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Mr Nick Relph
Chief Executive
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Dear Mr Relph

Outcome of integrated inspection of safeguarding and looked after children's services in Hounslow

I am writing about the recent joint inspection by Ofsted and the Care Quality Commission in Hounslow to provide you more detailed feedback on the findings from the CQC's component of the inspection. Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

As you will be aware, the team led by Ofsted colleagues provided feedback to your local Director of Children's Services at the end of fieldwork and the report to the authority is now published.

This letter sets out more detail of the underlying evidence which relates to your organisation and the provider units for which you commission services. It incorporates the findings from the overall inspection report, but provides greater detail about what we found, in order that your organisation can consider and act upon the specific issues raised.

The Inspection Process

The inspection was conducted between 28 September 2009 and 09 October 2009 and was conducted under the **framework for inspection** of safeguarding and looked after children's services published by Ofsted.

Ofsted's inspection principle takes account of the extent service providers have sought and acted on the views of children, young people, family and carers when reviewing and improving services and outcomes generally. Inspectors will also consider the views of those users and stakeholders they speak to during on-site evidence gathering. Details of the organisations involved are listed at the end of this letter.

The findings contribute to Ofsted's annual reviews of the performance of each local authority's children's services and its annual performance rating for each authority. The specific findings about health services' performance may also be used by the Care Quality Commission as a part of the assessment of NHS provision, registered health providers and PCT performance in delivering commissioning outcomes.

CQC's Involvement

As part of the overall inspection, CQC examined the effectiveness of the Commissioning PCT's delivery of outcomes for children and young people. We looked at the PCT and its health providers as follows:

- the role of the board: how boards assure themselves in relation to safeguarding and the health of looked-after children
- whether staff have the right skills and experience to recognise concerns, share information and escalate problems where necessary

The points discussed during meetings with the PCT commissioning board members were further explored with staff and, where possible local children across the Primary Care Trust, its providers, GPs, and community health teams.

Joint Area Summary

The integrated inspection focused upon health and social care services in relation to implementing child safeguarding procedures and delivering appropriate outcomes for 'looked after' children. It looked at outcomes for children and young people and practices to improve children's life experience**. The joint inspection report** was published within 20 days of completion of the inspection.

From the aggregated findings from the inspection, it was concluded that the overall effectiveness of the safeguarding services in Hounslow was **good** and capacity for improvement was **good**.

Overall effectiveness of services for looked after children and young people in Hounslow was judged to be **good**. The council and its partners were also judged to have **good** capacity for improvement

Inspection Findings for Health Partners

The following sections provide details of CQC's findings which contributed to the overall inspection report. These are separated into two sections: safeguarding and looked after children. Where possible, evidence is attributed to a specific organisation.

CQC used a range of documentary evidence in advance of and during this inspection, and interviewed individuals and focus groups of selected staff and, where possible, children and young people, their parents and carers in order to provide a robust basis for the findings and recommendations.

Key findings – Safeguarding and health

Extract from Inspection report of safeguarding and Looked after Children Services – Ofsted November 2009.

West Middlesex University Hospital accident and emergency department assessments are undertaken of all children of patients deemed to be vulnerable adults. The positive work of the board sub-groups ensures that service development is supported by evaluative and performance management material. The appointment of an independent chair coincides with a plan to strengthen the strategic influence of the board and its good links with the Children's Trust. These are both logical developments to build upon the good and respected work undertaken by the outgoing chair, the Director of Children's Services.

Staff recruitment and vetting processes are consistent with guidance and regulation. They are supported by comprehensive and clear policies and procedures. However file construction is not clear and records may be held or recorded in more than one place thereby posing a risk to an otherwise robust process. The partnership is effective in identifying new priorities and is swift to act when required, for example in developing and implementing a response when a newly established population of Somali children and young people were becoming victims of bullying. In addition, multi-agency work in relation to domestic violence, which involved locating a social worker in the police led domestic violence team, and an increased demand for child protection services following a high profile national case both received well targeted

attention leading to good outcomes.

There are excellent and highly effective safeguarding partnerships characterised by good communication at all levels of the organisation. For example, the specialist health visitor is alerted to all children who are diagnosed as having a learning difficulty or disability so that monitoring of family stress can take place and to ensure that appropriate services can be accessed if required.

