Torbay and South Devon NHS Foundation Trust

RA9

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RA9	Torbay Hospital	Torbay Hospital	TQ2 7AA

This report describes our judgement of the quality of care provided within this core service by Torbay and South Devon NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Torbay and South Devon NHS Foundation Trust and these are brought together to inform our overall judgement of Torbay and South Devon NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Overall services for children, young people and families was rated as requires improvement. We found that community health services for children, young people and families were 'good' for caring and ''requires improvement' for safe, effective, responsive and well led.

Our key findings are

- A variety of patient records were kept, the majority of staff used paper records they were generally comprehensive, clear and informative. Some staff had access to electronic record systems but these systems did not link and there was a risk that important information about children could be missed.
- Health visitors and school nurses were working with high levels of need, when covering for colleagues there was no robust system to ensure the level of need matched the capacity of the staff.Staff were not aware of contingency planning to ensure there was adequate caseload cover. There was inadequate administrative support meaning that staff spent inappropriate time on clerical duties.
- Some working environments were inappropriate either as a safety risk for staff or were ill equipped with insufficient computers
- A lack of capacity in the looked after children (LAC) nurse role had been identified as had a shortage of middle grade doctors.
- The trust had identified on the risk register that a large number of guidelines were in need of updating.
- The measurement of outcomes for children was inconsistent across the services.
- Community children's nurses were not receiving clinical supervision and did not have records of clinical competence.
- Initial health assessments for 'looked after' children were not meeting the statutory timescales.
- There was a long waiting list for an assessment to diagnose an autistic spectrum disorder at the Child Development Centre (CDC). At the time of our inspection for those aged 5 to 18 years documentation showed there was a 17 month wait time, this was on the trust's risk register.
- There was a lack of oversight of the Child Development Centre (CDC) and its future was uncertain. Staff working in the CDC faced challenges in meeting patients' needs in a timely manner and there was uncertainty over the centre's future. There were no clear plans on how to address the challenges in the CDC.
- There was a lack of clarity about future roles and the responsibilities for health visitors possibly changing or expanding. There did not appear to have been an assessment of the staff's competency and capacity to safely meet the needs of a wider remit of children and young people in vulnerable circumstances.
- People spoke highly of the caring and kind staff, they were involved in decisions about their care. Staff were passionate about providing good quality. Clinics were located in places where people could access them.
- Staff felt well supported in their teams but there was a lack of clarity about governance in one of the two provider unit/delivery units that covered these services.
- Business continuity plans were not robust with clear guidance to help staff know when to implement action plans.
- The trust had achieved stage 3 of the Unicef World Health Organisation (WHO) Baby Friendly Breastfeeding initiative and had doubled its uptake of breastfeeding.

Summary of findings

Background to the service

Torbay and South Devon NHS Foundation Trust provides community health services for babies, children, young people and their families in their homes, in GP surgeries, community clinics, children's centres, schools within Torbay and in the child development centre the John Parkes Unit at Torbay Hospital.

These services include health visiting, school nursing, a hybrid Family Nurse Partnership called the Family Health Partnership service, a community children's nurses, therapy services, services for 'looked after' children, children with a learning disability and sexual health services.

The staff work under one of two provider units. The therapy services, the community children's nurse service and the children with a learning disability service are based at Torbay hospital. Health visitors work in four localities from GP surgeries, the school nurses work in four localities from two community bases, the Family Health Partnership work from one community base, the sexual health service provides outreach from four community clinics and one community hospital and the looked after children nurse service for Torbay local authority works from one community base.

Children form 27,800 of the 375,000 population served by the trust. Children receiving the community children and young people health services live in Torquay, Brixham, and Paignton. Child health profiles for the area show the level of child poverty is worse than the England average and the number of children in the care of the local authority is higher than the England average. Infant and child mortality rates are similar to the England average. Eight percent of the school children in Torbay are from minority ethnic groups compared with 28% in England.

We observed a range of services in GP surgeries, community bases and in patient's homes. We talked with 25 people who used the service, and spoke with 60 members of staff. We looked at 24 sets of patient records and an extensive range of service documents

Our inspection team

Our inspection team was led by:

Chair: Tony Berendt, Medical Director, Oxford University Hospitals

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included two CQC inspectors and three specialist advisors; a community paediatrician, an health visitor and a childrens community nurse.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection of NHS trusts.

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 core service and asked other

Summary of findings

organisations to share what they knew. We carried out an announced visit on 2nd, 3rd, 4th and 5th of February 2016. During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists.

What people who use the provider say

People spoke positively about the care they were given. A parent with a young child at clinic said 'they have been lovely, I had a c- section, they came to the home, I didn't come to clinic for two months, I struggled with breastfeeding they came and really helped'. A young person using the sexual health service told us they were 'comfortable coming here, never felt awkward, has a friendly feel, aware of confidentiality'.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Ensure that where information is held on paper and electronic systems that staff are able to access information required.
- Ensure there are sufficient staff to meet peoples needs and cover caseloads of health visitors and school nurses
- Ensure initial health assessments for 'looked after' children meet the statutory timescales.

Action the provider SHOULD take to improve

- Ensure working environments are appropriate and staff have access to sufficient IT equipment to carry out their role.
- Review current guidelines to ensure staff have access to up to date guidance.
- Review the system for supervision for community children's nurses to ensure they are supported
- Ensure information on how to make a complaint is available for people who use the services
- Ensure information and plans for the future of services are reviewed and communicated to relevant staff.

Torbay and South Devon NHS Foundation Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated services for children, young people and families and requires improvement for safety because:

- There were times when staff did not have information about children in care or those subject to a child protection plan or were unable to access information about children for whom there maybe safeguarding concerns .This meant that important information to protect children from harm was missing.
- Health visitors used a recognised caseload weighting tool, in allocating work when covering for colleagues however there was no robust system to ensure the level of need matched the capacity of the staff. Staff were not aware of contingency planning to ensure there was adequate caseload cover.
- Some working environments were inappropriate for example external stairways for staff carrying equipment or ill equipped with insufficient computers and administrative support.
- A lack of capacity in the looked after children (LAC) nurse role had been identified as had a shortage of middle grade doctors. Staff in other roles were trying to cover their duties.

However:

- Staff knew how to report incidents and understood the value of this and of raising any concerns they may have about care. There was learning from incidents and Serious Case Reviews which had led to changes in practice.
- Mandatory training was at 95% compliance and safeguarding training on average across the three required levels was 90%. Staff we spoke with were able

to recognise safeguarding concerns for children and young people and showed a good knowledge and awareness of the safeguarding processes. They were able to seek advice as they needed it.

Incident reporting, learning and improvement

- The national reporting and learning system (NRLS) reported 18 incidents as occurring in any community setting related to a child between December 2014 and November 2015. Of these 15 were defined as being no harm and two were low harm. Low harm is defined as an incident resulting in extra observation or minor treatment and caused minimal harm.
- Incidents were reported using an electronic system and staff we spoke with knew how to use the system. Staff told us they used this system to report incidents and that they felt supported by their team leaders and managers to do this.
- We saw evidence of incidents reported, the main theme was a lack of communication between disciplines which resulted in care, support not being offered within expected timescales. Examples included health visitors not being notified of pregnant women and not being informed of children under the age of five registering with a GP and joining their caseload. Minutes from staff meetings showed that these incidents had been shared with staff with actions to improve liaison and referral processes to prevent them reoccurring.
- Staff told us there was regular feedback and learning from the incidents recorded. Feedback and learning was shared in a variety of ways via practice forums, awareness weeks, meetings and newsletters. An example of learning from incidents was the introduction of new guidelines in the identification and management of sepsis.
- Learning locally from Serious Case Reviews (SCRs) had identified a general lack of challenging management oversight in agencies, new standards had been developed for safeguarding supervision and a policy was being updated. There had been a review and adaptation of documentation to ensure professionals 'think family' considering others in the household. Following domestic violence incidents a policy was being rewritten with a presentation date for late January 2016. We observed the new family health assessments being used in health visiting practice.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This Regulation requires the trust to notifying the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology
- Staff told us they were encouraged to raise any concerns they may have about care provided or to escalate problems that could prevent them working safely.

