

London North West Healthcare NHS Trust

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Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
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This report describes our judgement of the quality of care provided within this core service by London North West Healthcare NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by London North West Healthcare NHS Trust and these are brought together to inform our overall judgement of London North West Healthcare NHS Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

- We gave an overall rating for the Community health services for children, young people and families of Good because:
 - Children and young people's services were effective. Care and treatment was evidence based and staff were competent. There were policies and procedures in place to support staff and ensure that services were delivered effectively and efficiently.
 - Services delivered by the trust were caring. Staff were dedicated and worked hard to ensure that patients received the best treatment and support possible. Patients were involved in decisions and understood the services being delivered to them. Emotional support was available to patients and their families who were dealing with difficult circumstances.
 - Children and young people's services were responsive to the needs of the people who used them. Generally, services were delivered to the right people at the right time within the commissioning framework of the trust. There were services in place to help protect vulnerable young people and children.
 - The service was well led at the local level. We had varying feedback from staff regarding their view of their place within organisation and the level of staff engagement. Most staff we spoke with felt the acute service did not understand community services. They felt the focus of the organisation was on acute services and community services tended to get lost within the larger organisation.
 - Staff were committed to providing a good service to their patients. However staff shortages and large caseloads placed too much pressure on staff resulting in them working extra hours. It was only due to the commitment of staff and the support of local managers' services were being sustained.
 - Staff generally reported good supportive leadership at local level and we met some very committed and enthusiastic managers who were working hard to develop and improve their services. With the exception of one team all staff were positive about the support they received.
- However;
- The safety of children and young people's services required improvement. This was because there were significant staff vacancies within the service in both nursing and therapy roles. The trust had developed the health visitor clinical academic hub, which had significantly helped to raise the profile of health visiting within the trust through publication of papers and nominations for national awards. With the work of the hub and streamlined recruitment processes there had been some success in recruitment but significant vacancies remained.
 - The impact of vacancies was that many staff were trying to manage caseloads well above best practice guidance of 300 families per health visitor. Health visitors working in Brent and Ealing did not know how they would meet the requirement for all parents to have a visit at 28 weeks of pregnancy. This is a national target to be implemented from October 2015.

Summary of findings

Background to the service

London North West Hospitals NHS Trust provides services to mothers, children and young people across the Boroughs of Brent, Ealing and Harrow.

The organisation provides services such as health visiting, community children's nursing, specialist paediatric nursing, family nurse partnership, physiotherapy, occupational therapy and speech and language therapy. School nursing services are currently provided in Ealing and Harrow. From January 2016 school nursing services will only be provided in Ealing.

Services are provided to people in their own homes, in schools and in clinics across all of the boroughs.

During this inspection, we visited a number of locations across the three boroughs, spoke with nine senior managers and team leaders, six therapists, 10 health visitors, three school nurses, four specialist nursing staff and six parents.

We observed staff practice in three clinics, one therapy group and in three patient homes. We spoke with six parents on the telephone. We looked at three clinical records. Prior to and following our inspection we had analysed information sent to us by a number of organisations such as the Royal College of Nursing, the local commissioners, Healthwatch and the trust.

Our inspection team

Chair: Dr Richard Quirk, Medical Director Sussex Community NHS Trust

Team Leader: Nicola Wise (David Harris supporting), Care Quality Commission

The team included a CQC inspector and specialist health visitor, school nurse and community midwife.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting the trust we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 19 and 23 of October 2015. During the visit spoke with a range of staff who worked within the service, such as managers, nurses, and therapists. We observed how people were being cared for and we talked with parents and reviewed a small number of treatment records of people who use services.

Summary of findings

What people who use the provider say

- We spoke with six parents who had been receiving services from health visiting and the family nurse partnership. Everyone we spoke with talked positively about the care and treatment they had received. They told us staff had been kind, caring, compassionate and respectful and valued the consistency of care they had received.
- They had no complaints about the service and told us any concerns about their child were responded to in a timely manner. They spoke about regular contact with the service and told us they felt well supported.
- Parents told us they felt very involved as a partner in care and had found health visitors were flexible around times of visits and were "very accommodating".
- Young parents receiving support from the family nurse partnership told us how much the service had helped them to prepare for the birth of their child and how they had been supported following the birth. They told us how their nurse had helped them to resolve problems and listened to them and gave advice. They valued the support and advice given to their baby's father and spoke about the support they had received to resolve issues with their families. One parent said "without the service they thought they would have panicked a lot; the advice they had received had been very valuable". Another parent told us they felt "it would have been a very different experience without the family nurse partnership".

Good practice

The family nurse partnership demonstrated a very effective evidence based service that was highly valued by the young parents they supported.

The health visitor clinical and academic hub was highly valued by all health visitor staff and was thought to have had made a considerable contribution to the recruitment and retention of staff.

The speech and language therapy schools buy in service demonstrated an innovative approach to dealing with high numbers of potential referrals.

Areas for improvement

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

- The provider must take action to reduce caseloads of staff in health visiting and paediatric therapy services.
- The provider must ensure robust protocols are in place for the transfer of necessary communication between midwifery and health visiting services.
- The provider must take action to ensure community staff are integrated and feel part of the organisation.

London North West Healthcare NHS Trust

Community health services for children, young people and families

Detailed findings from this inspection

Requires improvement 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

The safety of children and young people's services required improvement because;

There were significant staff vacancies within the service. The trust had developed the health visitor clinical and academic hub, which had significantly helped to raise the profile of health visiting within the trust through publication of papers and nominations for national awards. With the work of the hub and streamlined recruitment processes there had been some success in recruitment but too many vacancies remained.

The impact of vacancies was that many staff were trying to manage caseloads on average of 717 families, well above best practice guidance of 300 per health visitor. Health visitors working in Brent and Ealing did not know how they would meet the requirement for all parents to have a visit at 28 weeks of pregnancy. This is a national target to be implemented from October 2015.

Therapy staff were also experiencing high demand and in some cases it resulted in long waits for treatment. Occupational therapists reported a 12 months wait from assessment to treatment. Audiology services reported their current workload to meet the key performance indicator of children being seen in six weeks was not sustainable.

Staff worked hard to minimise the impact on patients but there were increased risks due to high caseloads.

Child protection supervision figures provided by the trust for July, August and September 2015 showed safeguarding supervision in health visiting team was generally above the trust's target of 90%. All staff we spoke with told us they had received training and were aware of processes to follow.

Safety performance

- There had been no never events within the community children and young people services. Never events are

Are services safe?

serious, largely preventable patient safety related incidents that should not occur if the available preventative measures have been implemented correctly.

- An electronic incident reporting system was in place (Datix) to record incidents; all staff we spoke with were able to tell us how they used it.

Incident reporting, learning and improvement

- Information provided by the trust showed most incidents were related to information recording issues and occurred in a primary care setting. A total of 43 incidents relevant to children, young people and family services were reported by the trust between August 2014 and July 2015 across the three boroughs of Brent, Ealing and Harrow. All of these incidents were classified as low (4.6%) or no harm (95.4%). The highest number of these incidents (37%) were categorised as related to documentation (including electronic and paper records, identification and drug charts)
- One manager we spoke with told us they expected staff to report "any incident that had a consequence to patients or staff". Two team leaders explained they would expect an incident report to be completed when there was a deviation from the correct process. For example if there had been a poor transfer of care to help to establish any trends.
- Health visitor managers told us it was expected any incident would be reported to the clinical lead to clarify if the incident should be recorded on the electronic incident reporting system. Incident reports were sent to the health visitors' manager and other managers depending upon the incident. Team meetings were used to communicate learning. Reported incidents were shared at team meetings and we saw the minutes of the Acton health visitor team meeting in October 2015 and noted clinical governance; including incident reporting was a standard item.
- A paediatric therapy manager told us they would expect any incident to be reported to the therapist's line manager and escalated to the head of service in addition to reporting in Datix. Recent incidents reported included one where a child caught their finger in a door in a children's centre. They told us the learning from the speech and language therapist's perspective was to talk with the centre about how doors were held open and a

conversation with the therapist regarding moving children from the waiting area to therapy room and parents' responsibility. This was shared in the team meeting.

