

Virgin Care Limited

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Community health services for children, young people and families	Capital Court	1-673822558
	Lescaze Court	1-673933279
	Springfield Court	1-673142083
Specialist community mental health services for children and young people	Capital Court	1-673822558
	Lescaze Court	1-673933279
	Springfield Court	1-673142083

This report describes our judgement of the quality of care at this provider. It 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.






Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider

Good 

Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Requires improvement 
Are services well-led?	Good 

Summary of findings

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Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection of Virgin Care Limited between the 16 – 19 January 2017 with a further visit on 1 February 2017 for an arranged focus group in the unannounced period.

Virgin Care Limited provides integrated children's services in Devon under Community health services for children, young people and families core service, and specialist community mental health services for children and young people core service.

During our inspection we visited the following registered locations:

Capital Court, Lescaze Court and Springfield Court.

We rated Virgin Care Limited as good overall.

Our key findings were as follows:

- 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 and reasonable adjustments to be made. Staff demonstrated their knowledge and skills around consent consistently. We saw 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.
- Caseloads were monitored through regular caseload supervision and job planning.
- Teams worked together to support each other and allocation of new patients was agreed jointly with staff and managers depending on staff capacity at the time.
- Staff offered psychological therapies and support as recommended by National Institute for Clinical and Health Care Excellence.
- Teams had good working links with primary care, paediatric services, social services and other teams external to the organisation.
- Young people participated actively in their care and there were opportunities to be part of the service development.
- The eating disorder and assertive outreach work had reduced length of stay and inpatient admissions to tier four psychiatric inpatient services.

However:

Summary of findings

- 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 targets 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 (IPC) processes were not followed by all staff. We saw examples of poor IPC practice.
 - There were differences in staff awareness of what should be reported as an incident and there were examples where reporting and learning was not always shared across services.
 - Care and treatment was not always received in a timely manner, particularly for therapy where some children exceeded the aim of an 18 week referral to treatment time. However, waiting times were reducing. Families and young people felt isolated and frustrated whilst waiting to be seen and resulted in complaints being received by the provider.
 - Turnover was high in some areas, and some posts were difficult to recruit to, such as psychology.
 - There were concerns with the safety of the environment at Evergreen house. With no alarms and security for staff and areas which had a low standard of cleanliness.
 - The learning disabilities services did not always have risk assessments in place for children and young people.
 - There was variability in recording consent in the learning disabilities and assertive outreach teams.
 - There were long waiting times from referral to assessment in the autistic spectrum conditions diagnostic pathway and for internal waiting times for treatment across CAMHS services. Shortages in psychology provision were affecting these waiting times for children and young people. However, waiting times were improving despite increased referrals.
 - The learning disabilities team did not have access to the same electronic records system as the rest of the service and systems did not interface to enable information to be shared.
 - Some families described difficulties with communications once they were in the system.
 - There was limited local oversight of the management of complaints and concerns. Complaints were not always responded to in a timely manner and learning and action points were not always clear.
 - Lone working procedures were not consistently implemented across all services to ensure the safety of staff.
 - The requirements under Fit and Proper Persons were not completed in full for director level staff.
- We saw several areas of outstanding practice including:
- 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 Virgin Care Limited.
 - 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.

Summary of findings

- The eating disorder pathway model was developed in collaboration with consultant paediatricians and had been successful in reducing the need for tier 4 inpatient beds. The pathway had been recognised as national good practice by NHS England and published in the British Medical Journal in May 2016. This pathway was embedded in Exeter and East Devon and had been rolled out across the county.
- The Devon wide assertive outreach team provided intensive community CAMHS support. Since this service was in place the number of children admitted to inpatient services had significantly reduced. The team was shortlisted for a health service journal 'value in health care' award in January 2017 in recognition of their work.
- The palliative care team assisted with planning of patient funerals at the request of patient families. The culture within the team encouraged staff to openly support and challenge each other.

However, there were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Reduce waiting times from referral to assessment in the autistic spectrum conditions diagnostic pathway and for internal waiting times for treatment across all services.
- Ensure that all patient areas are clean and well maintained.
- Ensure there are alarms and security for staff in community buildings.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of services.

Are services safe?

We rated the organisation as good for safe 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.
- There were not always robust systems in place that assured the communication of important information about children.
- The environment and facilities we visited at Evergreen were not always clean and well maintained.
- 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.
- Turnover was high in some areas, and some posts were difficult to recruit to such as, psychology.

Good



Are services effective?

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

Good



Summary of findings

- 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.
- Services demonstrated that they improved patient outcomes.
- Consent to care and treatment was sought in line with legislation and guidance.
- 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 / carers of the skills of their carers.

However:

- Consent was not always clearly recorded.
- 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.
- The “Let’s Talk More” project, which had been introduced to improve outcomes for two to three years old with a speech difficulty, had only just begun to collect data on outcomes despite having been running since 2014.

Are services caring?

We rated the organisation as good for caring 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.
- 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 or carers were supported by staff to gain the competencies required to manage their care at home

Good



Summary of findings

However:

- Patients and their families were not always kept informed about their treatment pathway and waiting times to access services.

Are services responsive to people's needs?

We rated the responsiveness of children and young people's services as requires improvement because:

- Not all patients were receiving care and treatment in a timely manner, this was the case across physical and mental health services. The speech and language therapy department had received five formal complaints all regarding waiting times in 2016. Healthy Child targets for new born and six week baby checks were not being met by the public health nursing team.
- 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.
- It was difficult for the local care effectiveness team to have oversight of complaints about services, as these were managed away from the area. Complaints were not responded to in a timely way.
- Leaflets displayed in clinics were not suitable for people with visual impairment and did not include easy read format.
- Complaints were not always responded to in a timely manner and learning and action points were not always clear.

However:

- The services, which the provider were commissioned to provide, were planned to meet the needs of the local population.
- 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.
- Waiting times were reducing in some services which had seen an increase in demand.
- School nursing services, despite staff shortages were able to see new patients within a week of their referrals being submitted.

Requires improvement



Summary of findings

Are services well-led?

We rated well-led for the children and young people's services as good because:

- 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. Teams had been nominated and received awards for their work.

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.
- The requirements for fit and proper person checks were not clearly demonstrated, however these were undertaken quickly when raised with the organisation.
- The service had not undertaken a Workforce Race Equality Scheme assessment did not understand the profile of its workforce or implement actions to improve equality.

Good



Summary of findings

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 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.

