service ensured patients, parents are carers were supported by staff to gain the competencies required to manage their care at home.
- providing praise when children not only completed an activity but also when the child attempted something, this helped improve the child's confidence and engagement towards the treatment they were receiving.
- All the families and children and young people we spoke with were positive about the staff saying they were "lovely" and "nothing is too much trouble"
- Staff responded to children and parents in a compassionate way. During a home visit, one member of staff was observed engaging with a child in a caring and sensitive way. The child did not like singing and became distressed. The staff member was very aware of this and used techniques such as talking through the words of a song with the child in order to adapt the activity.
- Staff had built good relationships with children. We observed staff using short words and phrases to engage with children and getting to the child's level by sitting on the floor or kneeling. Staff were skilled in the use of sign language to communicate and engaged children in meaningful activities.
- Staff in the specialist children's assessment team felt they worked in a person centred and flexible way. The key worker role was especially felt by staff to be beneficial in supporting families and also empowering them.

Detailed findings

Compassionate care

- Children, young people and their families were treated with dignity and respect. We observed doors being shut during assessments and treatment with staff knocking and waiting before entering. Families we also spoke with told us they felt themselves and their children were treated with dignity and respect.
- We observed staff introduce themselves and their role to the children and young people and their parents /carers. They showed empathy and kindness to the children and their families.
- Staff ensured assessments and treatments were carried out in a positive encouraging way. We observed staff
- Family members informed us staff had 'excellent attitudes' within the complex healthcare team and felt the workers knew their child very well.
- We observed staff within the multi-sensory impairment team working in a holistic way with teams talking about the 'whole picture', not focusing on the clinical diagnosis of the child but working with them to achieve their own goals.
- We observed health visiting staff interacting with expectant mothers using a respectful and compassionate approach. Staff were able to discuss a range of subjects sensitively, including the mental health World Health Organisation (WHO) questions. Staff

Are services caring?

explained why the questions were asked and how these would be asked at every visit. Staff took time to explain clearly the role of the health visitor and the service and support that was provided.

- If parents needed private discussion, health visiting staff guided parents to an alternative room to maintain confidentiality. We saw staff treating mothers with kindness and compassion, taking parents' concerns seriously. They discussed any issues and provided information about where to get further guidance if it was needed.
- Health visiting staff were sensitive to the needs of families from a variety of backgrounds and supported them to engage with health services in a way they could accept. We were told of areas where there were higher rates of families of non-British origin. Staff were confident and positive about this. They talked of access to language line, for example for interpretive services, but also to the sensitivities of different ethnicities.
- We were told how staff were sensitive to young people's needs when they attended the school nurse drop in. They described treating young people with respect and explained how they would keep information confidential. They felt that their sensitive approach helped young people to discuss their issues.
- In the immunisation service, we observed young people were treated with respect and that staff were polite and helpful during conversations. Staff were clear regarding the confidentiality of the young person. We also saw lots of reassurance being offered at these sessions to young people who were nervous.

Understanding and involvement of patients and those close to them

- All staff we spoke to understood the importance of involving the children, young people and their families in their care. Staff ensured they explained each step of what they were doing, and why, to the child and the family.
- Staff tailored the way in which they communicated and spoke to the needs of the child. We observed staff using sign language to engage with children who had

communication difficulties. One parent told us, "I come across a lot of professionals but all of the team seem to know how to communicate with the parents and the young people".

- Staff involved parents and carers as partners in the care of their children. We observed staff in the specialist children's assessment team working in teams of two on initial home visits to allow one staff member to lead activities with a child and the other to explain the role of the team to a parent and to answer any questions they may have. We observed a home visit where the parent was heavily involved in the assessment process. Staff took the time to explain the purpose of the visit.
- Families and carers were involved in developing care plans for their child. We observed assessments being carried out where goals were set with the aims of the parents and the child being clearly considered and taken in to account.
- Staff were aware that the needs of the children and the support families required went beyond their clinical sessions. One parent told us, "I can't fault the Children's Community Nurses at all. ...they are amazing - the care, the quality. Even if I am having a bad day I can phone up [named worker] and have a cry. They are a big part of our life."
- Parents and families were encouraged to plan for the longer term to ensure they were prepared for any upcoming change. When this was discussed it was tailored to the individual families. One staff member said that some families need more time to get used to the upcoming changes so these are discussed earlier giving the family time to think without feeling pressured.
- Within the enabling service we saw examples of children and young people working on their own goals of establishing relationships. We were told of one young person who had developed new relationships and was much more independent because of the enabling team input. This young person had even asked the staff member to sit on another table so they could sit with friends which demonstrated the development of the young person's independence.
- One parent informed us that prior to their involvement with the specialist children's assessment team they felt

Are services caring?

that they had been 'rejected' as a parent by their child. This child was given a diagnosis of sensory processing disorder. The parent described how this had 'changed our life' as it meant they understood their child's needs.

- We saw staff giving reassurance to parents about their child's health and ensuring parents were able to access reliable information before making further decisions about their care. Staff made sure parents felt able to contact them again if they needed further support.
- We saw that school nursing staff were non-judgemental in their conversations with young people. They helped young people to understand and make their own decisions about further care.
- Palliative care service staff recognised when patients and their families/carers required additional support to understand and be involved in their care and treatment. Staff told us of a patient whose father could only speak Bengali and in order to provide support an interpreter was used during each patient interaction. In addition, staff ensured all correspondence sent to the father, relating to the patient's condition and treatment, was translated into Bengali.
- The palliative care team staff were proactive in planning, discussing and supporting children and young people in respect of transitioning into adult services. Staff told us they discuss transitioning processes with children, young people and their families/carers from the age of 14 and explain in detail what will happen, what services they will require and attend appointments to ensure smooth transfer of care. Staff supported children/young people by coordinating care, liaising with clinicians and being available to children/young people and their families throughout the process.

Emotional support

- Parents we spoke with said staff supported them emotionally. Staff were aware that emotional support during sessions extended to the needs of the parent. We observed a staff member recognising when a parent was becoming distressed. This was respected and the session adapted.
- Staff took the time to listen to parents and families. Parents we spoke with told us staff took the time to

listen to them and always provided helpful advice. Information where families could get more support was also provided, for example the availability of other support groups within the local community.

