Your Healthcare Community Interest Company

1-328569033

Community health services for children, young people and families

Quality Report

Hollyfield House
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-727827222	Hollyfield House	Children's services	KT5 9AL
1-328569033	Hawks road clinic	Sexual health clinic	KT1 3EW

This report describes our judgement of the quality of care provided within this core service by Your Healthcare. 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 Your Healthcare and these are brought together to inform our overall judgement of Your Healthcare

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service

Requires improvement

Overall, the children and young people and families service requires improvement because;

- The timeliness of some of the five standard development checks within the universal offer in the Healthy Child programme fell below national targets for the new born and one year old checks, although the service performed better than the national average for 6-8 week checks.
- The sexual health clinics were performing below target in several areas.
- There were some staff vacancies in all service areas although a recruitment campaign was in progress.
- The budget for speech and language therapy only allowed the service to support children with higher levels of need. There was a paper process for prioritising provision but not all children were seen for a face to face assessment within 18 weeks of referral.
- The child continence service had not been provided for some months because of staff shortage and had only recently re-started; waiting lists were long.
- Mandatory training was reported by numbers attending without a percentage target, and the provider did not consider their central training record to be accurate, which made it difficult to determine the number of staff who had attended.
- There was an appropriate mission statement but no documented strategic vision for the children and families service as a whole.

However;

- Parents we spoke with had confidence in the staff that provided their children's care.
- Staff knew how to report incidents although very few incidents were reported.
- Staff working with children were trained in safeguarding and had access to regular safeguarding supervision with expert colleagues.
- There was evidence of good Multi-Disciplinary Team (MDT) working between school nurses and health visitors.
- Health visitors held clinics in a number of different locations across the borough so that families could access them without travelling long distances.
- Care and treatment was evidence based, and children, young people and families were protected from inappropriate care or treatment for which they had not given proper consent.
- Staff working for Your Healthcare were caring. They worked hard to ensure that children received good support. Families were involved in decisions about their children and understood the services available.

Summary of findings

Background to the service

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).

Your Healthcare provides some of the community, nurse-led, children's and families services in the Royal Borough of Kingston upon Thames, in south west London. The universal services provided to children's and families included health visiting, baby clinics and breastfeeding support and school nursing. Specialist services a newly introduced child continence clinic, a tongue tie clinic and a contraception and sexual health service, including a service for under 19s. One service was provided for children with special educational needs and disabilities: speech and language therapy.

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. New sexually transmitted Infections (STI) are worse than the England average.

Children and young people under the age of 20 years make up 24.0% of the population of Kingston upon Thames. 51.9% of school children are from a minority ethnic group. The health and well-being of children in Kingston is generally better than the England average. Infant and child mortality rates are similar to the England average.

73% of mothers are still breastfeeding at 6 to 8 weeks. 88.9% of mothers in this area initiate breastfeeding when their baby is born, compared to a national average of 74%.

The level of child poverty is better than the England average with 11.9% of children aged under 16 years living in poverty (England average 19%). The rate of family homelessness (3%) is worse than the England average of 2.3%. Children in Kingston upon Thames have better than average levels of obesity: 5.6% of children aged 4-5 years (national figure 9.3%) and 15.9% of children aged 10- 11 years are classified as obese, compared to 19% nationally.

There were 115 children in care at 31 March 2015, which equates to a lower rate than the England average. The rate of children in need was 56 per thousand in Kingston compared to an England average of 64.6 per thousand.

The area has a lower teenage conception rate compared with the England average, with 21.4% compared to the England average of 24.3%. 0.7% of women giving birth in this area were aged under 18 years. This is similar to the regional average. This area has a similar percentage of births to teenage girls compared with the England average and a similar percentage compared with the European average of 0.9%.

Our inspection team

Our inspection team was led by: Roger James, Inspection Manager.

Chair: Professor Iqbal Singh, consultant physician.

The team included CQC inspectors, a health visitor and a school nurse.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

Summary of findings

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?

We carried out our announced inspection between 16 and 18 November. Before visiting, we reviewed a range of information we hold about the core services and asked other organisations to share what they knew. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We talked with people who use services and carers, who shared their views and experiences of the service.

During the inspection we visited a sample of clinics held in children's centres, a sexual health clinic for young people, and some schools where speech and language therapy was provided for children in specialist units. We spoke with 28 staff at all levels, 28 parents and six children. We also held focus groups for school nurses, health visitors and speech and language therapists.

We observed staff practice in clinics and, with the consent of parents, in families' homes. We looked at 17 clinical records. Before and after our inspection we analysed information sent to us by the provider and sought the views of a number of organisations such as local commissioners.

The CQC held a number of focus groups where staff could speak with inspectors and share their experiences of working at Your Healthcare. We also received information from members of the public through comment cards and looked at users' feedback about the service over the past year.

Good practice

- As a way to tackle the high level of demand for speech and language therapy, group sessions had been introduced at a specialist nursery. 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 teaching or SLT team sat with parents to provide further insight on why children were doing the activities and was able to answer any questions parents have. However, only a small number of families benefited.
- The pilot tongue tie release service to enable more babies to have the benefits of breast feeding had been well received by local mothers.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Your Healthcare should increase staffing in speech and language therapy to reduce waiting times and enable more children to benefit from early intervention.

Action the provider COULD take to improve

- Improve central monitoring of training to ensure sufficient staff have completed mandatory and statutory training.
- Document a vision for the children and families service.
- Deliver all the standard child health reviews within the healthy child programme in a timely way.

Your Healthcare Community Interest Company

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as 'good' because

- Staff knew how to report incidents although very few incidents were reported.
- Staff working with children had safeguarding training and access to regular safeguarding supervision with expertise.
- Progress notes on children's care were completed promptly and stored securely, and contained a clear chronology.
- We observed staff carrying out appropriate risk assessments in people's home.
- HV and school nurses worked together to reduce duplication of work where families had children that were covered by both services.

However:

- In speech and language therapy the number of staff impacted on the number of children who could receive support.
- There were no service level agreements with other agencies such as for medical advice in relation to safeguarding.
- The central systems to monitor training were inaccurate so the organisation could not provide assurance that all staff had appropriate training.

Detailed findings

Safety performance

- There was good overall safety performance within the children and families services.
- There were no serious incidents directly relating to Your Healthcare services. However, in the area served by the service, there had been four allegations, or incidents, of

physical abuse and sexual assault or abuse affecting children covered in 2015. Staff were contributing to the investigation of two child protection incidents led by other agencies. One related to alleged abuse of a child by a third party and the other was a police investigation of an incident of physical harm.

- Health visitors told us they had feedback about learning from serious case reviews.

Incident reporting, learning and improvement

- An electronic incident reporting system had been used since April 2016. Staff we spoke with in the children and families division were aware of the system and knew how to use it. Staff told us no blame was attached to reporting incidents.
- Incident reporting was low. Only 23 incidents had been reported between September 2015 and October 2016, eight involving children. All were reported as causing no harm. We reviewed the incidents in that period which related to immunisation (a procedure no longer carried out by this provider), consent, communication, intimidation of staff and documentation. There were no particular themes.
- We were told incidents were reviewed across the whole organisation by the Audit and Assurance Board. However, we did not see any evidence of learning from and changing procedures as a result of incidents.