Information about the provider

Virgin Care Limited is a private healthcare organisation who provides integrated children's services, under a

contract with the NHS, across the county of Devon excluding Torbay and Plymouth. Virgin Care Limited was

Summary of findings

formed in 2013 and is known locally as Devon Integrated Children's Services (ICS), Virgin Care. The organisation is in the fourth year of a five year contract and employs around 1000 staff.

It serves a population of children and young people and their families and provides the following core services:

- Community health services for children, young people and families
- Specialist community mental health services for children and young people.

Virgin Care Limited has three registered locations, Capital Court, Lescaze Court, and Springfield Court. It provides services including public health nursing, specialist children's community services, and children with additional needs services, mental health and wellbeing services, and family support services. Virgin Care Limited delivers services in children and young people's homes and their local community, health centres, clinics, schools and residential homes.

What people who use the provider's services say

We received feedback from people who used the services provided by Virgin Care Limited. 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.

- Staff and professionals listened to what people had to say and were helpful in identifying specific needs.
- People said they felt children and young people were safe. Parents said the behaviour and actions of their children were evidence of this.
- Care was co-ordinated with other professionals and services.

- The palliative care team undertook a bereavement survey, the results of which were collated in October 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.
- Staff were supportive and had the necessary skills to deliver compassionate care which reduced the concerns of families during palliative care.
- Some people were concerned about continuity of care and the impact that this has.
- Waiting times were frustrating and caused concern for parents.

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 of 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.
- The Devon wide assertive outreach team provided intensive community CAMHS support. Since this service was in place the number of children admitted

to inpatient services had significantly reduced. The team was shortlisted for a health service journal 'value in health care' award in January 2017 in recognition of their work.

- The eating disorder pathway model was developed in collaboration with consultant paediatricians and had been successful in reducing the need for tier four inpatient beds. The pathway had been recognised as national good practice by NHS England and published in the British Medical Journal in May 2016. This pathway was embedded in Exeter and East Devon and had been rolled out across the county.

Summary of findings

- 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.
- 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 palliative Care team assisted with planning of patient funerals at the request of patient families. The culture within the team encouraged staff to openly support and challenge each other.

Areas for improvement

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

Action the provider **MUST** take to improve

- Ensure that all patient areas are clean and well maintained.
- Ensure there are alarms and security for staff in community buildings.
- Ensure waiting times are reduced from referral to assessment in the autistic spectrum conditions diagnostic pathway and for internal waiting times for treatment across all services.

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.
- The provider should share learning from incidents across all the services and ensure the learning is embedded.
- 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 of 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.
- The provider should ensure all services are fully staffed.
- The provider should ensure patient risk assessments are completed and regularly reviewed.
- The provider should ensure individual caseloads do not exceed the limits agreed in teams and on job plans.
- The provider should ensure consent to treatment is recorded consistently across all services
- The provider should ensure children and young people are offered a copy of their care plan.
- 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.

Summary of findings

- 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.
- Ensure the requirements under the Fit and Proper Persons are completed for director level staff.

Virgin Care Limited

Detailed findings

Good 

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We rated the organisation as good for safe 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.
- There were not always robust systems in place that assured the communication of important information about children.
- The environment and facilities we visited were not always clean and well maintained.
- 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.
- Turnover was high in some areas, and some posts were difficult to recruit to such as, psychology.

Our findings

Incident reporting, learning and improvement

- There was a good culture of incident reporting through the organisation however incident reporting was not always fully embedded in every team. Senior managers we spoke with told us staff were encouraged to report incidents and that each incident was managed locally



Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

within the relevant service. Some services we visited were not clear on what to report as an incident felt in their departments there was not a good culture of reporting.

- Staff had access to a web form to report incidents, this automatically populated the Virgin Care Limited's incident reporting system. The incident reporting system was managed by members of the care effectiveness team from the Capital Court location where the head of care effectiveness and the senior management team were located.
- Incidents were investigated by a manager in the service where they had occurred, or an alternative manager when this was not appropriate. The care effectiveness team showed us that whoever was responsible for investigating the incidents was clearly identified on the incident reporting system. Full investigations and outcomes of incidents were held locally by the service manager and we saw examples of completed investigations within services. The care effectiveness team ensured that an overview of the investigation and outcome was updated on the incident reporting system. If incidents were serious in nature then full details of the investigation, outcome, and communication to the child, young person and their family was held centrally by the care effectiveness team.
- Two serious incidents had happened during the period January 2016 to January 2017 and were associated with the CAMHS team. We reviewed these incidents and discussed with the head of service and the care effectiveness lead the investigations which were happening, the actions which had been taken, and the learning which had taken place. The head of service and care effectiveness lead were clear on their responsibilities and discussed how they were working with appropriate external organisations to learn and share information.
- 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 Quality Surveillance groups.
- Learning from incidents resulted in changes in practice. We saw multiple examples of learning and changes to practice including: a team who introduced a new storage system for equipment for all children cared for by the team, a change in the delivery of vaccines for the immunisation team, changes in practice in contacting children, young people and their families with information on their appointment, and changes in practice for risk assessments and care plan monitoring. However, in the learning disabilities service we found that there was lack of risk assessment planning and monitoring which indicated learning had not been shared, and in the autistic spectrum assessment team some staff had changed premises to ensure there were panic alarms available, but other teams continued to have no access to panic alarms.
- The senior management team had oversight of incidents as they were reported, and overview information of incident numbers, incident trends, and areas of concern. The incident reporting system alerted the appropriate member of the senior management team as soon as the incident was reported. It was the job of the quality and safeguarding group to review incident numbers, trends, severity, and learning monthly and this role was clearly defined in their terms of reference.
- Incident numbers, trends, severity and learning was reviewed by the quality and safety group which consisted of the senior managers in the organisation. However documentation of discussions around incidents by the senior management team were not comprehensive. We reviewed a comparison report for incidents for the service which presented a yearly overview between 2015 and 2016 of incidents for the whole service by month, type, severity, and for the top 20 reporting teams. We reviewed the quality and safety minutes for October 2017 and found under the heading, 'incident update – risk register' there was information around risk but no information on incidents.