- We observed one member of staff being aware that an appointment a child had the day before was particularly intense and the parent was given time to discuss this and was reassured by the staff member.
- Staff were very aware of the need to provide emotional support to children and their families. We were given examples where meetings had been tailored to meet the needs of a parent, in order to make them accessible and effective in the interests of the child.
- Staff treated and interacted with children in a way that was respectful of their emotional needs. They recognised when a child became distressed or disengaged with an activity and adapted the activity to ensure the child did not become upset. One parent informed us, "they treat him as an individual" and, "they know how to talk to children".
- A parent told us they found the specialist nursery nurse 'very easy to talk to' and that instead of feeling overwhelmed by the amount of professionals involved the key worker contact made them feel 'very secure' in the process.
- Staff were aware of how to support children and parents who became distressed through any activities telling us they take children and young people to a quiet place if needed when out in the community or will adapt an activity if it is causing distress.
- Where requested, parents were able to ask to see the same health visitor at each contact. For parents with particular concerns or problems, we saw the reassurance this provided them, and improved the quality of their engagement.
- School nursing staff helped children and young people to express their feelings and concerns. They continued to see young people who had been referred to Child and Adolescent Mental Health Services whilst they waited to ensure the young person was supported.
- Children's community nurses provided advice and support to families about how to manage the illnesses

Are services caring?

they were living with. This included teaching them how to administer injections, manage feeding tubes etc, as well as how to be confident with this. We saw the positive impact this had on the experiences of the child.

- Health visitors routinely offered reassurance to mothers; this was embedded in the practice of all the clinicians we saw and was reinforced by the feedback from families.
- The palliative care service ensured patients, parents are carers were supported by staff to gain the competencies required to manage their care at home. Staff told us they discussed with parents/carers whether they wanted to provide aspects of care to their children themselves and assured them they would receive all the required support to enable them to do so. If parents/carers wanted to provide care then they would be trained by the palliative care nurses and their competencies to provide the care were assessed. If and only when the parent/carers displayed the required competencies they were signed off as competent.
- Staff recognised and supported the broader emotional wellbeing of people receiving end of life care, their carers and those close to them. Staff told us if patients or single parents/carers did not have family to support them they would provide all the support, advice and guidance to ensure they felt supported by the team. Staff told us they have encountered situations where single parents/carers were struggling to care for their children but they were able, through the support of the palliative care team, to obtain additional support from their child's GP and paediatrician and if necessary arrange periods of respite.
- Following a child or young person's death staff ensured parents were invited to de-brief sessions to discuss what happened with their child's care and to give them a forum to discuss any issues they felt were relevant.
- Staff also provided bereavement support to families after the child death and often sign posted them to various local charities to help with specialised support. For example, if staff were invited they would attend funerals and even assisted in planning if requested.

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 the responsiveness of children and young people's services as good because:

- The services, which the provider were commissioned to provide, were planned to meet the needs of the local population. For example, the health visiting and school nursing teams had recently moved to a hub arrangement with the aim of providing a more flexible service to local populations.
- People were treated equally and those who needed extra help to access services were supported to do so. Translation services were used to help people with language difficulties understand their options.
- Children in care were supported with their health needs and young people were given access to health support in schools.
- School nursing services, despite staff shortages were able to see new patients within a week of their referrals being submitted.
- Not all patients were receiving treatment in a timely manner, but action plans had been written and we saw a downward trend in waiting times.

However:

- Not all patients within the speech and language therapy and occupational therapy departments were receiving care and treatment in a timely manner. The speech and language therapy department had received five formal complaints all regarding waiting times in 2016.
- Waiting times did not begin until a referral had been accepted by the single point of access team. This could be a number of weeks after the referral was made and therefore waiting times information was not an accurate reflection of the actual waiting times experienced by patients.
- Complaints were managed corporately by the customer service team and therefore there was a lack of local oversight of complaints, responses were not given in a timely manner, and learning and action points were not always clear.

- Leaflets displayed in clinics for were not suitable for people with visual impairment or in an easy read format.
- Healthy Child targets for new born and six week baby checks were not being reached by the public health nursing team.

Detailed findings

Planning and delivering services which meet people's needs

- Commissioned services were planned to meet the needs of the local population. Services reflected local needs and were flexible in providing continuity of care and choice. Managers told us they were confident commissioners had a realistic grasp of the needs of the local population. We were told of positive working relationships with commissioners, punctuated with monthly meetings where challenges could be discussed.
- Staff were committed to delivering care as close to home as possible as this helped to minimise disruption for children, young people and their families. We observed staff visiting children and young people in their own home, local clinics, schools and children's centres, at times that worked best for the child or young person.
- The service ensured the child or young person's care could be maintained and continued in the community. The speech and language therapy team provided workshops for teachers educating them in vocabulary and enrichment, as well as providing additional training to those teachers working in schools with children with a high need.
- The, 'Let's talk more' service was launched in April 2014 to ensure children presenting with speech and language difficulties received assessment and intervention in a more timely way. Any child between the ages of two to three who presented with a communication problem, not including stammering, were screened by the let's talk more team and given early intervention. This included attending children centres and programmes.



Are services responsive to people's needs?

These children were then rescreened after 12 weeks and given a rating, green meant no further intervention required, amber more targeted intervention required and red patient referred to the speech and language team. Outcomes of this service had been measured since January 2016 so data was limited; however the data provided over this time showed that 75% of children had showed improved communication skills following re assessment.

- The specialist children's assessment team had recently realigned their services to be able to assess children more frequently within their own homes or other community settings rather than being centre based. We were told by staff, that this had been a difficult process for families and carers of young people as it led to some groups held at the assessment centre being disbanded. The team were looking at ways in which social support could be provided to families and had set up working groups which was open to both professionals and parents. These groups looked at pathways for referrals, assessment and intervention. At the time of the inspection, no audits had taken place in terms of assessing the outcome of the service changes.
- The health visiting teams had developed clearer pathways into their care from midwives. This had followed incidents where missed visits had been the result of poor communication between the midwife and health visiting teams. Some teams shared offices with midwives and this further strengthened the partnership working between the two groups to meet patient need.
- The health visiting service provided the nationally prescribed four levels of care including the "universal provision" and "universal partnership plus". These provide additional packages of care and support to families. The type of package was agreed between the family and the service following an assessment of needs. Each had agreed specific content and objectives.
- Health visiting staff tried to provide continuity for families where possible by allocating work to the staff member who knew the family who was requesting support. This helped health professionals to form supportive relationships with parents to benefit their child.
- Antenatal visits were undertaken routinely by health visitors and was embedded in practice. Performance on achieving the five core contacts under the Healthy Child programme was monitored closely by operational

managers through a data programme. The data programme was an electronic system which provided information in a "dashboard". This data was collated through the use of mobile working by the teams and so was provided contemporaneously. Practitioners were clear of what is expected of them in delivering the core contact visits.