- Staff we spoke with told us they reported incidents such as a client who may be upset or distressed, accidents such as child hitting their head, slips, trips or falls, a misunderstanding with a parent, a child falling. Health visitors told us they understood the process for reporting and there was feedback on incidents and lessons learnt.
- There had been no serious incidents in the past year but we saw documentation for the most recent serious incidents dated August 2014 which had been updated in July 2015. These documents stated learning should be shared across all three boroughs and detailed lessons learnt from these incidents.

Safeguarding

- Child protection supervision figures provided by the trust for July, August and September 2015 for services in Brent showed the health visiting team safeguarding supervision was 93.75% in June; 100% July and 80% in September. Figures for the family nurse partnership were 100% for each of the three months. In Ealing figures were between 94% and 100% in September 2015 for health visitors, school nurses, safeguarding nurses, family nurse partnership and clinical nurse specialists. Supervision figures for health visitor and school nursing staff in Harrow ranged from 90% to 97% for the same three month period.
- Staff told us they were up to date with safeguarding training. Figures provided by the trust for school nurses completing level three child protection training across all three boroughs were 100%. Health Visitor figures for completion of level three child protection training ranged from 94.3% in Ealing to 90.19% in Brent. The trust target was 90%.
- Safeguarding supervision for allied health professionals has been included in the Safeguarding Supervision Policy 2015. Training had been provided to allied health profession managers in July 2015, to enable them to provide supervision to their staff. Further training had been arranged for December 2015 with the plan to start the supervision in January 2016. The Safeguarding Team would provide safeguarding supervision to the managers who were providing safeguarding supervision to their teams.

Are services safe?

- A speech and language manager told us senior speech and language therapy staff had received safeguarding supervision training and specific children safeguarding supervision groups were being set up. Multi-professional groups were being considered. All speech and language therapy staff had received level 3 safeguarding training with the exception of some new starters and staff on maternity leave.
- Therapists told us they were aware of the procedure to follow and named contacts for any safeguarding issue.
- Staff told us safeguarding incidents were reported to the safeguarding team. They reported good working relationships with the named nurse with clear lines of communication. Concerns were reported to the line manager and social services.
- Health visitors told us levels of child protection cases were high. Data provided by the trust for caseloads at the end of September 2015 showed there were 4.96 child protection cases per health visitor in Brent; 2.14 in Ealing and 5.98 in Harrow giving a total of 716.83 across the three boroughs
- All health visitors we spoke with told us midwives liaised with health visitors if there were any safeguarding concerns.
- We saw that a safeguarding alert was appropriately raised by a member of staff following a home visit. We saw safe service provision and the health visitor felt well supported.
- We saw information and resources relating to female genital mutilation had been highlighted to health visitors in the health visitor clinical academic hub news in June 2015. Female genital mutilation training had been scheduled for health visitors in November 2015.
- Managers told us there had been some problems with transferring data to the new information system.
- We reviewed three records and saw necessary assessments completed and clear comprehensive documentation. We saw records of the up to 14 days New Birth Visit, attendance at drop in clinic and a six to eight week visit.
- Records were electronically signed and dated. Records viewed included discharge information from the maternity service and neonatal hearing screening. We were told if there was no record of the hearing screening being completed this would be arranged by the health visitor. (The new-born hearing screening test helped to identify babies who have permanent hearing loss as early as possible.) This meant parents could get the support and advice they needed at early stage of child development.
- New-born blood spot results were recorded and we were told the health visitor would follow up if re-testing was required. (New-born blood spot screening involved taking a blood sample to find out if the baby had one of nine rare but serious health conditions.)
- The electronic information system linked with GPs in Ealing but GPs in Brent and Harrow had a different information technology system. Staff told us they were confident the system would meet their information needs and it allowed flexibility with specific templates which were user friendly. Although staff told us there had been some teething problems the new system had been generally well received. It did not interface with the hospital system which was seen as a problem.
- Health visitors told us the electronic information system had only been operational since September 2015 and they were looking forward to the introduction of mobile working which they hoped would mean they could enter information without returning to the office.
- Therapy staff told us they often had problems with slow internet connections which made data entry difficult.
- Therapists told us there had been some problems with the introduction of the new system which had been reported but it was hoped things would improve.

Quality of records

- Clinical records were previously held on an electronic information system and migrated to a new system in 2015. Handwritten and other paper documents had been scanned on to the new system. Families could be linked on the system; for example if it was noted on the baby's record the mother had a history of post-natal depression a record of the maternal mood assessment would be held in the mother's record. Paper copies of information were uploaded to the system and kept in the department for one month. Records were then double checked to ensure all information had been uploaded and then shredded.

Cleanliness, infection control and hygiene

- We observed two clinics and a language group in a children's centre. Staff cleaned toys and equipment after use with anti-bacterial wipes. Staff followed hand hygiene procedures.

Are services safe?

- All staff we spoke with confirmed they had all the personal protective equipment they required and had received infection control training.
- We joined health visitor staff on three new birth home visits and saw appropriate infection control measures being followed.

Mandatory training

- Staff told us the electronic learning system used to provide staff with mandatory training, was a good system and helped to ensure people were up to date with mandatory training.
- All staff we spoke with were very positive about access to training and told us they were up to date with their mandatory training.
- Staff told us that the organisation placed a high importance on training and managers made sure that staff attended mandatory training. Mandatory training included 12 topics such as equality and diversity, fire safety; health and safety, infection control, manual handling, safeguarding children and resuscitation. Figures provided by the trust showed attendance ranged from 50% to 100% on this training and varied across teams. The trust target for most training was either 80% or 90%.

Assessing and responding to patient risk

- There were mechanisms in place to identify patients at risk, such as vulnerable women and children. Details were recorded in electronic records, which all clinical staff had access to. The accident and emergency department sent information including safeguarding alerts via the electronic information system.
- Health visitors told us when working with complex and vulnerable parents issues would be shared as a team. The situation would be risk assessed and an assessment of needs would be undertaken; this would lead to the development of a personalised care plan.
- All health visitors we spoke with told us midwives liaised with health visitors if there were any safeguarding concerns.

Staffing levels and caseload

- Figures provided by the trust showed us in the month of September 2015 for all community children's services in Brent and Ealing 41.40 shifts (0.48%) were covered by agency staff and 235.77 shifts (2.7%) were covered by bank staff.

- Figures provided by the trust showed the whole time equivalent total (wte) for (both band 6 and 7 staff across the five health visitor teams in Brent) was 36.87. The total number of whole time equivalent staff appointed was 29.55 with recruitment pending for a further 5.6 staff. With the recruited staff in post this would bring the service to a total of 35.15 whole time equivalent staff.
- The Health Visitor Implementation Plan 2011 - 2015 A Call to Action published by the department of health highlighted the need for additional health visiting staff to meet new expectations of service delivery. In Brent the number of staff required to meet this best practice staffing guideline was 72.75 WTE staff. The Brent health visiting team was therefore 49.79 WTE staff or 51.1% below trajectory figure. Consequently caseloads were significantly higher than would be expected for health visiting staff. In Ealing the team were at their original establishment but an additional 15 WTE staff were required to meet the best practice staffing guideline. We were told the health visiting team in Harrow had recruited to the Call to Action trajectory figure.
- Health visiting staff caseloads exceeded best practice recommended case load level of 300 families per health visitor for the majority of staff. Data provided by the trust and extracted in October 2015 showed health visitor caseloads were on average 745 per health visitor in Brent, 604 in Ealing and 695 in Harrow. The average caseload per health visitor was 717 across the three boroughs, more than double the recommended caseload of 300.
- NHS England mandated health visitor visits to all women who were 28 weeks pregnant. This became effective from October 2015. Local authorities were made aware of these regulations in March 2015. Health visitor managers in Brent and Ealing boroughs reported they did not have sufficient resources to achieve this. Instead they targeted women with additional needs whilst all other women received a letter informing them of health visiting services. In Ealing managers told us appointments were planned according to referrals made by social care, GP's or midwives due to identified health problems and came via the electronic information system and duty health visitor email. A duty health visitor assessed referrals and then these were allocated to the team. Some referrals came before 28 weeks. Parents who were not referred for health problems did not receive a 28 week visit.