Information sharing protocols are well established. There is good evidence that the culture of collaborative working on the basis of shared information is established to good effect, with positive outcomes in individual cases and effective identification of new or changing local priorities. Work undertaken in the accident and emergency and paediatric departments of West Middlesex University Hospital in relation to their inter-disciplinary approach to safeguarding and joint work between the police and social workers in relation to domestic violence are two notable examples.

Workforce planning is imaginative, recruitment practice is compliant with statute and guidance, and some significant inroads have been made into long standing recruitment difficulties in some key areas.

Health visitor shortages has resulted in re-defining work in key areas to ensure that priorities are tackled and wider community nursing resources are deployed to best effect.

Achieving value for money has been a key issue for this authority and good progress has been made. There is a political imperative to negate the need for council tax increases and a recent corporate initiative has set a target of £50m of savings over a three year period. Partners in children's services have also experienced extreme financial challenge and the PCT is emerging from a three year 'turnaround programme' designed to balance its budget for the first time. Against this backcloth, the successful preservation of services at the front line is testimony to good quality and informed planning and strengthened commissioning arrangements, which have produced good levels of efficiency while promoting and defining quality requirements.

General

The evidence showed that the commissioner PCT board can be assured that staff are able to adequately safeguard children and young people.

The PCT child protection strategy identifies the statutory requirements and a board level executive director leads for safeguarding with designated professionals who are clear about their roles and have sufficient time and support to undertake them. The children's and young persons strategy has a number of good initiatives that supports world class commissioning and the national strategy "healthier lives, brighter future" in

accordance with the joint needs assessment. The PCT has adopted the London core offer for commissioning maternity services, which includes increased funding for health visiting, development of an immunisation team and the Hounslow overweight and obesity prevention programme (HOOPS). The PCT, despite having challenging budgets, has prioritised the provision of health visitors with a very active recruitment programme jointly funded by the local authority.

The PCT provides good support for children with complex and palliative needs and commissions a full range of CAMHS services for children with learning disabilities. All 16 and 17 year olds from the council area who require mental health services have access to services and accommodation appropriate to their age and level of maturity. There is 24-hour cover available to meet urgent mental health assessment and a full range of early intervention support services. These are delivered in universal settings through targeted services for children experiencing mental health problems. Commissioned by the local authority and the PCT in partnership with a joint comprehensive contract with the West Middlesex University Hospital, it includes all CAMHS community provision, including early intervention teams and therapeutic support within specialist provision and is monitored as part of CAMHS partnership board.

Mechanisms are in place for safeguarding and sharing of learning. Standard 5 of National Service Framework for Children, Young People and Maternity Services (NSF) has been incorporated into the PCT child protection action plans for 2009 and the LSCB health sub group action plan scrutinised by the LSCB.

The PCT provider has a number of good initiatives that have been recently implemented to address the risks identified and to meet the targets and objectives set out in the children's and young person's strategy. In staff interviews, it was evident that they were aware of the objectives and are enthusiastic and proactive to deliver these objectives. These include correlation with obesity and sexual relationships education to introduce evidenced based programmes, the recruitment of specialist staff to minimize risks for teenage mothers and a robust action plan to manage the capacity of health visitors including skill mix review and restructure. However, there was lack of clarity about the low number of referrals made by health staff and further work is needed to evaluate the outcomes of these initiatives to measure the impact on the health of children and young people.

School nurses carry out home visits for children who are the subject of child protection plans and this enables care plans to be monitored with early intervention if concerns are identified.

There is evidence that the commissioner PCT board is working with its partners to improve health outcomes for children and young people. Services commissioned to provide dental services include the young offenders unit to ensure that young offenders leave with good dental health and an action plan to reduce the amount of decay in children in the early years; low uptake of dental services and access to dental

services has assisted in reaching deprived families identified as a vulnerable group. Other examples include services such as weight reduction programmes with healthy eating and leisure passes to encourage exercise, specialist health visitors for the homeless and teenage mothers to minimize risks for this vulnerable group, clinics and out reach services for sexual health for young people with integrated services, safe sex messages and local provision providing C card (free condoms) available at 21 sites including community pharmacists. Chlamydia screening is also now widely available across the borough as part of the national Chlamydia screening programme for 15 to 24 year olds.

Evidence shows that the involvement of children and young people in designing, monitoring and evaluating services is not well established and although there are areas where this is working well, engagement needs to be improved to identify if children feel safe and to elicit the views of users on the competency of staff on safeguarding.