- The organisations managers were taking pragmatic steps to address the significant capacity pressure in the school nurse element of the public health nursing service. School nurses had been brought together into single bases in areas where practitioners had been isolated in teams predominantly made up of health visitors.
- We saw partnership working with children's centres in the communities served by the public health nursing teams. This had often been achieved in response to feedback from local communities about how they would like services such as clinics, to be run. In more isolated areas with poor public transport links, baby groups had been established in church halls to enable families with new babies to attend and socialise. We saw that many of these clinics and groups had a social feel to them. Parents spoken with said they liked this, and it was the type of service they wanted.
- Special school nurses and children's community nurses provided care to young people in school when this was most appropriate. It also enabled them to provide training to those people caring for young people during their school day. We saw an example of support assistants being trained in how to manage a feeding tube for example.
- Many of the health visitors spoken with described the challenge of time spent travelling. Where possible and suitable, families were encouraged to attend clinics. However, we observed mother's being offered home visits if that was their preference.
- Health visitors told us they had the autonomy to arrange their visits in the ways best suited to their patients. This allowed them to be more responsive to unscheduled visits, and provide support to families who needed at the time they needed it to happen.
- The public health nursing service had restarted a "sleep clinic" offering advice and support to families. Staff spoke positively about this service, of the training they

Are services responsive to people's needs?

had received, and of the good outcomes it provided to families. Families were able to self-refer into this service, and it's provision was individualised around the needs of each family.

- When needs were not being met, it was identified and used to inform how services were planned and developed. For example, the palliative care team identified an issue with how the service managed children and young people and their families / carers who did not require regular input. Upon review it became clear that these people could go for extended periods of time with limited contact. To address this, the team adapted their practices around contacting these families, resulting in increased contacts. In another example the immunisation service ran an evening clinic for young people who were unable, for a variety of reasons to receive their vaccinations at school. This included young people who wanted to be accompanied by their parents for example.

Equality and diversity

- The organisation was aware of how language barriers could affect communication and engagement with children, young people and their families. Translation services were available to support patients who required speech or sign language translation. Both face-to-face and telephone translation services were available, and staff told us the service was easy to access. One family who did not have English as their first language had declined the use of an interpreter. We observed a pathway meeting where staff discussed options to better engage with the family and ensure their understanding, a decision was made to trial using a staff member with the same nationality from a different service to support communication.
- At the different clinic locations we visited there were disabled parking spaces available near the main entrance, and the reception desks had a lowered section for wheelchair users.
- Information leaflets had recently been established that were suitable for patients and families who were visually impaired. This included larger text, braille and a variation in colour. However, the leaflets displayed in clinics were limited to English and not suitable for people with a visual impairment.
- Staff we spoke with were aware of the ethnic and religious backgrounds of the people who used their

services and described how they ensured they were culturally sensitive. They identified areas where there were more significant numbers of families of a non-British background. This allowed them to be more responsive to the needs of this population. Health visitors said they see the antenatal visit as a valuable opportunity to help families not native to Britain understand how the NHS works and what to expect from the health service as the pregnancy progresses.

- Staff told us they took time to learn about their patients and their family's cultures, religions and beliefs and took steps to understand their needs leading up to and when at end of life. Staff spoke at length with families regarding their wishes and made every effort to ensure they were respected. Part of this process involved discussing any potential issues with coroners to avoid any delays or confusion.
- We heard of examples of where written assessments were translated into the first language of a young person's parents / carers.
- The organisation had recently introduced accessible information training as part of the mandatory training programme and all staff completed three yearly equality and diversity training as part of their mandatory training. Staff reported this had helped them ensure they provided information based on the patient's communication need.
- We observed sign language and communications boards being used to communicate effectively with children who had sensory impairments.
- Within the electronic recording system the child's ethnicity and religion was not recorded on the front sheet which held the child's details. It was recorded further on in the record but this meant a practitioner accessing the record may not be immediately aware of this important information.

Meeting the needs of people in vulnerable circumstances

- Staff were able to meet the needs of people in vulnerable circumstances. For example, the multi-sensory team were able to work with a young person who used British Sign language. This allowed the young person to take part in a play and to communicate with a worker and their mother.



Are services responsive to people's needs?