Duty of candour

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

- The provider was meeting the requirements for private healthcare providers relating to duty of candour. 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 the organisation 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 within specific notifiable incidents.
 - Virgin Care had an up to date duty of candour policy which informed staff what duty of candour was, when it should be applied, what the requirements of duty of candour were for private healthcare organisations, and the steps which should be taken and by who when applying duty of candour.
 - Managers we spoke to had a clear understanding of duty of candour and their responsibilities in relation to this regulation. During the period January 2016 – January 2017 we were told there had been no incidents which had been classified as a notifiable safety incident and therefore needed duty of candour to be applied. We reviewed all incidents reported between the same timeframe, which confirmed this was the case.
 - Alongside duty of candour, the principles of, 'being open' were included in the duty of candour policy to encourage staff to be open and honest and say sorry if things went wrong but did not meet the duty of candour threshold. There was a staff guide available to help them, 'say sorry' and an overview of the actions taken to be open and apologise to children, young people and their families was included on the incident reporting system.
- Safeguarding**
- 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.
 - Virgin Care Limited had a safeguarding lead (level four trained) who was available as a point of contact for staff. In addition the organisation had an associate named nurse, a national named doctor for safeguarding, and four specialist safeguarding nurses based in Devon; all of whom were available to staff for support. The head of operations was the accountable person for safeguarding in Devon.
 - Staff understood their responsibility to report safeguarding concerns and adhered to local policies and procedures. Staff throughout the organisation demonstrated a sound knowledge of safeguarding procedures and multiagency working with social services. There was evidence in the public health nursing team where a member of staff had made appropriate referrals to the local multi-agency safeguarding hub (MASH). We heard from a number of staff within the organisation about safeguarding practice and there was a clear understanding of their responsibility to safeguard throughout all levels of staff.
 - Staff were supported by the organisation with complex safeguarding cases. Staff told us about safeguarding supervision they received every six weeks and we reviewed the minutes of safeguarding best practice meeting which demonstrated discussion of safeguarding issues and joint decision making and actions to consider.
 - 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 document. Staff had access to safeguarding staff at the local authority to help them make the best decisions regarding safeguard and promote the welfare of children and young people. We were told there had been an increase in early help, providing support as soon as a problem emerges, identified across Devon.

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

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.

- Virgin Care Limited participated in, learned from, and undertook actions from safeguarding reviews and serious case reviews. Managers told us about four current serious case reviews which the organisation were involved with as part of the investigation process. In response to a serious case review a timeline of events is produced alongside an internal investigation which then results in a detailed account of organisations involvement. We were told about previous serious case review learning; one of which had resulted in a change of practice, and a further case which resulted in child risk alerts being managed through the single point of access (SPA) to ensure the information was available to all appropriate staff.
- 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 number of other safeguarding groups linked into The organisation's meeting framework to ensure there was shared investigations, actions, and learning from safeguarding. The Devon Safeguarding Children's board was attended by a senior member of the virgin team, and there was a national Virgin safeguarding meeting held quarterly which the safeguarding lead for Devon attended with details of the safeguarding exception report for Devon.
- There were not always robust systems in place that assured the communication of important safeguarding

information about specific children. Children who may be subject to a child protection plan had this information flagged on their record within the electronic reporting system. However, staff using this system were dependent on staff within Single Point of Access finding this information on a system used by social care teams, and placing this manually onto the system. We were told of examples of when this information had not been passed on appropriately so information was not always shared.

- There was misidentification of child protection plans on the electronic recording system. These were labelled social worker plans, by administrators entering this information onto the system, from data provided by the local authority. This was a generic term covering all children on any type of safeguarding plan, as opposed to a specific child protection plan which carried with it specific management requirements. As a result of this lack of accurate identification, this key information that should be guiding day to day practice with the child, was not easily accessible to practitioners and managers. This increased the risk key actions and risk management would not be effectively carried out by the practitioner.
- There was not a robust system for identifying children who had safeguarding alerts on their records. There was variability in recording the safeguarding alert in the electronic record and there was not specific information on what level of safeguarding the child was subject to. The system was unable to provide managers with an overview of how many children were in each service and how many children The organisation had in Devon overall.

Medicines management

- 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.

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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.
- 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 Children's Homes, 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 and was attended by the SLA pharmacists. Medicine incidents and adverse events, were reviewed along with reviews of National Institute for Health and Care 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. As staff were not recording the temperatures the policy was not being followed. All

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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 further actions were taken to mitigate the risk.

- 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.

Safety of equipment and facilities

- Equipment was observed to be fit for purpose and supported safe care and treatment. Equipment was available for staff when needed and maintained in good working order. 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.
- Staff told us 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 an appropriate supplies would be placed. With the parents' consent, appropriate equipment and stock were kept in patient homes.
- The environment in some community clinics was not always appropriate however this was identified and managed. The public health nursing service provided

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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.

- Health and safety audits of buildings where CAMHS and learning disabilities services were delivered assessed risks including obvious ligature risks, such as blind and pull cords. Actions had been taken from these audits to minimise the risks, for example, the blinds at Lescaze Court in Dartington had all been replaced.
- Where services were delivered from premises, these were mostly secure and maintained the safety of children and young people using the service. We visited four community premises which provided CAMHS and learning disabilities services in Dartington, Barnstaple and two sites in Exeter. Access to entrances and exits were monitored by reception staff through the use of cameras and closed circuit television (CCTV). Most premises had alarms in the interview rooms and main treatment areas however, Evergreen House did not have any alarms in the building so staff were unable to raise an alarm and there was no guarantee that other staff would know if they were in difficulty.
- The environment and facilities we visited were mostly 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 were in place had been completed, this was in line with organisation's toy cleaning policy. Cleaning schedules were not consistently in place for some CAMHS and learning disabilities services and some areas at Evergreen House were not visually clean, this was raised at the time of our inspection and prompt action taken to improve the environment.
- The environment at Evergreen house, was not well maintained and posed a risk to staff and children, young people and their families. We observed a missing cover from a water pipe in the coach house meeting and interview room and loose wires on the landing.

Records management

- Records were written and managed in a way that kept people safe and protected confidentiality however some services did not demonstrate this all of the time. We saw evidence of when records were regularly audited and where required, improvements made.
- We looked at a sample of 30 records across the full range of services for children and young people. We reviewed 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.
- We looked at 26 records for children receiving treatment under CAMHS and learning disabilities. With the exception of the learning disabilities and autistic spectrum assessment service risk.
- Records were audited annually as part of an ongoing programme. Audits that we viewed showed generally good compliance with overarching principles of access 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.
- 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



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and had a good understanding of data protection and confidentiality requirements. However, we saw some incidences of 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 was recorded electronically.
- The information governance (IG) lead told us about their role in working with teams to ensure information was managed safely during the transition from paper to electronic records. The IG lead was monitoring incidents which occurred due to the transition of records and worked directly with services to make improvements. We were told about training which was being delivered by the IG lead and the health and safety lead to increase skills and knowledge associated with the new electronic systems and paperless ways of working.
- 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 and infection control

- Infection prevention and control (IPC) was seen to be everyone's responsibility. There were individuals who led on infection prevention and control 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 IPC group 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. Support was available to staff through a service level agreement from the local acute Trust's IPC team. Staff also had access to infection control policies and local procedures were developed where necessary, for example the 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 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 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.

