Your Healthcare Community Interest Company

Community health services for children and young people

Inspection report

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Ratings

Overall rating for this service	Good
Are services safe?	**Good**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Community health services for children and young people

Good ↑

Our rating of this service improved. We rated it as good because:

- Safeguarding processes and follow up were very robust and thorough. There was good evidence of comprehensive and regular safeguarding supervision
- The service had enough staff to care for the children and young people and keep them safe. Staff had training in key skills, understood how to protect children and young people from abuse, and managed safety well.
- Staff treated children, young people and families with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to children and young people, families and carers.
- The service planned care to meet the needs of local people, took account of children and young people's individual needs, and made it easy for people to give feedback.
- Families gave overwhelmingly positive feedback about the service. They praised staff for their help and support. They felt listened to, informed, and involved in their children's care.
- Managers ran services well using reliable information systems and supported staff to develop their skills.
- Staff gave very positive feedback about the service. Staff said the service fostered a good culture, they had very supportive management, and excellent staff wellbeing support.
- Staff understood the service's vision and values, and how to apply them in their work.

However:

- The timeliness of some of the five health visitor visits within the universal offer of the Heath Child Programme (HCP) fell below national averages for the 6–8-week, 1 year and 2-2.5 year check
- The service provided an enuresis (night-time bedwetting) service for children however this had a waiting list
- Consent was not always recorded in patients care records
- Equipment used by staff was not always within date

Background to inspection

Your Healthcare Community Interest Company (YH) was established as a mutual cooperative social enterprise on 1st August 2010. Staff formerly worked for the community services of Kingston Primary Care Trust (PCT).

YH provided some of the community nurse-led, children and families' services in the Royal Borough of Kingston upon Thames, in south west London (SWL). Your Healthcare provided a universal health visiting service to children and families which includes the provision of well-baby clinics and breastfeeding support. Your Healthcare also provided, school health services and Child Speech and Language Therapy (CSLT) services. The school health service delivered two universal provisions: the National Child Measurement Programme (NCMP) and the School Health Surveys, it also

Our findings

provided health promotion activity within all the borough's state maintained mainstream schools, one Special Educational Needs (SEN) school, and Kingston College. Referrals were accepted from schools, children and families, and social care for supportive input. The child continence clinic did not sit within 0-19 services, but within the urology and colorectal service. The uncommissioned tongue tie clinic was no longer offered. Their contraception and sexual health service included a service for under 19s. All services supported children with SEN and/or a disability and CSLT provided specialist interventions.

Other universal and specialist services for children such as vision checks, immunisations, physiotherapy, occupational therapy, dental services and the integrated service for children and young people with special educational needs and disabilities and their families, are the responsibility of other local providers. Child and Adolescent Mental Health services are provided by the local mental health organisation.

The health of people in Kingston is generally better than the England average. Re-infection rates for sexually transmitted Infections (STI) are worse than the England average.

CQC last inspected the service in November 2016. We rated the service Good for Safe, Caring and Well-led, and Requires improvement on Effective and Responsive. We rated the service Requires improvement overall.

There is a registered manager in place.

The service is registered to provide the regulated activities:

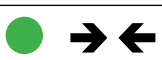
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures

What people who use the service say

We spoke with 12 families and carers. The feedback we received was overwhelmingly positive. Parents told us they received comprehensive and helpful information from the beginning. They praised all of the staff, including clinical and administrative staff, and said they were supportive, proactive and responsive. Parents said they felt involved in the care for their child and knew who to contact in an emergency.

Direct comments from parents, which were representative of this feedback, included: "Staff are supportive, lovely, professional", "they are responsive, helpful, providing support whenever you need", "if I had any concern, I could go back to them", "my daughter is on medication, they were very clear in giving me all the instructions including all the side effects".

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good.

Mandatory training

Our findings

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. The training rates for both health visiting and school nursing teams was 93%. The mandatory training was comprehensive and met the needs of children, young people and staff. This included training in clinical risk assessment, conflict resolution and anaphylaxis.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. The service included the Oliver McGowan mandatory training on learning disability and autism as part of their mandatory training. The training rate for the school health team was 88%. However, the training rate for the health visiting team was 78%.

Managers monitored mandatory training and alerted staff when they needed to update their training. At our previous inspection in 2016 the organisation needed to improve its central monitoring of training. At this inspection we found service used a centrally managed system and both staff and their manager would receive an email when training was to be out of date. The team managers also discussed this with staff at 1:1 meetings.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

At the time of inspection we were told there had been an increase in safeguarding referrals since the pandemic. Managers told us this was becoming harder to manage and staff needed to work longer hours to meet the statutory requirements. We reviewed safeguarding records for 10 children and young people. In all records the service ensured that the families had received the right level of care and support when they transferred in or out of the service. In March 2023 there were 144 children on a child protection plan in Kingston and 115 children looked after.