Are services safe?

- We were informed the team in Harrow had stopped eight and 24 month reviews over the past two years due to lack of capacity; with the exception of known safeguarding and universal plus children who did get these reviews. (Universal plus children require a rapid response from the local health visiting team when specific expert help is needed for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting.) They were able to undertake reviews for all universal children and ages and stages questionnaires in partnership with children's centres. Eight and 24 week reviews had now been re-instated.
- We were told health visiting teams prioritised their work and usually met the 10 to 14 day visit target. Appointments were parents' led but increasing numbers of parents were not able to make a date for these visits. The team were being creative and linking with parenting craft classes with the mid wife and looking at how best the antenatal target could be met. Parents knew who to contact and the midwife or GP would pass on any concerns (such as safeguarding) and the health visiting team would follow up the referral.
- The workload was mitigated through forward planning, prioritising and flexible working. Bank staff were used to help to meet the shortfall and there was a strategy to "grow your own staff" which allowed staff to develop new skills and progress within the organisation.
- Health visitors told us there had been a long periods when they worked under pressure due to a shortage of staff and high caseloads. Staff told us they worked additional hours and administration staff were also under "huge pressure". They said they felt their clients did not suffer but this placed considerable pressure on staff with reliance on staff goodwill and loyalty. Health visitors told us they worked an additional five hours a week; there were some extra paid hours once a month. They rarely took breaks but there was no pressure from managers for them to stay.
- We were given examples of work being undertaken to recruit to the health visiting service. These strategies included: "grow your own" which for example supported band five staff being appointed on a one year fixed term contract to develop competencies and then apply for health visitor training. We were given an example of an administrative assistant supported to undertake nurse training and then train as a health visitor. Retired health visitors had also been encouraged to return to part time work. In one team health visitor assistants had been trained to input records into the electronic information system; a health visitor manager told us health visitors checked and validated these records. Band four and five staff also undertook reviews and supported health visitors in clinics. We were informed a policy had been agreed for newly qualified health visitors to undertake birth visits whilst waiting for their registration personal identification number.
- In December 2014 short-term funding from NHS England was used by the trust to appoint a recruitment lead to support the work they were doing to increase health visitor numbers in accordance with the health visiting national implementation plan 'A Call to Action'.
- A senior therapy manager described the key challenges for paediatric therapy services as an increase in population of children and young adults of 16% in Harrow and a change in the ethnic demographic. There was a high level of birth of low weight babies and increasing numbers of children with disabilities. There had been a 50% growth in referrals to speech and language therapy in five years and 20% growth in referrals of children with disabilities to physiotherapy and occupational therapy; there had been no increased funding to match this. The trust reviewed current working arrangements to ensure resources were used efficiently; they also identified areas where less specialist work could be reassigned to external agencies such as schools.
- The therapy manager had voiced concerns the paediatric therapy staff vacancy rates were high and had asked staff to escalate their concerns. Staff were committed and worked increased hours and time in lieu arrangements were in place. They reported Ealing and Brent had significant staffing problems.
- We were told the paediatric audiology service was stretched with no administration support after two staff had left (one full and one part time) and it was not clear if these would both be replaced. To date the team were meeting all targets with no waiting list; staff were working additional hours to ensure the service did not suffer but this was not sustainable. This situation had been discussed with the manager but it was not felt to warrant an incident report at this stage.
- A physiotherapist told us they were in a small team and two colleagues were on maternity leave. They had a caseload of around 90 - 100 children. They told us they "worked really hard to meet the six week waiting time

Are services safe?

target". Their priorities were universal clinics across the borough and complex needs clinics. They worked to their contracted hours but it was very hard. They worked remotely to input records. A speech and language therapist reported the team were short staffed. However, they worked additional hours because "they were passionate" about their job.

- An occupational therapist reported it was difficult to recruit paediatric therapists in London and this had been acknowledged by the college of occupational therapy. The six week referral to assessment target was achieved but some children had to wait a year for treatment following the initial assessment.
- Paediatric therapists told us they had minimum administrative support they managed their diaries, wrote reports and letters (with the exception of referral and initial letters). One therapist told us they felt guilty about taking time off when sick "it is very stressful we can't afford to take time off".
- Therapists' workload and capacity in the speech and language therapy service was being recorded. We were told the service had undertaken baseline recording of all work undertaken, children seen and hours worked. They were now repeating this with a priority list of work and only worked contracted hours; reporting when it was not possible to undertake work on the priority list.

- The speech and language therapy service had reviewed their service during the school holidays and introduced changes made to ensure the service was being provided as effectively as possible. Physiotherapy and occupational therapy services had begun negotiations with commissioners regarding workload.

Managing anticipated risks

- Every Monday morning health visitor staffing figures were collated and sent to the information office and the service manager was copied in so they could be aware of any issues. A manager told us the Brent service had been prioritised by the trust as requiring additional staff and it was hoped with innovative practice the difficult situation should change and ease.
- Health visitor managers told us there was a business continuity and escalation plan which could be implemented at times of staff shortages. We saw it was written in December 2014 and reviewed in October 2015. The plan was invoked when the workload in the team could not be covered and allowed for staff to help across teams.
- Health visitor managers told us there was an on call manager's rota. They had received on call training and carried an on call pack. They had also received major incident training.

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 good because;

There were processes in place to ensure that care and treatment delivered by staff followed best practice, such as NICE and other guidelines.

A wide range of audits had been undertaken and the outcome of audits were used to improve the care delivered. Various patient outcome measures were used by different teams and there were examples of accredited and evidenced based services being provided.

Staff reported good access and support for training and stated they had regular supervision and appraisals.

The health visitor clinical academic hub had developed a standardised induction pack for health visitors. There was a competency framework for staff at all levels and the induction pack included the competency framework; this was followed up as part of the appraisal process.

Staff generally reported good inter-professional and multi-agency working.

Although the electronic information system had only been operational since September 2015 health visitors were looking forward to the introduction of mobile working which they felt would help to improve effectiveness.