Duty of Candour

- From November 2014, NHS providers were required to comply with the duty of candour regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty related to openness and transparency and requires providers of health and social care services to notify patients of certain notifiable safety incidents and provide reasonable support to that person.
- We found managers understood their responsibilities for duty of candour.

Safeguarding

- Your Healthcare had up to date safeguarding policies and procedures. The child safeguarding policy was supplementary to the London safeguarding children policy. The lead for child safeguarding in the Kingston area was the local council who managed the single point of access for child safeguarding referrals, although Your Healthcare had its own internal safeguarding lead.
- The post of named nurse for safeguarding was vacant at the time of the inspection but an appointment had been made and the new post holder was due to start in January 2017. The safeguarding adviser was covering the named nurse post in the interim. She was accessible to staff and staff were able to give examples of when they had needed to seek advice. During our inspection, we saw the adviser's open door policy in action.
- The safeguarding team had good working relationships with the Kingston Multi Agency Safeguarding Hub (MASH) through the single point access (SPA) and Multi Agency Risk Assessment Conferences (MARAC).There were about 142 children on child protection plans in the area, and about 120 looked after children. Your Healthcare staff attended all case conferences. This ensured that they were aware of important information shared between agencies.
- Health visitors and school nurses said most of their work was with children on the Children in Need (CIN) register.
- 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.
- All staff working regularly with children were trained to level 3. This was a full day of face to face level 3 safeguarding training in line with good practice. We saw training slides which were comprehensive. We were told there was 94% compliance, just below the national expectation of 95% compliance with Level 3 Safeguarding updates, although the figures supplied by Your Healthcare in advance showed 80%. Compliance at level 2 (which were only given for all clinical staff in the organisation, not specifically those working with children), and which staff need to complete in addition to level 3, was recorded at 57%. We were told that there were problems with the recording system for training.
- Training in safeguarding included domestic violence, a train the trainer course: Workshop to Raise Awareness (WRAP) of PREVENT, the national scheme to prevent violent extremism.

Good

Are services safe?

- Staff working with children, young people and families had opportunities to attend further training provided by the Local Safeguarding Children Board (LSCB) which included: working with resistant families, child sexual exploitation, domestic abuse awareness, learning from serious case reviews, recognising self-harm in young people, and harmful cultural practices relating to FGM/FM/religious and cultural beliefs.
- Health visitors and school nurses knew what action they should take if children were not brought to appointments or if they were notified by the hospital's liaison health visitor that a child had attended an accident and emergency department. There was a flag on the electronic recording system for highlighting children where there were safeguarding concerns and we saw this in use.
- Most of the health visitors we spoke with told us they had regular safeguarding supervision of their work with their most vulnerable babies, children and families with a member of the safeguarding team. The national health visiting service specification 2015/6 says supervision must be every three months. We saw evidence of recent supervision recorded with a note of key concerns and an action plan. However, some health visitors said that supervision was less often than three monthly. There was team supervision rather than individual supervision for staff working in sexual health services, community staff nurses and nursery nurses.
- The named midwife for safeguarding was employed by the local acute hospital. Your Healthcare had limited involvement with women before birth but to ensure handover of care from midwife to health visitor was well-managed, a service level agreement would be usual. Your Healthcare had no named doctor for safeguarding, because no doctors were employed. Staff told us that medical advice in relation to safeguarding, if needed, was available through their medical adviser's links with the named doctor for safeguarding at the clinical commissioning group (CCG). Formalised service level agreements are recognised as good practice.
- Your Healthcare staff contributed as needed to serious case reviews carried out by the Local Children Safeguarding Board (LSCB). There were no current serious case reviews. Kingston LSCB was part of the Social Care Institute for Excellence (UK) pilot for serious case reviews. Staff told us learning from a recent serious case review had been disseminated in the annual Level 3 safeguarding training update about understanding families from a cultural perspective and greater awareness of young people with Asperger's syndrome and their use of the internet.
- Health visitors told us they had good relationships with local authority safeguarding teams and social services, although working arrangements were not formalised. Health visitors felt current arrangements were sufficient to provide a rapid and joined up response in cases where they had safeguarding concerns. We saw evidence within electronic records of contacts with vulnerable children and families, as well as details of how they were being supported by other agencies such as social workers. Within the children's and families services, staff told us that if they had any concerns about children and young people, they would arrange home visits in order to assess the home environment and thus the level of risk.
- Within the sexual health team, staff were aware of action they should take if they had any safeguarding concerns about young people attending clinics. Staff working with sexually active young people and those at risk of child sexual exploitation (CSE) used the LSCB's screening tool.
- 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 did not use any volunteers. However, they did take young people on work experience. They did not have a policy about safeguarding and work experience.

Medicines

- There were effective policies and procedures to manage the storage and administration of medicines at external locations. Medicines, including first aid boxes, were kept secure and handled safely. Staff were aware of the protocols for handling medicines so that the risks to people were minimised.
- Patient Group Directions (PGD) were used to allow school nurses and some health visitors to administer medicines in line with legislation. PGDs are written instructions for the supply or administration of

medicines to groups of patients who may not be individually identified before presentation for treatment. Copies of the PGDs were available on line. They had been reviewed regularly and were up to date.

- Prescriptions had to be signed for and the numbers were recorded. Nurses could only book out small numbers of prescriptions at a time.
- Relevant staff received training in medicines management and could demonstrate competency around the safe and effective use of medicines. Medicines management training was mandatory for nurses.
- We saw that medicines for the sexual health clinics (a small number of drugs and medication such as the oral contraceptive and local anaesthetics) were ordered appropriately and stored securely at Hollyfield House. Nurses then took the medicines to the schools and clinics. The service had identified a potential risk in the storage arrangements at clinics and school sites and as a consequence the pharmacy team was undertaking an audit of these storage areas.
- We observed good storage practice at the sexual health clinic at Hawks Road where there was a separate cupboard for equipment, including sharps boxes which were correctly assembled and labelled. Within that cupboard was a locked cupboard for pills and injections with all the expiry dates visible.
- No vaccines were administered by the service.

Environment and equipment

- Clinics were provided at nine children's centres and some GP medical centres across the borough. Most of these locations 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. We noted that one children's centre used for a baby clinic/ breastfeeding clinic had no sink in the clinic room itself, so staff and women had to wash their hands in either the toilet or kitchen. Staff told us this had been risk assessed.
- The equipment we checked, such as scales, was calibrated appropriately. Health visitors each had their own set of scales which they took with them to clinics and on home visits. There were set days throughout the year for checking and calibrating equipment. This was done by an external contractor.
- Staff told us that they had enough equipment to deliver care and they had no problems ordering equipment. The paediatric therapy teams reported they had good access to equipment for children using the service, and most items were readily available and delivered promptly.
- There were first aid boxes and fire extinguishers in each of the locations we visited to comply with health and safety legislation.
- Staff said that it was hard to find quiet space for confidential calls in the open plan office at headquarters, and that storage was limited.