There are plans to set up a children's trust that the commissioner PCT believe will strengthen partnership working and more user engagement and provide opportunity for a strong single commissioner for children services with the provision of more pooled budgets.

Primary Care Services

The evidence showed a need for further development of safeguarding awareness in primary care. There is lack of clarity in general practitioners' understanding of thresholds for referral and the standard of documentation provided by general practitioners both in referral and case conferences is variable. Within the CAMHS service, 42% of referrals from GPs have been rejected as inappropriate and health visitors reported that improved communication between general practitioners and health visitors would be of benefit. GPs are alleging that work pressures prevent them attending child protection case conferences though they do provide reports or record of contact. It was unclear how many safeguarding referrals are made by GPs and there is difficulty in tracking children with child protection plans when they move, until they receive a request for medical notes from the new general practitioner.

Acute Hospital Care – West Middlesex University Hospitals

Safeguarding arrangements in West Middlesex University Hospital are good. The safeguarding board guidance clearly outlines the expectations from partner agencies in relation to child protection and as a result the trust has a well established team of clinicians led by a paediatric consultant. The safeguarding team participate in developing and implementing policy at local and strategic level and are responsible for case management investigations, serious case reviews and training and development of front line staff. 24-hour support is provided for staff engaged in caring for vulnerable families, in preparing reports and attending case conferences. Information on each child presenting at the accident and emergency department is reviewed daily for any potential concerns to identify safeguarding issues and information is shared between

accident and emergency, wards, community, psychiatric and alcohol and substance misuse teams, hospital social worker and liaison health visitor to identify trends and risks. Specific cases are discussed to develop and improve support across the site. Trust staff have participated in murder reviews for cases where domestic violence has resulted in a maternal death and are represented on the MARAC committee to support victims/survivors of domestic violence.

The named professionals meet regularly with Hounslow PCT designated leads for child protection and the named nurse and midwife receive supervision as part of the local SLA agreement. Supervision is provided for the children's community nursing team and special care baby unit (SCBU) and a pre-birth antenatal group review all child protection issues within maternity. Equality and diversity is included in assessment of safeguarding risk and staff training has included risks and observations related to cultural practices that are included in the risk factors they take into consideration on assessment.

Partnership working

There is evidence of good partnership working between hospital maternity services and primary care. For example, awareness of the increased risk of poor outcomes in families experiencing domestic violence or teenage pregnancy has resulted in the practice of referral to health visiting services so that these women are prioritised for community contact. Children that present at accident and emergency who self harm are reviewed by CAMHS before discharge and good partnership working between hospital, community health and CAMHS proactively manages issues. For example, over time it was noted that a number of self harming children came from the same school so CAMHS and the named safeguarding nurse visited the school to provide a talk at the school. Sure start has been the model for a multi-agency approach to include social workers within teams and has provided more capacity for health visitors.

There is an encouraging initiative, the "think family strategy", which plans joint study days with adult mental health, children's and family services to educate and discuss issues around mental illness not being an automatic trigger for concern. Adult mental health staff and social services work in partnership enabling inpatients to be reassessed on admission by a social worker and throughout their stay participating in any planned leave /discharge. Following any leave, social workers feed back to the clinical team on how they coped at home so this is communicated to the community team as part of discharge planning.

The child death review processes including rapid response to all unexpected child deaths has been developed with effective multi-agency working between health, police and local authority children's services. A joint child death overview panel (CDOP) with Richmond and Kingston takes place every two months. At the time of this report it was too early to identify learning from the overviews, but annual reports have been submitted locally and nationally under the auspices of the Local Safeguarding Children Board (LSCB).

There is good partnership working between therapists, specialist health visitor special needs, the named nurse and the local authority with good communication to facilitate the care of children although improvement is needed with some processes between social services and health. In interviews, staff felt the response from social services was not always timely and a lack of clarity between the PCT, adult mental health and social services of referral thresholds led to repeat follow up calls to monitor progress. Also in the accessing and provision of home equipment or building adaptations for children the current system in place is resulting in children receiving an inadequate service and delaying hospital discharges.