Evidence based care and treatment

- The children and young peoples' service followed a national initiative called the healthy child programme. This is a Department of Health programme of early intervention and prevention for health visitor contacts with babies and children. It offers regular contact with every family and includes a programme of screening tests, immunisations and vaccinations, development reviews and information, guidance and support for parents.
- Health visitor teams were using a maternal mood assessment in line with NICE guidance. (NICE postnatal care quality statement 10 'Women who have transient psychological symptoms ('baby blues') that have not resolved at 10–14 days after the birth should be assessed for mental health problems'). Work had been undertaken by the health visitor academic clinical hub to develop a 'post-natal depression wheel'.
- Health visitors used a family health assessment tool (new birth) which was family/parent led. We saw it was signed and dated by the parents. This was evidence based tool, developed with a view to increase parents' involvement and encourage active participation.
- The trust implemented other evidence-based initiatives to achieve positive care and treatment outcomes. For example, health visitors told us about the 'father's read every day' (FRED) 10 week programme, originally developed in the USA which had been shown to be effective especially for boys improving attainment. They were also involved in 'health exercise and nutrition for the very young' (HENRY) a national evidenced based programme.
- Speech and language therapists offered the 'I CAN' programme and had received an I CAN accreditation (I CAN is the children's communication charity helping children develop the speech, language and communication skills). We observed a group facilitated by a speech and language therapist which was informed by the I CAN accredited communication programme.
- The trust had family nurse partnership teams (FNP). This is an evidence-based, preventive programme for first time young mothers. The family nurse partnership is a targeted programme which complemented the healthy child programme (HCP) the universal clinical and public health programme for all children and families from pregnancy to 19 years of age.
- DANCE (Dyadic and Naturalistic Caregiver Experiences) was an assessment tool used by the family nurse partnership. It was used to assess the quality of a parent/child relationship, identify areas of strength and areas for growth in parenting behaviours. DANCE steps identify tools to address any areas for growth interactively with clients.
- All health visitors and student health visitors received annual membership to the institute of health visitors giving them access to evidence based resources.

Are services effective?

- The trust was using the antenatal/postnatal promotional guide system (a structured, flexible, evidence-based approach that promoted early development, the transition to parenthood and accurate, well-informed decisions about family need). Some members of the team had been trained in the use of these so they could cascade the training to other staff. They told us using this system would help to avoid duplication with midwives and help to prepare parents for parenting.

Patient outcomes

- The health visitor clinical academic hub produced a bi-monthly newsletter we saw these newsletters contained information such as NICE guidance and other national updates. Therapists told us the trust sent details of updates of NICE guidance and audits were undertaken based on NICE guidelines or clinical policies.
- The trust had been collecting data for the perinatal mental health national audit which was contributing to the national picture.
- Key performance indicators included new birth visits within 10 to 14 days of birth and this was being achieved.
- Neonatal screening tests were undertaken in the hospital. Breast feeding rates were no longer part of health visiting key performance indicators.
- There was an annual record keeping audit. The audit was undertaken by colleagues from another team. For example as a result of the school nursing audit in January 2015 it was recommended all demographic client details must be completed and current. This is the responsibility of all team members', clinicians and administrative staff. Records should be written within 24hrs and clinicians should refrain from using abbreviations unless fully explained in the text.
- There were a wide range of clinical audits completed within children and young people's services for example in speech and language therapy services these included the effectiveness of Ealing stammering groups (April 2015) We saw detailed recommendations and an action plan for improving the outcome of these groups.
- Other audits included a head teacher satisfaction survey for school nurses and a clinic survey. This was undertaken prior to reorganisation of school nursing services in October 2015 in order to help review child health clinics and what people using the clinics wanted from them.
- The Ealing multi-agency safeguarding hub (MASH) had completed an audit of referral health visiting and school nursing follow up. Following completion of this audit we saw a pathway had been developed.
- Other various audits had been completed including antenatal and new birth visits and assessment of perinatal mental health. This audit had led to the development of new guidelines (based on the antenatal and postnatal mental health: clinical management and service NICE guidance 2014). Training had been implemented and the post-natal depression wheel was given to all staff undertaking training. An assessment template was included on the trust information system.
- In addition to local trust reporting the family nurse partnership submitted information to the health and social care information centre portal; a specific database for reporting key performance indicators such as breast feeding, smoking, contraception, domestic abuse and safeguarding.
- Health visitor managers told us the results of a three month pilot of the friends and family test were in the process of being collated and the results would be available in November. The team were looking at how to gain feedback from home visits without parents feeling pressured due to the presence of the health visitor. They were also looking at the possibility of using mobile "you said we did" boards in clinics.
- Physiotherapists used the 'goal attainment scale' (GAS) to identify and agree goals with parents. These were reviewed every three months. (Goal attainment scaling is an individualised criterion-referenced measure to evaluate treatment by quantifying achievement of specific goals over time.) We saw a comprehensive report which detailed the support needed to achieve each outcome, when and how often will this happen, who would support it, how progress would be monitored and evidence of impact against agreed outcomes.
- Physiotherapists also used the 'gross motor function classification system' (GMFCS) to explain to parents the needs of their child. (This tool looked at movements such as sitting and walking and provided families and clinicians with a clear description of a child's current motor function and possible mobility equipment they may need in the future.)
- Various outcome measures were used in speech and language and occupational therapy (audiology was a diagnostic service). These included measures for speech

Are services effective?

and language therapy based on five points scale with clearly described targets. This was a new introduction and results would be collated on a term basis. Occupational therapists used parent goals and goal attainment scales.

- We saw a speech and language therapist giving a parent satisfaction survey to the parent during a clinic visit.
- We saw a speech and language therapy outcome sheet for groups facilitated in children's centres that had recently been introduced. There were three stages to the process, which involved assessing if the desired outcomes had been met at the start of the group, at the end and at a review six weeks after the end of the course. The intention was to collate these figures and produce a report every term. Because this was a new development a report had not yet been compiled.
- Activities undertaken by health visitors and the health visitor clinical academic hub included research with a doctor of parents' decision making when attending A&E with their child, research into fathers' mental health and wellbeing and the post-natal depression wheel.

Competent staff

- The occupational therapy service had a strong graded structure ranging from band 8a to band 6 staff; there were no band 5 posts. Senior staff had leadership responsibilities for different areas such as special schools, autism, special needs and mainstream schools. Speech and language therapists also reported a strong professional leadership for around 60 staff, which also included clinical leadership posts with specific responsibilities including the implementation of clinical specialism groups which all staff were involved in.
- Therapists we spoke with reported they received good regular supervision and support from their line managers; they had up to date appraisals. They told us there was good access to training and professional development. We were told the electronic learning system (ELM) helped to ensure people were up to date with mandatory training. A physiotherapist said "we are so lucky with training" but went on to say their large caseload made it difficult to find time to access training. Requests for external training were usually accepted.
- Support and supervision was available to health visitor staff. Immediate support was available if required, and the trust recognised the day to day job impacted emotionally health visitor due to the complexity of

needs and the difficult circumstances of some clients. There was opportunity for staff to discuss the more complex visits with their team leaders on their return to the office.

- All health visitors we spoke with gave us very positive feedback about the health visiting clinical academic hub. They told us there was good access to training including leadership training and skill meetings were held for professional groups across all three boroughs such as health visitors, nursery nurses and staff nurses. The health visitor clinical academic hub was introducing restorative supervision (a model of clinical supervision designed to support the needs of professionals working with complex clinical caseloads). Approximately 20 health visitors had been trained and the programme was being rolled out across the teams although we were told not everyone was currently receiving this. A health visitor team leader told us they had access to good management support and could speak to another clinical lead clinical support was required. We were told there was a culture of looking after each other within the team.
- Health visitors told us there were monthly team briefing meetings and one to one supervision held usually every two weeks. They told us they felt able to go to their manager anytime for support.
- We were given many examples of training arranged by the hub for example domestic violence training, infant mental health and female genital mutilation training. The institute of health visiting training for health visitors in the use of the ages and stages department of health outcome measure (which was required to be implemented from April 2015) was also being implemented.
- Health visitor student learning sets were held every six to eight weeks and topics for these were chosen by students.
- The health visitor clinical academic hub had developed a standardised induction pack for health visitors. There was a competency framework for staff at all levels and the induction pack included the competency framework; this was followed up as part of the appraisal process.
- We were told the trust was in the process of developing specialist health visitor posts to improve retention and provide career opportunities. Health visitors were also encouraged to undertake masters training and other opportunities to develop staff were encouraged.