Staff completed safeguarding training. Safeguarding adults and children was part of the mandatory training programme for staff. Different levels of training were provided according to their job role. Level 1 training was delivered to all staff on induction and updated three yearly. Level 2 training was for all clinical staff in the organisation, not specifically those working with children. The uptake was 100% for the health visiting team and 94% for the school health team. All staff working regularly with children were trained to level 3. At the time of our inspection, the mandatory training compliance rate for level 3 was 98% for the health visiting team and 93% for the school health team.

The named nurse for children's safeguarding and a safeguarding advisor provided specialist safeguarding training for the service. This included domestic violence awareness, harmful sexual behaviour and safeguarding children with disabilities.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The safeguarding team had good working relationships with the Kingston multi agency safeguarding hub (MASH). Safeguarding referrals were made through the single point access (SPA). All safeguarding strategy meetings organised by the borough's children's social care team were attended by school nurses or health visitors despite a significant increase in requests. Between April 2022 and March 2023 the school nurses attended 224 safeguarding meetings. The children's safeguarding team continue to cover a significant number of the meetings to support the health visiting and school health teams.

Our findings

Staff received regular and comprehensive safeguarding supervision in line with the providers policy. All records we reviewed had good evidence of clinical safeguarding supervision. Staff who held safeguarding cases received safeguarding supervision every 3 months for health visitors, and termly for school health practitioners from the safeguarding advisor or the named nurse for safeguarding. The health visiting team held group supervision led by a trained health visitor supervisor. School health practitioners who are staff who do not hold a nursing registration attended group supervision every 3 months with the school health team safeguarding specialist nurse. Staff had access to ad hoc supervision which they could access by open door at Hollyfield House, video conference, email and phone. The school health team also had access to 4 to 6 drop-in mental health supervision sessions provided by a clinical psychologist.

All the staff we spoke with had undergone training about female genital mutilation (FGM) and were aware of the action they should take if they identified a child or young person at risk.

The service had up to date safeguarding policies and procedures in place. We reviewed these polices and the information contained was correct and comprehensive and would guide staff on how to respond to a concern.

Staff had access to the Your Healthcare child safeguarding team which included the named nurse for safeguarding and a child safeguarding advisor. These staff were available during core working hours to respond to frontline colleagues needing advice and support. The service had a named nurse for safeguarding children.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

The service had an infection control policy in place that guided staff in how to ensure infection control principles were upheld. We inspected the areas that the staff used to see children and young people at Hollyfield House. These areas were clean and had suitable furnishings which were clean and well-maintained. Staff followed infection control principles and used antibacterial wipes to clean equipment after patient contact. Staff ensured that they allowed enough time between each family so that they could thoroughly clean the clinical areas and toys.

We attended home visits with health visitors and observed clinics in the community. We saw staff using hand gel to clean their hands when they visited homes. In families' homes and in clinics, equipment such as scales were cleaned after use with cleaning wipes. When weighing a baby, scales were covered with paper roll which was changed after every baby. All the clinic locations we visited were visibly clean, tidy, well organised and clutter-free.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use the equipment. Staff managed clinical waste well.

Clinics were provided at children's centres and GP medical centres across the borough, with a Saturday clinic provided at Hollyfield House for working parents. Children's centres and GP medical practices were managed by other providers. Staff had no storage at children's centres so had to take all necessary equipment with them for each clinic. We found the environments were clean and tidy and suitable for children and their families.

Our findings

The equipment we checked, such as scales, were calibrated appropriately. However we found one set of scales had expired in June 2021. We raised this with the service on the day, and this set of scales was immediately removed from the room. Health visitors each had their own set of scales which they took with them to clinics and on home visits.

Staff were trained to use the equipment. Staff had personal alarms they used for lone working. Home visits were risk assessed and if this was a new family or there was a known risk staff would visit in pairs. The service had a system where staff would put their whereabouts in the calendar and carry mobile phones when going on home visits. The service had a lone working policy in place to guide staff when working alone.

Assessing and responding to patient risk

The service offered all aspects of the Healthy Child Programme. Staff completed and updated risk assessments for each child and young person. Staff identified and prioritised children and young people with extra needs.

The service offered all aspects of the Healthy Child Programme (HCP) to families on the universal pathway. The HCP is used by health visitors to assess and monitor the welfare and key stages of development in children, young people and families. This is a national mandated public health programme, requiring staff to screen, advise on immunisations, and review the development of children at specific points in their lives. The programme allows staff to identify risk of harm, disorder, ill health, or the need for additional support.

Staff completed new birth visits (NBV) at the child's home in person. From April 2022 to March 2023 86% of births received an NBV. The service contacted 100% of antenatal mothers to introduce them to the service. If the mother was already known to need an enhanced service the service would ensure they were seen by a health visitor.