Training and supervision

Training is a high priority for the Board and is delivered in-house to PCT staff and to all health professionals across the health economy and partner agencies as part of LSCB training sessions. Audits are carried out to monitor compliance with appropriate action plans where needed. There is a gap in level 3 training for healthcare assistants that are employed by the PCT to care for children in their own homes, as part of a continuity of care package and although they are booked onto this training they are currently caring for children unsupervised. Effectiveness of training for all staff is assessed through a competency framework at regular supervision meetings and training ensures health professionals are aware of their statutory responsibilities in the child death review processes including undertaking home visits. There is evidence that lessons are learnt from serious case reviews that informs training to improve staff knowledge and understanding.

There is a good training strategy and training plan in place at the West Middlesex NHS University Hospital that is multi-agency with input from the police child protection team, children's services, obstetricians and midwives and specialist areas of training are incorporated within the training packages to include: female genital mutilation, domestic abuse, young people and self-harm, risk to the unborn child, ritual abuse and forced marriage. 100% of accident and emergency staff and inpatient, outpatient and community home team paediatric staff have attended level 1 and 2 safeguarding training and some have attended level 3 training, including the consultant paediatrician. The recording of level 3 training has not been robust, but IT systems are now in place to record all safeguarding training broken down to what level, department and staff group to more effectively monitor compliance to mandatory training. Some staff still require training and this is being addressed.

At interview the accident and emergency staff and inpatient, outpatient and community home team paediatric staff at all levels demonstrated a good knowledge of safeguarding including the different kinds of abuse and risks to children and young people from parents with delusional beliefs. They also had high awareness of the risks to children of parents presenting at the accident and emergency department, as a result of substance misuse or domestic violence. This has led to staff noting additional risk factors for children around domestic violence and substance misuse. Staff have regular supervision and have prompt access to advice from the safeguarding named

nurse, designated nurse and designated doctor. Although there was no documented evidence to identify the content of supervision, the knowledge and practice of the individuals demonstrated that this was effective. Named professionals supervision is monitored by the LSCB and relevant sub groups and specific professional groups and specialities have been targeted for advanced training this year.

The adult mental health team's safeguarding training within the last year provided by LSCB and in house has had a positive impact on staff practice. It has raised their awareness of wider issues that they have implemented in their patient assessment which includes identifying children in the family and how the patient's mental health/admission may impact on their care and safety. They review whether any patient's children have a child protection plan in place or if there are any potential child safeguarding issues. Good practice was noted in that following any change to a patients treatment / medication there is a review of the impact this may have on children and their care.

The CAMHS team participate in trust wide training as detailed in the PCT training strategy in accordance with the intercollegiate document and have a robust training plan for safeguarding children that covers levels 1, 2 and 3 training for the appropriate staff groups. Safeguarding leads monitor training and attend team meetings where developmental issues are discussed. Review of serious incident cases also inform the lead of any training needs and where these are identified the specified trained is sourced. Training has impacted on staff attitudes that have resulted in good assessment of risks to children and staff working in adult mental health now have an understanding of their role in children and young persons' safeguarding and the children of mental health inpatients now feature highly in assessment/care and discharge planning.

There was evidence of training for contracted services. As part of the clinical governance programme child protection events are held for dentists in dental practices across Ealing, Hounslow and Hammersmith & Fulham. The uptake has shown that and 92% of practices have sent representatives, but it is unknown if this has been disseminated to all practice staff. There has been no evaluation if this has impacted on referral rates from dental practitioners. All primary care staff have attended annual child protection training, which included awareness, scenarios and referral process but it was unclear whether this was level 1 or 2 training. However there is evidence of safeguarding training having a positive impact in some areas of primary care. The emergency dental service that triage on the telephone, provided a good example where concerns identified were followed up to ensure an appropriate referral was made.

Training for community pharmacists has taken place including specific information relating to the safeguarding aspects of prescribing and dispensing emergency hormonal contraception to under 18 year olds and specific training to pharmacy staff involved in Chlamydia screening programmes. There was less evidence for Optometry.

Training to providers is monitored via the LSCB health sub group which is chaired by the designated nurse child protection who reports to the LSCB.

Contracts and performance management

The PCT board annually reviews safeguarding across the organisation and audit programmes assure the board that safeguarding systems and processes are working. Safeguarding monitoring and partnership working is managed by director level representation on the LSCB and the named professionals and child protection co-ordinator on various sub-groups. Contract and performance monitoring is ultimately via the LSCB health subgroup where any shortfall in meeting safeguarding expectations is monitored through action plans. The LSCB sub-groups monitors practice across agencies with a particular emphasis on children seen at The West Middlesex University Hospital and within the local community. The LSCB quality subgroup meet regularly and are aware of their key role within the LSCB however, they find there is insufficient time available for this work and are proposing to adopt a more profound and urgent function, with support from an LSCB development worker with protected time.