Safeguarding

- Staff were able to recognise safeguarding concerns for children and young people and showed a good knowledge and awareness of the safeguarding processes and their responsibilities in protecting children from harm. All the staff we spoke with told us they were able to access the safeguarding policies and safeguarding advice as they required.
- The trust had a child protection policy in place. The policy had links with related policies. Examples being the identification and prevention of child sexual exploitation, female genital mutilation and the policy for those children and young people not brought to outpatient appointments. All but one member of staff we spoke with had regular planned safeguarding supervision with a group of colleagues in their team. We saw that the one member of staff who had not had supervision was scheduled to begin supervision within a few days of our announced inspection.
  Supervision varied across the disciplines from once a month to every three months.
- Safeguarding supervision had recently been reviewed although the policy on the staff intranet was two years out of date.A lack of capacity to provide safeguarding supervision was identified on the risk register, additional safeguarding supervisors were being trained to provide this, the local Clinical Commissioning Group (CCG) was to monitor for any incidents or concerns related to this in safeguarding practice. Those currently providing safeguarding supervision were specially trained to provide this role. In the sexual health service safeguarding supervision was provided by three members of the sexual health team.

Requires improvement

Are services safe?

- We saw that health visitors and school nurses were routinely notified when a child or young person had attended the emergency department and minor injury units at the local hospitals. They were responsible for assessing the information and ensuring that any required action was taken. A paediatric liaison nurse would contact community staff directly if there was a need to share or gain additional information including safeguarding information.
- Across the trust safeguarding children training at level 1 was completed by 97% of those staff requiring it, level 2 by 81% of staff requiring it and for those requiring level 3 training 93% had completed it. The trust's training target was 80%.
- The trust had two named nurses for safeguarding children, two named consultant paediatricians and a named midwife. In addition there were safeguarding supervisors, a paediatric liaison nurse and one specialist health visitor working with families where children were subject to a child protection plan. There were two named doctors for safeguarding, one for the acute and one for the community and they had monthly supervision with the designated doctor for child protection. There was a newly appointed specialist health visitor who worked exclusively with child protection families approximately 17 families who was responsible for all of the family, supporting them through the safeguarding process and for a period of six to nine months after.
- Members of the safeguarding health team worked on a rota basis with the Multiagency Safeguarding Hub (MASH). Staff working in the community would contact the hub with its focus on early co-ordinated intervention to support both children, young people and vulnerable adults. Information from the monthly Multiagency Risk Assessment Conference for domestic violence which involved children was shared with health visitors and school nurses so that those working with the children were aware of any risks of serious harm.
- Two health visitors and two senior staff told us that health visitors had begun working with school age children subject to a child protection plan up to the age of eight years and that they would attend the child protection case conferences and meetings for these children. Other health visitors we spoke with told us there had been a consultation meeting about this with a working party to start.
- Health visitors and school nurses attended child protection case conferences and 'child in need' support meetings. The number of children and young people subject to a child protection plan had increased from 150 in January 2015 to 212 in December 2015 of which 131 were of school age. National data published in October 2015 for March 2015 showed that Torbay local authority had a rate of 620.2 per 10,000 of 'children in need this being the second highest rate in England. At the time of our inspection there were 290 'looked after children' in the care of the local authority, this was almost double the England average.
- The lack of interface between electronic systems was identified on the risk register in relation to sharing safeguarding information. Physiotherapists told us that the electronic system they used had not alerted them to a child going into the care of the local community. Staff in the sexual health service told us that alerts on their information system identifyingyoung people subject to a child protection plan or being a 'child in need' were updated only once a month. Although the registration process or questions used may identify if there were safeguarding issues, there was a risk that that this information could be missed. This meant that staff working with families and young people may miss important safeguarding information about those they provided care for.

Medicines

- School nursing and community children's nursing staff supported children, young people and parents in the management of the children's medication**.**
- School nurses were responsible for delivering the school health immunisation programme, the pharmacy at Torbay hospital had responsibility for the storage of the vaccines. During our inspection there was no school immunisation session running.
- We saw the trust's policy which included the handling and storage of the vaccines and the packaging used from base to the satellite clinics. Patient Group Directives (PDGs) were in place for medicines used in the immunisation programme, and signed by a

'responsible clinician' with staff signing to show they had read them. This meant there were written instructions for the supply and administration of immunisations for this group of patients. PDG authorisation for the sexual health service was not in line with legislation as the authorisation had not been signed by a 'responsible clinician'. The medication in the sexual health service was securely stored with good stock control and accountability with regular checks, this meant there was sufficient and appropriate medication available.

- Competencies were in place for school nurses administering specialist medicines for example in the treatment of anaphylaxis, a rapid severe potentially life threatening allergic reaction. During our inspection we found that community children's nurses were not having yearly updates on the administration of intra venous fluids. This meant that the trust could not be assured that the nurses were competent in the administration of intra venous fluids.
- In one school location the community children's nurses visited, medication was stored in a non-medical fridge with no temperature monitoring this had been raised with the nurses' managers.
- Health visitor and sexual health nurse prescribers had systems in place to keep their prescription pads secure. Serial numbers, the medicine prescribed and the patient number were recorded in their records, health visitor prescribers also recorded the information on the General Practitioner's (GPs) electronic records.

Environment and equipment

- Maintenance of equipment went through the trust's medical equipment maintenance programme. Staff told us that equipment used such as scales were annually checked and calibrated through the trust's programme, stickers on equipment confirmed this.
- Occupational therapists (OTs) managed equipment across social care and health with referrals from social care disabilities team, schools and paediatricians. Community children's nurses told us there was no general budget for equipment, if a patient needed a specific piece of equipment a request had to be put through to the CCG, no equipment requests had been refused. Staff told us and we saw the risk register from December 2014 reported a lack of equipment for use in the community and identified saturation monitors used to monitor blood oxygen levels as lacking. There was no plan to address this but staff told us that this had not impacted on patients as they had been able to locate equipment as it was needed.
- Health Visitors were based in GP surgeries, two members of staff described and showed there were insufficient computers and space to accommodate all those who needed to use the office. We saw in one office that there was two computers and three desks with potentially five members of staff trying to access computers and desk space at the same time. Sexual health staff also told us there were not enough computers or office space at their base, and would on a daily basis have difficulty accessing a desk and, or computer. Community children's nurses worked from an office accessible up a steep flight of external stairs within Torbay hospital grounds, they often had to carry equipment and did not have allocated parking nearby. Both these environments impacted on the staff's ability to carry out their work in a timely manner. Staff were provided with work mobile phones.