- Staff were aware of the importance of building a relationship with a child before care was undertaken. Special school nurses undertook home visits for all new starters prior to them attending school.
- One member of staff informed us of work being completed with a traveller family, which had succeeded due to the flexibility and sensitivity of the service.
- We saw numerous examples where children with disabilities were supported with communication, development and promotion of their independence. Staff were skilled in specific communication methods and could access further training if required.
- Health visitors spoke of, and demonstrated competence in working with parents with mental health issues. They used the Whooley questions in the antenatal visit and encouraged disclosure of anything making life difficult. Whooley questions are a series of questions designed to ascertain the risk of mental health difficulties, by discussing how a woman feels and the effect these feelings have. This supports the disclosure of domestic violence or domestic abuse as well as financial difficulties. Health visitors also used a "How are you?" tool to assess maternal emotional and mental health. We saw sensitive care, delivered effectively. Parents told us they felt supported by their health visitor through a difficult time.
- The public health nursing service had introduced an "Intensive Health Visiting" service to families who were identified as having an increased vulnerability. This programme was based on learning from a neighbouring service in Devon, but adapted to meet the needs of the local population. Based on the Maternal Early Childhood Sustained Home Visiting (MESCH) model, the MECSH program is a structured program of sustained nurse home visiting for families at risk of poorer maternal and child health and development outcomes. We saw an example of this in action where a vulnerable family were visited regularly by a health visitor. Feedback showed this was proving to be a positive and effective model, providing good outcomes for families.
- At the time of our inspection, there were four unaccompanied asylum seeking children (UASC) in Devon. However, Devon was scheduled to receive 100 UASC over the following three years. An unaccompanied asylum seeking children's health care pathway was in the process of being developed, but was not in use at the time we inspected.
- The team of children in care nurses had not had specific targeted training on the asylum seeking experience and how specific needs and experiences should be considered and addressed in review health assessments. The service recognised this as an area for development.
- Over the past 12 months the area-based operational performance meetings overseeing improvements in looked-after children's health service delivery have been replaced by a single, countywide operational children in care health group. This group reports to the Health Steering Group on the progress made on the delivery of the children in care health action plan. It is chaired by the local authority operational manager and, starting recently, is attended by a senior local authority manager. Managers reported this group is more effective in driving consistency of practice across the county than the previous localised operational groups.
- Case records of review health assessments undertaken by children in care nurses for school aged children and young people, demonstrated comprehensive and good quality assessments which made good use of strengths and difficulties questionnaires. They were child centred and strong on the Voice of the Child with the words of the young person quoted throughout the assessment giving a good sense of the young person as an individual. Health plans developed by the children in care nurses were achievable and effective with overarching health and wellbeing objectives accurately reflecting the health needs identified, with specific timescales for actions and accountabilities identified clearly.
- Virgin Care nationally had developed a new model of service delivery to looked-after children to ensure children and young people coming into care had good and timely access to Child and adolescent Mental Health Services support if they had identified mental health needs. All children aged three years and over on first entering the care system had an assessment of their mental health undertaken by a band four mental health

Are services responsive to people's needs?

practitioner. This mental health screening was linked to the timing of the initial health assessment and the outcome informed the development of the looked-after child health plan.

Access to the right care at the right time

- Responsibility for managing waiting times lay with managers, with the service lead having oversight of all waiting lists within the children's with additional needs services. Risks posed by long waits were discussed at monthly service managers meetings.
- Not all service users were receiving care and treatment at the right time. At the time of our inspection, within the occupational therapy department 80 people out of a waiting list of 293 had been waiting above 18 weeks, this equates to 37.6%. In the speech and language therapy department 26.9% of people were waiting above 18 weeks. However, action plans were in place to address this and there had been a consistent reduction in those patients waiting above 18 weeks month by month. Further information received in March 2017 demonstrated waiting times were reducing.
- The biggest concern for management and the staff we spoke to within the children with additional needs service was the increase in demand and referrals to services. The speech and language therapy department had seen an increase in referrals by 19% and the occupational therapy department an increase by 53%. These concerns had been recognised as a strategic priority by Commissioners with additional funding being identified to support the increase in demand.
- At the time of our inspection we found there was a patient within the speech and language department who had been waiting 80 weeks to be seen and a patient who had been waiting 38 weeks to be seen by the Specialist Children's Assessment Centre. However, action plans were in place to address these problems and mitigating actions had taken place to ensure these patients were not at risk of deteriorating. The child waiting 80 weeks was known to the service as they had received input from them previously. The service was actively involved with this patient and was managing their needs in a way which mitigated the risks caused by the wait.
- The clock start of waiting times was from the point of an accepted referral at the single point of access. We were told this was in agreement with the commissioners of the service. This was an inaccurate representation of waiting times because there was often a delay between receipt of the referral and acceptance to the waiting list. The ambition was for this process to be completed in one week, however the organisation told us they were far off achieving this and some complex referrals could be waiting up to six weeks. As a result this extra time was not considered when reviewing waiting time.
- When a child or young person was accepted on to a waiting list they received confirmation via a letter. This information from the single point of access team did not include information about the wait times and so it was unclear how long they were likely to need to wait for their appointment; this resulted in children, young people and families being left wondering when they would be seen.
- When the service was able to offer an appointment, children and young people were offered appointment times to suit them. We observed individual staff members discussing with families what appointment time and dates would be most appropriate for them and they would reschedule as needed. For example, we observed a staff member changing the next appointment to accommodate the parent taking her child to a playgroup.
- There was good monitoring of health actions identified in the health reviews of looked-after children by the children in care nurse team. The children in care nurses undertook a follow-up contact telephone call with the looked-after child and their foster carer three months after the review health assessment, to check whether health actions identified in the health plan had been completed. These follow-up calls were also identifying new health needs which had emerged since the review health assessment and these were taken forward to ensure these needs were met where required.
- Health visitors had autonomy to manage their visits and be responsive to unpredicted events. We were given an example of a call received from a new mother in distress requiring a visit. The health visitor called her patients and rearranged the times to accommodate the extra visit. She said that she was empowered to do this, by her manager.
- The health visiting teams were working to the national "Healthy Child Programme" which stipulated targets for key contacts of babies and young children. The aim of this programme is to optimise the health and wellbeing



Are services responsive to people's needs?

of children at an early age and identify risks to the same at the earliest opportunity. At the time of our inspection, the health visiting teams were performing above national averages for checks for children of one and two years. Checks for one year old children were completed in 86% of children, this increased to 90% by the age of 15 months; there were above the national averages of 73% and 82% respectively. Checks of children aged two and a half were completed in 83% of children, this was also above the national average of 74%.