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- There was a health visiting forum across the three boroughs which facilitated sharing and learning. There were also forums for nursery nurses and community nursing staff.
- The family nurse partnership had "practice skills" protected time on Tuesday mornings. This time was used to practice difficult conversations such as how to support labour without being a birthing partner and how to end relationships. Clients were vulnerable with safeguarding concerns and challenges and the staff felt this protected time was essential.
- We were told all of the family nurse partnership team had recent appraisals and individual learning and training needs were identified. Staff competencies were assessed regularly and signed off after two years.
- A health visitor clinical lead told us there was good interagency working with social workers. They said children centres were a "god send" and reported good multi-disciplinary working.
- One health visitor clinical lead told us health visitors were meant to attend a monthly GP meeting but pressure of work meant this was not possible. However, there were good links and communication with GP's through a direct telephone line and confidential email.
- The family nurse partnership (FNP) delivered the entire healthy child programme including the birth visit, developmental checks and ages and stages in accordance with the trust health visiting standards and therefore there were no health visitor interactions with the family until the child's second birthday. If a person referred was not eligible for the service the FNP would liaise with health visitors to hand over. This would change with the development of the early start programme with more integration but there would be no cross over with clients. There was more communication with school nurses if there was a safeguarding concern or the young person was going back to school. There was good liaising with the speech and language therapy team.

Multi-disciplinary working and coordinated care pathways

- Physiotherapy and speech and language therapy services provided a service into the acute hospital; we were told there were lots of good links due to an almost daily visit.
- When undertaking home visits different therapists would often visit together which ensured a joined up assessment and reduced number of visits for the family.
- Therapy teams tried to coordinate multi-disciplinary reports for children with complex needs. There was good multi-disciplinary working between occupational therapy, speech and language therapy, and physiotherapy. Joint visits would sometimes be undertaken for children with complex needs and in special schools all therapists worked closely together. Therapy managers shared an office and they worked well together.
- Health visitors described multi-disciplinary working with GP's and school nurses, the multi-agency safeguarding hub (MASH), allied health professionals, community paediatricians and child development centres as "smooth". The team particularly worked closely with speech and language therapists and children were usually seen quickly. They told us they referred a lot of families to the children's centres and there was very close working between the health visiting team and children's centres. They said "good liaison has sustained us".
- The FNP had invited heads of midwifery to attend the advisory board the following day. They felt more integrated with community services and social care and GP's received a copy of all assessments of interventions. The family nurse partnership was building positive relationships with GP's in Ealing.
- Health visitor and school nurse managers reported the interface with the midwifery service could be better; we were told handover and relationships could be improved. A health visitor clinical lead told us they thought midwives should leave more information in the home than just the discharge summary. For example information should include up to date recorded weight and birth weight and Guthrie test date. (A routine blood test carried out on babies a few days after birth to detect the condition phenylketonuria). Health visitors told us there was often a lack of, or incorrect, demographic information.

Referral, transfer, discharge and transition

- Occupational therapy and physiotherapy teams only accepted GP referrals, speech and language therapists had an open referral process which meant referrals were received from GPs, parents, schools and nurseries.

Are services effective?

Referrals were triaged daily by senior staff. The triage process could lead to a referral to another team and a joint visit. Speech and language therapists knew the health visitors in their locality. Speech and language therapists had a health visitor programme, which helped to raise awareness of when to refer to the service. There was good communication between speech and language therapy and health visiting teams when children did not turn up for clinics.

- Sometimes GP referrals to therapy services contained limited information for example "hands not working". In situations like this the referral would be returned and more information was requested.

Access to information

- All staff we spoke with were positive about the recent introduction of the new electronic information system. Although the system had only been operational since September 2015 health visitors were looking forward to the introduction of mobile working. The system templates were user friendly and although there had been some teething problems. The system did not interface with the hospital system although we were told A&E could send information including safeguarding alerts via the electronic system.
- The electronic system linked with GP information in Ealing but GPs in Brent & Harrow did not use the same system. Despite this we were informed there was good community handover and information was passed through a direct telephone line and confidential email.

- Therapists told there had been problems with access speeds. Staff used "hot desks" and speech and language therapists had 16 computers for 60 staff. This meant staff came in to work earlier or left later to secure a computer. Peripatetic teams had been issued with laptops but staff said these were slow and it was not possible to enter data in some locations. They reported there had been some problems with transferring data to the new system; for example safeguarding logos were missing and an action plan was required to address this. It was unclear if the whole record would transfer.
- The intranet was available to all staff and contained links to current guidelines, policies, procedures and standard operating procedures. This meant that staff could access advice and guidance easily.

Consent

- Clients were asked consent and it was expected health visitors would inform the parent if there were any safeguarding concerns. If a parent stated they did not wish to see a health visitor this would be reported to the GP.
- Parents' consent to the referral was recorded on the referral form to therapy services. Parents of children at school would be informed of when they would be seen for the first appointment and follow up visits and invited to attend. There was a trust policy which addressed sharing of information.

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;

Parents we spoke with told us that they were treated with compassion, dignity and respect. They were involved in discussions about treatment and care options and were able to make decisions

Staff we spoke with were very passionate about their roles and were very dedicated to making sure the people they cared for were provided with the best care possible.

During our inspection we observed children and their family and carers being treated with kindness and compassion.

Parents told us they felt listened to, able to express their opinions and were included in making decisions about future care and treatment plans.

Compassionate care

- All staff we spoke with were very passionate about their roles and were very dedicated to making sure that the people they cared for were provided with the best care possible.
- Staff told us that they often worked above their employed hours to make sure that patients received the care and treatment they needed.
- We observed three home visits, a speech and language therapist's clinic, a health visitor's clinic and a language group in a family centre. In each of these locations we observed compassionate, patient centred comprehensive care being offered. In the speech and language therapy group the therapist engaged well with the children who had a severe language delay, and demonstrated good interaction.
- We observed respectful, kind and patient interactions with the parents and child.
- We spoke with three parents on the telephone (who had health visitor involvement) and they told us they had always been treated with kindness and respect when attending clinics. One parent told us they had always found staff to be kind, caring, compassionate and respectful.

- Health visitors were undertaking a three month pilot for the friends and family test and results were due in November 2015.

Understanding and involvement of patients and those close to them

- A parent told us they had no concerns or complaints about the service they received. They had been helped to feel very involved as a partner in care but told us they would have liked more of an explanation about the roles of midwives and health visitors as the system of health care in England was new to them. A foster mother who had fostered a large number of children for a number of years and had used the local clinic all of this time, spoke very highly of the health visiting team and told us they always allocated a single health visitor for the duration of the placement. Other parents we spoke to were also happy with the service and said health visitors were professional and caring.
- A health visitor clinical lead told us health visitors used a family health assessment tool (new birth) which was family/parent led and signed and dated by the parents. This was developed from an evidence base and as a consequence of parents not really signing up to what had been written in their records. The tool was "owned" by the parents and was described as an enabling tool. A health visitor manager told us care plans were written and reviewed with clients.
- On home visits we observed patient needs were taken into account and the purpose of the visit was explained to them.
- Therapists communicated well with children and their carers. Home exercises were given to parents to be undertaken with a child to encourage speech patterns and turn taking exercises. These were also to be given to the child's school.
- Therapists involved parents in discussion regarding a referral to the child development centre and asked their consent prior to making the referral. They confirmed they would speak to the school speech and language therapist and explained the role of the educational psychologist to parents. They gave detailed information regarding the process for obtaining extra help at school. They explained the educational and other support a

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child could require and confirmed this would be in the report they would prepare. Therapists also gave information to the parent regarding a parenting workshop that was available.

- We spoke with three young parents supported by the family nurse partnership and they all told us how much they valued the support and approach of staff working with them. One young parent told us they were given advice and helped them to quit smoking and tried to encourage them to go to support groups. They said the nurse would sometimes go with them at first. The nurse explained what would happen through pregnancy and what could happen if things did not go well. They told us they had “loads of problems” and the nurse helped them to find an alternative accommodation. “They listened and gave advice”.