Quality of records

- Health visitors, school nurses, OTs, speech and language therapists, physiotherapists and community children's nurses were using paper patient records, sexual health staff used a combination of paper patient records and electronic notes. Sexual health outreach staff spoke of losing connectivity in clinics with their lap tops while school nurses did not have access to records at schools unless the child, young person already had a care plan. This meant that these staff were sometimes unable to access patient information whilst with the patient. Staff would have to hand write notes and then later type these onto the computer. new electronic birth book had been recently introduced into health visiting this contained details of all the children on a caseload and scheduled when contacts were due in line with the national Healthy Child Programme
- We looked at six Personal Child Health Records held by parents for their children and used by staff working with children and also reviewed 24 other patient records. The Personal Child Health Records held appropriate information about the child, recording assessments, development checks, immunisations, and the child's progress with weights plotted on centile charts. They

were accurate, complete, legible and signed. The health visiting records contained comprehensive family health assessments, information from other agencies working with the family and identified the level and type of support required. They were accurate, complete, legible, signed and stored securely. The majority of community children's nursing patient records were up to date, clear and concise and contained excellent discharge summaries from the children's ward.

- During our inspection we saw evidence of notes audits in the physiotherapy service, children's learning disability service and the speech and language therapy service. From these learning was identified, shared with the team and amendments made, an example being asking for preferred name of the child to be recorded. We were provided with information showing there had been audits of specific health visitor development reviews including recording of information in April 2014 and May 2015 with other note keeping audits having taken place in community children's services in October and November 2015.

Cleanliness, infection control and hygiene

- All areas we visited appeared visibly clean. In the clinics and sessions that we attended we observed staff cleansing their hands by using hand sanitizer between contact with different people using the service.
- In child health clinics we observed disposable paper lining the baby weighing scales and changing mats used, these were cleaned before and after each baby was weighed. Staff told us that toys in clinics were cleaned at the end of each clinic session however no cleaning log was maintained
- Arrangements were in place for the handling, storage and disposal of clinical waste including sharp items. Personal protective equipment was available for staff such as aprons and gloves as required. There were safe systems for the disposal of waste such as nappies. We did not see any audits of hand hygiene.
- The training information provided by the trust for infection prevention and control showed compliance ranged from 70% for the sexual health service to 83% for the health visitors and school nurses. The directorate with community children's nurses and children's therapists, OTs, speech and language therapists and physiotherapists had a compliance rate of 84%.

Mandatory training

- Completion of mandatory training was monitored and staff working within community children's services, therapies and sexual health were required to keep up to date with a range of topics. These included safeguarding children, safeguarding adults, conflict resolution, equality and diversity, fire training, health and safety, infection control, information governance and manual handling. Training rates for December 2015 showed that provided by the trust showed 95% compliance overall for staff working within these services. The trust had training participation targets of 80%. Staff also attended PREVENT training in relation to preventing and mitigating the impact of a potential terrorist attack.
- Most staff reported that access to training was good, and they had found the training useful in their role. For some staff budgetary constraints impacted on the ability to gain non-mandatory training. Paediatricians told us they had good access to training in their job plans.

Assessing and responding to patient risk

- The trust used the Healthy Child Programme and the National Child Measurement Programme assessment stages and tools to identify and respond to children, young people between 0 and 19 years and their families who may be at risk of harm or ill health. The Healthy Child Programme was used by midwives, health visitors and school nurses to identify and support children, young people and families according to their level of need. The levels of service used depending on need and the risk of harm were the universal service, the universal plus for those requiring a brief period of extra support and the universal partnership plus for those families requiring intensive support involving other professionals.
- The health visiting service had taken account of areas of deprivation where families were at higher risk of experiencing social and health disadvantages by allocating smaller caseloads. This meant staff were able to respond to and support the needs of children and families. Health visitors provided antenatal contacts to all pregnant women, these visits and information from the midwives helped identify those women and families requiring extra support. This meant that needs were identified early and support could be offered to reduce the risk of harm or ill health.

Requires improvement

Are services safe?

- Health visiting teams had weekly allocation and team meetings. This was to plan and allocate work including Healthy Child Programme work, families to meet who had transferred into the area, feedback on training, discussion of emergency department and minor injury attendances and referrals for early intervention, support at the weekly early help panel. The scheduled Healthy Child Programme work was generated by an electronic birth book. Once a month the meeting also included allocating regular child health clinics, development checks, liaison on supporting families who were within the universal plus and universal partnership plus level of service. Team business such as reviewing their key performance indicators leave and training arrangements was also discussed. In the meeting we observed there was no robust system regarding allocation of families and their level of need with the capacity of the staff to meet the need. This meant that staff may not be able to respond to family's needs in a timely manner.
- Notification of emergency department and minor injury unit attendance was emailed to the relevant team's secure generic email account. We saw in message books used by staff there was no process to capture what had been reviewed and what action if any had been taken. Staff told us they arranged amongst themselves who would respond to phone messages, emails and phone calls. Staff told us they received on average an hour of clerical support a day and so relied on team members to take and respond to messages. Minutes from a recent health visitors' and school nurses' team leaders' meeting had emphasised the importance of practitioners keeping their answerphone messages and out of office information up to date.
- We observed community children's nurses giving information to parents on the signs and symptoms to look for in case their child became unwell or deteriorated and the necessary action to take. Parents told us they received this information and we saw printed advice and information in PCHRs. School nurses completed education health plans in conjunction with parents and teachers to identify children and young people's health needs and advised how best to support them in school. In the children's learning disability service and in the community children's nursing service those children attending special school we saw that risk assessments had been undertaken. We found there was variable use of risk assessments in the therapy services, there was not a systematic use of them this meant that that some elements of treatment had not been routinely fully assessed or actions planned to minimise risk of harm.

Staffing levels and caseload

- The trust had achieved its planned trajectory of 58.54 whole time equivalents (WTE) by the end of March 2015 for the recruitment of health visitors in line with the expected increase in workforce through the 'Call to Action; Health Visitor Implementation Plan 2011-15'. At the time of our inspection there were 2.58 WTE health visitor vacancies, with one WTE advertised and one held for a health visitor on secondment.
- The health visitors used a recognised caseload weighting tool to determine the number of families they worked with and reported this worked well and they were able to support families appropriately. Caseloads in turn varied from one WTE per 100 children in areas of high deprivation, to one WTE per 400 children in the least deprived areas. Most WTE staff worked one per 150 children. This compared favourably with national benchmarks, meeting nationally recognised targets for numbers of families to health visitor.
- School nursing had 12 WTE school nurses with one WTE vacancy at band 6 and one WTE band 5. The band 6 was being advertised, the band 5 was covered by bank staff with three school nurse students due to qualify in July 2016. The school nursing team were responsible for 44 schools including nine secondary schools. National guidance from the Royal College of Nursing (RCN) recommends one qualified school nurse for each secondary school and its cluster of primary schools. The trust was meeting this recommendation. Staff told us that around 40% of the school nurses workload was working with children and young people in relation to safeguarding. The school nursing service was using a recognised weighting tool based on a demand led approach to inform what staff were needed and where. A weekly allocation meeting was used to plan the delivery of the service and meet the varied needs.
- At the time of our inspection there were 290 'looked after children' in the care of the local authority, the trust had identified a lack of capacity and was looking at increasing the hours in looked after children' nursing. There was one WTE looked after children nurse jointly

funded with the CCG who worked with the local authority. Over a ten month period health visitors undertook review health assessments for 48 'looked after children' under the age of five years, while school nurses undertook 78 'looked after' children review health assessments in this period. Given the number of review health assessments completed and the capacity of the looked after children nurse the trust was not able to complete all the review health assessments required for the 'looked after children'.