Staff completed patient records with good detail. Patient records demonstrated how risk was assessed and managed in accordance with the provider's own policy. We reviewed 10 patient records in total, including safeguarding records. The records contained all necessary important information such as safeguarding alerts to highlight to staff that the child was at risk of abuse, and evidence of safeguarding supervision.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

At the time of inspection the health visitor and school health teams were fully staffed. At our previous inspection in 2016 the service was required to increase staffing in children's speech and language therapy (CSLT) to reduce waiting times and enable more children to benefit from early intervention.

At this inspection we found the CSLT team was fully staffed and had over-recruited speech and language therapists. However we found there was still a long waiting list for children and young people to be seen. From April 2022 to March 2023 695 children and young people had been referred to the CSLT service, of these 296 children and young people had waited over 16 weeks for their first appointment. Staff told us they felt the service would benefit from more CSLT therapists.

The CSLT team leads told us that since the last inspection that as a result of a wider children's therapy review across the borough, they had received gradually increasing funding over 3 years to address waiting times and this funding increase

Our findings

remained recurrent. They said there had been an increase in referrals in 2022 following the pandemic and so the service prioritised seeing children at risk or those with an Education Health and Care Plan (EHCP) which sets out a child's special education needs (SEN) and provision that needs to be made for them. The service managed children and young people on the waiting list by providing contact details for staff, information leaflets so parents were able to start managing their child's needs, group sessions and informational videos. The service would regularly review the waiting list to ensure they continued to prioritise children most in need.

Team leaders assessed the size of their team caseloads regularly and, where possible, helped staff to manage the size of their caseloads. The health visiting team had a caseload of 480 children and young people per health visitor. Staff we spoke to said their case loads were manageable and health visitors were able to allocate more time to parents and families that required more support.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

A Your Healthcare supplier had been the victim of a cyber-attack in August 2022 which affected many NHS provider systems, including Your Healthcare's externally hosted electronic patient records system. This meant the service did not have full access to this system until it was restored by the supplier in January 2023. The provider responded by building an interim replacement system to enable teams to access data held on the system and ensure that notes could be accurately recorded during this time.

We reviewed 10 care records. The records we reviewed were comprehensive, up to date and stored securely. When children and young people transferred to a new team, there were no delays in staff accessing their records.

Staff were provided with laptops so they could easily record notes while they were working in the community. Staff told us these worked well.

Medicines

The service worked with partner organisations to ensure medicines were managed safely.

The health visiting and school health service did not stock medicines. Clinical staff told us that they did not manage medicines as part of their role. Health visitors only issued vitamins to families as part of the Healthy Start scheme.

Families and carers, we spoke with told us that their health visitor or school nurse gave advice about medicines, but their GP was required to prescribe medicines to them.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Our findings

Staff knew what incidents to report and how to report them, although very few incidents were reported. Staff reported incidents using an electronic incident reporting system. There had been no serious incidents from April 2022 to March 2023. Managers told us there had been an increase in incidents reported recently resulting from the electronic patient records system outage. Learning from incidents was shared at 1:1's, personal development reviews, supervision and team meetings. We saw evidence of these discussions in the minutes from these meetings. Staff were able to give us examples of learning from recent safeguarding incidents.

Staff understood the term duty of candour. Providers of healthcare services must be open and honest with patients and other 'relevant persons' (people acting lawfully on behalf of patients) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Staff were able to provide examples of when they would offer support and apologise.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Staff protected the rights of children, young people and their families who were in their care.

Health visitors and school nurses delivered the national Healthy Child Programme (HCP) as part of the universal pathway. Health visitors and community nursery nurses used the 'ages and stages questionnaire' (ASQ), which is an evidence-based assessment tool that encourages parents as experts to provide information about the development of their child across five developmental areas.

The service was commissioned to deliver the maternal early childhood sustained home visiting (MECSH) programme. MECSH is a structured programme for sustained home visiting for vulnerable families with identified risk factors, that aims to improve parental and child health and developmental outcomes.

The children's speech and language therapy (CSLT) service used the balanced system framework, which was a way of making sure that in a setting, school or local area, the right provisions are available for parents, carers and professionals to help children and young people develop their speech, language and communication, and enable them to eat and drink safely. This was recognised by the Royal College of Speech and Language Therapists as a framework for planning and commission CSLT services.

Health visitors used the ASQ to assess child development in 2 of its 5 mandated developmental reviews. ASQ is an evidence-based assessment screening tool that asks about a child's development in different areas.

The service carried out regular audits, which included infection prevention control, handwashing and clinical care record keeping audits.