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- 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, there were inconsistent practices in some teams around the cleaning of toys which were not in line with the policy. 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 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 their own washing machines. 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.
- 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 these 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%.
- Mandatory training for new staff had recently been included in the induction programme which all new staff attended before commencing clinical practice. This was seen as beneficial by the senior management team as it gave them assurance that all new staff were up to date with mandatory training when they started.
- There were systems in place to monitor and remind staff when training was due. Each service manager could review their staff members training record to see level of compliance.
- Mandatory training was delivered using classroom and electronic learning which provided a varied approach to training. However, some staff found it difficult to access the training as the availability of the classroom based training modules in their locality was sometimes limited making it harder to attend due to the impact on their time and clinics.
- New medicines training modules had been recently introduced for clinical staff and the completion of this training was a current risk on the medicines risk register. Staff told us it was difficult to complete the training due to a lack of computers, a lack of time, and the level the training was set at. There was also a problem with getting correct data from the system relating to who had completed the training and so current compliance levels could not be reported.

Assessing and responding to patient risk

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- Risks to children and young people were assessed apart from one service. We reviewed risk assessments in the complex healthcare team which were robust and included documentation of the risks and the actions taken to mitigate the risks. Likewise in the public health nursing team we saw risk templates which were completed to identify and document risks to the child. In the CAMHS team we saw completed risk assessments including the use of a FACE risk assessment which is accredited by the department of health. We reviewed risk assessments in the learning disability service and found risk assessments were not in place for each patient. Only one of the four learning disabilities records we sampled contained a risk assessment and the manager advised that the team only completed risk assessments where a risk was indicated. On review of a care record where a risk was indicated we found that the risk assessment had not been regularly reviewed.
- When risks were identified they were managed positively. 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 it was 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, the process was to call for a GP or ambulance depending on the severity.
- We reviewed some individual children's emergency procedure files. All were in date with the exception of 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.
- 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.
- 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.
- The palliative care 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 additional care and support as part of 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

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recruiting, this was being managed using alternative ways of working and there was an ongoing recruitment programme in place. Recruitment and vacancy rates were highlighted on some of the service risk registers for CAMHS and learning disabilities this was due to a number of factors including high turnover and difficulty in recruiting staff due to the wide geographical spread of the services. Managers we spoke to were fully aware of where recruitment risks were located and spoke positively about the strategies in place to recruit.

- 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 retaining cases up to the child being eight years old where they need ongoing public health nursing intervention and there were younger children in the family.
- 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. 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.

- 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 did not have a palliative care consultant and this 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.

Managing anticipated risks

- Potential risks were taken into account when services were being planned. Staff we spoke with were aware of

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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 The organisation provided services but did not own or manage the buildings staff 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

- Arrangements were in place to respond to emergencies and major incidents. An up to date business continuity

plan including responding to winter weather was available to staff on the intranet. The policy clearly outlined types of incidents which could affect services and what to do if they occurred.

- Business critical services were identified as the SPA and specific patients in the Assertive Outreach, Palliative Care and Complex Health Care. The effect of major incidents on these services was examined in detail using a business impact assessment tool.
- Staff reported incidents related to business continuity. We reviewed the incident records and saw examples of incidents staff had reported including fire alarms going off, a flood, and winter weather which had affected services.
- Service specific business continuity plans were available throughout the service. In the children's and young people's services we visited we saw specific business contingency plans in place to respond to emergencies and other major incidents. These plans were written in conjunction with the organisational procedure and included information about managing the impact of adverse weather for the service.

Are services effective?

Good 

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 of findings

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 and 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.
- Services demonstrated that they improved patient outcomes.
- Consent to care and treatment was sought in line with legislation and guidance but was not always clearly recorded.
- 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 / carers of the skills of their carers.

However:

- 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.

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.
- 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 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

Our 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

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Good 

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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.

- The organisation 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 the organisation 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 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.
- The palliative care team followed guidance set out in the Formulary for Association of Paediatric Palliative Medicine Master Formulary for indications, routes and standardised doses for paediatric palliative medicine. The Basic Symptom Control in Paediatric Care which are guidelines for treating a wide range of symptoms experienced by children with life-limiting or complex health conditions, and the British National Formulary for Children for paediatric prescribing and

pharmacology. 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 pain 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 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.

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. We saw evidence that a child's daily food intake was recorded in care notes as well as regular checks on weight being completed.
- 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.

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- 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.
- 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.
- 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.

Use of technology and telemedicine

- Technology was used to enhance the delivery of effective care and treatment. There had been a significant focus on improving information technology (IT) across the service since the start of the contract in 2013. Managers we spoke with all told us about the improvements which were being made to IT and how this was having a positive effect on their services, however managers also identified that the fast pace of change and new IT which was being used did prove difficult for some staff.
- The organisation was 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 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.

Outcomes of care and treatment

- There was oversight of outcomes of care and treatment and manager and senior manager level in the organisation. Senior managers we spoke to told us how they reviewed outcomes for their own services and were responsible for presenting this information at various meetings. We reviewed minutes of meetings for the care effectiveness meeting which referenced to presentations which had been made and outcomes which had been discussed.
- 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 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

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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 of patient records, safeguarding, infection control, information governance and medicines. The results of these were benchmarked both between services and externally to other 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. 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, 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. An action plan was developed from this audit 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.
- The palliative care team service was benchmarked against national standards by Together for Short Lives. This charity holds a national event with parents of end of life patients, hospital representatives, hospice representatives and community representatives come together to feedback on best practice and key themes within end of life care. The service lead regularly attends the conference and submits data which allows for the benchmarking to take place.

Competent staff

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- Staff had the right qualifications, experience and knowledge to undertake their roles and were supported to undertake further development and 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 induction had prepared them well for their role and included consideration of their wellbeing as well as preparing them for their job. We reviewed the corporate induction pack which staff received to welcome them to the organisation, including a tea bag so they could settle into the session with a cup of tea. 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 and 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 the appraisal rate for all staff was 95.6% compliance. The lowest level of compliance was in the CAMHS team (92.6% for 134 staff) and the highest level of compliance was in the family support services team (100% for 158 staff). 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 four to six 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.
- 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 More" 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.
- The team leader of the Newborn Hearing Screening team had been supported to achieve a master's of science (MSc) module at University. This had been funded by Public Health England, with travel, expenses and accommodation funded by the organisation This enabled her to lead the service, with appropriate qualifications, and impart this knowledge to her dedicated team.