- Targets for the Healthy Child Programme for babies were below the national average. New birth visits should be carried out within 14 days of birth. Data collected for the second quarter of the 2016/2017 year show a national completion rate of 88.5%. For services provided by Virgin Care Limited, this figure was below the national average at 82.6%. This performance was however, above the South West average of 81.8%. A further review should take place at between six and eight weeks of age. Virgin Care Limited performed below the national average rate of 81.9%, with a completion rate of 78.7%. This was also below the South West average of 81.8%. Managers said they were not concerned about performing at below targeted levels, because the service was on an upward trend and they were confident they would attain the required levels. The main reasons given for not achieving the targets were staff shortages and non-engagement of families.
- There were no waiting lists within the palliative care service. The standards they were required to work to were that urgent referrals were to be seen within seven days. Referrals received by the palliative care team were predominantly urgent and so patients were seen within the specified time period but staff saw many patients within the first 24 hours after the referral was accepted and allocated.
- The palliative care team had a duty system which operated geographically, with staff working in the south and east or north and west of Devon. Each palliative care nurse was paired with a children's community nurse who covered non-urgent visits, if the palliative care nurse was unavailable, to ensure patients were cared for and seen without delay.
- Parents had access to numbers for staff for support and to avoid admissions into hospital. The duty system was in operation from 9am to 3pm Monday to Friday. Parents/carers of the child were given the contact number for end of life nurse and the single point of access. If the parent/carer could not reach the palliative care nurse they contacted the single point of access and were directed to the duty nurse. The duty nurse would then put the parent/carer in touch with the applicable children's community nurse to assist. Staff told us they have been able to avoid hospital admissions as a result of the duty process. For example, parents/carers have called when their child's nasogastric line needed to be reinserted and instead of going to the hospital, visits have been prioritised to ensure a nurse has visited to re-insert the line. Senior staff told us the duty system has increased the efficiency of the end of life team.
- If a patient required more frequent visits the palliative care team could be contacted directly but this was usually anticipated and planned beforehand. However, when there was a sudden change in circumstances which now required urgent visits, the duty nurse contacted the lead nurse for that patient and arranged a visit. The lead nurse highlighted which tasks/visits in their diary they were unable to perform. These duties were recorded on a sheet and reallocated to her buddy and/or other members of the end of life team, ensuring duties were still performed, e.g. patient visits and equipment deliveries. The duty nurse also contacted the patients/families to update them on the change.
- Throughout the period from April 2015 to April 2016 five patients, who were well known to the end of life service, died expectedly. Of the five patients, three died at a local acute NHS hospital and two died at home. Of the three who died at hospital, two wished to die at home but had deteriorated suddenly and were unable to be transferred to their preferred place of death. The third had been supported by the end of life team in hospital while they died and it had been the parents wish for the child to die at hospital. Two of the five died at their preferred place of death which was at home.
- Patients had access to palliative care advice at any time of the day or night as the service operated an end of life out of hours service but this was commissioned on an individual basis. End of life children and their parents/carers could access advice and treatment from the team. Staff endeavoured to pre-empt patient needs by liaising with GPs and paediatricians to address medications, dressings and equipment needs. This

Are services responsive to people's needs?

empowered parents/carers and avoided night visits. We saw 'just in case' boxes, containing dressings, gloves, aprons and equipment, which were given to patients and their families.

Learning from complaints and concerns

- At the locations we attended, we saw information was displayed about the complaints process and how to raise a complaint or concern. There was also information available to families and carers directing them to the Patient Advice and Liaison Services.
- Staff explained how they tried to resolve issues locally if possible but would direct patients to their manager if this could not be done. The managers explained how this could resolve issues in the majority of cases but would direct people to the complaints procedure if required. As many complaints were managed informally, it meant little analysis could be made.
- Information available included how to make a complaint, how to provide feedback and recognition and support of domestic abuse
- Learning from complaints relating to the different services was recorded within the Quality and Safety report for November and December 2016. This detailed the cause of the complaint, the learning and action to be taken. Learning from complaints and concerns was shared at team meetings and via the organisation wide newsletter or website.
- Feedback from parents was varied in terms of making a complaint. Parents felt able to complain, but the response they received was mixed. We were informed about issues relating to care that were dealt with well, for example changes to a rota or asking for a specific carer to be taken off a rota. However, we were also informed of situations where parents felt that complaints were not handled effectively and they had received little feedback and support.
- Managers told us of a process whereby learning from complaints formed a standing agenda item in regular team meetings. Front line staff told us learning from complaints was shared with them.
- We saw an example where a parent had raised concern about the layout of a baby clinic, where it was felt to be dangerous due to the number of obstacles in areas of high usage. The area had been rearranged for further clinics, and staff advised to keep the area clear.
- At the time of our inspection, the organisation did not contact the complainant post final response letter to gauge complainant satisfaction. We were therefore unable to ascertain whether patients were satisfied with the way in which their complaints were managed. The organisation told us they were due to take part in a national pilot from March 2017 called 'my expectations' to gather this information.
- The complaints team was a corporate customer service team based in Surrey with no connection to the services provided. Local staff in Devon care effectiveness team who also had complaints responsibilities were only aware of complaints status from looking on the electronic system, or speaking with staff in Surrey or the individual services. They did not oversee, manage or monitor the system but offered support as requested by the staff in services. This resulted in frequently not meeting timeframes and no apparent live oversight locally.

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 for the children and young people's services as good because:

- Nationally Virgin Care had a corporate core set of values and behaviours that were promoted and known by all of the staff we spoke with.
- There was evidence of clear lines of accountability within the services we visited with a clear management structure. Staff were aware of their responsibilities and roles and who they were accountable to.
- Staff across the different teams we spoke to told us they worked within an open culture and felt confident they could discuss any issues of concern. We were told managers were approachable and responsive.
- There was a positive culture within the teams we met, with teamwork being a strong element of their work.
- There were numerous examples of staff engaging with the users of services to gain feedback and use this information to influence service development.
- We saw examples of teams and individuals engaged in improving their services and its delivery through research and sharing of learning and participating in innovative projects.

However:

- Staff told us they felt there was a lack of consultation about changes made within services.
- Public engagement was not always as effective as it could be with parents saying there was a lack of communication about changes.
- Lone working practices could be strengthened to improve the safety of staff working outside of business hours.

Detailed findings

Service vision and strategy

- The vision for the Children with additional needs services was to provide the best service with children at

the heart. The strategy to achieve this was to devise evidence based care pathways based on the changes the speech and language therapy team had already undergone. Staff were aware of the vision and the strategy to achieve it.

- Staff were aware of the corporate organisational values and said they were linked to their personal developments reviews and appraisals. However, not all staff felt involved in the construction and decision on what the values were. Some people said that these were the same as their personal values as professionals and care givers, and that they felt they held these values first.
- Teams we spoke with relied on the cascading nature of the management structure to be kept abreast of organisational developments and news. They told us this worked well, and demonstrated an awareness of corporate messages.
- Staff commented on the unknown of the future of the Virgin Devon contract and therefore felt this obscured the vision for the service. The service was in year four of a five year contract at the time of our inspection. Staff had received an email from the regional manager outlining the options for the recommissioning of services and confirming the current position that the outcome was not known.
- The specialist children's assessment team manager had a vision in place for the service based on parent partnership, goal orientated and child specific outcomes. This service was still in a period of realignment at the time of inspection.
- Managers told us of recent drives towards working more collaboratively across teams who were geographically together. The aim of this strategy was to be more flexible and responsive in their ability to provide care to local populations. In the main, the staff we spoke with told us they felt this was positive. School nursing teams in particular said their working conditions had been greatly improved by working more together. The public

Are services well-led?

health nursing service teams we spoke with, said they had been consulted with throughout the transition to new team structures. This took the form of meetings where they were informed of plans and timescales.