Quality of records

- The service used an electronic record system (ERS) to input and access children and families' records. Records were password protected in line with data protection guidelines. The new computer system had been introduced a year before our inspection. The transfer appeared to have been achieved without data loss; however there had initially been some loss of productivity in both clinical and administrative teams because of problems with the functionality of the new system. This was on the risk register and managers were still seeking to resolve the issue with the suppliers.
- The computer system was available to all staff and professionals. Staff recorded information from clinics and home visits sessions in chronological order including history, consent and referrals. As all staff working for Your Healthcare used same system this enabled them to share information.
- We looked at 17 care records across school nursing, health visiting including records of looked after children. Records were concise and well-written without abbreviations. Consent was recorded appropriately. Your Healthcare was not responsible for children's care plans (this was the responsibility of social services). Your Healthcare's child records were mainly progress notes, detailing each contact with child and parent/carer.
- Health visitors told us they liked the computer templates which helped to structure their notes even

though there was some duplication. However, some items were missing from the templates. For example, there was no prompt to record other adults in a household. Where necessary, staff scanned in needs assessments, which were usually completed on paper, reports, letters and minutes from meetings to complete the chronology of children's' care. The records we looked at showed a clear history of care.

- We found that records of vulnerable children contained enough appropriate information and were updated in a timely manner. The detail of some records was hidden appropriately from general view. One example was where a child's health information was only available to the sexual health team
- Some safeguarding records were on paper and stored in a locked filing cabinet. Records reported the safeguarding assessment, and showed a reason, outcome and plan.
- Records were kept on site for two years after the last contact or child protection input, and were stored securely to await archiving. Keys were all coded and kept in a key box. The list of codes was locked away separately.
- Information governance was part of the mandatory training programme staff were required to complete. Across all services, 61% of staff had completed this training. The provider did not set a target for training.

Cleanliness, infection control and hygiene

- The organisation had recently employed an infection control nurse, after a long period without one. All nurses in the children and families service now attended annual infection control training.
- We attended home visits with health visitors, and observed clinics in the community. All the clinic locations we visited were visibly clean, tidy, well organised and clutter-free.
- 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.
- Staff had access to personal protective equipment (PPE). We saw staff using this equipment. Staff were aware of how to dispose of used equipment safely and in line with infection control guidelines in people's homes and in clinics.
- The clinic used for tongue tie appointments was clean and we observed nurses using aseptic techniques and washing their hands.

Mandatory training

- The mandatory training programme for health visitors, nursery nurses and school nurses included record keeping, risk assessment and basic life support. Statutory training included equality and diversity, health and safety, information governance, adult and child safeguarding, fire safety and moving and handling.
- Your Healthcare used an electronic monitoring system to manage staff mandatory training. Staff told us that they were responsible for making sure that they were up to date with their training. They could access their training records online but the system did not generate reminder emails when their training was due to expire.
- It was evident from the risk register that uptake of mandatory and statutory training had been low early in 2016. Considerable efforts had been made to increase training uptake by staff. Staff told us there had been improvements but problems with the software meant the improvements did not show in central records organisation-wide, so we could not corroborate what staff told us with the central information from the provider.

Assessing and responding to risk to those using the service

- There were mechanisms to identify service users at risk, such as vulnerable women and children. Details were recorded in electronic records to which all clinical staff had access.
- Staff told us that communication from midwives about vulnerable women who had recently given birth ensured they could offer timely support. There were 50-60 new-born babies a month in the area.
- We observed health visitors and community children's nurses conducting risk assessments while on home visits and in clinics. We saw health visitors record the

observations of infant development parameters such as height, weight, communication and motor skills. These were recorded in the baby record book and on the ERS. Infants were assessed for actual and potential risks related to their health and well-being and we saw evidence of this in notes.

- Speech and language therapists used a parent-completed questionnaire alongside referral information to assess children's speech or communication issues. This helped staff have an awareness of the speech development of children on the waiting list in the absence of a universal service which would have enabled more timely assessment for children referred.

Staffing levels and caseloads

- There were 34.6 whole time equivalent (WTE) health visitors (headcount 49). Vacancies were 18% which was high. There was also a high level of sickness: 5.3%.
- We were told there were 12546 children aged under- five which implied average health visitor caseloads of about 360 if all families used the health visiting service. This was worse than the Government's target of one health visitor to every 300 children. Health visitors were deployed so caseloads were smaller in areas of higher population need. However, even in the more deprived part of the borough, the caseload was 292 per health visitor, which implied there were much higher caseloads in other areas. We noted this impacted on delivery of the Healthy Child programme (HCP). The HCP is the universal public health programme for children and families from pregnancy to 19 years of age, which seeks to improve outcomes and reduce health inequalities. Vacancies were affecting the service's ability to achieve the key visits on time, even though the health visitors we spoke with did not appear to be under undue pressure.
- Health visitors and school nurses worked together, especially when families had children of different ages so were eligible for support from both services, so that there was minimal duplication of work. This was efficient and effective and broadened staff skills. Both groups of professionals had undergone training to staff the sexual health clinics.
- There were 13.8 WTE (headcount 23) school nurses with 5% vacancies and 5% sickness. One role of school nurses was to deliver the national measurement programme in all Kingston schools. In their health promotion and education role, school nurses supported schools and pupil referral units with sex and relationships education as well as with personal, health and social education when schools commissioned these services.
- School nurses told us they prioritised safeguarding work and could respond very quickly to safeguarding concerns.
- School nurses and health visitors also worked in the young people's sexual health clinics to support the reduction of under 18 conceptions and to improve chlamydia diagnosis. There were eight staff solely working in sexual health.
- The highest vacancy level was among speech and language therapists. There were 18.19 WTE SLT therapists, many of whom worked part time. The vacancy rate was 20%.This was on the risk register because the organisation was not meeting commissioner's targets. Sickness levels were low at 1.8% so few therapist cancellations occurred. About 4.8% of children were not brought to appointments. A number of therapists worked term time only.
- Staff turnover for the organisation as a whole was higher than some comparable south London services; 16.6% for October 2015 to September 2016.

Managing anticipated risks

- The head of children and family services was aware of the staff shortages which, we were told, were being actively managed locally. Your Healthcare were concerned that proposed changes to health visiting models nationally together with budget cuts would reducing staffing levels further. Kingston Public Health had imposed an in-year 10% budget reduction for the 0-19 service from 2017, but the provider had agreed to absorb this cost pressure rather than reduce the level of service.
- Each team held weekly meetings, concentrating on allocation of staff to ensure full capacity coverage and cover for holidays and sickness so these did not affect the service to families.
- Your Healthcare had a lone working policy and staff showed good awareness of this. They informed colleagues of their home visiting schedules through a diary in the office. Staff had mobile phones. Home visits

Good

Are services safe?

were not allowed if there was an identified risk to staff. Risk information was set as an alert on the ERS system and relevant families would attend health centres instead of having home visits.

Major incident awareness and training

- The organisation had protocols and standard operating procedures in place. An Emergency Planning Officer had been appointed. The organisation was awaiting confirmation of approval from NHS England Emergency Preparedness, Resilience and Response, following a review meeting in November 2016.
- We saw a business continuity plan which identified the top priority as children and families at risk, and the next priority new birth visits. The plan covered electrical failure, telecommunications failure, IT failure and loss of mains water as well as other eventualities. There was also an up to date major incident plan which was reviewed annually. Both plans had been written in August 2016. There had not been a drill to test this.