- The children's learning disability team had a permanent 0.8 WTE lead specialist nurse, a 0.67 band 5 nurse, a key worker and a temporary 0.40 band 6 nurse and 0.40 admin support. The temporary band 6 had been employed as a result of a long wait list. The service had been closed in the recent past due to staff sickness. At the time of our inspection the team had an active caseload of 67 children.
- The community children's team consisted of 1.0 WTE team leader, 2.0 WTE team co-ordinators (one for diabetes), 2.0 nursery nurses, a 1.0 WTE epilepsy nurse, a 0.80 WTE respiratory nurse, one 0.8 WTE paediatric nurse, and a newly appointed respiratory/allergy nurse. The total active caseload for these staff was 195 children. There was 0.62 WTE registered nurses, who supported children in special schools. There were also 3.31 WTE specialist nurses supporting a caseload of 140 diabetic children. The number of community children's nurses for the child population of the trust met the recommendation set out by the Royal College of Nursing.
- The sexual health outreach service consisted of a matron, a team leader and three health advisors who undertook assessments for vulnerable clients and contact tracing and a young men and boy's worker (who had sexual health training).
- The trust had two named doctors for safeguarding, one for the acute and one for the community and a designated doctor for child protection.The trust had identified on their risk register a shortage of middle grade doctors, this was being discussed at a regional level. There were two associate specialists and three community paediatricians with particular interests who saw children and young people in the child development centre.
- In speech and language therapy there was a clinical manager and 18 WTE posts with staffing allocation in response to capacity and demand.
- The physiotherapy team had nine members of staff with two technical assistants based at two special schools. They did caseload analysis regularly and used a prioritisation tool, they had some surplus hours and were planning to recruit some band 3 hours. There were eight WTE occupational therapists with referrals coming from children's social care disabilities team, schools and paediatricians.

Managing anticipated risks

- Health visitors and school nurses were working with high levels of need, staff we spoke with were not aware of contingency planning to ensure there was adequate caseload cover. Staff reported they helped each other out but did not have criteria that would trigger a response or a course of action. Staff told us they could call upon their team leader if they needed extra help. The trust incident plan published in May 2014 and due for review in January 2016 stated that if a major incident occurred health visiting activity would be suspended up to five days and school nursing suspended indefinitely. There were no management plans for example for seasonal fluctuations in demand due to adverse weather or disruption to staffing.
- On a daily basis health visitors and community children's nurses used a white board in their office to indicate to colleagues where they were visiting and their schedule for the day. Health visitors also had an office desk diary with their diary schedules in. We saw in family's and children's records where staff would visit that homes had undergone a risk assessment to minimise the risk of injury to staff. Staff with shared electronic calendars to share schedules, reported variable use of these. Each member of staff working in the community had a mobile phone with an alarm on that went straight to the security department at the hospital. Staff told us these were tested regularly.

Good

Are services effective?

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

Summary

We rated services for children, young people and families as good for effective:

- The trust had identified on the risk register that a large number of guidelines were in need of updating.
- National and evidence based practice guidelines were used to define services and followed. The trust was following the Healthy Child Programme.
- The trust was not meeting all of its key performance indicators but it was performing in line with the England average.
- The trust had achieved stage 3 in the UNICEF Baby Friendly Breastfeeding accreditation. The trust had achieved 50% uptake of the annual flu immunisation surpassing the trust target of 30%
- There were many good examples of multidisciplinary (MDT) working and joint pathways across the services. Staff were able to contribute to professional practice.
- There was a preceptorship programme with set meetings and guidance in place to support newly qualified health visitors and school nurses.

Evidence based care and treatment

- The service delivered the full Healthy Child Programme with a schedule of screening, immunisation and health and development reviews as set out by the Department of Health. A main theme of this programme is the early identification of need and the support of families to improve health and wellbeing and reduce health inequalities. Health visitors were using a family health needs assessment based on the framework of assessment and a genogram to assess the needs of the family and how best to support them. As well as the level of service, to the community and as indicated by need to individual families, the DH advocates six high impact areas of work. These areas include the transition to parenthood, maternal mental health, breastfeeding, healthy weight, managing minor illness and accident prevention and healthy two year olds and school readiness.
- The Healthy Child Programme the health visitors provided was an antenatal visit at 28 weeks of pregnancy, a new birth visit between 10 and 14 days postnatally, a 6 to 8 week post-natal review with a maternal mood review, a 3 to 4 month review, a twelve month review and a two to and a half year review. In addition to the six high impact areas of work some health visitors provided an antenatal class using an evidence based model to promote sensitive effective parenting so supporting the transition into parenthood.
- Regular child health clinics were held across the area for parents to access advice and to monitor the growth and development of their young children, parents were also signposted to regular baby weaning groups. We observed health visitors discussing accident prevention and managing minor illness with parents. The health visitors were using a tool with pregnant women to help prepare support they might need to look after their mental health, acknowledging it can be a time when women can experience changes in their emotional health.
- The health visiting service had achieved the UNICEF and World Health Organisation (WHO) final stage 3 Baby Friendly breastfeeding accreditation. This is an evidence based approach to support breastfeeding by improving standards of care and support. The stage 3 assessment had involved assessing that mothers were supported with feeding so they could continue to breastfeed for as long as they wished and that they had been given useful accurate information. Also it had assessed that parents had been supported to recognise the importance of relationships and how to build these.
- The school nurses delivered the routine school immunisation programme and the NCMP as set out by Public Health England and the DH. The National Child Measurement Programme consisted of measuring the weight and height of children in reception class (age 4 to 5 years) and year 6 (age 10 to 11 years) to assess overweight and obesity levels. This provided staff with an opportunity to engage with children and families about healthy lifestyles. School nurses also provided termly meetings with schools and a regular drop in for students in the school.

Good

Are services effective?

- Staff across the services told us how had presented proposals for new guidelines based on their specialist interest and new guidance, this then went through a trust ratification process and implementation. The pregnancy and post birth wellbeing plan used antenatally by health visitors had been developed in this way.
- The sexual health service was meeting the objectives of the National Chlamydia Screening Programme, we saw how the service was ensuring that young people had access to sexual health services and normalised the idea of regular chlamydia screening among young adults. Sexual health services followed guidance and service standards from the Faculty of Sexual and Reproductive Healthcare and other professional bodies. An example of this was the management and follow up of a woman or young person requesting emergency contraception.
- The children's learning disability team had accredited trainers for 'talking mats', this was an interactive resource with three sets of picture communication symbols, topics, options and a feelings symbol. This was used to give the child a 'voice', the team had used a talking mat with a child not going to school, the child was able to communicate their likes and dislikes.
- The community children's nurse working with children with epilepsy was using guidelines from the National Institute of Clinical Excellence (NICE) to guide practice. The speech and language therapy service used guidelines from the Royal College of Speech and Language therapy to prioritise clients and manage the caseload. The physiotherapy service had developed clinical pathways following NICE guidelines an example was a spasticity pathway following NICE guidance.
- For 'looked after' children there were health assessments determined by national statutory guidance.
- The trust had identified on the risk register that a large number of guidelines within the directorate responsible for therapies, paediatricians, community children's nurses, the children's learning disability and the sexual health service were in need of updating, this was being looked at by the trust's clinical effectiveness group. At the time of our inspection the trust provided a hybrid Family Nurse Partnership service called the Family Health Partnership, this provided a service to teenage parents expecting their first child until the child reached two years of age. The team was only able to provide a service to 50% of the eligible young people (19 years and under and care leavers up to 24 years of age). We were informed during the inspection that this service would end at the end of March 2016. This service was not part of the national Family Nurse Partnership , which is based on over 35 years of research, having been introduced into England in 2007 and rolled out in certain parts of England.

