TORBAY COUNCIL

Minutes of the Children and Young People's Overview and Scrutiny Sub-Board

19 January 2026

-: Present :-

Councillor Law (Chairwoman)

Councillors Fellows (Vice-Chair), Foster, Nicolaou and Tolchard

Statutory Co-opted Member
Jo Hunter (Church of England Diocese - virtual)

Non-voting Co-opted Member
Jim Funnell (Voluntary and Community Sector and Alternative Provider (Education))

(Also in attendance: Councillors Bye, Chris Lewis and David Thomas)

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33. Apologies

Apologies for absence were received from Nigel Yelland (Non-voting Co-opted Member) and it was reported that, in accordance with the wishes of the Conservative Group, the membership of the Sub-Board had been amended to include Councillor Foster in place of Councillor Spacagna for this meeting.

34. Minutes

The minutes of the meeting of the Sub-Board held on 17 November 2025 were confirmed as a correct record and signed by the Chair.

35. Declarations of Interest

No declarations of interest were made.

36. NHS Devon - One Devon's Children's Strategic Approach and Action Plan

The Director of Women and Children's Improvement NHS Devon - Su Smart presented the submitted report on One Devon's Children's Strategic Approach and Action Plan and responded to questions. The key themes from the report were:

- A focus on six strategic initiatives including Special Educational Needs and Disabilities (SEND), safeguarding, mental health access, neurodiversity, early identification, prevention, and multi-agency working.
- An emphasis on reducing waiting times for mental health and ADHD/ neurodiversity assessments.

- Shift to digital technologies, community-based care and reducing hospital reliance.
- Target improvements in neighbourhood teams, exploring co-location possibilities with schools and Family Hubs.
- Challenges managing children with complex needs in the community without funding following them.

Members heard first hand from a young person who shared their experiences highlighting stigma, lack of early recognition in schools and challenges explaining mental health.

The following questions were raised:

- The Strategy was very high-level, what exactly was changing on the ground to make it happen?
- How would results be shared across health providers and schools, and how would ADHD assessments be completed more quickly?
- How "integrated" would the system be? Would this model reflect the Adults' integrated system (GPs, hospitals, community teams)?
- What happens during transition from Children's Services to Adults' Services, e.g. for young people with epilepsy but without SEND?
- What was meant by an Integrated Board, and how was this different from Adults' Services?
- How would funding and team organisation work?
- What would co-location of neighbourhood teams look like? Where would this be based? How would joint working between social care, police, and health be implemented?
- How many children were waiting for ADHD/Neurodiversity assessments, and how were they prioritised?
- How does shifting traditional acute care into communities work in practice for short-term, high-intensity needs?
- Why was there no place for those "suffering silently" with complex mental illness?
- Why do schools fail to recognise autism or anxiety early enough?
- How could culture change so young people were better understood?
- How do we overcome parental distrust of a new system and improve access?

Members received the following responses:

- Multiple internal and partnership work programmes underpin the Strategy.
- Additional investment had been put in place for ADHD and Neurodiversity assessments to increase capacity. A recovery programme was increasing assessment throughput and there was support for families on waiting lists.
- Information Governance and IT programmes (including EPIC hospital system) aim to improve secure information sharing with schools and community services.
- The Children's model would not fully mirror the Adults' integration model. The Integrated Care Board (ICB) was the funder, while the ICO (Integrated

Care Organisation) was reviewing its operating model for delivery of adult social care.

- Children's Services were structured differently from Adults' Services, with future locality-based multi-agency teams planned.
- Planning for transition starts age 14–16, working with Adults' Services and NHS providers. Gaps may still occur due to team capacity limitations.
- Health services were currently provided from the John Parks Unit at Torbay Hospital.
- Co-location may include Schools (e.g. speech and language therapists working inside schools), Family Hubs and community spaces rather than traditional office settings.
- ADHD and Neurodiversity assessment prioritisation was based on clinical need, medical urgency, or for safeguarding concerns. All referrals undergo clinician triage and could be escalated if new risks emerge.
- Community-based acute care supports children earlier to avoid hospital admission. Short-term high-intensity needs could be managed by community teams to reduce inappropriate hospital stays.
- The system acknowledges trauma caused by late recognition and welcomed the feedback from the young person. There were plans for more mental health support in schools, staff training to improve awareness and multi-agency commissioning changes based on feedback from young people.
- Building parental trust would require a culture shift, more transparency and consistent relationships with families. Digital tools and multi-agency hubs aim to make access easier.