Requires improvement

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 effective as 'requires improvement' because:

- The timeliness of some of the five standard visits within the universal offer in the Healthy Child programme fell below national targets for new born and one year old checks, although Your Healthcare performed better than the national average for 6-8 week checks.
- There was limited data on the numbers of children and young people achieving their treatment goals through speech and language therapy. However managers later told us the service was at an early stage of moving to a new measurement outcome tool which was expected to improve the quality of monitoring information.
- Not all the targets for sexual health were being met. For example, they were below the 80% target for dual chlamydia and gonorrhoea screening with an average 41% for adults and below the 20% target for long acting contraception at 11% for young people.

However

- Staff gave evidence-based advice and guidance to families using the service.
- There was effective internal and external multidisciplinary working.
- There was evidence of partnership working with local authorities and other safeguarding partners.
- Consent processes and documentation were robust and applied consistently.
- Staff felt they were supported through supervision structures for staff.
- Care pathways which included language disorder, stammering and dysphasia pathways were evidence based.

Detailed findings

Evidence based care and treatment

- Your Healthcare'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.
- Staff we spoke with in the health visiting, school nursing and sexual health teams were mostly aware of the guidelines relevant to their sphere of practice. For example, the infant feeding policy had been developed to support and reflect the recommendations for clinical practice and training around infant feeding, as outlined in the NICE Clinical Guidelines for Postnatal Care (CG37, 2006), and Maternal and Child Nutrition (Public Health guideline 11, 2008).We observed staff and saw they were following these guidelines.
- Some health visitors we spoke with told us they had only very recently had training on Whooley questions (open ended questions to assess maternal mood post-natally). They were unaware of and unable to find a pathway or protocol relating to post-natal depression on the provider's intranet. The provider later gave us a copy of the protocol, dated April 2016, which recommended use of Whooley questions.
- No data was held centrally on the number of mothers referred for further support after maternal mood screening, despite the plan in the protocol to audit this work every two years which meant trends could not be identified.
- Care pathways included language disorder, stammering and dysphasia pathways which were evidence based and we saw some of these therapies being used.
- We saw written standard procedures for bleeding after a tongue tie procedure. Mothers were encouraged to breast feed after their baby attended the tongue tie clinic to ensure the baby felt no pain and to help stop any bleeding.
- Health visitors used the Ages & Stages Questionnaires (ASQ), a parent completed screening tool that asks about a child's development in different areas.
- We observed contraception and sexual health practitioners in their clinics. Staff gave appropriate advice and education and provided reassurance and guidance to patients. NICE had accredited the process used by the British Association for Sexual Health & HIV

(BASHH) to produce its UK national guidelines which staff followed. Accreditation was valid for five years from January 2011 so re-accreditation was due soon after the inspection.
- The service carried out a range of audits, which included a pilot programme that offered telephone breastfeeding support, by trained breastfeeding peer supporters, to mothers in Norbiton.
- The service also took part in some audits run by others, an example was Kingston LSCB Domestic Abuse audit.

Nutrition and hydration

- During our inspection, we saw staff gave parents up to date and relevant advice about breastfeeding, weaning and nutrition and hydration in babies and children. Staff supported breastfeeding one-to-one with families and ran regular breastfeeding support groups in different parts of the borough.
- Your Healthcare had achieved UNICEF accreditation at level 2: 73% of mothers in the borough were breast feeding at six to eight weeks after birth. Health visitors ran drop-in centres and gave mothers details of the national breastfeeding helpline and a helpline run by a charity. Health visitors referred mothers who needed more support to the infant feeding team.
- We saw an evaluation of a Targeted Breastfeeding Telephone Support pilot carried out in one of the more deprived areas in November 2015. The aim was to improve breast feeding rates by contacting mothers with support within two or three days of giving birth. The pilot was found to have some limitations because of the lack of maternal demographic information including previous breastfeeding experience. It also highlighted administrative challenges and the need for better training of peer supporters and more robust monitoring. The recommendation was for all mothers to be offered feeding support through peer support , whether breast feeding or bottle feeding, but we did not see the recommendation followed through to extend the use of peer support.

Technology and telemedicine

- Staff across universal and speech therapy services had access to laptops, secure mobile internet connections and smart phones to support remote and mobile working. There was a pilot in one part of the borough giving staff tablet computers.
- Staff had laptops with good connectivity through 3G dongles, so were able to input data at home or elsewhere if they preferred rather than returning to the office. Staff were encouraged to work in the ways that best suited them.
- Mothers were able to telephone health visitors for advice and women told us they could always get a reply within 24 hours.
- Some school nurses told us work was underway to develop internet-based support services for children and young people at school, for example, allowing school pupils to ask questions by email. The KU19 service already delivered services through a variety of media.

Patient outcomes

- The Healthy Child Programme was the responsibility of Health Visiting (0-5) and School Nursing (5-16), although other agencies provided other parts of the programme such as immunisation and vision checks. The child and adolescent mental health services (CAMHS) and the integrated service for children and young people with disabilities were run by another provider.
- The Healthy Child programme for under-fives includes a series of universal screening tests and developmental reviews. One of the programme targets is that a new baby review should take place by 14 days with both mother and father in order to assess maternal mental health, discuss infant feeding and how to reduce sudden infant death syndrome. Health visitors carried out 83% of new birth visits within 14 days in the period July to September 2016. This was below the commissioner's target of 95% and below the England average of 88%. However, 95% of mothers received a new born visit within 18 days of birth. We were told that a reason for not always being able to complete the visit within 14 days was because some mothers remained in hospital for a few days following birth or had been discharged to a different address to that given on admission. This indicated there was room for improvement in communications with the maternity services.
- For the next mother and baby review visit carried out between six and eight weeks: 94% of mothers were visited by the time the baby was 8 weeks old, which was good, and better than the London and England average. However, health visitors achieved less good results for the timeliness of the 12 month review: only 53% of

babies had a review by 12 months of age. By 15 months 70% of children had received this check which was still below the England target of 85%. Although the provider said that all parents and guardians received a letter about the one year old check, there was no guarantee that the provider held correct addresses. For the final health visiting review, for children aged between two and two and a half years of age, health visitors saw 85% of children, below the England average of 86%.

- School nurses captured heights and weights of 99% of children as part of the school measurement programme which feeds into national data as part of the Government's strategy to tackle obesity. The programme also provides a vehicle for engaging with children and families about healthy lifestyles and weight issues. The nurses told us they could refer families of underweight or overweight children to other agencies for support if families were willing to participate, but none of the follow up was carried out by Your Healthcare.
- There was limited data on the numbers of children and young people achieving their treatment goals through speech and language therapy. However the provider later told us that the service was at an early stage of moving to a new measurement outcome tool which was expected to improve the quality of monitoring information. The service was also training some teachers about speech and language and beginning to develop materials for teachers in mainstream schools.
- We saw that school nurses offered all schools Personal, Social and Health Education (PSHE) sessions, although only some schools took these up. We saw that of the schools that took up the offer,100% reported sex and relationships (SRE) sessions as 'very good' or 'excellent' with demonstration that emotional and relationships issues were covered.
- Staff told us the sexual health service KU19 (an abbreviation for Kingston under 19) was a popular service, although we noted the service fell below the target attendances for the year. There were 865 attendances by October 2016 against a target of 1172. For the target of 20% of young people using long-acting reversible contraception (LARC), the service achieved 11% on average between April and October, although but they were exceeding the target for uptake of STI testing (83% compared to a target of 60%). There were very low numbers registered on the scheme to provide free condoms. The annual target for new registrations on the scheme to provide free condoms was 500. 100 new registrations had been achieved which was lower than target. However, YH had a total of over 630 people registered on the scheme, many of whom returned. Staff were not aware of an action plan to improve performance against targets.
- The number of students attending some drop in sessions were fewer than 10, however, this allowed for delivery of a service, not inhibited by time constraints for the student. The commissioners did not set a target for attendances at this service.
- Attendance at adult contraception and sexual health clinics was close to target attendances from April to September 2016, although below target for dual chlamydia and gonorrhoea screening with an average 41% take up against a target of 80%. All those tested were notified of the result within 10 working days, but the service was below the 95% target for those testing positive for an STI being treated within six weeks of the test date.