Emotional support

- The family nurse partnership (FNP) communicated with everyone who was involved with a mother including her parents and extended family. They supported and worked with the family network and provided specific support to young fathers.

- A young parent told us when first referred they were facing homelessness and the nurse “helped to apply for a hostel and benefits”. Closer to the due date they were helped to understand labour. The FNP nurse did activities and brought information sheets to talk through and helped to understand “what it is to be a mum”. “What is labour and weaning”, we were also told the nurse brought models like toy babies to see size and models of birth canal so the patient knew how labour would be. The nurse also helped child's father; “he found that very helpful”.
- To ensure clients had good access to the service the health visiting team had appointment clinics but there were also opportunities for clients to telephone and “drop in” ensuring an immediate response if this was required.

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 good because;

We saw examples of services designed to meet the needs of particular groups of patients. For example the new integrated service for children up to five years in Ealing and the family nurse partnership a specially designed programme for women under the age of 20, having their first baby.

On-line interpretation was used very regularly and we were told this service worked well. We observed cultural awareness demonstrated on visits we undertook with health visitors and in a speech and language therapy clinic we observed.

Services were able to be flexible to work with vulnerable people. For example offering longer sessions to patients where English was not their first language or arranging visits to environments most suitable for the child or their family.

To ensure patients had good access to the service health visitors offered clinic appointments but there were also opportunities for clients to telephone and "drop in" ensuring an immediate response if this was required. Speech and language therapy groups and clinic times were arranged around the needs of their patients.

The service overall received a low number of complaints and records indicated that complaints were dealt with appropriately as guided by the trust's policy and procedures.

Planning and delivering services which meet people's needs

- Early Start Ealing is a new integrated 0-5 years' service that brings together health visiting teams, the family nurse partnership, social workers, therapists and local authority early years' service into one holistic service.
- School nursing teams provided a service for school age children and young people. The team included nursery nurses and school nurses. Nurses were working on a "social readiness project" to look at the use of buggies, toileting and dummies of children attending school.

This work had been funded by the council. In Harrow there were high levels of dental decay and toileting problems at school entry the service was looking to support children with these problems.

- The early enuresis service was provided by the bladder and bowel service in Ealing. In Harrow the enuresis and special school nursing service and nappies were delivered by the school nursing service. In Brent the enuresis service was provided by school nurses from central London community healthcare NHS trust.
- Occupational therapists offered a diverse provision including services to children in mainstream schools with individual health care plans, special schools, home based interventions including the provision of equipment and assessment of children in home environments with a range of needs and medical conditions.
- Speech and language therapists worked with children and staff in clinics, mainstream and special schools and family centres where there were concerns about the child's speech, language, communication or feeding.
- The family nurse partnership (FNP) is a specially designed programme for women having their first baby. Access criteria are, having a first baby; less than 28 weeks pregnant and aged under 20. The FNP worked with mothers from pregnancy and visited every week for four weeks and every two weeks until birth. After the birth they did a weekly visit for six weeks and then fortnightly visits until the baby was 20 months old. There was a monthly visit until 'graduation' when the child had reached two years. Planning with the mother began three months prior to their graduation with the mother being back at work or in education and engaging with children's centres.
- Health visitors were involved in the HENRY programme ('health exercise and nutrition for the very young') a national evidenced based programme. They had close working links with children's' centres where some programmes were implemented; health visitors also joined management boards.
- Health visitor services gave examples of effective ways of working such as a breast feeding clinic that had been set up by a health visitor and handed over to a support

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worker in a children's centre. The support worker continued to receive regular monthly supervision from the health visitor who no longer had to facilitate the group.

Equality and diversity

- Health visitor team leaders in Acton told us recruitment had changed to meet changing needs and teams tried to recruit staff in line with the ethnic population of the locality. Health visitors reported a good skill mix and diverse cultures within the team which reflected the local population.
- On-line interpretation was used very regularly to support patients' who did not speak English, we were told this service worked well. An asthma specialist nurse told us asthma up produced leaflets in different languages for professionals and parents in different languages.
- Staff were aware of various cultural needs of the people they supported and were able to respond appropriately to it. For example we observed a member of staff on a home visit removed shoes on entry to the house. We also observed, in a speech and language therapy clinic, therapists' awareness of cultural issues.
- Health visitors told us the "ages and stages" questionnaire (a developmental screening tool designed for use by early educators and health care professionals) was "was very wordy" and there was too much duplication and was only available in English.

Meeting the needs of people in vulnerable circumstances

- Brent health visitor teams told us they had good links with the travelling community who engaged well with the health visiting service.
- There was an appointment system for new births and healthy child programme. Where there were safeguarding concerns the child would be seen at least once a month and more often if needed depending upon knowledge of the family. Occasionally families would appear who were not known to services. An example was given of an eastern European family who were not previously known to the team who were brought to the attention of the team by a social worker on a Friday evening. The family attended the health visitors clinic on the following Monday.

- Health visitors supported parents with learning disabilities by working alongside the learning disability team; we were told there was good communication between these teams.
- The speech and language therapy service gave examples of flexibility in therapists' timetables and the opportunity to undertake additional visits if these were required. Families, where English was not their first language, required almost twice the length of a usual appointment and this was accommodated for. They also gave an example of a child attending a clinic and parents had reported the child presented as less communicative than usual. It was agreed a home visit would be undertaken where the child may feel more comfortable.
- The family nurse partnership (FNP) attended some of the young people's appointments such as those organised by the housing department, and helped them to integrate with children's centres. They also facilitated father's relationships with partners and babies.

Access to the right care at the right time

- To ensure clients had good access to the service the health visiting team had appointment clinics but there were also opportunities for clients to telephone and "drop in" ensuring an immediate response if this was required. Health visitors told us the child health clinics and walk in service were well attended.
- NHS England mandated health visitor visits to all women who were 28 weeks pregnant. This became effective from October 2015. Local authorities were made aware of these regulations in March 2015. Health visitor managers in Brent and Ealing boroughs reported they did not have sufficient resources to achieve this. Instead they targeted women with additional needs whilst all other women received a letter informing them of health visiting services.
- We were informed the team in Harrow had stopped eight and 24 month reviews over the past two years due to lack of capacity; with the exception of known safeguarding and universal plus children who did get these reviews.
- New birth visits were undertaken by health visitors in 10-14 days.
- One year reviews were followed up with a second appointment if there was no response or parents did not attend, routinely a second appointment was

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offered; if the parent did still not attend a third and final letter would be sent which was copied to the GP. There was a similar process for two and two and a half year reviews.

- The feedback received from parents was positive. For example a parent we spoke with told us they thought the health visiting service was very good. They had visited at home 11 days after their baby was born. Another parent said the health visitor would always call back if they were out when they visited. The health visitors were flexible around times of visits and were "very accommodating". another parent told us any concerns they had about their child were promptly responded to in a timely manner.
- The speech and language therapy service had few clinics between 3.00pm and 5.00pm due to parents often collecting older children from school at this time; a typical day was usually 8.00am to 4.00pm. Clinics were held in various community environments to make them more accessible. Older children being treated for a stammer would be offered groups outside of school hours as they preferred this. Teenagers with a stammer were often seen at half term and school holidays. Home visits were undertaken at meal times if there were concerns about feeding. The team worked closely with parents to find the most suitable time to visit.
- Parents of children in the language group had the contact details of the speech and language therapist so they could contact the therapist if they had any concerns.
- The occupational therapy service achieved the six week referral to assessment target but some children had to wait for a year for treatment. There was a priority system in place and some clinics were undertaken jointly with physiotherapists. Following the assessment a written report was sent to parents with a treatment programme they could follow. Parents were able to contact the service for an update. We saw comprehensive reports which confirmed the child would be placed on the allocation list and what intervention the child and parent would receive when allocated.