Resolved (unanimously):

That an annual update on the implementation of the One Devon's Children's Strategic Approach and Action Plan be added to the Work Programme for the Children and Young People's Overview and Scrutiny Sub-Board.

37. NHS One Devon Children and Young People Long Term Conditions

The Director of Women and Children's Improvement - Su Smart and Children's Commissioning Manager NHS Devon – Georgina Minifie presented the submitted report on Long Term Conditions for Children and Young People Plan and responded to questions. The key themes were:

- Asthma admissions were high, with Devon the fifth worst Integrated Care Board (ICB) area in England for children at high/very high asthma risk.
- A fuel poverty pilot in two Primary Care Network (PCNs) showed improvements in inhaler use and risk reduction.
- Major improvements had been made in diabetes care due to hybrid closed-loop technology, with a rise in uptake from 40% to 73%. A transition pilot in Torbay had successfully re-engaged 32% of patients.
- Gaps remained in asthma care with not enough cases diagnosed or with action plans.
- There were multi-agency challenges with housing, damp/mould, and other environmental factors impacting on asthma.

Members also received feedback from a young person and their experiences.

Members asked the following questions:

- Asthma attacks and deaths were often avoidable, what was being done to improve asthma care?
- Why was Torbay-specific data hard to provide? Could data be broken down further than "Devon averages"?
- What was the role of schools, school nursing, housing, and wider services in preventing asthma episodes?
- Were 65% of children truly in high/very high-risk categories, and why was this so high?
- What was the cost of the diabetes transition pilot, and was it sustainable after NHS England pilot funding ends?
- How many children get home visits from health visitors?
- What power do health professionals have to require landlords to fix damp and mould?
- What was the difference between Type 1 and Type 2 diabetes in children?
- Could obesity-related diabetes be considered neglect?
- Why were some children and young people not given diabetes training?
- What training exists for teachers and youth workers?
- 65% of asthma-risk sits in primary care — what work was ongoing with GPs?
- Were children being directly educated about asthma management?
- What was the fuel poverty trial measuring, did this include heating or temperature? What were its triggers, and how would the findings be used?
- Why were Devon's admissions higher, despite lower accident and emergency attendances?
- How were long-term conditions managed if diagnosed late (e.g. age 16–17)?

The following responses were received:

- Asthma care improvements included ensuring annual reviews, follow-up after hospital attendance, correct medication, and personal asthma plans including school copies.
- National minimum standards were used as framework.
- Data was often aggregated at Devon ICB level. PCN - and hospital-level data was available and used internally. It was acknowledged that Devon averages could mask Torbay trends.
- There was a role for the wider system for example Housing/Health Group to address damp, mould, and environmental triggers. Work with education to create "asthma-friendly schools". Environmental Health were involved in dealing with hazardous housing conditions.
- The Diabetes transition pilot was funded by NHS England and there were outcomes presented through a business case which had now been adopted permanently in Torbay and South Devon.

- Regarding enforcement of damp and mould, health visitors could report concerns. The Legal powers differ between private landlords and social housing. Awaab's Law strengthens requirements for timely landlord action.
- The difference between the types of Diabetes were Type 1: autoimmune, not lifestyle-related and Type 2: linked to childhood obesity, was increasing globally was reversible with lifestyle changes.
- Very rare cases of obesity-related harm could reach child protection thresholds.
- School staff receive diabetes training from local teams. Training outside education (e.g. youth workers) was limited and identified as a gap.
- GPs were responsible for most asthma monitoring including annual checks. It was recognised that education for children could reduce admissions with work ongoing through schools and family hubs.
- The fuel poverty trial looked at triggers including indoor/outdoor air pollution and home energy efficiency. This was carried out by Exeter Community Energy and the report had not yet been published.
- Torbay allows direct short-stay paediatric referrals from GPs, which reduces Emergency Department attendances but increases admissions.
- For young people receiving a late diagnosis e.g. 16–17 year olds transition planning begins immediately upon diagnosis.