Competent staff

- Staff and managers told us that most staff, other than recent starters had an annual appraisal, called a Personal Development Review (PDR), which had been introduced the previous year. Line managers were still being trained in the process during 2016/17. The PDR process set expectations and objectives for staff and ensured staff had the competencies and skills for their roles.
- All managers were required to undertake a PDR with each of their staff members each year and ensure the staff had access to regular supervision, in the form of 1-1 support or group sessions. No monitoring process had been introduced. Before our inspection, in the absence of central records, all staff had been asked about whether they had an up to date PDR. Of the 74% of staff who responded, organisation-wide, 66% confirmed they had had an annual appraisal. All staff should have an annual appraisal.
- All staff new to the organisation received an induction handbook, had a face to face induction on the first induction day and a combination of discussion and an e-learning session on the second day.
- Staff said they were encouraged to develop themselves. They had a personal dashboard on training system. They were encouraged to seek out free training including training run by other local agencies. There was

some access to training funds from Health Education South London. There were plans to provide development support for a health visitor and two school nurses over the next year.
- The organisation had run a series of workshops to support nurses with nursing re-validation.
- There was training for the health visitors and school nurses working in sexual health from a consultant at the local hospital. The hospital was also the source of clinical support.
- A new scheme for apprenticeships was being developed for staff below Band 6.
- Staff were able to attend further safeguarding training provided by the Local Safeguarding Children's Board (LSCB).

Multi-disciplinary working and coordinated care pathways

- Several agencies in Kingston had responsibilities for different aspects of the Healthy Child programme so health visitors and school nurses worked in partnership with others, immunisation teams, social care teams, teachers and youth workers to deliver the evidence based interventions within the programme.
- Practitioners worked with other agencies as a team around the child so that information was shared across services where there were concerns about a child in vulnerable circumstances. Data on referrals to social care showed there had been one or two referrals a month on average over the past year. Your Healthcare staff told us they prioritised attendance at multi-agency safeguarding hub meetings.
- We observed both internal and external multidisciplinary (MDT) working. For example, shared information between health visitor and school nurse teams, as well as work with GPs, school staff, social services, the police and the provider of integrated care. There was a named health visitor for each GP surgery to support continuity. GPs and practice nurses who gave immunisations (another local agency was responsible for school immunisations).
- Speech and language therapists supported children in schools with special units for autism and hearing impairment, and in special schools. They supported teachers in these schools with teaching to help them implement strategies when the therapist was not present. They also supported parents within those schools. In the schools they worked in, they shared offices with teachers which enabled them to share information and assessment with other professionals. The team worked collaboratively with the Educational Service for Sensory Impairment (ESSI) run by another local provider.
- Initially Your Healthcare was not commissioned to work with children in mainstream schools and nurseries but had now reached an agreement to provide services to children with an EHCP in mainstream schools. This service was paid for by the schools. They also provided training for partner organisations and some mainstream school teachers. We reviewed an evaluation of the courses run between September and November 2016. One of four recommendations to improve support for teachers had been implemented at the time of the inspection.

Referral, transfer, discharge and transition

- Health visitors attended one of the antenatal clinics with midwives so that mothers were aware of the service. However, Your Healthcare not commissioned to visit mothers at 28 weeks or greater which is the standard first HCP visit.
- The electronic patient record system used by Your Healthcare was not the same as that used by midwives for mother and baby records. The provider of health and social care for children with special needs also used another system so staff could not access records held by other providers on the same child, so written reports were required at transition.
- Most handovers from midwife care to the health visiting service used secure email. Face to face meetings were held when there were safeguarding concerns in line with good practice. Health visitors also had information through the Personal Child Health Record(also known as the PCHR or 'red book'). This is a national standard health and development record given to parents. There was also an online version of the red book. Your Healthcare was encouraging mothers to sign up for the new e-red book. All child health records we looked at had an NHS number and could be linked to the mother's notes.
- Referrals to the tongue tie clinic came from GPs, midwives and the infant feeding team. Health visitors had been given information about how to check for tongue tie.
- Referral of children over five to the night time bedwetting clinic were made by GPs, school nurses

(with parental consent), parents and other professionals involved with the family. All those referred were sent an assessment questionnaire in the first instance to help the nurse with prioritisation. There was a waiting list.

- Children's records were transferred from health visitors to the school nursing service when the child was 4 years 10 months. Beyond the age of 16, children who were 'Looked After', had a pathway plan, to help them transition to leaving care when they reached the age of 18. Your Healthcare was not involved with young people at this stage.
- Speech and language therapists explained that most pathways started with referral by GPs or health visitors, although parents could refer their own child. When children were referred for speech and language assessment, most parents were sent a questionnaire relevant to the age of the child. Staff told us they reviewed the new questionnaires weekly. In July 2016 the open caseload was 147 children under five. At the time of the inspection 25 children had been referred to the Eating and Drinking service, and the caseload of children with special educational needs in mainstream schools was 485. The Early Years' service saw eight to 12 new cases a month at the time of the inspection. During 2015/16, the entire SLT service received a total of 368 new referrals.
- Staff had a good awareness of the other services available to children and families, including the local child development service, and were able to contact other teams for advice and referred children when necessary to social care, paediatricians, occupational therapists, physiotherapists and family support workers.
- We saw processes for passing on information when children moved out of the area and for dealing with families moving into the area. However, these guidelines did not mention the requirement for transfer of records within two weeks of notification, which is important for ensuring no child is missed.

Access to information

- The intranet was available to all staff and contained links to current guidelines, policies, and standard operating procedures, as well as contact details for colleagues within and outside the organisation. However, on searching for some policies ourselves, we found that not all policies were stored in one place, for example policies being revised were moved elsewhere. This meant that staff could not always access advice and guidance easily.
- SALT practitioners had provided some training for special educational needs coordinators (SENCO) in schools so that they were better informed about how to support children with communications issues. They had audited this to identify ways to improve the training in future. They had also contributed to an In-Service Training day (INSET) in schools.
- The teams currently had no access to GP notes on children and families. However health visitors had a schedule of monthly meetings with their GP for collaborative service delivery.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Service users told us health visitors, school nurses and therapists had explained the purpose and evidence for different clinical assessments and confirmed their consent before proceeding with any actions. Consent and Mental Capacity Act (MCA) training was mandatory for clinical staff but we were not given data on what proportion of CYP staff had this training.
- Staff within the sexual health services described to us how they obtained consent from people attending the service.
- School nursing and sexual health staff had a good understanding of how to gain consent for children and young people and used Fraser guidelines and Gillick competences to make decisions about whether young people over 13 had the maturity, capacity and competence to give consent themselves. The service could not give advice to under 13s because a safeguarding referral was needed when a child of that age was engaged in sexual activity.
- Staff we spoke with understood how to manage mental capacity or learning difficulties and what to do if they felt someone lacked capacity.