- The long term vision for the palliative care service was to have a specialist paediatric palliative care consultant either employed directly by the organisation or have service level agreements with a regional specialist paediatric palliative care consultant who was soon to be appointed within a local hospice. Although not commissioned to provide specialist paediatric palliative medical care and treatment, the issue had been escalated to the senior management team. At the time of our inspection there was no confirmed plan on how this vision would be achieved.
- Part of the vision for the palliative care service was to be able to develop a permanent out of hours service to their patients. The service lead informed us a business case for this had been submitted but a decision had not yet been made. The service wanted to improve planning efficiency and increase their responsiveness. At the time of our inspection the service had not been commissioned to provide a 52 week out of hours service.
- The palliative care service was working towards having nurse prescribers to start prescribing medication to children to improve responsiveness. In order to do this the service lead was undergoing further training and increasing competencies in prescribing. The operational lead was to complete a nurse prescribing course. At the time of our inspection both internal and external supervisors were being considered but had not been appointed.

Governance, risk management and quality measurement

- Risk registers were used for each service line to identify, record and manage risks. These risk registers were updated regularly through management at service level and reviewed at governance meetings. Any risks deemed to be high were further discussed at quality meetings which then fed up to higher management teams through a process of regular meetings. On review of risk registers we identified risks which had not been mitigated. On the family support services risk register, the lack of safeguarding training at the appropriate level had been identified. No actions were identified that assured this risk was lowered and actions were not dynamic. However, we saw examples of where risks identified within the public health nursing service were mitigated and communicated effectively. This included the vacancies within the school nursing service, and the lack of available BCG vaccines. This showed and awareness by management within this service of the issues faced by frontline staff, who corroborated these issues as a significant concern.
- Staff were aware of what was on their service risk register and they felt it reflected the concerns they had, for example the increase in referral rates was an area of risk.
- The performance of each service was reviewed regularly. During the monthly children with additional needs meeting, an hour was set aside each meeting to review each services up to date performance reports, including referrals, waiting times and referral to treatment times. Performance targets were established by the local commissioners.
- Staff that we spoke with were clear about their roles and the limits of their responsibilities. We saw they had sufficient support and autonomy to offer a responsive service that was flexible and met the needs of patients.
- Team leaders and managers were clear and confident in the reason for, and use of the organisations performance management policy. We were given an example where incidents had been attributed to the poor performance of an individual clinician. Through increased regularity of supervision, and the provision of additional training, the issues which had caused this poor performance were addressed and the situation remedied. This showed the policy and procedure was effective in the management and performance of staff.
- There was a systematic approach to audits within the service. Managers were confident the audits completed allowed them to have clear information about how services were performing, both in relation to comparable times, but also against similar services elsewhere in the country.
- The organisation had been working closely with its clinical commissioning groups (CCG) to provide more efficient leadership of the children in care services provided by the organisation. In partnership, the

Are services well-led?

organisation, and the CCGs had designed a more effective structure which allowed for the service to be more responsive to the needs of the children in care population it served.

- The care effectiveness lead had oversight of safeguarding reports and information through a series of governance meetings, however it was not always clear how other senior managers had oversight. The care effectiveness and safeguarding group met monthly and discussed both internal safeguarding matters and external safeguarding matters which were relevant to the organisation. This meeting fed into the quality and safety committee which we were told reviewed safeguarding, however when we reviewed minutes of this meeting for October 2016 there was no evidence of safeguarding discussions being held. The quality and safety committee fed into the senior management team meeting and on reviewing minutes for this meeting in December 2016 safeguarding training for staff was discussed but there were no details or discussions around safeguarding practice.
- A lead looked-after children's nurse post was already in place and was well established to support the named nurse post-holder when appointed.
- The service leads attended monthly heads of service meetings, following which all relevant and significant information related to clinical governance was disseminated at all team meetings. The service lead for the palliative care team also sat on the quality and safety committee and reported all updates at the heads of service meetings.
- The operational lead of the palliative care team attended bi-monthly band seven meetings and disseminated all relevant and significant clinical governance information to staff during team meetings.
- Staff within the end of life team, special school nursing and children's community nursing teams had quarterly meetings, which all staff were required to attend. During the meetings a formalised agenda was followed and minutes were taken, which were disseminated to all staff by email. We reviewed three sets of minutes and relevant areas of practice and risk were discussed.
- Palliative care team staff attended weekly meetings which followed a set agenda but was also a forum to unload and support each other as they acted, on occasion, as informal de-brief sessions. We reviewed three sets of minutes and saw discussions were relevant and detailed.
- The service lead for the palliative care team attended quarterly mortality and morbidity meetings at the local acute NHS trust and any lessons learned were shared with the palliative care team at debriefs, team meetings and one-to-one meetings which served to promote improvement and best practice.
- There were clear lines of accountability including clear responsibility for cascading information upwards to the senior management team and downwards to the clinicians and other staff on the front line. We were told by senior staff what information they provided to the various clinical governance committees in terms of care effectiveness, infection prevention control, medicines management, safeguarding, adults and children. Representatives from services sat on the care effectiveness, infection prevention control and medicines management clinical governance groups and fed information back to staff at team meetings.
- We saw effective use of regular meetings as a means of governance of services. Meetings at all levels were held regularly; monthly team meetings, six weekly service lead meetings and management meetings that were held either monthly or six weekly. We reviewed minutes of these meetings and found that the subjects discussed were relevant, and provided for the efficient sharing of information about a variety of topics. Staff told us that these meetings allowed them to be aware of what was happening in the organisation, outside of the teams in which they worked.
- When new policies were introduced they were discussed at team meetings and shared by weekly newsletter and emails. Important and significant issues shared by email were red flagged and marked as important. Staff told us they read flagged emails as soon as possible.
- There were effective arrangements in place to ensure the information used to monitor and manage quality and performance was accurate, valid, reliable, timely and relevant. The services all submitted key performance indicator data monthly to the board and commissioners, which included their referral to treatment times, whether a lead professional had been

Are services well-led?

identified for each of their patients and what was delivered to patients and at what cost. A combined monthly newsletter contained information regarding changes to governance practices and policies as well as sharing incidents from other healthcare providers including advice on how to avoid or reduce the risk of the incident occurring. There were also training opportunities advertised with the details of the training, dates and location included. Alerts regarding training updates were included.