Pain relief

- The children's community nursing team included pain as part of their nursing assessment and used tools appropriate to the child's age to assess pain.

Nutrition and hydration

- Staff supported breastfeeding one to one with parents and were able to signpost families to regular breastfeeding support groups in local facilities. The latest national data available indicated that in the first quarter of 2015/16 nationally 73.8% of women initiated breastfeeding at 6 to 8 weeks postnatally 45.2% of women were breastfeeding. Information provided by the trust during our inspection reported that 55% of women initiated breastfeeding and 41.4% were still breastfeeding at 6 weeks. The initiation rate provided by the trust was not available on the national database but the percentage of 55% was within the ten lowest initiation rates recorded nationally. The percentage breastfeeding at 6 weeks was slightly lower than the national average. Health visitors signposted parents and carers to local regular baby weaning groups.
- School nurses offered advice on healthy eating through school drop in sessions and following on from the NCMP delivered in schools. Other members of the community children and young people services supported children with complex health needs to support their nutritional and hydration needs. An example of this were community children's nurses supporting children with a gastrostomy, where the child required feeding via a device inserted through an opening in the child's abdomen.

Technology and telemedicine

Good

Are services effective?

- The sexual health team had laptop computers they could take with them to the clinics however they reported there were often problems with connectivity. They often had to write on paper notes and then input it onto the electronic notes at the base. Staff in the community children and young people service did not use electronic health records or mobile working (staff having the ability to access children's clinical notes when out on visits using laptop computers).

Patient outcomes

- Performance indicators for the Healthy Child Programme showed the percentage of parents and children who had received checks within the prescribed timescales, these indicators were provided by the trust and were also available from national data for the year to date (YTD).
  - 85% of women for the YTD had received an antenatal contact at 28 weeks gestation with no target set by the trust or nationally.
  - For a new birth visit between 10 and 14 days postnatally 87% had received this, this was comparable with the England average, the trust's target was 95%.
  - For the 6 to 8 week 79% of children had received this comparable with the England average, with a target of 40 to 90%.
  - The percentage of children who had received the 12 month review by 15 months was 91%, for England it was 79%, the trust's target was 98%.
  - The percentage of children who received a two and a half year review was 84%, for England it was 72%, the trust's target was 95%.
  - Audits had been completed on health visitor Healthy Child Programme checks in relation to timeliness and content.
- In school nursing the service was on track to achieve its trust target of 85% in the NCMP. The trust had achieved 50% uptake of the annual flu immunisation surpassing the trust target of 30%. In the sexual health service the chlamydia detection rate was higher than the England average, the syphilis and gonorrhoea diagnosis rates were below the England average. There were lower numbers of HIV diagnoses than the England average. The teenage conception rate was not significantly different from the England average. The trust was not performing well on the national diabetes audit, it performed worse than the England average for the paediatric national audit though the mean HbA1C measurement which showed increased risk of long term conditions was comparable with the average and within the threshold region.
- Figures provided by the trust for December 2015 showed that over a twelve month period 42 out of the required 78 initial health assessments for when children and young people first came into the care of the local authority, were not completed within the statutory time frame of 20 days. The trust provided a graph identifying the numbers of initial health assessments that were delayed and the numbers that they cited were due to a delay in paperwork being received by health, we were unable to verify this. This delay in meeting the time scales was identified in the risk register with an action plan for the prompt administration of paperwork. Senior staff told us it was a challenge for the review health assessments to be completed. The latest national figures for 2014 for children in the care of the local authority showed that locally 85% of 'looked after children' had received an annual health review, this compared with a national average of 88%,and locally 71% were up to date with their immunisations, compared with a national average of 87%.
- Physiotherapists and OTs gave us examples of setting outcome measures for groups held and recording these in the patients' records. The speech and language therapists kept records of the number of referrals and discharges.
- Community children's nursing staff told us there was no outcome measuring being undertaken.

Competent staff

- The majority of staff told us they had good access to training and had regular clinical supervision and team meetings, a few told us that budget constraints meant it was difficult to attend more than mandatory training. Those having clinical supervision and team meetings told us they found them helpful for their professional practice. There was no record of clinical competence for community children's nurses, they were deemed to be 'competent if don't have a break in service'. Some of

these staff received opportunistic specialist training by colleagues. OT staff spoke of lacking in sensory and autism training. Community children's nurses told us that they did not have a palliative care nurse but that if a patient was near the end of their life they would support the family and child 'out of good will'.

- Staff told us that training and appraisals were flagged up electronically 90 days before they were due both to the manager and the staff member. Paediatricians told us they had signed appraised job plans. Paediatricians and OTs spoke highly of having good access to peer support. Appraisal rates varied from 77% to 100% across the community children and young people services. Staff told us they found appraisals useful and meaningful.
- Paediatricians and OTs spoke of having good access to peer support. Health visitors reported that restorative supervision was to start, the aim being to support the needs of staff working with complex caseloads, one member of staff described it as 'helping us to be emotionally resilient'. There was a preceptorship programme with set meetings and guidance in place to support newly qualified health visitors and school nurses. Health visitors told us of joint preceptorship with social work and midwifery students. Newly qualified health visitors told us that they felt well supported. Health visitors reported good support for training and development. Both school nurses and health visitors spoke positively of the practice forums which offered staff clinical expertise and where staff could propose possible areas of further work to support families and children. During our inspection we found that health visitors and their nursery nurse colleagues were having to complete multiple administrative tasks, including dropping and picking up internal post between community bases, answering the phone and filing. Health visitors spoke of having one hour of administrative support a day, although there was a plan to move to electronic records, this was an inappropriate use of their time and skills.

Multi-disciplinary working and coordinated care pathways

- There was good engagement with other providers and across disciplines, we saw some excellent examples of multidisciplinary working. These included a representative from the sexual health outreach team sitting on the monthly Missing Child and Sexual Exploitation (MCSE) group and the community children's nurses working with the generic school nurse in special schools. The community children's nurses worked closely with the children's ward and the paediatricians. Examples of these were nurses working with the gastroenterologist in the care of children with gastronomies and an observation of a community children's diabetic nurse liaising with the acute team that a family may not be able to download their blood results.
- We observed multidisciplinary meetings involving many professionals. These ranged from an early help panel whose purpose was to identify how to support families at an early stage to prevent an escalation, deterioration in their wellbeing, to looking into how best to support a child with epilepsy. In many areas we saw clear referral criteria and pathways for effective evidence based care such as the joint hyper mobility physiotherapy and OT clinic and the chronic fatigue clinic physiotherapists had with psychology.
- We observed comprehensive discharge summaries from the ward to the community children's nurse and from the paediatric liaison nurse to the health visitor. Children centre staff attended child health clinics once a month to share information about the services they provided and to give healthy start vitamins to those who were eligible.
- Health visitors were based in GP surgeries and had monthly safeguarding meetings with the GP and the midwife. Workers from the Child and Adolescent Mental Health Service (CAMHS) also held meetings every three months with teams of health visitors to discuss how to support some families with their children. Health visitors were also able to liaise with members of the perinatal mental health team and do joint visits as appropriate. The Learning Disability CAMHS nurse link attended the children's learning disability team for their 'referrals' meeting every two weeks. The health visitors attended the Children's Centre advisory board meetings and the health visiting teams jointly provided some services there. The practice forums held for the health visitors and school nurses also invited other disciplines to share best practice, recently the children's learning disability team had attended. Health visitors and school nurses worked closely with the LAC nurse to undertake the review health assessments. Other examples of

multidisciplinary working were the neurodevelopmental clinics and the physio postural management clinics held at a special school with the consultant and having access to the hip database.