Good

Are services caring?

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

Summary

We rated caring as 'good' because:

- Staff were passionate about their roles and were dedicated to making sure that the people they cared for had high quality care.
- Parents and children were treated as individuals and we saw that staff and families had built up good working relationships.
- Parents had confidence in the staff they saw and the advice they received.

Detailed findings

Compassionate care

- The majority of families we spoke with were very happy with the services provided by Your Healthcare. We observed that staff were polite, patient and informative. Direct comments from parents, which were representative of this feedback, included: "Staff are very approachable", "the staff give consistent advice", "my health visitor gives me all the information I need to know",
- Although there were only small numbers of mothers attending the feeding clinic, mothers at these clinics said staff were 'relaxed and friendly'.
- We observed a sensitive interaction when a health visitor shortened a home visit because the mother was obviously tired.
- Service users consistently told us they would recommend the service to their families and friends.
- Friends and Family Test (FFT) results were consistently very good across CYP services and locations, with 93% recommendations for the three months prior to our inspection. However, the response rates were low as a proportion of users, for example there were only two comments on speech therapy.
- 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 in the sexual health service for under 19s were welcoming to those attending and non-judgmental. Users were asked for feedback on their experience of clinics and drop in sessions in a dipstick survey and all said the clinic met their needs and they would recommend the service to friends.
- In a KISH survey of all age sexual health clinics, 32 were very likely to recommend and 13 likely to recommend out of a total of 39 responses

Understanding and involvement of patients and those close to them

- Staff explained what was going to happen during an appointment and parents were given opportunities to raise concerns or issues.
- Parents and carers told us they felt involved in discussions about care options and told us that they felt confident to ask questions and make decisions based on the information they received.
- We also saw health visitors engaging fathers and answering their questions. We observed very clear information provision and support by health visitors during home visits. They picked up issues raised by mothers, for example, about feeding concerns.
- We spoke with three parents whose children with hearing loss were having speech therapy. They said it was helpful to meet other parents in a similar situation and learn strategies they could use with their child at home to develop language skills.
- Staff communicated with children and young people in an age appropriate way and involved them in decisions about their care.
- We saw that staff in all services used written information to supplement verbal information, which was good practice. For example, health visitors recommended weighing weekly in the first month, monthly up to 12 weeks and then 8 months, one year and yearly thereafter, and mothers were given leaflets about this as a reminder of the discussion.
- Those using sexual health services said staff involved them in reaching decisions.

Good

Are services caring?

Emotional support

- Health visitors were attached to GP surgeries so mothers generally met the same health visitor at each appointment. This consistency meant that health visitors were able to build up relationships with mothers and children.
- We observed health visitors 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, such as counselling. Health visitors worked with local maternity services to improve mothers' psychological support needs where midwives passed on this information.
- Mothers told us they found health visitors reassuring.

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 responsive as 'requires improvement' because:

- Very few children with routine referrals for speech and language therapy were seen within the 18 week target. We saw no plans to reduce the waiting times.
- There had been a long break in provision of the children's continence service and catch up was estimated to take six to eight months, although managers hoped this could be achieved more quickly.
- Uptake of the sexual health services was below target in a number of areas and data was not analysed to understand the reasons for this.

However

- Local people had convenient access to services because they were provided in a range of locations, and offered varied appointment times and days to suit people's different circumstances.
- Baby clinics were held in child and family friendly environments.
- Staff showed understanding of the different cultural needs and backgrounds of service users, with access to translation and interpreting services as needed.
- Staff provided a weekly tongue tie clinic so that Kingston parents did not have to travel with their baby to a hospital in another borough for this service.
- The enuresis service (night-time bedwetting) was well embedded and had no waiting list.

Detailed findings

Planning and delivering services which meet people's needs

- Speech and language therapists have a role to play at the universal, targeted and specialist levels of need, in collaboration with parents and carers. Your Healthcare did not offer a universal service or drop in centres for parents. SALT practitioners provided some training to teachers in mainstream schools to help them identify and support children with communication problems, but the number of mainstream teachers reached was small. There was therefore a risk of delay in the identification of need for some children.
- Fewer than half the children referred to speech and language therapy (SALT) were actively triaged by meeting a therapist face to face. Between July and September 2016 therapists saw an average of six new cases each month. There had been 26 referrals a month on average in the period April to September 2016.
- We observed school speech therapy sessions for primary aged children with autism spectrum disorder (ASD), a condition that affects social interaction, communication, interests and behaviour, and another for hearing-impaired primary age children. Anecdotally, some teachers we spoke with were complementary about the results achieved by therapy; however the service did not formally measure teacher or SENCO satisfaction through, for example, before and after questionnaires.
- The speech therapists' role also included supporting parents through attending coffee mornings and parties which parents appreciated.
- Therapists told us they contributed to Education, Health and Care Plans (EHCPs) for ASD children. EHCPs set out the special educational needs of a child or young person and the support they should receive. Staff said that differences in the way boroughs prepared EHCPs made it harder to support children from outside the borough. We were told that from January 2017, Your Healthcare would charge schools for professional contributions to EHCP. EHCPs bring together a range of professional advice on achieving health and care outcomes that will enable young people to progress in their learning. On average there were five EHCP requests a month.
- The SALT service was confident that schools themselves would commission bespoke pupil-specific packages of care for pupils with social and communication needs. An extra therapist was being employed to support this service. We questioned the appropriateness of schools and families having to purchase a service to meet children's assessed needs.
- Three health visitors were based in the clinics of large GP services. The rest were based at Hollyfield House, Surbiton, but a named health visitor was linked to each GP practice.

Requires improvement

Are services responsive to people's needs?