Our findings

The service's policies and procedures were available on their intranet. We reviewed a sample of these and found appropriate reference to relevant national institute for health and care excellence (NICE) and Royal Colleges' guidelines

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

The service monitored the effectiveness of care and treatment. The service had arrangements in place to monitor the health and treatment outcomes of children, young people and their families. Since 2019, the service used Therapy Outcome Measures (TOMS). Data from these was shared with a national programme run by the Royal College of Speech and Language Therapists, to contribute to the development of effective evidenced based practice. The leaders of the service used data to monitor the team's performance and maintain oversight on the delivery of the mandated Healthy Child Programme (HCP) development review contacts. These were antenatal new birth visits (NBVs), 6 to 8 week reviews, 1 year and 2-2.5 year developmental reviews. The service offered antenatal contact to families on the universal pathway. Pregnant women on the universal pathway were monitored via the local midwifery service which the provider did not manage, who would refer to the service if they identified an early need. The service would then have a face to face antenatal contact with a health visitor. From April 2022 to March 2023 the service had seen 203 pregnant women antenatally.

The service achieved 86% of NBV against the England average of 80% for April 2022 to March 2023. The NBV should take place with the child's primary carers to assess maternal mental health, discuss infant feeding and how to reduce the risk of sudden infant death syndrome. Some families requested a later NBV therefore their NBV took place after 14 days.

The service was constantly working on initiatives to engage parents and families in HCP reviews. The service was commissioned to only offer face to face and virtual visits. The service sent three reminders to families to book. The service also provided information on health visiting via other services the families may attend such as the dentist, and if the family had a social worker they would try and arrange a joint family visit with the social worker.

The service still needed to improve rates of HCP reviews for children under 5, although the service has shown improvement since 2020. Performance data from April 2022 to March 2023 demonstrated that the service had achieved 68% for 6 to 8-week reviews against the England average of 80%, 67% for 1-year reviews against the England average of 71% and 53% for 2-2.5year reviews against the England average of 74%. The service worked to a commissioner defined service specification which required them to deliver all mandated developmental reviews face-to-face, utilising a range of assessment tools. As part of the developmental reviews the service sent parents an age appropriate ASQ, a self-reporting developmental assessment tool which parents were requested to complete prior to contacting the service for an appointment.

As part of the 2-2.5 year review the service was commissioned as one of only two areas in London to deliver the Early Language Identification Measure assessment, which can only be delivered face-to-face.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held clinical and safeguarding supervision meetings with them to provide staff with support and development.

Our findings

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families.

In the health visiting team 98% of staff received a Personal Development Review (PDR) and all staff in the school health team received one. The PDR process sets expectations and objectives for staff and ensured they had the competencies and skills for their roles

The service provided regular supervision for staff. We reviewed performance data for the service and staff were receiving 1 to 1 clinical supervision every 6 weeks with a trained supervisor and safeguarding supervision every 3 months. The service also provided clinical group supervision for the health visiting and school health teams. This included maternal early childhood sustained home visiting (MECSH) supervision with a trained MECSH supervisor every 2 months. The school health team had access to mental health supervision provided by a clinical psychologist 4 to 6 times a year.

The provider had recruited specialist roles. The school health team had a safeguarding nurse specialist. The health visiting service had a lactation specialist who led the infant feeding service which included provision of drop-in sessions for parents.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Both the health visiting team and school health team had monthly team meetings. We reviewed minutes from the meetings in 2023 and found these contained good detail for staff that could not attend the meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

The service provided staff with specialist training required for their role. For example, staff from the CSLT team were part of the Achieving for Children assessment team for autism diagnosis. Achieving for Children was a community interest company delivering children's services in the area.

Multidisciplinary working

All healthcare professionals responsible for delivering care worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Several agencies in Kingston had responsibilities for different aspects of supporting children and young people's outcomes. The health visiting and school health teams delivered the HCP and worked in partnership with other local services including social care teams, teachers and youth workers to deliver evidence-based interventions with children, young people and their families.

Staff worked with other agencies and shared information where there were concerns about a child in vulnerable circumstances. For example, the service used female genital mutilation information sharing (FGM-IS), which was a national IT system that supported the early intervention and ongoing safeguarding for girls under the age of 18 with a family history of FGM. The service worked with achieving for children which was a community interest company that provided children's services in Kingston and attended weekly integrated team around the child (ITAC) meetings. Staff told us they prioritised attendance at multi-agency safeguarding hub meetings.

Our findings

We observed both internal and external multidisciplinary (MDT) working. For example, the service shared information between health visiting and school nursing teams, worked with GPs, school staff, social services, the police and the south west London integrated care board.

CSLT staff supported children within nurseries, state-maintained schools, specialist units for children with autism , or those with speech and language, hearing impairment and social emotional and/or mental health needs and SEN schools. This support was provided by training education staff in these schools to create communication friendly environments and promote speech, language and communication development. The CSLT staff also provided parents and families with support within school and in the family home, virtually or face to face. The CSLT staff also supported children with eating and drinking needs alongside parents, education staff and other health professionals such as occupational therapists and paediatric dieticians.