Meetings between the commissioner PCT and West Middlesex University Hospital shows good monitoring of safeguarding practices within the commissioned services. There are mechanisms in place to monitor commissioned prison health with monthly reports and quarterly meetings of the prison partnership board where safeguarding is monitored.

The commissioner PCT contracts include appropriate references to safeguarding. Monitoring is predominantly through the QOF process and review of cases with support in their management when it has been identified that cases should have been managed differently. Monitoring is fed though to the LSCB and the PCT director of commissioning sits on this board. This alone was insufficient to assess whether GPs practices are having any impact on the safeguarding of children as this monitors inputs but not outcomes. The main outcomes the commissioner PCT monitors are the world class commissioning outcomes and Vital Signs targets. Many of the initiatives are relatively new and as yet little information was available on the impact. It was evident that the processes in place are robust and there is strong correlation between good processes and improved outcomes and evidencing the outcomes to support this needs to be developed.

Assessment, referral and case planning systems

There are mechanisms in place to ensure all staff are aware whether any child who passes through accident and emergency, paediatric out patient department and inpatient admissions have a child protection plan in place. Good assessment and case planning of patients referred to the social services safeguarding team or any child that has raised some concern are discussed at paediatric psychology meetings and those that do not meet the criteria for referral are reviewed by the liaison health visitor. There

is evidence of good communication and proactive management between acute services and community services to manage risks and the CAMHS team maintain a risk profile, continually reviewing children where concerns do not meet referral thresholds to ensure that in combination, if they constitute an increased risk, this may then be escalated to a referral.

Key findings – Looked after children and health

Extract from Inspection report of safeguarding and Looked after Children Services – Ofsted November 2009.

Good partnership work has meant that their health and educational needs have been met and actively promoted through the work of dedicated teams, supported by good access to specialist services such as those provided by the child and adolescent mental health service.

Significant progress has been made in relation to children and young people's health

Imaginative ways to offer services to older young people have been developed, such as the looked after children nurse being based in a very popular resource centre as opposed to a clinical setting, and these have contributed to the comparatively high take up.

Newly arrived asylum-seeking young people receive sensitive support from health professionals and great emphasis is placed on ensuring that they receive the necessary immunisations. Access to therapy services, such as speech and language, physiotherapy and occupational therapy, for all looked after children and care leavers is good and young people who are identified as needing emotional or behavioural assistance receive equally good support from dedicated specialists within the child and adolescent mental health team.

The 'strengths and difficulties questionnaire' that has been used with looked after children and young people has proven effective in identifying mental health needs and in planning interventions where necessary. There is good access to timely and individually focused sexual health, drugs and alcohol services and good evidence that effective targeting is impacting successfully in reducing teenage pregnancy among the looked after children cohort. Health plans are seen as essential elements in the stages of transitions and every effort is made to ensure that an up to date plan is available.

Overall Being Healthy Grade - Good

Partnership working

There is good partnership working with Local Authority looked after children (LAC) staff. The LAC nurse works with two social workers to complete health action plans. The designated nurse receives a copy of health plans and ensures these go to the relevant provider service, giving all professionals involved in the care or treatment of a looked after child access to relevant information.

Communication between health visitors and GP's is variable. GP's are not usually part of the multi-disciplinary training, which again reduces the opportunity to discuss cases and issues.

GPs are not always aware of health plans in place for looked after children and this needs to be addressed to ensure any follow up appointments take place.

Assessment, referral and case planning systems

Medical assessment of the health needs of looked after children is carried out by a specialist nurse for looked after children, a specialist doctor community paediatrician and locum looked after children medical advisor and a looked after children psychologist. These professionals see children who are looked after by the London Borough of Hounslow who live in Hounslow and those within a twenty mile radius, which accounts for 70% of the looked after children.

Looked after children and young people have good access to all health professionals and referrals to the child and adolescent mental health services, sexual health services, drug services and all community therapists including speech and language therapists, physiotherapists and occupational therapists.