Referral, transfer, discharge and transition

- When families moved into an area and registered with a GP there was an effective system of notifying the health visitor and an agreed process and timescale in which to make contact with the family and assess their needs. Families were invited to a child health clinic and if the family came from out of area they were also offered a home visit. Health visitors and school nurses had clear criteria and referral processes to other disciplines. When families or children transferred out of the area or moved onto school the health visitor would inform the new practitioner. School nurses offered school entry checks to those children starting school in reception class. Community children's nurses, the children's learning disabilities team, and the therapies teams had referral and discharge criteria. They had methods for triaging, signposting, prioritising patients for treatment and for managing caseloads, waiting times.
- The sexual health team referred patients to other services when necessary for example gynaecology.
- General referrals for an assessment by a paediatrician came through to the community paediatricians who met monthly to discuss the referrals as to whether they were appropriate. Some staff told us that there was no criteria or forms to assist referrers. Some referrals came through 'Choose and Book' from other areas. There was no auditing of the various referral routes.
- The trust was in the process of developing a transition plan showing the processes and professionals to be involved in a patient moving from children's services to adult services and a transition flow chart for use by outpatient staff for those patients attending specialist clinics of which we saw copies. The transition plan set out the process of referral to a single point of access leading to a triage meeting with a multidisciplinary team with eligibility criteria to actions in response to the decisions agreed on.

Access to information

- The child health service was responsible for collecting and requesting information about children living or moving into the area including information on immunisation status, birth details and development checks. It also forwarded information when children moved into a new area. Child health were collating information on the 12 month and two and a half year review undertaken by the health visitor and inputting this onto national data sets. The child health service created lists of children who required immunisations and sent these to the GPs and school nurses. An electronic birth book had recently been introduced to the health visiting service it contained details of the children and families on the caseload and was used to schedule and record the contacts aligned to the HCP.
- The community children and young people's service used paper patient records, the sexual health service had access to laptops and their own electronic record system but often used paper records when there was poor connectivity. Some disciplines were able to access the hospital electronic notes but staff spoke of systems not linking. All staff had access to the trust wide intranet on computers in their office. The intranet held the trust's current policies, different disciplines had access to information such as the assessment and referral forms they used. OTs were able to access the hospital electronic patient records system. Health visitors were able to access GP records. We saw in documentation provided after our inspection that an introduction of the universal electronic system was planned for roll out in early summer 2016 firstly to the health visitors and school nurses.

Consent

- Staff told us they obtained children, young people and families' consent prior to commencing treatment. They were aware of the assessment of competency/Fraser guidelines for children and young people. This framework was used when deciding whether a child or young person was mature enough to make decisions without parental consent.
- There were protocols for gaining parental consent for school entry checks. Procedures had been modified for gaining immunisation consent. Observations of practice within the services showed staff asked for people's consent before any interventions of care.

Good

Are services caring?

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

Summary

We rated services for children, young people and families as good because:

- All the parents and young people we spoke with told us they were treated with respect and kindness and felt involved in all decisions about their care. Staff provided information in a variety of ways and people were able to access help in communicating.
- People were supported emotionally. At the antenatal contact health visitors asked the woman to think about the support they may need to look after their mental health and wellbeing.
- Staff were passionate about the care they provided and wanted to support and improve outcomes for the families, children and young people.

Compassionate care

- In all the areas we visited staff provided treatment and care in a kind and compassionate way and treated people with respect. A parent with a young child at clinic said 'they have been lovely, I had a c- section, they came to the home, I didn't come to clinic for two months, I struggled with breastfeeding they came and really helped'. All the parents, carers, and young people that we spoke with were very positive about how staff had treated them.
- Staff took time to listen and were considerate, when a clinic was busy and the person wanted to discuss a personal matter the staff member took them into another room to talk. Staff saw children as individuals with their own emotional and social needs with advice guided by being attuned to your child and responding to their cues, and needs.
- A young person using the sexual health service told us they were 'comfortable coming here, never felt awkward, has a friendly feel, aware of confidentiality'
- All the staff we spoke with were passionate about the care they provided, one person said 'we're here to give the best care for our patients, we want to empower them'. Staff were sensitive and experienced in responding to children and were able to adapt their approach to make the child feel more comfortable. An example of this was when a nursery nurse encouraged a child to join in an activity while the carer spoke to a health visitor.

Understanding and involvement of patients and those close to them

- We saw that staff took the time to tell the child in an age appropriate manner what was going to happen and encouraged them to ask any questions about the treatment. We observed interaction between health visitors and parents being parent led. This meant that the needs of the parents were foremost and listened and responded to. Future care and support was always jointly agreed.
- We observed that staff provided information on how to access services and support and in various formats.
- Children and parents were involved in the development of education health plans. 'Looked after' children were involved in agreeing their health plans and these were written appropriate to their age. Parents and young people were fully involved in multiagency meetings and were encouraged to think about what support would help them and the planning, scheduling of it. The school nurses had given smiley faces to children after they were given the flu immunisation and asked them to draw on it to indicate how they tolerated it. Children and young people were able to access advocates and children who needed additional support to express their views were able to use communication aids such as talking mats. Team members within the children's learning disability team were able to use Makaton, a form of communication using signs and symbols.

Emotional support

- We observed that clients were supported emotionally. Mothers we spoke with described discussions about their emotional wellbeing and how they had been supported. At the antenatal contact health visitors asked the woman to think about the support they may need to look after their mental health and wellbeing, they were also given a sheet with some questions to

Good

Are services caring?

reflect on. A maternal mood review was offered postnatally to assess emotional wellbeing, there was a pathway with guidelines with actions to be taken as appropriate.

- Evidence shows that nationally 10 to 15% of all postnatal women will suffer from mild to moderate depression with the majority being supported by their GP and health visitor. For those who require more intensive support the trust provided a perinatal mental health outreach service. Parents had access to post-natal groups in local venues that offered social interaction and parenting information and support for parents with young babies. Looked after children were able to access dedicated psychological support.

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We rated services for children, young people and families to requires improvement for responsive because:

- Initial health assessments for 'looked after' children were not meeting the statutory timescales.
- There was a long waiting list for an assessment to diagnose an autistic spectrum disorder at the CDC. At the time of our inspection for those aged 5 to 18 years documentation showed there was a 17 month wait time, this was on the trust's risk register. This meant that there was a delay in assessing the developmental needs of these children and accessing treatment and support appropriate to their needs.
- Guidance on how to make a complaint was not on display. This meant people were not prompted to formally make a complaint. It was recognised by the trust that complaints handling was an area requiring improvement.

However:

- Staff told us that they prioritised work with people in vulnerable circumstances and would see people at times and places convenient for the young people and parents or carers. We saw evidence of person-centred care that showed community staff were responsive to individual needs and worked flexibly with people towards improved health and wellbeing. There were specialist workers available such as the young men and boy's worker (who had sexual health training).