Resolved (unanimously):

1. that NHS Devon be recommended to put in place training for wider partners and those who have contact with young people for diabetes care;

2. that the results of the fuel poverty pilot be presented to a future meeting of the Children and Young Peoples Overview and Scrutiny Sub-Board; and

3. that NHS Devon be requested to bring an annual update on long term conditions for children and young people to the Children and Young Peoples Overview and Scrutiny Sub-Board.

38. 0-5s with School Nursing and Family Hubs - Update

The Director of Public Health – Lincoln Sargeant and the Public Health Specialist – Children and Families – Joanne Needham presented the submitted report which provided an update on the 0-5 with school nursing and Family Hubs contract (previously known as 0-19) and responded and responded to questions. Key points included:

- A new 9-year contract for 0-5s with school nursing and Family Hubs commenced in April 2025.
- There was good performance on mandated indicators but there were challenges with meeting the targets for the New Birth Visit within 10–14 days due to priority for continuity of care and a part-time workforce as well as babies being cared for on the Special Care Baby Unit (SCBU) or mothers remaining in hospital.
- Universal plus targeted offer through school nursing had increased staffing investment.

- The aim was to increase Good Level of Development (GLD) to 78% by 2028 and this required 9% improvement over 2023/2024 baseline figures.
- Speech and language support was aligned through the locality model with the 0-5s with School Nursing Service supporting children who were below the threshold for specialist support.

The Sub-Board asked the following questions:

- Could the Sub-Board have a document showing percentage of Good Level of Development (GLD) achievement for pupil premium and free school meal (FSM) children?
- Why don't primary schools receive Specialist Community Public Health Nurse (SCPHN) support when early childhood was when issues arise such as communication, speech and medical conditions?
- How do pupil premium and FSM families access the targeted offer?
- How often do school nurses attend primary and secondary schools?
- How does confidentiality work when secondary pupils disclose issues to nurses? When does the school get informed of what had been discussed?
- How does speech and language therapy integrate without duplicating or creating gaps?
- What would happen to early years development if all 0–5s received free school meals?
- What was happening with the Best Start in Life Plan, and when would it be published?

The following responses were received:

- Currently 68.5% of children achieved GLD and 50.7% of children eligible for Free School Meals (the following update was received after the meeting: for 2024/2025, Torbay had 68.5% of children at a good level of development (GLD) overall and 50.7% of children eligible for free school meals reaching a GLD. The overall target for children reaching a GLD by 2028 was 77.8% and for children eligible for free school meals was 61.6%.)
- Focus on pupil premium would be examined.
- The School Nursing Service had been agreed following positive feedback through primary-aged workshops where schools and families were happy with the support being provided. There were limited resources which required focus on GLD and early speech/language. Early years and primary support is available through early language consultants and advisory teachers as part of the wider Home Learning Environment Programme.
- Targeted offer used data systems linked to Family Hubs and 0–19 services and looked at families who miss developmental checks to proactively contact families.
- School nursing is offered to every primary school through a weekly clinic led by registered nurses and community nursery nurses and every secondary school through fortnightly drop-in sessions with the SCPHN.
- Nurses follow strict guidelines about disclosures and only certain issues must be shared with parents/school.

- Children who need support for speech and language were referred to specialists, with the service supporting families while awaiting specialist input. There are speech and language therapists located within Family Hubs to remove duplication and ensure timely access.
- Most early years settings were not run by the local authority and therefore rollout of free school meals for 0-5s was complex. Benefits included improved cognition, nutritional health, and reduced inequalities. A detailed impact sheet would be circulated following the meeting.
- The Best Start in Life Plan is being prepared. The report is scheduled to be published by 30 March 2026.

Resolved (unanimously):

1. that the Best Start in Life Plan be presented to the Children and Young People's Overview and Scrutiny Sub-Board on 16 March 2026; and

2. that the Director of Public Health be recommended to explore the roll out of auto-enrolment of free school meals to early years settings to enable it to be rolled out as soon as possible in order to benefit our younger children.

39. Children and Young People's Overview and Scrutiny Sub-Board Action Tracker

The Sub-Board noted the contents of the submitted action tracker.

Chair