Leadership of this service

- Staff informed us leaders were visible and approachable. Staff said they were respected and valued by their managers and they were always approachable and encouraged them to develop ideas.
- Leaders were kept up to date with information about the current issues faced by their teams. For example, information was provided to the children with additional needs team lead from individual teams. This information included work pressures, safeguarding concerns, waiting times and any other critical information regarding the staff and teams.
- Staff felt well connected to local level management but not necessarily to the corporate level leaders. Staff described managers as being visible and available. Staff spoke of managers being open to challenge and could affect change if necessary.
- One member of staff informed us they were supported through a period of ill health and felt that the manager was compassionate at this time.
- Family members stated they felt managers took the time to recruit the right people for the job.
- One parent informed us that one manager in particular was 'passionate' and that you 'could not find someone who is more committed to children'.
- One staff member told us how a concern over a colleague's performance was escalated to their manager and dealt with appropriately.
- Leadership and management arrangements in the organisation for the operational specialist children in care nurse team were being strengthened through the recruitment of a dedicated full-time named children in care nurse post as operational manager of the service.

Monitoring and governance arrangements between the organisation as the provider of the children in care nurse team with the clinical commissioning group (CCG) had been clarified through the creation of a discrete designated children in care nurse sited in the CCG.

- Managers and team leaders we spoke with had many years of clinical experience prior to their appointment to management roles. Staff told us this gave them confidence their leaders understood their pressures, and they had the necessary skills to manage services.
- Recent drives towards hub working meant team leaders shared the leadership of some teams, providing cover through leave and an increased management presence to their teams. Staff confirmed they had good access to their managers.
- The palliative care service lead encouraged appreciative and supportive relationships among staff. After difficult experiences where a child or young person had died, debrief sessions were held where all those involved in the event were in attendance. Staff supported each other and gave feedback on what was done well and what could be improved. We observed staff comforting and praising each other on their practice and reviewing what was done well and acknowledging how difficult the situation was. They empathised with each other and shared similar experiences to help each other.

Culture within this service

- The culture centred on the needs and experiences of people who used the services. All staff we spoke with mentioned patient care was at the forefront of their focus. One staff member said 'I enjoy the reward of being a small part of a child's life and to support the family'.
- Staff we spoke with told us there was an open culture where patient care was at the forefront of everything they did. They said managers were approachable and they felt listened to and not judged.
- Staff explained there was a no blame culture where incidents were seen as a means to learn and improve clinical practice.
- Each service we spoke with reported a strong ethos of teamwork and teams worked together for the benefit of

Are services well-led?

the child or young person. All staff spoke highly of their colleagues and the work they undertook. Staff reported they felt proud of the teams they worked in and the relationships they had with other teams.

- There was a lone working policy available for staff on the intranet and staff were supported by lone working procedures which varied depending upon the service. The policy described the actions staff should take to mitigate the risks of working alone. Most staff told us they were familiar with this policy.
- Some teams used a board in their office where information regarding their working hours was kept along with the name of their buddy. The 'buddy system' involved the staff member on the visit contacting a colleague once they had left the premises of a family home. However, due to the remoteness of some areas that were visited, phone signal was limited and the lone working policy could not always be followed.
- The introduction of mobile working meant colleagues based in offices or hubs could identify where a staff member should be at any given time. In addition, there were practices in place such as positioning cars so they could be driven away quickly if needed that were embedded within the services we saw.
- Within the occupational therapy teams there was a set 'danger word' that staff would use to discreetly request support or help over the phone whilst undertaking a home visit.
- There was a process to support staff lone working within the complex healthcare team. It did however, rely on the cooperation of families to be truly effective. Staff within this service were aware of processes to follow to remain safe, but were not always following these in the same way. Health care assistants within the complex healthcare had access to mobile phones that were kept within the home of the family they were visiting. Staff were advised to keep their own mobile phones on them at all times because of potential issues with signal of mobile phones. The team worked overnight and there was out of hours support from the family support services manager, for them to call upon if there was a concern. Families being supported by this team, were provided with information at the start of their child's service which explained to them the expectation of them in certain situations. This included that they would contact the on call manager if a staff member did not arrive for a shift. There was a qualified nurse on duty Monday to Friday between 9am and 5pm. A rota team had recently been disbanded and staff therefore had to call a parent directly if they were sick and unable to attend their shift. The on call manager did not have authorisation to allocate staff, and so in this instance the issue would be escalated to a member of the senior management team on call. This manager had access to rotas and the authority to arrange agency staffing if needed. Staff stated this generally worked well, although there had been complaints raised by family members.
- At the time of our inspection staff were trialling an electronic device which tracked staff location and operated as an alarm system. It had not been decided whether the devices would be implemented on a long term basis. This information was being evaluated at the time of our visit.
- The electronic patient record system used a flag system to identify any concerns with individual families, which could put staff at risk when visiting. However, not all members of staff used the same computer system which meant not all staff would be aware if an alert had been placed. Staff told us if they had any concerns about a child or their family, they would not visit alone. Instead, they would try to get the child and family to attend a clinic, or if this were not possible, they would visit with a colleague.
- There were various schemes to recognise staff achievements and good work. This included shout outs on the weekly newsletter, the sending of thank you emails and cards and the, 'star of the year, awards where staff could be nominated by their peers.
- Management spoke strongly about how well their teams worked together and were incredibly proud of the culture and the support that had been established. For example, one manager we spoke with stated their team always wanted to do things better and strived to achieve this. One manager informed us they were 'in awe of their staff.
- From talking to staff across different teams the culture appeared supportive and staff were positive about working for the organisation. However, the biggest challenges and pressures included IT, geography, staffing and caseloads.
- There was however, a feeling of low morale in services where there had been substantial changes. Some staff

Are services well-led?

felt there had been a lot of change and that they did not feel consulted about these changes. Some staff felt decisions had already been made, and consultation constituted a meeting where they were informed of this change. Managers informed us changes were communicated to staff via team meetings and development days.