Learning from complaints and concerns

- Data supplied by the trust showed there were five formal complaints relating to children and young people services between October 2014 and September. A common theme of these complaints related to written and verbal communication. These was confirmed by the health visitors who told us there were not many complaints within the health visiting teams. Usually the client would contact the clinical or service lead and the concern were addressed at this local level. If the client wanted to make a formal complaint they were given details of the patient advice and liaison service (PALS). At the time the response letter was written to the client a "lessons learnt sheet" was also completed and this was shared with the team.
- During a home visit we made with a health visitor the parent made a verbal complaint due to feeling traumatised by an experience whilst in a hospital. The health visitor advised the parent to contact the patient advice and liaison service in the first instance and told us they would report this as an incident on Datix and ask for feedback. They would escalate to the team lead and feedback to their client.
- A health visitor clinical lead gave us an example of a verbal complaint made by a parent who had not engaged with the allocated health visitor. The health visitor had persisted but the family thought they were being pressurised to be seen. The clinical lead explained the protocols they were required to follow and worked with the parents to accommodate their needs by allocating an alternative health visitor.
- A speech and language therapy manager told us there had been three or four formal complaints since 2005 although the service received many telephone calls from parents asking when their child would be seen. Staff would offer parents the opportunity to talk to the patient advice and liaison service but they often just wanted to talk to a more senior person. They ensured they had all the information to hand about the child and clarified what the therapist had done and what the family could do. They clarified their child was on the waiting list and apologised for the delay.

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 were highly committed to providing a good service to their patients. However due to staff shortages and large caseloads this placed a lot of pressure on staff resulting in them working extra hours. Our conclusion was services were being sustained due to the commitment of staff and the support of local managers.

There was a comprehensive programme of audits in place and processes to feedback information to staff via newsletters, emails and staff meetings. Staff were informed about the outcome of complaints and incidents within their area of practice. Team managers would feedback to the team if an action plan was required following an incident.

Staff generally reported good supportive leadership at local level. We met some very committed and enthusiastic managers who were working hard to develop and improve their services.

We saw good examples of innovation by the health visitor clinical and academic hub and speech and language therapy schools buy in service.

Most staff we spoke with felt the acute service did not understand community services. They felt the focus of the organisation tended to be on acute services and community services tended to get lost within the larger organisation.

Service vision and strategy

- Staff told us the trust was developing a new integrated model of health visiting in Ealing. Early Start Ealing was a new integrated 0 - 5 years' service that brought together health visiting teams, the family nurse partnership, social workers, therapists and local authority early years' service into one holistic service. School nurses were not part of the new integrated teams. The service focused on improving outcomes for young children and reducing inequalities at individual, family and community level. The service was split into

three localities. The transition had been planned for the past two years and there were two, out of three, service leads in post at the time of inspection with a third lead due to start in January 2016.

- Staff in Ealing told us they were excited about moving to the new model. They said time had been invested in the team and stakeholder workshops and staff had been involved in the vision; there had been opportunity to challenge. They saw the re-organisation and development of early start as an opportunity to engage with the community.
- Harrow school nursing service was to be provided by Central London Community Healthcare Trust (CLCH) from January 2016 and Brent school nursing service had been provided by CLCH from April 2015. Immunisation services for Ealing and Brent were also provided by Central and North West London NHS Trust (CNWL)
- Commissioners for Ealing were reducing the school nursing service by 50%. We asked team managers what action had been taken to manage this reduction in staff. They told us there was a very positive and collaborative working relationship with the responsible commissioner (London Borough of Ealing) and a Project Manager had been appointed to support this development. After July 2015 managers had begun to meet with teams on a regular basis to plan how to cope with the reduction in staffing and a plan a way forward. Risk assessments had been completed and we saw a consultation paper had been prepared.
- A head teachers' survey had been undertaken in 2015. In response to the outcome of the survey an action plan had been written to address the gap between the new service specification (due for publication in December 2015) and the service previously provided. We saw this action plan (published in October 2015) and noted it included clustering schools and linking with a school nurse. It had also been decided not to offer individual training to schools but a central training hub for teachers and schools had been agreed and this training was to be delivered by school nurses. A master signposting folder was being developed for all special education needs officers which were to be maintained by school nurses. The information included details of

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alternative provision that could be accessed if the school required more information. We were told the role of the school nurse in safeguarding required addressing as capacity was currently stretched due to involvement in safeguarding work where there was no health need.

- The health visitor clinical academic hub described their vision as “the health visiting services of Ealing, Brent and Harrow will ensure the delivery of high quality, primary and early intervention health visiting services. In doing so every child and family will be supported to be happy, healthy and well. The health visiting service will be delivered by a team who embrace the best of practice and achieve the best of outcomes for children and families.” To achieve this vision they provided training and development, support mechanisms for staff, succession planning and career progression, developing the ‘grow your own approach’ and quality improvement and governance. We were told some health visitors had chosen to work for the trust because of the health visitor clinical academic hub.
- All staff we spoke with told us about the challenges they faced in recruiting and retaining staff and told us about the strategies in place to address this; including reference to “grow your own staff”.
- A speech and language therapy manager outlined the strategy for speech and language therapy and explained how this fitted in with other therapists. They told us the strategy for speech and language therapy was to support all children in the locality who had speech, language and communication difficulties to develop skills to socialise and succeed. They felt with some children this was being met but others (especially those children waiting to be seen) could be better.
- Staff told us the objectives and vision for the trust were listed on the trust’s intranet page.

Governance, risk management and quality measurement

- The organisation had a non-executive director representative for children and young people’s services sitting on the organisation’s board.
- We saw there was a comprehensive and extensive clinical audit programme with a range of audits undertaken by a variety of teams.
- There was a process in place to feedback information to staff via newsletters, emails and staff meetings. Staff

were informed about the outcome of complaints and incidents within their area of practice. Team managers would feedback to the team if an action plan was required following an incident.

- There was a central monthly governance meeting attended by managers. Information was cascaded down to the monthly paediatric health service governance meeting, which was chaired by the manager and then cascaded to team meetings with seniors. They felt this worked well and team leaders shared information.
- Joint health and social care learning events were held following a serious incident review and these were open to all staff to attend. We were told a health visitor had occasionally attended it and had fed back to the team to ensure learning from it was cascaded to the rest of the team.
- Staff were aware of how to access policies and procedures on the trust intranet.

Leadership of this service

- A general view amongst staff we spoke with was that “acute services did not understand community services”. They felt the focus of the organisation was on acute services and community services tended to get lost within the larger organisation.
- Staff received daily bulletins broken down into localities and also weekly bulletins. Policies across the organisation had been merged and there was common core mandatory training. Therapists in acute and community services felt separate. There were many diverse pathways and we were told “more uniformity would be helpful”. They did not feel part of a larger trust but did not feel this was a problem as most of the work was focussed in the community and with the local authority.
- Staff were aware of the ‘talk to the chief executive officer’ sessions but no member of staff we spoke with had taken this opportunity. They told us this was due to lack of time but also said they had always been located on the hospital site and this made them feel separate.
- Paediatric audiology services did not have a clinical manager and clinical support was obtained from adult services. One of the audiology team was assuming the role of audiology lead and took responsibility for leadership of the audiology service which was additional to their role.
- The community services director held a briefing for all therapy, health visitor and nursing lead staff. Although

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this was a briefing to impart information managers felt able to ask questions and ask for clarification when they did not understand something. They felt valued and could talk openly with their managers, they also felt listened to.