There are systems in place to 'fast track' referrals to other health professionals, ensuring looked after children get prompt assessments and appointments with health professionals. The LAC nurse receives information from health professionals when looked after children attend or fail to attend appointments, which are then followed up and will be re-booked to ensure the health need is met.

The LAC nurse is invited to attend all looked after children reviews and either attends or sends a report for the review, again ensuring updates in health issues are covered. Health visitors with looked after children have these cases in their supervised caseload which are reviewed three monthly or more frequently if required to ensure any actions are addressed, providing good outcomes to these children.
An action plan for the promotion of health of looked after children is in place with most timescales due for completion after Autumn 2009 so there is to date no clear evidence

of how the plan is working. However, the plan sets out clear steps which are being taken to promote healthy lifestyles with access to a range of sporting activities and sexual health clinics, training for foster carers and staff in residential homes, plans for healthy living days and first aid training for looked after children.

Involving Users

Involvement of children and young people or their carers in planning how services are delivered is limited and at a very early stage. Hounslow PCT are aware that more work is required to improve engagement and involvement of children, young people, their parents and carers at both strategic and operational levels.

Areas of Strength

- Staff have a high awareness of the risks to children of parents where there is domestic violence, substance mis-use or delusional beliefs and risks and observations related to cultural practices of the local community are included in the risk factors take into consideration on assessment.

- Those children of concern that do not meet the criteria for referral are monitored and risk profiles ensure that in combination, if they constitute an increased risk, this may then be escalated to a referral.

- The emergency dental service that triage on the telephone have good awareness of what may constitute a concern and ensure an appropriate referrals are made.

- Children who self harm are all reviewed by CAMHS before discharge from hospital.

- There is a robust action plan to manage the lack of capacity of health visitors.

- The joint working and access to CAMHS for looked after children, children with child protection plans and children with disabilities is good.

- Adult mental health staff and social services work effectively in partnership participating in any planned leave /discharge and have a high awareness of the wider issues that may impact on the care and safety of children, as a result of a patient's mental health/admission or change to a patient's treatment / medication.

- The health needs of looked after children are well met with a number of good initiatives to support teenagers in particular to attend health appointments.

Relevant recommendations for Improvement from joint Inspection Report

There are no health related recommendations in the joint inspection report.

Additional recommendations for improvement

- Evaluate the outcomes of recent initiatives to measure the impact on the health of children and young people.

- Develop further engagement with children and young people in the designing, monitoring and evaluating services to identify if children feel safe and to elicit the views of users on the competency of staff on safeguarding.

- Continue development training of general practitioner to ensure clarity in their understanding of thresholds for referral and improvement in the standard of documentation provided for referrals and case conferences.

- Develop evidencing outcomes to support assessment of whether general practitioners' practices are impacting on the safeguarding of children.

- Review processes between social services and health to improve the access and provision of home equipment or building adaptations for children and improve clarity between the PCT, adult mental health and social services of referral thresholds.

- Improve clarity about the number of referrals made by health staff to ensure that information is up to date and accurate.

- Progress any outstanding safeguarding training provided for all staff including all contracted services.

- Address gaps in level 3 training for relevant staff ensuring robust recording of all safeguarding training, broken down to the relevant level, department and staff group to more effectively monitor compliance to mandatory training.

- Evaluate safeguarding training to identify whether it is being effective in impacting on the safeguarding outcomes for children and young people.

Conclusion

Your CQC Regional Director is copied into this letter and will arrange follow up on any actions detailed. We have also copied in the Strategic Health Authority and CQC's Head of National Inspection and Assessment, who has overall responsibility for this inspection programme. We also recommend that you share specific findings in this letter with your provider units. In respect of the recommendations, please complete an action plan detailing how they will be addressed and submit this to our regional director and your SHA Chief Executive within 20 working days of receipt of this letter.

Yours sincerely

Charlotte Trimm
Project Manager – Children's Services Inspections
Operations Directorate

Cc Ms Ruth Carnall, Chief Executive NHS London

Mr Colin Hough – CQC Regional Director London
Mr Nigel Ellis – CQC Head of National Inspections and Assessment
Mr Chris Batty HMI – Ofsted Managing Inspections
Mr Steve Hart HMI – Ofsted Lead Inspector

Other organisations involved in this inspection

Hounslow Community Healthcare
West Middlesex University Hospital NHS Trust
West London Mental Health NHS Trust