- We saw evidence of individual risk assessments for visits to patient homes where lone visits presented varying degrees of risk. As part of the risk assessment measures had been put in place to mitigate the risk, for example the provision of joint working, restricting the length of visits and code words for communicating with buddy members of staff.
- Staff received psychological support from a psychologist once every three months to assist with their wellbeing. There were varying feelings on whether this was enough, with some staff stating they felt they had enough psychological support and others feeling that more would be helpful.
- Staff felt respected and valued. They told us they felt proud to work for their services and wanted to maintain the high performance of the team and where possible, improve the service for their patients.

Public engagement

- Changes to the service had been made based on feedback from children, young people and their families. Within locations, there were posters containing, 'you said, we did' outcomes.
- The provider had provided various ways for the public to be engaged. This included focus groups, parent/carer voice meetings and parent/carer feedback events. The provider recognised that the take up of these events was something they had struggled with.
- The occupational therapy team sent forms asking for parent's feedback regarding the care their child had received. The responses were then collated and fed back to the teams providing areas for praise and improvement.
- We saw mobile devices being used effectively to capture feedback from parents. A friends and family test application was used which was described as 'very

straightforward' and was used on the last visit made by staff from the specialist children's assessment team to gain feedback. Feedback from the friends and family test were discussed at team development days.

- The specialist children's assessment team recognised that the disbanding of children's centre groups was a loss for parents and were in the process of setting up a parent participation group to discuss the changes. A questionnaire was being developed for parents and it was hoped a sample of 100 parents would be undertaken to establish their viewpoints.
- Family support services produced newsletters for parents, children and young people. Initial feedback suggested the letter had been received positively. Staff have stated they would like children and young people involved in taking charge of this newsletter in the future and were making plans for this.
- As part of a recent recruitment process for appointing nurses, parents and children were part of the interview panel. The feedback provided by the panels influenced who the service appointed as the service wanted to employ nurses who demonstrated qualities important to service users.
- Children and young people were involved in the training of staff. For example in the family support service, one young person was working with their psychologist to develop autism training to deliver to workers.
- The organisation talked about a participation user group, however this group did not have any children or young people or their parents in it, and they had not been involved in forming the group and its focus. It was hoped in the future children and young people would sit on this group to provide an active user voice.
- Graffiti walls were used at locations to obtain feedback from children and young people. At the end of each school term this information was captured and the white board cleared, and the graffiti started again.
- Leaders did not engage with the families of people the service supported. We were given examples whereby frontline staff were responsible for communicating changes to services directly with parents. Staff told us this was difficult for them and it would have been more appropriate for leaders to deliver this message.

Are services well-led?

- Parents gave us examples where changes had been communicated by letter, without any further communication from the service. Parents told us they did not feel consulted about these changes, and they were only informed once decisions had been made.
- Managers of services told us they were aware that public engagement was an area that they needed to improve.

Staff engagement

- All staff attended a monthly team meeting as well as twice-yearly development days. This ensured staff received regular messages with updates, and learning from incidents and complaints. Staff also told us they were kept up to date through the provider intranet site, 'Jam' and the weekly provider newsletter in addition to a manager's newsletter which was sent monthly.
- Staff we spoke with reported there had been a lot of development of the services they provided. However, the level of changes they were undergoing meant they felt there was not enough time for one aspect of change to fully be implemented before the next one was taken.
- Staff we spoke with felt informed when decisions were made but were not always informed about the reason for the decision or involved in the decision making process. This includes the ongoing changes to the single point of access system.
- Staff had the opportunity to increase their knowledge and skills. One staff member said, "we have good autonomy to grow whilst being managed well".
- Staff in certain teams informed us they would prefer to have a 'base office' so they could have more contact with other colleagues as their roles meant they were isolated in the community.
- Staff within the specialist children's assessment teams were involved in developing the referral and assessment pathways for the service via a professional advisory group. However, this group commenced once changes to the service had already been made so some members of staff felt this was not timely.
- Staff said the organisation 'looks at people on grass roots and drives innovation', locally they are 'still willing to change things'.
- Staff forums were in place for local managers and clinical leads; however these forums were not inclusive of staff below band seven.
- Staff in the public health nursing teams told us they felt confident to raise issues and concerns and that these would be taken seriously by their managers. Some did report feeling disconnected from managers at higher levels as they felt they were not visible. Staff said they felt confident their line managers ensured their views were communicated to higher level management.
- Following the most recent staff survey prior to our inspection, an action plan was written that identified the actions to be taken in response to the points raised. This plan was written in January 2017, and so we were not able to see whether these actions were completed or not. We were not told of this action plan by the staff that we spoke with, so we were not able to confirm how effectively this plan had been communicated with staff.

Innovation, improvement and sustainability

- Staff were able to bid for money from a Virgin innovation fund. This was a national fund of one hundred thousand pounds which was available for staff members to submit bids to achieve funding for service level projects. Staff had access to previous winning bids to learn from and increase the chances of achieving funding.
- We were given examples of how innovative practices were encouraged to improve the quality of care offered. For example a health visitor spoke of being facilitated to attend training that encouraged the bonding experience of babies and parents. However, they also spoke of frustrations at not having enough time in their working day to use what they had learned as effectively as they would like.
- The palliative care team were awarded the award nationally for excellence in commitment and dedication in demonstrating and practicing the six Cs (care, compassion, courage, communication, commitment and competence) from Virgin Care in 2015. The team were also awarded with the team of the year the same year, at an organisational level.
- Information was used proactively to improve care. A recently introduced programme could be used by the palliative care team to assess referral to treatment times

Are services well-led?

and other key performance indicators electronically. The team planned to introduce clinical information into the system so they could look at whether patients had advance care plans and treatment escalation plans.

- The public health nursing service, in partnership with the local authority were working to a plan called “Best start in life and Beyond”, a project aimed at improving

health outcomes for children, young people and families in Devon. The aim of this programme was to ensure that all children in Devon, received the full “Health Child” programme, from age 0 – 19. Within The organisation this work was being led by the head of the public health nursing service.