- Health visitors held 13 baby clinics and three antenatal clinics a month in children's centres and GP practices. Clinics were held in locations served by public transport and all locations were accessible to people using wheelchairs. Each of the locations had information boards and user information leaflets. Staff told us that home visits were usually available if requested.
- Health visitors were encouraged to meet families' needs, without prescriptive direction from managers. The service had decided to absorb funding reductions and subsidise the health visitor service from income generated by other services.
- Staff had arranged that school nurses would take responsibility for families where two out of three children were school age, to avoid duplicated involvement of health visitor and school nurse.
- School nurses visited home-schooled children as part of the national child measurement programme. The responsibility for follow up with those under or overweight lay with other organisations.
- School nurses offered PSHE for pupils in primary schools: in Year 5 this covered relationships and in Year 6 contraception. Secondary schools could request a nurse to run confidential drop-in sessions. Simple drop-ins were where young people could ask questions and enhanced drop in was for emergency contraception or chlamydia testing. 21 out of 32 Kingston primary schools used the service and 11 out of 13 Kingston secondary schools used the service. School nurses adjusted the type of sex and relationships drop-ins according to the school's need. An example was adaptation for a roman catholic school where staff wanted nurses to give students physical and mental health services information but not contraceptive services.
- Children and young people were asked to complete evaluation forms after PSHE sessions, but although school nurses reviewed responses at the end of each session to understand any gaps in information presented, there was no detailed analysis of children's views.
- A Tongue Tie Release Clinic had been set up in January 2016, after midwives at the local hospital stopped doing this and instead referred cases to outpatient appointment at another hospital. The clinic ran one day a week for babies under 6 weeks old, with feeding problems. A baby had an initial assessment, was brought to the clinic for the procedure and then attended for a check-up a week later. Health visitors gave feeding advice after frenulectomy (tongue tie release), and referred mothers to the Infant Feeding clinics.134 cases had been referred between January and Oct 2016. The service covered those families living within the Kingston area and had been well-received.
- Most staff appeared to have a good knowledge of the people they had on their caseload, or who attended the schools they worked in.
- The KISH (Kingston Integrated Sexual Health network) client satisfaction survey was used at all KU19 and CASH Clinics to gain up to date client feedback. The service had been redesigned in the past year to meet people's needs better. This included the opening of a Saturday clinic. However, no detailed analysis had been carried out to see if the goals of the reconfiguration of sexual health services had been achieved.
- Four clinics were part of the first group of six of Kingston's young people's health services to be successfully accredited under the 'You're Welcome' standards. Subsequently all school nurse enhanced drop-ins and Hawks Road CASH services had achieved You're Welcome accreditation. KU19 (Kingston under 19s) allowed young people to call, text, email, or drop in for advice and support. There was also a website for advice and information. At the Hawks Road clinic, there was a separate waiting area for young people. The young people's clinics took place a different locations on different days, mainly 3.30 to 5 or to 6.30
- There were other drop in sexual health centres in the borough run by other providers.

Equality and diversity

- Most staff were aware of the ethnic and religious makeup of the people who used their services and were able to describe how they could modify their recommendations to take account of cultural sensitivity. People who used the services told us that they were treated as individuals.
- Staff had access to interpreters when needed and also to telephone translation. There was a large Korean population locally. We were told they did not engage much with services. Your Healthcare had not set up any outreach specific to this group of families.
- The SALT service produced leaflets for parents on the development of speech sounds, stammering and modelling correct speech which gave parents tips on how to help their child. We did not see any leaflets in

other languages produced by Your Healthcare although we noted that some Kingston-wide leaflets produced by other organisations had a telephone number to call if English was not the reader's first language.
- Leaflets were available for parents and carers, and for teachers about who to contact with concerns about communication. We were told that materials for teachers to use in the classroom were in development.
- Service user language requirements were confirmed on family records.
- Buildings were easily accessible and adhered to the Disability Discrimination Act 1995.

Meeting the needs of people in vulnerable circumstances

- The CYP service worked in partnership with other local organisations, including social services to support the needs of people in vulnerable circumstances.
- Services were designed with the needs of vulnerable people in mind. Staff were aware of the areas of greatest deprivation.
- The organisation's record system included alerts for those with specific needs to ensure administrators and practitioners were aware when reviewing individual records.

Access to the right care at the right time

- Your Healthcare provided telephone advice lines for health visiting so that service users could obtain advice directly without making an appointment. A duty health visitor was available for advice and support during out of hours and women told us they received return phone calls after leaving a message.
- A few children referred urgently to speech and language therapy could be seen quickly, but the delivery of speech and language therapy was rated as a high risk on the risk register because the service could not deliver the service as commissioned.
- Waiting times for speech and language assessment were managed to prioritise assessment of children at certain developmental points to match staff availability. The service did not hold a traditional waiting list, but described a risk managed monitoring list. Those with a stammer or those identified as having special educational needs and disabilities were seen first. Different staff variously told us that the wait for routine assessment by a therapist was between six, eight or 10 months. The number of referrals was increasing and the number of routine appointments within 18 weeks was getting smaller. Only six children were seen as routine appointments in September 2016. We were aware from other data that waiting lists had been long historically and we did not see an action plan to reduce waiting times.
- Therapists told us they ran parent groups, called i-chatter, every other month to support parent/child interaction and parents waiting for an assessment could attend these. These only reached a small number of families. We were given data on absolute numbers, but not percentages of applications seen within different time periods to provide comparable data on referrals, waiting times, and breakdown of types of intervention to allow comparison with similar services in other areas.
- Staff told us they were unable to be proactive in picking up speech and language delays in children in nurseries borough-wide despite the recognised importance of early intervention.
- A few early years' children on the waiting list, deemed to have higher levels of need were referred for group 'dynamic assessment'. There was a maximum of six children such groups which took place half termly. About 28 children a quarter experienced this compared to an open caseload of over 100 and an average of 20 early years children on a waiting list at any one time. We were not given figures of older children on waiting lists.
- After assessment indicated a need, children's interventions started immediately. The system allowed staff to prioritise children needing the most specialist intervention. However, staff did not know how many parents referred for an assessment ended up seeking help for their child elsewhere. We were aware that some parents in the area had done this.
- On average about 34 children referred to SALT for eating, drinking and swallowing difficulties were discharged each quarter.
- A child continence clinic had been running for a week at the time of the inspection in November 2016.. The plan was first to see the 20 children over 5 awaiting initial assessments in the weekly clinic. The new service was run by a former school nurse, with involvement from three other team members who completed initial assessments. Telephone support was offered for parents of children of 5 to 6 years. For 7-16 year olds, referrals

were put on a waiting list. When accepted, the family would be seen every 3-4 weeks for 6 months. If there was no progress the child would be referred through the GP to a paediatrician at a tertiary hospital.

- The enuresis service (night-time bedwetting) was well embedded and had no waiting list.
- At the time of the inspection, 70-80 children were awaiting re-assessment because there had been a period of several months with no service. The clinic had formerly been part of the provider's adult incontinence service. The new service would supply continence products as well as training advice. We were told would take six to eight months to catch up with the referrals.
- SALT was provided for some children under-five at Hollyfield House. Sessions were also run at some schools with specialist units for autism and hearing impairment, and at special schools.
- School nurses 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 contraception and sexual health services provided walk-in clinics for women and men of all ages, at different times of day, so people could access provision at a time convenient to them. Anyone could attend a Community Contraception and Sexual Health (CASH) clinic whether or not they were registered with a GP or lived in the area. The service offered condoms, contraception for women (pills, contraceptive injections, patches, implants, IUD/IUS (coils) as well as emergency contraception, screening for sexually transmitted infections, treatment and pregnancy tests. However, there were not doctors at most clinics. Clients were advised to telephone clinics if they wanted an IUD/IUS (coil) inserted to check that the service would be available. The newly opened clinic at Hollyfield House had a doctor in attendance one Saturday a month.
- The under 19 clinics and CASH clinics did not collect information on waiting times for patients or have targets for patients being seen within two hours of arrival. Staff told us that all patients arriving before the cut off time would be seen at a clinic, but there was no information for patients about the cut off time. We were told that patients who could not be seen for some reason, for example if the relevant specialist was not available, the patient would be seen 'within a week'. No data was kept on these case by case events.
- The service provided screening for chlamydia for women and men between the ages of 16 and 24 as part of the national Chlamydia Screening Programme. Uptake was 50% below the target of 80% for adults and also below the 60% target for under 19s.
- Surveys of user satisfaction were carried out in the sexual health service but commissioners did not require formal audit so there was no learning captured from these to affect practice.
- There were other sexual health services in the area with different opening times and some specialist services, which some patients might have chosen instead of those offered by Your Healthcare.