The service was commissioned to work with children within nurseries and state maintained mainstream schools identified as requiring SEN support or with an EHCP which sets out a child's special educational needs and the provision they require. They also provided training for partner organisations and educational staff.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The school health service delivered the national child measuring programme (NCMP) in state-maintained primary schools measuring the height and weight of children in reception and year 6, to establish levels of obesity and to identify underweight children across the borough. The commissioned service was required to provide a letter to every parent when their child was measured. This letter included the weight category and appropriate signposting to resources and services and, referral to the licensed evidence-based programme on health, exercise, nutrition (HENRY) which was delivered by the service. The service had agreed with commissioners to proactively follow up the NCMP results of those children measuring as very underweight and overweight, which they did.

The service was commissioned to deliver the HENRY programme, to help improve the knowledge of food and activity for children under 12 years old and their entire family through a holistic approach that looked at nutrition, activity, screen time and family mental health. Parents could self-refer or be referred through schools to the programme. HENRY was an 8-week online group programme, with up to 11 programmes a year to be made available and up to 12 families in each group. There was a lead and 5 facilitators in the school health team and a lead and 7 facilitators in the health visiting team. Staff received 2 full days of face-to-face training and additional online training to deliver the course online and the service provided practice development supervision sessions for the facilitators. HENRY was a group programme and parents were encouraged to provide support for one another. For the summer and autumn terms in 2022/23 100% of families who completed the programme reported an improvement in their family's lifestyle. In addition, the service was commissioned to deliver standalone workshops on a variety of topics such as fussy eating.

The service provided an infant feeding drop-in session 4 times a week for parents, led by the specialist infant feeding team. These sessions included peer support groups supported by the wider health visiting team who had the skills and knowledge to make this provision, as well as specialist clinics led by a lactation consultant.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Our findings

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff told us they knew how to support parent or carers when making decisions for their baby or child. Staff completed training on the Mental Capacity Act. The compliance rate for mental capacity act training was 90% for the health visiting team and 93% for the school health team.

However, care record keeping audits for January to March 2023 showed that consent had not been recorded in any of the health visiting records reviewed for the audit, and in only 33% of records reviewed for the school health team. The action plan to address this included communicating to all frontline service managers the results of this audit immediately so this could be communicated to the team, as well as relaunching the use of reason, consent for contact/intervention/to make a record, observation, plan and evaluation (RCOPE) in all records. The deadline was June 2023 to implement these actions.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Parents and families had overwhelmingly positive feedback about the service. We observed interactions between staff and families to be friendly and caring. We spoke with 13 individual families and observed 2 home visits. They told us that staff were kind and supportive. They told us staff provided all of the information regarding their child's care and it was all clearly explained. Parents and families knew how to contact staff and who to contact in an emergency. There were no concerns or complaints raised with us regarding the service.

We observed positive interactions between staff and families, which were caring and responsive. We saw that staff created a relaxed environment in home visits and clinics.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

We attended 2 home visits and observed 1 drop-in clinic. For 1 home visit mother the health visitor was able assess whether they needed extra support and was able to provide extra visits for this mother. The health visitor was

encouraging, and the mother told us she felt reassured after the visit. We observed the health visitor sensitively discussing mothers' feelings and emotional well-being during home visits. They asked about help from families and if the mother needed any additional support. During the visits the health visitor understood and respected each family's cultural and religious needs.

We spoke with 12 families that had used the 0-19 service and they all reported a positive experience. Families told us that the health professional they spoke with provided advice when they needed it and made them feel comfortable.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff followed a family centred approach. Two fathers we spoke to at the drop-in clinic we observed told us they felt listened to and involved by the health visiting team. The service provided access to an interpreting service for families where English was not their first language.

The service gathered feedback from parents and families though a service user engagement survey called the friends and family test. We reviewed the results from the 3 years prior to inspection and this showed between 90% to 100% of responses were good or very good over that time. The service responded to feedback and made improvements to the service. Learning from feedback was shared in team meetings. Across all children and young people's services from April 2022 to March 2023, 1,535 responses were received.

We saw health visitors used written information to supplement verbal information, which was good practice. For example, during a health visit the health visitor explained effective breastfeeding techniques and the immunisation schedule and provided a booklet on each of these discussions for the mother's reference.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Service leads met regularly with commissioners to discuss performance targets and improvements they needed to make. They also worked with others in the wider system and local organisations to provide updates about the service and to plan care moving forward. The service provided quarterly commissioner narrative report for the health visiting and school health teams.

Staff met children, young people and their families at various locations in the community dependent on the needs of the child. Health visitors usually met children and their families at their homes or in children's centres and also provided a

'walk and talk' option. During term time the school health service carried out their health promotion work on school premises and also provided home visits, telephone, text and virtual contacts to deliver a full year-round service. The 0-19 service was open during core working hours Monday to Friday 9am until 5pm. The health visiting service held Saturday morning clinics monthly at Hollyfield House for working parents and carers. The CSLT team offered home visits on Saturdays to address the waiting list for this therapy.