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- 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 co-ordination of 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.
- Multidisciplinary working was evident between managers and senior managers. We were told about service improvement projects which were being delivered jointly between teams, cross department working by the care effectiveness team, and support from IT and administrative staff to help staff gather and present information.
- 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 with support from a multi-disciplinary clinical team to make a clinical decisions on the needs of the child or young person. Any complex cases were taken to pathway management meetings where the referral was discussed in detail by multidisciplinary 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 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 working and meetings in many services. In the palliative care team we attended a 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

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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 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

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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 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.

Availability of information

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- 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 across the services. 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 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 and some examples of where it was not 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. However, in the learning disabilities team there were gaps in recording consent in some records.

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- Where 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 of findings

We rated the organisation as good for caring 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 about staff was positive. People told us that staff took the time to explain and ensure they understood the care and treatment they were involved in providing.
- 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 and carers were supported by staff to gain the competencies required to manage their care at home.

However,

- Patients and their families were not always kept informed about their treatment pathway and waiting times to access services.

- Staff ensured assessments and treatments were carried out in a positive encouraging way. We observed staff 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.
- Family members informed us staff had 'excellent attitudes' within the complex healthcare team and felt the workers knew their child very well.
- 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 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

Our findings

Dignity, respect and 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.

Are services caring?

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

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.
- **Patient understanding and involvement**
 - 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 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.

Are services caring?

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- 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.
- Staff did not always communicate clearly with young people and their families when they were waiting to be seen. In the CAMHS and learning disabilities team parents and carers told us that they were frustrated with the lack of involvement and information which made them feel isolated.
- 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.

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

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- 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 of findings

We rated the responsiveness of children and young people's services as requires improvement because:

- Not all patients were receiving care and treatment in a timely manner, this was the case across physical and mental health services. The speech and language therapy department had received five formal complaints all regarding waiting times in 2016. Healthy Child targets for new born and six week baby checks were not being met by the public health nursing team.
- 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.
- It was difficult for the local care effectiveness team to have oversight of complaints about services, as these were managed away from the area. Complaints were not responded to in a timely way.
- Leaflets displayed in clinics were not suitable for people with visual impairment and did not include easy read format.
- Complaints were not always responded to in a timely manner and learning and action points were not always clear.

However:

- The services, which the provider were commissioned to provide, were planned to meet the needs of the local population.
- 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.
- Waiting times were reducing in some services which had seen an increase in demand.
- School nursing services, despite staff shortages were able to see new patients within a week of their referrals being submitted.

Our 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. 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.

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- Service managers were taking pragmatic steps to address the significant capacity pressure in services including 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.
- 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 had received, and of the good outcomes it provided to families. Families were able to self-refer into this service, and its provision was individualised around the needs of each family.
- When needs were not being met, this 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.
- 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 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

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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.

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. In CAMHS and learning disabilities service each building had been converted so that there was full disabled access including accessible toilet facilities and meeting rooms.
- 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. Easy read leaflets were also available through the customer services team. However, the leaflets displayed in clinics were limited to English, not suitable for people with a visual impairment, and did not include easy read format.
- 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.
- 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.

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- 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 use 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 the 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.
- The organisation 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 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 head of service 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.
- The organisation was working with the CCG to redesign pathways and had implemented improvements to reduce the waiting times. A significant pressure on

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waiting times was the increase in demand that some services were seeing. The autistic spectrum diagnosis and assessment service had seen an increase of 54% between 2013/14 and 2015/16. The learning disabilities team estimated an increase of demand to be 22%.

- Waiting times in some services had reduced. The average waiting times in CAMHS had reduced from 14 weeks at the start of the contract in 2013 to 6.6 weeks in December 2016 despite the increase in demand. This had been a focus for the organisation and the head of service told us that they were continually working with commissioners and changing practice to continue to improve.
- 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 (37%) people out of a waiting list of 293 had been waiting above 18 weeks. 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 times.
- 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.

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- 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 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.
- The palliative care service was responsive to referrals in line with . The standard 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

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team. Staff endeavoured to pre-empt patient needs by liaising with GPs and paediatricians to address medications, dressings and equipment needs. This 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.

Complaints handling and learning from feedback

- There had been 98 formal complaints about the organisation between January 2016 and January 2017. The number of concerns and locally resolved issues were requested but were not able to be provided by the organisation.
- Complaint responses were not always given in a timely manner, and learning and action points were not always clear. Complaints were managed corporately by the customer service team in Surrey and the care effectiveness team in Devon provided a link between the Surrey location and teams in Devon. This arrangement posed a number of difficulties including lack of oversight of full complaint information and delays in communication. The result was that timeframe of 25 days for resolving a complaint was rarely met. We reviewed six closed complaint files and none of them demonstrated responses in 25 days and only one had learning and action points recorded on the master electronic file.
- 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.
- 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.
- There was a lack of oversight and quality of complaint responses and staff were often not aware if the complaint had been upheld or not. This part of the process was managed by the team in Surrey and so the information was not freely available in Devon. Response letters we reviewed provided information on the complaints ombudsmen, gave details of the investigation, and answered questions however some were defensive in nature, did not apologise for the delay in the response, and in examples which included waiting time complaints did not outline why this had happened.
- 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, complainants were not contacted 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.

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Summary of findings

We rated well-led for the children and young people's services as good because:

- Virgin Care Limited 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. Teams had been nominated and received awards for their work.

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
- The requirements for fit and proper person checks were not clearly demonstrated, however these were undertaken quickly when raised with the organisation.

- The service had not undertaken a Workforce Race Equality Scheme assessment did not understand the profile of its workforce or implement actions to improve equality.