Learning from complaints and concerns

- All the staff we spoke with, including speech therapists, school nurses and health visitors were aware of the complaints reporting process. Your Healthcare staff said they would liaise with other local service providers in cases where a complaint involved other agencies.
- There had been seven formal complaints about children and young people's services between September 2015 and 30 October 2016. Four were about continence services and three about school nursing. The responses were detailed and a written apology had been provided. However one of the complaints about continence services was about someone who had been awaiting an appointment for over a year which indicated a poor service in the past. The letter informed the mother that the service was re-starting and an appointment had been arranged for her son to be seen.
- Staff told us they tried to deal directly with complaints as far as possible by talking to service users.
- Mothers were given a comments and compliments form about Your Healthcare services when they attended baby clinics. The form was also used to collect ethnicity data. The form was quite long which may have affected the response rate. No other methods such as hand held computer tablets were used for collecting feedback to try to increase response rates.

Good

Are services well-led?

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

Summary

We rated well-led as 'good' because:

- Staff reported service leaders were very supportive, accessible and approachable.
- Many staff we spoke with demonstrated the values and vision of the organisation, where staff felt autonomous and trusted to make decisions without micro-management from senior staff.
- There was representation of children and families issues, such as safeguarding, at the top level of the organisation.
- The staff survey from February 2016 showed staff were engaged with the organisation.

However

- Although the service had a general mission statement for services for 0-19 year olds, we did not see a written statement of strategic direction for services for children and young people.
- There was limited data collection and analysis to assess service performance, particularly on outcomes for children and young people. Managers told us commissioners did not require them to report health outcome measures for many aspects of the service.

Detailed findings

Service vision and strategy

- Although the service had a mission statement we did not see a documented strategic vision for the service for children and families delivered by Your Healthcare in the future. Some staff told us they were unsure of the strategic direction. Some previously commissioned services had been taken over by other providers in the past year. The number of different providers commissioned to provide different aspects of children's health services in the area in made it difficult to set a coherent strategic direction.
- Your Healthcare had a non-executive director representative for children and young people's services on the board. This was intended to ensure that the children and young people were considered by the board when making decisions.

Governance, risk management and quality measurement

- Your Healthcare was headed by a membership council made up of community and staff members to act as a critical friend to managers. The Chair and the Deputy Chair (a community member and staff member respectively) sat on the partnership board which provided strategic leadership to the managing director. The managing director (and Registered Manager) was the board lead for frontline services, which included support to the lead for children and young people. Below the partnership board, an audit committee focused on external scrutiny and contractual obligations to commissioners, and an integrated governance committee received operational summary reports from frontline services (the provider's term for services working with patients). The head of children and family services attended a monthly frontline services meeting.
- The governance structure also included a number of committees that reported to the Integrated Governance Committee, which provided assurance for the Audit & Assurance Board on care quality, information governance standards, and the establishment of effective risk management.
- Your Healthcare submitted quarterly key performance indicators to the Kingston Clinical Commissioning Group, but not all staff knew what the key performance indicators were.
- All groups of staff had weekly team meetings to share information.
- A monthly newsletter, Quality Matters, was circulated to staff to keep them up to date with central policy changes.
- The risk register for children and families contained few risks. Not all operational staff we spoke with were familiar with the key risks in their areas of the service.
- There was limited data collection and analysis to assess service performance, particularly data that focused on health outcomes for children and young people. Managers told us commissioners did not require them to report outcome measures for many aspects of the service or benchmark against others.

Good

Are services well-led?

- SALT practitioners considered they were well managed at an operational level and felt management listened to them and were responsive, however some staff were not aware that their service was rated the highest risk in children's services. However, managers told us that this had been discussed at team meetings and the funding of the SLT service was the subject of discussions with commissioners..

Leadership of this service

- Staff said some uncertainty was caused by the decision to implement Kingston Coordinated Care, a programme to develop a coordinated and sustainable health and care system. Within children's services another provider was responsible for children with complex health and social care needs.
- Operational staff such as health visitors, school nurses and speech therapists told us senior leaders were visible, accessible and receptive to staff feedback.
- Most staff felt that the organisation was well managed.
- We saw that team managers were very dedicated to their teams and led by example. Staff appreciated being given freedom and autonomy to deliver services up to the limit of their capacity.
- There was a team leader responsible for health visitors and another for school nurses. Work was allocated on a rota basis from referrals.

Culture within this service

- We found a constructive working culture within the children's and families service with very dedicated staff. Staff we spoke with felt that Your Healthcare was a rewarding place to work, although the level of vacancies indicated some staff turnover.
- Staff sickness was relatively high compared to comparable organisations, over 5% in both health visiting and school nursing.
- SALT practitioners said their stress levels were high, but also stated, 'the work we do is recognised, which goes a long way', and 'feedback from schools and parents helps too'.
- The proportion of BME clinical staff (24.69%) to white staff (70.92%) was higher than in the previous year. However, the service did not have a breakdown specifically for staff in children's services.
- Health visitors, school nurses and therapists reported approachable and supportive colleagues. The staff we met told us that they felt cared for, respected and listened to, and senior staff were proud of their teams and the support staff gave one another.
- A number of CYP services had transferred to other providers in the year of our inspection, including immunisation and vision checks in schools. Some staff we spoke with felt that this had created uncertainty as children's services became more fragmented .
- The Children's Services Lead communicated local news, organisational achievements, changes and policy updates through emails. These were also disseminated through the Band 7 team leads. We were told that wider staff meetings were held approximately quarterly to exchange information, often with external speakers. Informal meeting notes were taken.

Public engagement

- The organisation took part in the friends and family test. This is a nation-wide initiative to help organisations to assess the quality of their services by asking people who used the service whether they would recommend the service. Although questionnaires returned indicated 95% of respondents would recommend the services, the response rates were low.
- Your Healthcare invited people living within the community to join the service as a member and provide their views on services. A membership council was held four times a year and its views influenced the main board.
- The organisation had introduced a public newsletter in early 2016 to provide information on services.
- The organisation sought qualitative feedback from those using services. Managers gave us two examples of how services had been changed in direct response to feedback. When the local acute hospital discontinued its tongue tie release service in early 2016, Your Healthcare trained three staff in this technique who now delivered this service to Kingston babies, to save mothers travelling to a tertiary hospital for this treatment. The Saturday sexual health drop in clinic was initiated in response to young people who said that they could not attend during the week. A Saturday service was started in June 2016.

Good

Are services well-led?

Staff engagement

- The staff survey from February 2016 was positive for the organisation as a whole with good levels of staff engagement and staff feeling they could contribute to team decisions, future planning and service priorities; staff felt recognized and valued for their work. The results were not broken down specifically for children and young people's services or sexual health services, or by sites where staff worked.
- Staff we spoke with felt a strong sense of belonging to their teams (90%) and felt that the organisation played an important part in the local community (95%).
- There was a staff benefit scheme although not all staff we spoke with were aware of this.