The service was commissioned to provide a CSLT service in Kingston to preschool, mainstream schools and children with special education needs (SEN) attending specialist schools. At the previous inspection in 2016 the service had high waiting times for CSLT. At this inspection we found wait times were still high, however there were improvements in triaging and managing the waiting list and managers were actively working to reduce the wait times. The service had received increasing recurrent funding over a 3-year period to address waiting times. The waiting list was triaged so children with the highest need were seen first. The waiting list was regularly reviewed, and families on the list were offered interventions such as information videos, group sessions and a dedicated advice telephone line. For example, the service provided "More Than Words" which was an online course for parents providing information and strategies to support their child with social communications difficulties.

Staff contributed to education, health and care plans (EHCPs) including those for children with autism spectrum disorder (ASD). EHCPs set out the special educational needs of a child or young person and the support they should receive. We reviewed an anonymised support document for a student and this outlined the communication needs and agreed strategies specific to this student.

Health visitors gave advice regarding feeding issues and tongue tie and the treatment for this which was frenulectomy (tongue tie release). Staff referred mothers to the infant feeding clinics.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. The Your Healthcare Neuro-developmental Service (NdS) service had been commissioned to develop speech and language therapy packages for young people 16 to 25 years old attending further education colleges. These packages focused on practical communication and learning skills and desired communication skills for employment.

Managers monitored and took action to minimise missed appointments, and followed up with families when appointments were missed. All parents and families in the Kingston area were offered all 5 visits for children under 5 years old. If parents and families did not respond they would receive a reminder letter. If the family was in receipt of a targeted specialist level of service, which would include those children with an enhanced social care package, the service would keep attempting contact through letter and phone until they contacted the family. If the family had a social worker, they would attempt contact through the social worker or by visiting with the social worker.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

The service was inclusive and took account of individual needs and preferences. For example, the service offered evening programmes and Saturday clinics for working parents. Health visitors were able to assess whether parents needed more support and could offer visits in addition to the mandated child health reviews.

Our findings

The service had identified a lack of continuity of care when young people made the transition from child to adult specialist healthcare services. The NdS had responded by proactively developing a programme to support this transition. The NdS identified that referrals to their service were usually between 18-25 years old and so identified those young people requiring specialist support early and worked with child services to gain prior understanding of their needs to support and facilitate their transition.

The service had created autism training and was developing attention deficit hyperactive disorder (ADHD) training materials for GPs, schools and special educational needs co-ordinators (SENCO).

The children's speech and language therapy (CSLT) team had competed an innovative project to improve the referral systems into the service. Previously there were 4 paper forms for referrals to different parts of the service, now there was 1 online referral form that needed to be completed. This had improved the recording of caseloads and waiting lists and provided a streamlined referral into the service.

The service continued to run group sessions at a specialist nursery for families waiting for CSLT. One afternoon a week over six weeks staff worked together with parents to learn more about their child and the way that they communicate and interact with others. Parents could observe their child in this group through a 2-way mirror. A member of the CSLT team sat with parents to provide further insight on why children were doing the activities and was able to answer any questions parents have.

The service was commissioned to provide the maternal early childhood sustained home visiting (MECSH) programme in Kingston. MECSH is a structured programme for sustained home visiting for targeted families that aims to improve parental and child health and developmental outcomes. Staff were trained in perinatal mental health and accident prevention. Families remained on the MECSH programme until the child was 2 years old. The health visiting service continued to work with the family until the child was 5 years old.

The service was commissioned to deliver the HENRY programme to help improve healthy lifestyle knowledge for families and children which included the Right From The Start programme for the under 5s and the Growing Up programme for children 5-12. HENRY was an 8-week programme with up to families in each group. The group had weekly check-ins. The programme aims to help families embed lifestyle changes around food and activity to improve health. Parents were encouraged to support one another. The service was flexible regarding cultural needs, for example they offered a one-to-one programme to families who are from Afghanistan and would have struggled to access the general programme.

The service had achieved the gold standard for the Baby Friendly Initiative which supported parents to build close relationships with their baby and feed them in ways which would support health and development. The team consisted of 2 trained experts in breastfeeding and also peer supporters who provided drop-in sessions to support mothers. The staff were trained in facilitating breast feeding and were able to train staff in children's centres.

Access and flow

Most children, young people and families could access the service when they needed it and received the right care promptly. There were waiting times for some of the services however patients waiting could access support and patients with the highest needs were prioritised for treatment.

Our findings

The service offered all of the standard child health reviews that were set out in the healthy child programme. Between April 2022 and March 2023 86% of births received a new birth visit within 14 days by a health visitor, 68% of babies received a timely 6-to-8-week review, 67% of children received a timely 1-year review and 53% of children received a timely 2-2.5 year review.

All pregnant women in the Kingston area where sent a letter introducing them to the provider and inviting them to contact their health visitor to schedule their child health reviews. The service received referrals from midwives for pregnant women identified with a greater need, or the service would use previous knowledge of the mother, and these women would be offered a face-to-face contact.