- Health visitors told us the team lead had attended conferences and had met the director of nursing and felt the organisation was becoming more integrated. They also felt they could influence decisions locally and were listened to as a group. They reported the chief executive officer had visited and had seen some of the other directors.
- Specialist nurses we spoke with told us they felt they were not listened to or supported by their manager and there was very low morale within the team. All other staff we spoke with were very positive about the support they received from their managers and also colleagues within the team. For example therapists told us they had very able team leads and there was good support throughout the paediatric therapy service at all levels. They spoke about good links with between heads of service, they knew who to go to for advice and there were a range of meetings in place. Health visitors told us their team leader was very supportive and knowledgeable. They listened to concerns and worked collaboratively. Their manager was also approachable.
- A health visitor manager told us the work was challenging at times because there was “so much more to do”. They told us things were improving with a clear management structure and good peer support. The team was also very supportive. In Ealing a health visitor manager reported one of the challenges was the capacity to manage the teams well and ensuring “team leaders were walking with them”. School nurses reported the school nursing team managers worked well together and there was a good communication between teams.
- A team leader told us no one on the team was more important than another. They described the culture as “lively” with a lot of good energy and humour. There was active listening, enabling and freedom for members of the team to express themselves whilst also feeling contained. Work was shared to help colleagues in difficult circumstances. We were told “when push comes to shove we work together”.
- The recruitment of new heads of health visiting services had enabled the development of an embryonic management team; they were working hard to engage clinical leaders in new ways of working and wanted to be confident staff were working with them.
- The occupational therapy service was going through a period of change with a new manager. They were proud of how therapists had adjusted and the manager had responded to feedback. They felt listened to and had been encouraged to introduce new ideas. Therapists described the culture as open and reflective with dedicated and hardworking staff with limited resources. They told us they had opportunity to be involved in boarder service development.
- Staff we spoke with felt the organisation was open and transparent and would feel supported if they needed to whistle blow. They felt they could go to anyone for support. A manager told us they had been invited to a meeting with the community services director, which they felt had been very positive. They also felt they could openly voice out any concerns they had to any member of the senior management team. They told us they felt the trust encouraged openness and they would be listened to.
- Managers had received information about duty of candour from the trust and this had been shared with staff; they told us Datix prompted requirements for duty of candour. Staff we spoke with were aware of duty of candour and told us it was about being honest when things go wrong and apologising They told us processes were in place to record this.

Culture within this service

- Therapy and health visitor staff had large caseloads which placed them under considerable stress. There was a high commitment to providing good quality care and we observed staff were hard working and many worked additional hours to complete their work. Some staff had more than one role, for example one person was a health visitor team leader and a specialist community practice teacher, which meant additional hours were worked to fulfil both roles. One member of staff had been in an acting up role for three years which meant they continued to manage a regular caseload and additional management responsibilities. They did not know how long this arrangement would be in place.

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- One manager told us they felt the organisation was caring with good occupational health and counselling facilities; there was excellent stress management counselling available.
- The school nursing team were demoralised due to the Harrow school nursing team losing the tender and were experiencing a sense of loss due to the service in Ealing having been reduced by 50% by the commissioners. In our discussion with managers, they recognised they needed to spend more time with the school nursing teams to reinforce what was happening and support the team leaders.
- The trust had a lone working policy. Staff in therapy and home visitor teams explained the processes they followed including information boards detailing where staff were, buddy systems and telephoning to confirm visits had finished at the end of the day if they were not returning to base. Staff would sometimes undertake joint visits. All staff had been issued with mobile telephones.
- In March 2014 the health visiting teams were awarded the trust 'unsung hero's award'. We saw an issue of 'hub news' (the health visiting clinical and academic hub newsletter) reported a health visitor in Harrow had been awarded Queen Mother's award for outstanding service in the UK and two health visitor specialist community practice teachers from Brent and Ealing were awarded the Queen's Nurse title for their commitment to high standards of practice and client-centred care. There were eight queens nurses within the trust health visiting service.

Public engagement

- Health visitors sat routinely on the board of children's centres. They reported it was useful as it allowed them to know what was happening locally. New visits to parents included information about children centres. Delivering services and working with parents in children centres helped them to access and use other services available. These good links meant vulnerable people could be drawn in to access this additional support.
- Health visitors were involved in an African 'well woman project' which fully engaged with the local communities. This led to the development of a female genital mutilation leaflet. This had been identified as good practice and continued to be worked on by the midwifery service.

- New guidelines and pathways had been developed in conjunction with health visiting teams and using expertise from other agencies and professions where appropriate. The A post-natal depression wheel had been developed in consultation with a diverse group of parents and also perinatal health specialists at the Marcé Conference in September 2014. Based on feedback from these sources the wheel was finalised and had been endorsed by both the institute of health visitors and Boots family trust.

Staff engagement

- Different teams reported different levels of engagement with the trust. For example there were cross borough forums for health visitor staff at all levels and we were informed some staff had said this was the first time they felt their voice was heard". However, school nurses in Harrow felt they had not had the opportunity until quite late in the tendering process to be involved in writing the bid for school nursing services.
- There was a health visiting programme board which was not usually attended by health visiting leads; general managers attended and fed back; health visiting managers met with general managers regularly..
- One health visitor team leader told us when appointed to their post they asked staff to identify concerns and developed a fourteen points plan. They had worked through it with their team and felt dynamics within the team had changed as a result. They felt the team was now "more empowered". A health visitor told us they had been involved in writing post-natal depression for adopting mothers' guidelines.

Innovation, improvement and sustainability

- Information provided by the trust explained when the three boroughs of Brent, Ealing and Harrow came together there were many inconsistencies, no standardisation of policies or pathways and different levels of training. It was difficult to recruit and meet the expectations of the health visitor implementation plan a 'Call to Action' (DH, 2011). Staff consultation events were held, facilitated by the deputy director of nursing, and funding from Health Education England and NHS England was used to develop the health visitor clinical academic hub. It had been identified staff wanted more training, support forums and a newsletter. It was decided to focus on students and existing staff. The hub was set up to focus on four areas; workforce

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development, quality improvement, collaborative working and research and innovation. The trust had agreed to continue to fund the hub until the end of March 2016. A business case had been developed with a proposal to extend the remit of the hub to adult community services. All health visitor staff we spoke with were very positive about the hub and the positive impact it had on their services.

- The hub had published a number of papers in national journals and had been shortlisted for Health Service Journal awards in 2015 for developing the workforce through the development of the hub. It was also nominated for the Nursing Times Awards 2015 in two categories.
- We were given examples of how the "grow your own staff" had been successful including a health visiting assistant and a volunteer in sure start who were both now qualified health visitors
- A speech and language therapy manager told us 55 of 66 schools were purchasing additional speech and language therapy time that equated to 10 whole time equivalent staff. Three packages were offered; one day a fortnight, one day, or two days a week. These packages were budgeted with support from the finance department and contracts developed with the legal department to ensure robust contracts were in place. The package included clear governance arrangements

and continuity was guaranteed with access to all resources. A document had been written that outlined what was a health or education need and confirmed there had not been a reduction in health funding.

- The speech and language therapy school buy in service had helped reduce waiting times and the early years' service had been re-designed. This had led to even closer working with the local authority to reduce referrals for children with mild and moderate language difficulties. Local authority staff had received advice, training, support and speech and language therapists had modelled facilitating groups at 'stay and play' groups and drop ins. The occupational therapy service were looking to develop a similar service and had met with the finance department with speech and language therapy to look at consistency between budgets. A marketing pack had been prepared by speech and language therapy and this had also been shared with the occupational therapy colleagues.
- The speech and language therapy service had won a lottery bid six months ago to purchase six tablets to be used with families. These were to promote language development. They felt the effectiveness of this was beginning to be seen and a report was to be prepared for the national lottery. In a clinic we attended we saw this device was used during the assessment.