Our findings

Leadership

- Leaders in the organisation were visible and approachable. We observed senior leaders based at the Capital Court location interacting with and being approached by staff on a regular basis. We were told that recently senior leaders had decided to start working more frequently on different sites and together they had set out a rota to make sure they were visible to staff during a normal working day, rather than just for a specific meeting or event. A number of members of the senior team acknowledge how important this was due to the large area the service covered.
- In some areas of the service there had previously been a lack of management which had left staff feeling unsupported. In the south Devon CAMHs team staff told us about a previous lack of management and support which had affected their morale. At the time of the inspection they had a new manager in place and reported feeling much more supported.
- Leaders from Virgin Care at a corporate level who were based in other parts of the country, such as the chief executive, clinical director, and lead nurse visited the services when they were able. During the inspection we spoke with the clinical director and lead nurse who told us about meetings or events they would attend in Devon. However, some staff we spoke to felt they were not well connected to these corporate level leaders.
- Leaders had the skills, knowledge and experience they needed to complete their roles. Managers and team leaders we spoke with had many years of clinical experience prior to their appointment as managers. Staff felt this gave them confidence in the leadership of their services. Families told us that managers took the time to recruit the right people for a job.
- The development of leadership skills and knowledge for staff was evident in the service. We reviewed

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information on the district nurse leadership programme which provided an in-house leadership and management skills programme. This was developed in response to a local need to fill a practice gap and improve services. Staff were given the opportunity to complete an Institute in Leadership and Management (ILM) qualification if they were a middle level manager so they could prepare for senior management responsibilities.

- Leadership development at every level was encouraged through a number of development opportunities. We reviewed the talent development briefing which gave details of leadership development which started with new staff in the organisation and progressed through programmes which allows staff to become clinical experts or directors. The programmes were named: Arrivals and the Virgin Care Way, Foundations, Flourish, Aspire, Specialise, and Inspire. Staff were encouraged to consider these programmes during their career conversations and progress was documented in their career conversations.
- Professional leadership for clinical staff was available but did not include all professional groups. Nursing leadership network days were held for nursing staff to review professional issues, develop their practice, and hear from guest speakers. This development was not currently available for other clinical staff such as allied health professionals.
- Leaders understood the challenges to good quality care and could identify the actions needed to address them. Senior managers we spoke with told us about the need to develop improved information technology for the service to improve the quality of care. This information technology focus had been significant for the organisation over the last four years and had resulted in investment in this area and improvements to the quality of care. A need for strengthened leadership in the children in care nurse team had been identified and recruitment for a dedicated specialist to lead this team had taken place, and joint working arrangements with the clinical commissioning group (CCG) in this area had improved.

Vision and strategy

- There was a clear short term purpose and vision for service. The quality improvement plan for 2016 to 2017 clearly identified Virgin Care Limited's purpose which was to, 'inclusion, choice, prevention.
- The purpose and vision together with the business objectives came as a visual 'road map'. There was an overall road map for the five year duration of the contract, and individual yearly road maps which provided specific detail on the purpose, vision and objectives for that year. We reviewed the year four road map which clearly identified both service wide areas for focus such as, 'health and wellness for colleagues', and, 'stakeholder engagement', together with more service specific areas of focus such as, 0-5 Integrated Pathways Children's Centre Developments'.
- A longer term strategy had not been developed for the service. We spoke with senior managers who explained that The organisation were entering the fifth and final year of their contract in April 2017 and so there was little information currently on what the recommissioning services would be. There was a plan to review and clearly define the future strategy when further was known; we were told by staff that they had received an update on this from the regional manager and so were being kept informed.
- There were clear links between the purpose, vision and objectives for the organisation and the purpose, vision and objectives within the teams. Managers and staff in the specialist children's assessment team, school nursing team and palliative care service told us about their own services purpose, vision and objectives which reflected those presented on the 'road map'.
- There were clear values set for the organisation. Staff in the CAMHS and learning disabilities team were aware of and able to explain the values which were 'striving for better' (think), 'providing a heartfelt service' (care) and 'working as a team' (do). These were values that staff were positive about and worked toward in their teams. The values and objectives formed part of the values based staff appraisal system. Staff at all levels told us how the values were used for their appraisals.
- Staff did not always feel involved in the development of the vision, values and strategy for the organisation. Managers we spoke with told us they had been involved in developing the vision, strategy and objectives for their

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services which fitted with the organisational 'road map'. Staff we spoke to did not feel so involved in developing these things, however they felt what had been developed did reflect their opinions. We spoke to the Chief Nurse of Virgin Care who works at a national level, who told us about work being done to align the values and behaviours of Virgin Care to those of nurses and healthcare professionals. We reviewed a draft document which set out how values could be aligned and how this linked to improving the quality of services.

- Progress against delivering the strategy was monitored and reviewed. We reviewed the quality improvement plan 2016-2017 which set out all of the individual projects which were included in the 'road map' and gave details of target dates, outcomes, the responsible member of staff, and if there was a current action plan in place. Projects were categorised as either, 'transformation, engagement, outcomes, service transformation, or workforce development,' and it was clear which reports and meetings each project was reviewed at and how frequently the SMT received a report.

Governance, risk management and quality measurement

- A governance framework was in place for Virgin Care at a national level which linked with the governance framework of Virgin Care Limited in Devon. This included the Virgin Care board, virgin care executives, risk and performance committee, and clinical governance committee. Senior managers we spoke to clearly described how the national framework linked to the local framework for Virgin Care Limited in Devon and how information was both passed up and down from the national meetings to the local meetings.
- We reviewed the governance framework which included the following meetings: senior leadership team, heads of service, service, quality and safety committee, care effectiveness and safeguarding, care records management, infection control, and medicines management.
- However, there was not always clear information on how the governance framework operated. We reviewed the locally set terms of reference for the care effectiveness and safeguarding meeting, senior management team meeting, transformation board,

records management group, and infection control group. Some of the terms of reference were comprehensive and included adequate detail however some did not. For example the terms of reference for the heads of service meeting were very brief and did not include information on who was the chair, how many members needed to be present for the decision making process to be quorate, and how this meeting linked with the rest of the governance structure.

- The governance framework was supported by a computer programme which provided information to senior managers to review. At the point of our inspection this programme included a range of information on the performance of services. Senior managers told us about the plan to include service wide data in the future and the IT team explained how this was being planned and undertaken so that more services and data was included. We reviewed the computer programme and saw that it was easy and intuitive to use and highly adaptable to the needs of each service. It was able to provide a real time overview of information in a dashboard format, detailed reports of specific data, comparisons between any of the data in the system, and tracking reports to see if particular aspects of the service had improved or deteriorated. Staff we spoke to in departments and managers throughout the service told us how useful this was and how it was an excellent tool to use.
- Staff were clear about their roles and what they were accountable for. Senior staff we spoke to included registered managers who told us about their responsibilities in that role. We were told about how the registered managers were supported by peers with their registered manager responsibilities with supervision sessions. There was a clear staff structure which included roles and responsibilities which linked to the governance framework.
- There were arrangements in place for working with partners and third parties. Within the governance structure there were meetings with the Clinical Commissioning Group (CCG), Devon County Council, and Devon Safeguarding board. These meetings facilitated integrated working and joint decision making. We spoke to a number of stakeholders who worked with Virgin Care Limited who gave us details of how they worked together.