All families were offered each of the 5 mandated child health reviews. If a family did not respond they were sent a reminder letter. If a family did not respond they were sent a reminder letter. If the family was receiving a specialist targeted health visiting service, including those receiving an enhanced social care package, the service would attempt to make contact until they had made contact. If the family had a social worker the service would liaise with the social worker to make contact or engage on a joint visit to the family with the social worker.

We spoke with the health visiting service lead about the drop in visits as the child grew older. They had identified a trend where parents needed more support and information when the baby was born and in the early months, especially if this was their first baby. Once the baby was older, or the parents went back to work, or if the family had other children, then the parents had less need for support and were less likely to engage with the service. The service attempted to engage parents through children's centres, nurseries and other health care areas where parents would attend such as the dentist, by providing reminders at these services. The service had a Saturday morning clinic for working parents and this was usually booked. If parents were bringing their babies to a clinic they were encouraged to bring older children for their health visits as well.

The service provided children's speech and language therapy (CSLT) and at the time of inspection there were 313 children waiting for this service. Of those waiting 92 were seen by 18 weeks which meant 221 children were waiting longer than this. The service prioritised seeing those children that had the highest risk or time critical needs. This included children with a safeguarding alert on their record, children who were starting or finishing school and children who had been assessed with having dysphagia.

Children and families on the waiting list had access to support while they were waiting. The service provided an advice telephone service, group sessions with other families waiting, and leaflets and videos that provided information, advice and therapies families could implement at home. The service was fully staffed and had recruited CSLT assistants which offered group sessions at schools. The service had meetings with commissioners and the integrated care board regarding the priorities of this service.

To respond to demand, the service provided an unfunded enuresis (night-time bedwetting) service for children. The school health team offered tier 1 advice and support to children living in Kingston, and tier 2 face to face assessment, intervention and clinical review. At the time of inspection there were 15 children under the age of 7 waiting for this service and 34 children over the age of 7 waiting for this service. The longest wait time for a child was 11 months. However, at the point of referral parents and carers were provided with an information pack with early intervention advice, guidance and signposting to support including the offer to further access the service if they had concerns. The service was developing an early intervention parent workshop. As this service was not commissioned at the time of inspection and the provider had identified a need that was greater than they could support, they had engaged with

Our findings

south west London Integrated Care Board (ICB) and submitted a proposal to commissioners to support early intervention and signposting in order to reduce the wait times for a face-to-face assessment. The service was still awaiting a response. Without additional funding the capacity required to address the waiting time could not be obtained.

The school health team offered regular drop-in sessions for pupils to attend and discuss concerns or questions they had about sexual health, smoking, alcohol consumption, drugs or general health.

The health visiting service was notified when families had moved into the area. The service sent letters within 10 working days to all families transferring in, introducing the service and other local services. All the under 1-year olds and children transferring from abroad were followed up by a health visitor and offered face to face contact.

Learning from complaints and concerns

People were able to give formal feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

The service had a system in place to manage complaints received. In the 12 months prior to our inspection the health visiting team had received 1 formal complaint and the school health team had not received any formal complaints. The complaint related to a service user who was unhappy with an interaction with the health visiting service in a clinic. The complaint was upheld. Managers told us they addressed informal complaints promptly so these did not escalate into a formal complaint. Managers investigated complaints and shared identified themes during team meetings.

Parents and carers we spoke to understood how to complain and feedback to the service. The families told us that they were happy with their experience and did not need to complain. One parent told us they had written feedback to compliment to the service. All of the parents and carers we spoke to had no concerns or complaints.

The service provided feedback surveys to families and carers after every contact and in clinics and drop-in sessions.

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good.

Leadership

Managers had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

Managers and senior leaders were very experienced. Staff unanimously told us that they felt well supported by leaders.

Managers and senior leaders had a good understanding of the challenges to the service.

Our findings

Managers and team leaders supported staff to develop their skills. For example, a school health practitioner had trained in mental health first aid and then delivered training to staff in the service. Staff told us if they were asked to do something new they were provided with appropriate training and support.

Although managers told us the leadership structure of the service was flat there was evidence of career progression within the service, for example the neuro developmental service lead had worked with the service since they began and had developed into a lead position. They told us they did not think they could have developed the same way elsewhere.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

At our previous inspection in 2016 the provider did not have a documented strategic vision for the service. At this inspection the provider showed us their documented manifesto for the service which included their vision and strategy, as well as mission statements for the health visiting, school health and speech and language therapy teams. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The provider had created the 5 freedoms, which included the freedom to change things, to ask questions, to share positive outcomes to grow the service, to innovate and to work with community partners.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff we spoke with told us they felt respected and valued within their roles. Morale within the team was very high and staff were happy and proud to work for the organisation. Staff told us they felt well looked after and trusted by managers and leaders.