Planning and delivering services which meet people's needs

- The service managers of the community children and young people service told us they had a good working relationship with the commissioners of health visitors and school nurses, these being the local authority and the local CCG.
- Information provided by the trust showed that local children and young people had been involved in interviews for paediatricians in November 2015, the children and young people's views were sought over how knowledgeable and approachable they thought the candidates were.
- The health visiting and school nursing services were aligned with the Healthy Child Programme and the National Child Measurement Programme. The school immunisation programme was commissioned by NHS England.
- The health visiting workforce had increased as a result of the national Call to Action: Health Visitor Implementation Plan. The caseload weighting was linked with levels of deprivation and health visitors were identifying and responding to need at an early stage. Senior staff told us that health visitors were to extend their role to include children subject to a child protection plan up to the age of eight years on their caseload. This was in response to the increase in children subject to a child protection plan and the larger health visiting workforce.
- Health visitors and school nurses undertook review health assessments for 'looked after' children, twice a year for the under-fives and annually for the over fives. There were 290 'looked after children' at the time of our inspection, a reduction from 297 in October 2014. There was one WTE looked after' nurse, this had increased from 0.40 WTE one year ago. The 'looked after' children preferred to be seen after school for their reviews and were reported to prefer to see the school nurse. The service managers reported that they needed a total of three WTE looked after' children nurses to meet the needs of the 'looked after' children.
- The trust had a significantly higher number of teenage mothers than the England average, the targeted service which had been reaching 50% of the eligible young people was finishing at the end of March 2016.
- The OT team was setting up a parent group to address sensory issues, it reported they were lacking in autism resources with a lack of capacity in the child development centre, they had raised this as a concern with the chief executive officer.
- Contraception services had walk in sessions over one lunchtime period a week at secondary schools and there were young people specific walk in sexual health sessions in general health centres, clinics and in one community hospital.

Equality and diversity

Requires improvement

Are services responsive to people's needs?

- We observed that the clinical areas we visited were accessible to people with disabilities. There was an interpretation service where an interpreter could be booked to join the staff member for appointments. The leaflets for clients we saw were in English, we did not see leaflets in other languages.
- Staff received equality and diversity training as part of their mandatory training. Physiotherapists were able to do a report with pictures for parents with a learning disability and had done videos for those who were unable to read.

Meeting the needs of people in vulnerable circumstances

- Health visitors and school nurses undertook review health assessments for 'looked after' children, identified health needs and took action on these. National data showed that the immunisation rate for 'looked after children' was lower than the England average for this group of children and young people.
- Staff told us that they prioritised work with people in vulnerable circumstances and would see people at times and places convenient for the young people and parents or carers. There was a specialist school nurse working with vulnerable families focusing on work with children aged 11 to 18 years and supporting their emotional health and wellbeing. The sexual outreach service had a young men and boy's worker (who had sexual health training).
- Children centres positioned in areas of multiple deprivation ran groups for families and these were well used.
- The children's learning disability team had looked at the 'did not attend' appointments and they now held clinics more centrally at Paignton library. The team was trying to set up a text service as a result from parent feedback. OTs undertook home visits and physiotherapists would do a home visit to meet the needs of a patient. Staff told us that when there was a child with a learning disability on the ward, the adult learning disability liaison nurse was called to the ward and not the child learning disability lead.

Access to the right care at the right time

- There was a long waiting list for an assessment to diagnose an autistic spectrum disorder at the Child Development Centre. At the time of our inspection for those aged 5 to 18 years documentation showed there was a 17 month wait time, this was on the trust's risk register. The average waiting time for general community paediatric assessments was between 14 weeks and six months. In the Child Development Centre sessions there was a nurse from CAMHS working with children and young people with attention deficit hyperactivity disorder (ADHD).
- The community children's nurses worked from 9am until 5pm, during these hours they covered each other, outside these hours if a child was unwell they would have to access the emergency department at the hospital. There was no response line or open access to the ward.
- The sexual health service ran clinics in community bases and sessions in all but one of the secondary schools (one school did not accept the service). Clinics, sessions and school drop ins were organised to be convenient and accessible for young people. Child health clinics ran throughout the week in various locations so that parents and carers could access them.
- OTs, physiotherapists and speech and language therapists working in the Child Development Centre spoke of a lack of capacity and that appointments had been doubled to increase the amount of children coming through but with the same amount of staff. Staff reported finding it difficult to cope with the increased workload and had difficulty doing follow up work. Speech and language therapy had waiting times in their service of 13 weeks and reported that referrals from consultants were increasing each year. Staff told us there was limited psychology capacity for assessments, this had been identified on the risk register with a control measure being that new staff had recently been recruited. The OTs held weekly joint assessments in the Child Development Centre, speech and language therapy took part in multidisciplinary (MDT) meetings each month. Staff spoke of lack of capacity from CAMHS, at the end of our inspection we understood that CAMHS was now meeting with the paediatricians and we saw a plan for the development of multiagency pathways to ensure children and young people's emotional health needs were addressed.

Learning from complaints and concerns

- Guidance on how to make a complaint was not on display in clinical areas where families, carers, children

Requires improvement

Are services responsive to people's needs?

and young people were seen or treated. This meant people were not prompted to formally make a complaint or able to be informed of the patient advise and liaison service (PALs).

- The trust had informed us that complaints handling was an area for the trust to improve on.
- The Feedback and Complaints policy was published in October 2013 and was due for review in October 2015. Minutes from the complaints panel meeting did not clearly show what learning had occurred or change it had affected in the organisation.
- Staff told us that there had been a few complaints from parents about long waits for CDC assessments and they had counselled parents about long waits. The possibility of complaints regarding long waits for appointments for those children and young people with ADHD was on the risk register and stated that complaints would be forwarded to the commissioners.

Requires improvement

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated services for children, young people and families as requires improvement for well led because:

- The community children and young people services came under two separate delivery units in the trust. In one of the delivery units the staff were unclear about responsibilities above team leader level where it became disjointed.
- There was a lack of oversight of the Child Development Centre and its future was uncertain. Staff working in the Child Development Centre faced challenges in meeting patients' needs in a timely manner and there was uncertainty over the centre's future. There were no clear plans on how to address the challenges in the Child Development Centre .
- One service had closed temporarily due to staff sickness, there did not appear to have been a risk assessment as to the impact this could have on the children and young people it served.
- There was a lack of clarity about future roles and the responsibilities for health visitors possibly changing or expanding.
- There did not appear to have been an assessment of the staff's competency and capacity to safely meet the needs of a wider remit of children and young people in vulnerable circumstances.

However:

- There was strong leadership in the majority of the teams and staff spoke of working well in their teams.
- Staff spoke positively of their managers, peers and of senior leadership. Staff told us that leaders were visible and had spent time with them in their clinical areas. Staff felt that they were making positive changes to the lives of the children and families they worked with. Most staff told us they felt involved in making decisions about their work.

Service vision

- There was a trust vision but not a vision for the community children and young people's service. This service came under two delivery units in the trust. Health visiting and school nursing sat under one manager within the public health provider unit. Within the women's children's diagnostics and therapies service delivery unit there were the therapies, with an associate. In child health there were the community children's nurses, the CDC, the paediatricians and safeguarding with the looked after children's nurse and under women's health was sexual medicine.
- The relevant themes in one strategy were to provide a sustainable medical model in child health, a community medical devices loan service, to improve accessibility to sexual medicine services and to increase the safeguarding resource across the whole trust. The other strategy was the service transformation of health visiting service to follow national specification and evidence based practice to meet the needs of the complex demography and to further develop services with the commissioners.
- The trust's vision was 'a community where we are all supported and empowered to be as well and as independent as possible, able to manage our own health and wellbeing in our homes; when we need care we have choice about how our needs are met, only having to tell our story once'.
- The trust wanted to have integrated structures underpinned by performance management framework and to support the staff through the changes ahead. The trust's mission statement was 'working with you for you'. Staff spoke of working well in their teams but many identified a lack of strategy for the Child Development Centre and some in senior roles spoke of services needing to be logically aligned.