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- 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.
- The governance frameworks for Virgin Care Limited in Devon were not regularly reviewed to provide assurance that they were fit for purpose. There was no assurance framework in place and no review had taken place to determine if the current governance framework was fit for purpose or needed changing. We spoke to the head of operations who explained he was confident in the governance framework due to the staff, systems and process which were in place, however acknowledged that a formal review had not taken place.
- The information to monitor and manage quality and performance was accurate, valid, reliable, timely and relevant and actions were taken when issues were identified. Inaccurate information had been identified in the children in care team which resulted in inaccurate data submissions. This had been escalated to senior managers, added to the risk register, monitored frequently, and details were shared with the CCG.
- There was a systematic programme of clinical and internal audits which was used to monitor quality and systems, however there was not always identification of where action should be taken. We reviewed the schedule for clinical audits between March and August 2016 which presented the planned audits in which service these related too, and if an internal audit report had taken place. We reviewed a sample of the clinical and non-clinical audit information including audits of public health nursing, sepsis (2016), hand hygiene audit (March 2016) and information governance (IG) audit (July and August 2016). Each audit clearly presented the results however actions were not identified in response to the results. When we reviewed audits for the individual teams we saw an example in the palliative care team where clear actions had been identified and action plans had been written. Therefore there was inconsistency across the services.
- There were robust arrangements for identifying and recording risks and issues but mitigating actions were not always clear. There was an overall risk register for The organisation which identified risks scoring 12 and above. Each risk had updated risk scores, controls which had been put in place to reduce the risk, and a date for review. The overall risk register was reviewed in the senior management meetings. Risk registers were also in place for each service and identified at a local level both clinical and other risks which existed, however there was variation between services in identifying actions to take to reduce risks. This was the case in the family support services where a risk around the lack of safeguarding training had been identified but not actions identified.
- There was alignment between the recorded risks and what people say is on their worry list. The top four risks on the risk register in November 2016 included two financial risks, a performance risk associated with meeting key performance indicators, and a risk to a specific service involving lack of staffing and inaccurate data collection. Senior managers we spoke with told us about these risks as well as the risks on their service risk registers and what actions and risk reduction plans in place.

Culture across the provider

- Staff working for The organisation felt respected however not all staff felt they were valued and rewarded fairly for some aspects of their work. Staff we spoke to at different levels in the organisation told us they felt proud to work for the organisation and that everybody worked together for the needs of the child, young person and their family. Managers worked together to provide support to each other and they told us how this made them feel valued and part of a cohesive team. Staff told us that in some job roles there was a difference in

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pay between The organisation and other healthcare providers in the area and that they didn't always have the access to additional training. This made a small number of staff feel undervalued.

- Behaviour and performance that was inconsistent with the vision and values was addressed. Three managers told us about performance management processes which they had been through or were going through with their staff due to behaviour and/or performance not being at the required level. We reviewed a performance management file which showed a clear process, completed in a timely way, which was following the policy. Managers were supported by the human resources team with this process and felt confident to challenge behaviour and performance if needed. We were told about the performance management of a member of staff which had been open, honest and supportive and resulted in the individual changing teams to better suit their requirements and going on to perform to a high level in their role.
- The culture of the service was centred on the needs and experience of children, young people and their families who use the service. All staff we spoke with mentioned patient care was at the forefront of their focus. During the inspection we were shown a video of a service user who had written a song about their illness and how they managed it, staff reflected on how this was so important as the experience of the young person was what really mattered.
- The culture encouraged candour, openness and honesty. Staff told us how there was a no blame culture where incidents were seen as a means to learn and improve clinical practice. We saw and staff told us about learning from incidents which had been shared throughout the service so lessons could be learnt. Two serious incidents had affected the CAMHS team and staff felt these were dealt with candour, openness and honesty.
- We reviewed examples from each service for 'you said we did' in the patient experience report. This is an initiative where feedback is taken and action put into place to make improvements. Improvements included Learning Disability Nurses attending parents evenings at Special Schools, equipment being delivered by the manufacturer to reduce the delay to a child and their family, and setting up text message reminders for the CAMHS service.
- There was an emphasis on promoting staff safety and wellbeing. There was a lone working policy available for staff, and individual services had lone working procedures which related to the type of work which took place in that service. Managers were confident about the lone working policy and procedures and commented that lone working was of upmost importance to them to ensure staff and children and young people who use the service were safe. In the complex healthcare team the lone working procedure relied on the cooperation of families to be truly effective however there was a clear policy in place and managers available to escalate concerns.
- Opinions of staff and information on their wellbeing and needs was collected in the twice a year staff survey. We reviewed the survey from June 2016. The survey had a response rate of 65% which had increase from 46% the previous year. Staff engagement (3.6/5), satisfaction (3.0/5), and likelihood to recommend as a place to be treated (3.8/5) and to work (3.3/5) had all increased from the year before and scored. The highest scoring questions were: staff had their progress and development discussed within the last six months, staff felt their line manager recognises and values them, people at work care about their physical and mental health and wellbeing, and staff know what is expected of them. The lowest scoring questions were: I see the senior leaders in our organisation role model our values, I see the organisation making decisions that are purpose-driven and aligned to our values, I have opportunities to develop and grow, and I have the tools and equipment to do my job.
- Staff wellbeing was supported through actions and areas for focus from the staff survey results and wellbeing initiatives. Staff received psychological support once every three months to assist with their wellbeing, however some staff felt they would have liked this support more frequently. The manager of the CAMHS service told us how staff had been provided with support and supported each other during a difficult time when two serious incidents had occurred.

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- Staff and teams worked together collaboratively and constructively to deliver services. Each service we spoke to reported a strong ethos of teamwork and teams worked together for the benefit of the children, young people and their families. The assertive outreach team had worked collaboratively to reduce the length of stay and admissions to inpatient wards and the eating disorder service had worked together with other services in the region to reduce the need for in-patient stays. We observed managers and staff working proactively with each other at the capital court location including staff from all services working with the single point of access team to answer queries and triage referrals into the service.