Staff told us there was an open culture where they could raise concerns without fear of retribution. All staff we spoke with told us they would not hesitate to raise concerns. They were confident that they would be listened to and action taken.

Without exception all staff told us that their wellbeing was supported and could give many examples of different types of support. All staff had the opportunity to work flexibly, and the managers worked hard to adapt and flex the workforce to make this happen. Staff received a one off cost of living voucher in 2023.

Governance

Managers operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Our findings

Managers had effective governance processes in place. Policies and procedures were up to date and included a date for review. Managers were held to account by commissioners and attended quarterly meetings with them. The service provided commissioners with quarterly commissioner narrative reports.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the services. Staff we spoke with were aware what was working well within the service and what could be improved.

Management of risk, issues and performance

Managers and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a risk register in place. Managers and senior leaders were aware and focused on the priorities on the risk register. Managers and senior leaders we spoke to identified the increase in safeguarding referrals and case conferences as the highest current risk to the service. The service provided data for public health and were planning to submit a proposal for one off funding to recruit a qualified nurse to support with this.

Managers routinely monitored and reviewed their audit schedule. Managers produced a quarterly commissioner narrative report which indicated any areas of perceived risk.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to the relevant data they needed to effectively carry out their roles.

The service submitted data to external organisations as required. They provided quarterly reports for commissioners. There were no statutory notifications regarding the health visiting or school health teams to CQC in the 12 months prior to the inspection from this service.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for children, young people and families.

Managers collected feedback from families and staff. Feedback from families was discussed in team meetings and this was mostly very positive. The service had received a range of compliments describing positive experiences of feeling listened to and looked after. Any areas that required addressing were considered, and wherever possible acted on.

The service completed annual staff surveys. At the time of inspection, the service had just completed the 2023 survey however the results were not available yet. The latest staff survey in 2022, had a high engagement level of 89%. Staff reported feeling valued and supported. Based on the results the service planned to invest in career progression for staff.

Our findings

The service worked with partner organisations to improve services for patients.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Managers encouraged innovation and participation in research. The service had a good understanding of quality improvement methods and the skills to use them.

The service was completing a research project utilising random controlled trials to support building resilience for children when they go to secondary schools. The service had completed 2 data collections and found a significant reduction in anxiety. The service was planning to complete a third data collection.

The service had created autism and attention deficit hyperactivity disorder (ADHD) training materials for GPs, schools and special educational needs coordinators (SENCOs).

Since 2017 the service had delivered an annual mental health conference and ambassador programme to secondary schools. In 2021 the programme was adapted for primary schools and a pilot programme was delivered to year 6 pupils, which became part of the service offer to all of the borough's schools. The programme supports children to develop the knowledge and skills to promote mental health and wellbeing within their school by developing and implementing an action plan. 58% (18) of primary schools and 91% (10) of secondary mainstream schools participated against commissioner targets of 30% and 50% respectively. A separate programme was delivered to pupils at the secondary school for children with SEN. In addition, the school health service was commissioned to deliver the Snapback programme to children in the first year of secondary school. This was designed to support their transition and acknowledge the impact on the mental health and wellbeing of pupils at this life stage. This programme had been running for several years and worked to a 'train the trainer 'model, with staff supporting school staff to run the programme in schools. The programme had been part of an additionally funded research project over the previous 2 years with significant outcomes for anxiety reduction.

Our findings

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that they continue work to improve performance in completing checks for the mandated milestones outlined in the Healthy Child Programme. (Regulation 12 (1)(2)(a)(b))
- The service must ensure that staff are recording consent clearly (Regulation 11(1))

Action the service SHOULD take to improve:

- The service should continue their work to reduce waiting times for speech and language therapy
- The service should continue their work to reduce waiting times for the nocturnal enuresis service
- The service should ensure that all staff are up to date with their Oliver McGowan mandatory training on learning disability and autism
- The service should ensure that all equipment used by staff has not expired

Our inspection team

The inspection team consisted of a lead inspector, another inspector, 2 specialist advisers and an expert by experience. An expert by experience is someone who has experience of care and treatment in a community health service.

How we carried out this inspection

During the inspection, the inspection team:

- reviewed the environment of the clinic rooms where staff saw babies and children
- spoke to the two service leads
- spoke with 12 staff including a locality lead, a research lead, speech and language therapists and assistants, health visitors, nursery nurses and safeguarding advisors
- spoke with 13 families and carers
- observed a health visitor clinic, a speech and language therapy assessment and a healthy lifestyle meeting
- accompanied a health visitor on 2 home visits
- attended and observed a drop-in clinic
- conducted a focus group consisting of a school health locality lead, a school health practitioner, a health visitor, and a community nursery nurse
- reviewed 10 care records
- looked at a range of policies, procedures and other documents relating to the operation of the service

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 11 HSCA (RA) Regulations 2014 Need for consent