Governance, risk management and quality measurement

- The community services for children and young people came under two delivery units in the trust. HV and school nursing came under the public health provider unit. Women's children's diagnostics and therapies held therapies, a child health unit that comprised of community children's nurses, the CDC, paediatricians, safeguarding with LAC, with sexual health under women's health.

Requires improvement

Are services well-led?

- On the risk register the long waiting list of 17 months for children on the autistic spectrum to be seen in the CDC was identified as needing a long term plan to resolve the situation. This had been identified in November 2009 and had been on the risk register for six years. A plan to reduce the backlog of those waiting to nine months by May 2016 had been initiated by doubling the amount of children being seen but with no extra resources. The uncertain future of the CDC was on the risk register with a new location being sought. There appeared to be a lack of oversight of the CDC.
- There was some inconsistency in that one service, the community children's nursing service, staff did not receive clinical supervision or have their competencies assessed. There were also a risk of physical injury for staff with the access to their office which was via a steep external stairway, staff often had to carry equipment up and down the stairs
- One service the children's learning disability service had been closed temporarily in 2014 due to staff sickness, there did not appear to have been a contingency plan in place to prevent this occurring or a risk assessment as to the impact this could have on the children and young people it served. In the public health provider unit there appeared to be clear processes for the cascading of information and for accountability
- There did not appear to be robust procedures in health visiting for weighting and allocating work given to colleagues when staff were on unplanned leave. There was no robust process to ensure messages and the emails on the generic email accounts, related to families they supported, had been acted on in a timely manner. We observed that staff ticked to indicate they had seen a written message but did not sign or record what action had been. When we looked at two message books, some messages had not been ticked from a couple of days previously, this meant it was not clear what if anything had been done, when and by whom. Staff told us there was no rota or duty system for checking emails and messages and they relied informally on each other. This meant there was not a trail of what messages had been received, the timeliness of response and the action taken. Good communication and information sharing have been identified as key in work with vulnerable families. Health visitors had minimal administrative support, health visitors and nursery nurses spent inappropriate amounts of time on administrative tasks.
- There was a lack of clarity about future roles and the responsibilities for health visitors possibly changing or expanding. There was the disbanding of the Family Health Partnership and the plan was that the young parents would be absorbed into the generic health visiting teams with the current FHP health visitors joining the generic service. There was also a change for health visitors in the extension of their role to include children up to the age of eight years subject to a child protection plan. Some staff stated the expansion in their role of working with children up to the age of eight years had started while others stated it was in development. There did not appear to have been an assessment of the staff's competency and capacity to safely meet the needs of children and young people in vulnerable circumstances such as the high numbers of children subject to a child protection plan, the high numbers of 'looked after children' and 'children in need' and a significantly higher number of teenage mothers than the England average.

Leadership of this service

- Staff spoke positively of their managers, peers and of senior leadership. Middle managers did not appear empowered and needed support to further develop in their role. Staff told us that senior members of the trust were visible and had spent time with them in their clinical areas. Consultant paediatricians told us they could approach the trust board at any time and the children's learning disability team told us the Chief Executive had spent a day with them resulting in changes to their base. There appeared to be a lack of leadership and oversight, redesign of the Child Development Centre and of addressing the issues identified on the trust's risk register relating to this service.
- The majority of staff amongst the services had regular team meetings within their teams and then meetings with their team leader. For the majority of the team leaders the managers for their services were supportive, within the women's children's diagnostics and therapies delivery unit beyond team leader level it then became disjointed and staff were unclear about responsibilities.

Culture within this service

Requires improvement

Are services well-led?

- Staff we met were passionate about their work and dedicated to providing an excellent standard of care. People told us there was an open culture and they were encouraged to report anything they were concerned about.
- All community staff described their teams as supportive and working well together. Most staff we spoke with did not work extra unpaid hours but some did not take adequate breaks.
- Staff felt that they were making positive changes to the lives of the children and families they worked with.
- The risk register also stated that morale was low amongst staff in the CDC and staff were unclear about its future. Staff told us of difficulties they faced working there.

Staff engagement

- Most staff told us they felt involved in making decisions about their work. The trust had an awards presentation to give public recognition to the hard work of those working within the organisation. This was called the 'Blue Shield Awards', we saw that the Torbay Sexual Medicine Service received a highly commended award for 2014 to 2015 and the team leader in school nursing had received an award at the previous presentation. The trust had been winners of the national WOW awards 2015 for 'best use of the awards'. The awards come from people using the service being invited to nominate a service or person for an award from who they have had great service. The aim of these awards are to engage employees and improve customer service, they are awarded to a wide range of public and private organisations.

Public engagement

- We requested information on patient feedback from community children and young people's services. Results for September 2015 to the end of January 2016 from the Friends and Family Test (FFT) were provided for those using the health visiting and school nursing service. 82% had reported that they were extremely likely to recommend the service, with 15% likely to and the remainder had reported 'don't know'.

Innovation, improvement and sustainability

- The trajectory for the training and recruitment of health visitors had been met and there had been an increase of 160% over four years to this workforce. The school nurses had had minimal recruitment and yet much of the safeguarding work was in the school age population.
- Staff working in community children and young people's services were guided by evidence based practice and were able to initiate new pathways of care. Staff told us there were opportunities to lead on areas of interest and to develop their role.
- Staff working in the CDC faced challenges in meeting patients' needs in a timely manner and there was uncertainty over the centre's future. There were no clear plans on how to address the challenges in the CDC. Some staff told us that there were budgetary constraints on equipment and training. Staff were mostly able to order and obtain particular items for individual patients and if particular training was required either sought it in house from colleagues or put a bid in for specific funding.
- The trust was involved with the Social Work Innovation Fund Torbay (SWIFT) a project developing a public services trust for Torbay, the project brought together such agencies as the local authority, education, police, and the voluntary and community Sector. This project was looking at enabling co-commissioning and co-delivery through pooled budgets.
- A reduction in the public health budget from the commissioners for 2016 to 2017 was resulting in removing the difference in funding from band 7 for FHP nurses to band 6 for generic health visitors. This was leading to the FHP service being disbanded and the families transferring to the generic health visiting team.

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	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2)(c) Records must be accessible to authorised people as necessary. Not all staff were able to access the electronic and paper records when required to access information.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitability qualified, competent skilled and experienced staff must be deployed to make sure they can meet peoples needs Regulation 18 (1) (c) A lack of capacity in the looked after children (LAC) nurse role had been identified as had a shortage of middle grade doctors.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(1) Care and treatment must be provided in a safe way for service users

This section is primarily information for the provider

Requirement notices

12(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include –

(a) assessing the risks to the health and safety of service users of receiving the care or treatment

(b) doing all that is reasonably practicable to mitigate any such risks.

Initial health assessments for 'looked after' children were not meeting the statutory timescales. There was a long waiting list for an assessment to diagnose an autistic spectrum disorder at the CDC. At the time of our inspection for those aged 5 to 18 years documentation showed there was a 17 month wait time.