Fit and proper person requirement

- The organisation was subject to Regulation 5 of the Health and Social Care Act 2008 which states that individuals in authority (directors) in organisations that deliver care are responsible for the overall quality and safety of that care. The regulation is about ensuring that directors are fit and proper to carry out their role.
- The organisation had a corporate Fit and Proper Person (FPP) policy which applied to directors. The structure of the services in Devon included a regional manager who was part of the Virgin Care board and so subject to the FPP regulation.
- We reviewed the personal file of the director which showed that the requirements of the organisation's policy were not always met as not all information was included. There was a reliance on self-declaration of some aspects of FPP with no external checks carried out to validate this. For example, tests of insolvency / bankruptcy and disqualification from the directors register were not verified by external checks. We raised these issues with a manager who told us that this information was held centrally, however when this information was provided there continued to be sections missing. The organisation took steps to resolve this issue and provided evidence that these external checks had taken place and that their policy was updated to clearly reflect this requirement.

Workforce Race Equality Scheme

- The organisation did not meet the needs of the workforce race equality standard and so actions could not be taken where improvements were needed in their workforce race equality.
- The Workforce Race Equality Standard applies to NHS Trusts and Independent acute healthcare providers. Where Independent acute healthcare providers have an annual aggregated income from NHS-funded care of at least £200,000 they are required to demonstrate progress against nine indicators of workforce equality, including a specific indicator to address the low levels of black and minority ethnic (BME) board representation. The equality delivery System2 (known as EDS2) was designed to review and improve organisations performance for people with characteristics protected by WRES data and take action where needed to improve their workforce race equality.
- We reviewed a Virgin national corporate strategy called, 'Diversity and Inclusion Strategy/Action Plan (2016-2020)' which identified goals for each year however no local review for the services in Devon had been completed and no local action plan put in place.
- The organisation collected data on race of applicants at the initial recruitment stage but did not collect data for any other aspects of the service. Therefore the organisation was unable to assess the nine workforce indicators and determine whether there were any areas for improvement. The Head of People who was a regional manager for Virgin in the South West of England told us there were no local plans for diversity and inclusion or any indications on how they are meeting the national corporate strategic goals. We were told that there were plans to collect WRES data during 2017.

Public engagement

- Views and experiences of children, young people and their families are gathered and acted upon to shape and improve services. Staff told us about how they engaged with children, young people and their families to gain feedback and make improvements. We reviewed the user participation report which identified all services that had gathered feedback from the public and details of what format this feedback was in. Examples included

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questionnaires including the Friends and Family Test, feedback sheets, annual service reviews, and graffiti walls. Electronic devices were used to help gather feedback from parents quickly and efficiently.

- The public were engaged to participate in the service to improve quality. Managers told us about recent interviews for the children in care team where there were three care leavers on the interview panel, staff training sessions for the CAMHS team which involved children and young people, and children being included in the planning of activities in the activity scheme.
- A new participation user group had been set up however this group did not yet include any children or young people. We were told by managers the plan was to recruit children and young people on to this group over the next six months.
- Leaders did not engage fully with the families of people the services supported when there were changes to the services. We were given examples whereby frontline staff were responsible for communicating changes directly to parents. Staff told us this was difficult for them and it would have been more appropriate for leaders to deliver this message. Parents gave us examples where changes had been communicated by letter, without further communication from the service. This left parents feeling that they were not consulted about the changes. Managers told us they were aware that public engagement was an area they needed to improve.

Staff engagement

- Staff were not always actively engaged and their views were not always reflected in the planning and delivery of services. Staff reported that there had been a lot of development of services they provided however they felt the level of changes they were undergoing meant here was not enough time for one aspect of change to fully be implemented before the next one began.
- A number of events were held to promote staff engagement. We reviewed staff engagement activities held between May and October 2016 which included consultation events for the public health nurses, workshops for the school nurses, a visit from a Virgin Care non-executive director, the head of public health nursing service attending team meetings, and a child health information services away day.

- 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 which was not being used to accept and triage all referrals into most of the services. Some staff told us that this change was not beneficial and did not improve the experience for the children, young people and their families, however other staff told us this was a very beneficial change.
- Staff forums were in place for local managers and clinical leads; however these forums were not inclusive of staff below band seven.
- Staff were kept up to date of service specific information through a series of team meetings. Staff we spoke with all said they attended monthly team meetings and 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 were confident to raise issues and felt supported and valued when they did so. Managers spoke of a very open and honest culture where they felt able to raise issues and discuss them. Senior managers told us how they were able to confidently raise issues which affected clinical quality at the senior management meeting, or the quality and safety group. They felt they were always taken seriously and supported to make changes which improved care. Staff from the single point of access team told us that they were able to raise concerns and ask others for help if they needed to. They felt this was very important for the single point of access as it was a new service which was improving all the time.

Innovation, improvement and sustainability

- Improvements and development opportunities were identified and staff and managers encouraged to change services. If an innovation or improvement was identified staff were able to bid for money from a Virgin innovation fund. This was a national fund of £10,000 which was available for staff members to gain funding for service level projects. Staff were encouraged to apply and had access to previous winning bids to learn from and increase the chances of achieving funding.

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- Innovative practices were encouraged to improve the quality of care offered. 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.
- Information was used proactively to improve care. A recently introduced computer programme could be used by the palliative care team to assess referral to treatment times 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 palliative care team were awarded the award for excellence in commitment and dedication in demonstrating and practicing the six Cs (care, compassion, courage, communication, commitment and competence) from The organisation in 2015. The team were also awarded with the team of the year the same year, by Virgin Care.
- Staff were involved in the development and changes to services and worked with others to achieve this. 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.
- The assertive outreach service had improved the service to reduced length of stay and admissions to in patient wards. The team was shortlisted for a health service journal ‘value in health care’ award in January 2017 for recognition of their work. The eating disorder pathway service in East Devon CAMHS and the paediatric service in Exeter, East and mid Devon had received Beacon status and were recognised as national good practice by NHS England. The pathway work has reduced the need for in-patient stays in tier four psychiatric units.
- Services worked in partnership with Universities to develop accredited programmes, such as mindfulness and access to psychological therapies courses and delivering care through pathways.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

12 (1)(2)(a)(b)(d)(h) Care and treatment must be provided in a safe way for service users.

The provider must address the cleaning and maintenance in all patient areas at Evergreen House and ensure that there are adequate alarms.

This was a breach of Regulation 12.-(1)(2)(a)(b)(d)(h)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17(2)(a) Assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity (including the quality of experience of service users in receiving those services).

The provider must address the long waiting lists for CAMHS patients to access services, including internal waiting lists. This is a breach of Regulation 17(2)(a)