APPENDIX

April 2017

Overview and Scrutiny Committee

Review of the Health Visiting Service

Report from Scrutiny Challenge Panel

Members of the review group

Councillor Janet Mote (chair)

Councillor Chika Amadi

Councillor Camilla Bath

Councillor Michael Borio

Councillor Barry MacLeod Cullinane

Councillor Phillip O'Dell

Councillor Mina Parmar

Councillor Kanti Rabadia

Councillor Sasikala Suresh

TABLE OF CONTENTS

1. CHAIRS FOREWORD

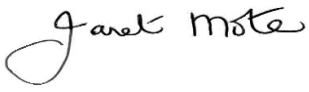
When I first chose to be on the Health visiting Challenge Panel and to be Chair, little did I know what an exciting and privileged journey I would undertake. I wanted to explore all avenues with this review and to start at the ground roots with practitioners and clients and experience first-hand what their views were. Therefore I was delighted with other panel members to attend Antenatal checks, Birth visits, 6-8 weeks, 1 year and 2 – 2 ½ checks with Health visitors and Mothers, Fathers and Babies.

All of us who were lucky enough to have been able to attend these visits and clinics were very impressed by the skills, dedication and professionalism of all the health visitors and other colleagues who allowed us to observe. We all learnt – I have just been telling my daughter-in-law that her baby's feet should be at the bottom of the cot!

We are making a series of recommendations and these should be read in the context of our respect and admiration for the professionalism of all the staff that we met.

Then we continued with our journey to have a meeting with the Director of Public Health, General Managers of the London North West Trust and Public Health England. Lastly we had teleconference opportunities with Norfolk, Leicestershire, Merton, Hillingdon and Greenwich to find out about the best practice carried out.

Finally all of this journey would not have been possible without the dedication of my fellow councillors on the panel and the officers, especially Mohammed and Jonathan.



Councillor Janet Mote
Chair, Harrow Health Visiting Service Review

2. EXECUTIVE SUMMARY

As part of the review, information and intelligence was gathered through desktop research, visits to clinics, teleconferences with other Local Authorities and a Challenge Panel. The Challenge Panel gathered substantial evidence, heard from and questioned several key witnesses and considered evidence put before them to understand the impact of the Council's current Health Visiting Service. The Panel had particular regard to the first hand intelligence gathered from the clinic visits by members of the review. The Panel also sought to obtain vital best practice information from other local authorities and to produce a report that could inform managers and councillors in re-procuring the new Health Visiting Service as part of a combined 0-19 service including school nursing.

The Panel's key findings and unanimous recommendations (pages 14-27) put forward by the Panel are presented in the report, grouped by the following themes:

- Staffing Levels and Caseload
- Training and Staff Development
- Booking Procedure and No shows
- Performance
- An Accessible and Inclusive Service

The Panel recommends the Council incorporate the recommendations into the procurement of the new service.

3. RECOMMENDATIONS

1. To ensure the vacancy rate is filled across all the grades and not just he Health Visitors in order to meet the demand of the service, which will reduce the caseload per HV and improve the efficiency of the service.

2. To improve the level of skill-mix within the Health Visiting teams to deliver the Healthy Child Programme focusing mainly on the underperforming 12 months and 2-2.5 year developmental checks while maintaining performance levels for the other mandated checks.

3. To develop and implement a programme to recruit, develop and retain HV staff to meet the demand in service, which will reduce waiting times and deliver a more efficient service.

4. That Health Visitors (HVs) are trained to ensure information and advice provided to parents is consistent across the board including knowledge on language line and providing the service in various community languages

5. That HVs undergo diversity and cultural awareness training to develop an understanding of different cultures and how this impacts on their roles improving the quality of service being delivered.

6. That HVs are trained to recognise cultural pressures and are able to provide the relevant support, information and advice in a confidential and safe environment to mothers/parent, which will help pick up and address potential issues such as depression and domestic violence.

7. To further promote appointments within dedicated Saturday clinics to address the low take up of Antenatal and 12 months and 2-2.5 year Health Reviews to reduce the number of parents not attending.

8. To undertake a publicity campaign (including posters, social media, engaging with the voluntary and community sector, faith groups, schools and partners) to raise awareness and educate parents on the importance of the clinics, which will educate parents on the importance of the clinics and could reduce the no shows.

9. To ensure adequate information (posters) is displayed at all clinics and also available to provide to parents, as lack of information was available at a number of clinics.

10. **[Council]** To agree targets (comparative to neighbouring boroughs) and include these as Key Performance Indicators (KPIs) within the contract to be monitored on a regular basis, which will help to improve performance.

11. To change the way ethnicity and mother tongue/language competence are recorded on patient records. At the moment the Health Visiting patient record system records 132 different ethnicities. It is recommended that ethnicity is simplified and the Council's Diversity Monitoring categories **(Appendix 4)** are used and a separate record is kept of language and language proficiency.

12. To review the contact material (letters) to ensure they are inclusive and incorporate a strap line offering the information in alternative formats and community languages, which will contribute to addressing the language barrier.

13. To ensure all staff are aware of and trained to arrange for interpretation services if required to address the issue of language barrier.

14. To undertake a review of the set-up of all clinics to ensure customer confidentiality is maintained at all times so that no more than one visit is conducted in the same room at any one time.

15. **[Council]** That a fully comprehensive Equality Impact Assessment is undertaken to highlight potential barriers and identify ways to improve the service. The findings and requirements of this to be incorporated in the service specification of the new contract.

16. That the service develops and supports five groups for the five most common language groups. The purpose of these groups would be to act as a sounding board for translated documents and invitation letters etc., and be able to support other parents from those communities

4. INTRODUCTION AND SCOPE

The Scrutiny Leadership Group (SLG) agreed to undertake a review of the 'Health Visiting Service' in Harrow, which involved site visits and a challenge panel. The site visits took place between the 16th January and 5th February, and the Challenge Panel took place on the 7th March 2017. The membership of the Panel consisted of nine (5 Conservative and 4 Labour) councillors and was supported by a Policy Officer from the Corporate Policy Team. The aim of the review is to understand the current service performance and how it compares to other London Boroughs.

The main aims of the Panel were to:

- Understanding the service on the ground through work-shadowing, meeting parents and meeting London North West service managers;
- Understanding how other boroughs' HV service works;
- Understanding how it fits with LBH Early Years Service;
- Understanding the current budget;

- Examination of the expenditure involved in provision of the service;
- Meeting national representative of e.g. PHE or Institute of Health Visiting to understand the national picture.

The formal scope for the project is attached at **Appendix 1**.

5. POLICY BACKGROUND

The Health Visiting Programme

Every child is entitled to the best possible start in life and health visitors play an essential role in achieving this. By working with, and supporting families during the crucial early years of a child's life, health visitors have a profound impact on the lifelong health and wellbeing of young children and their families.

In recent years the 4-5-6 model has been developed which represents the following:

4	levels of service: Your community Universal Universal plus Universal partnership plus
5	universal health reviews*: Antenatal New baby 6 – 8 weeks 1 year 2 – 2 ½ years *mandated for 18 months
6	high impact areas: Transition to parenthood Maternal mental health Breastfeeding Healthy weight Managing minor illness & accident prevention Healthy two year olds & school readiness

The 4 Levels of Service

These levels set out what all families can expect from their local health visitor service:

1. **Community**: health visitors have a broad knowledge of community needs and resources available e.g. Children's Centres and self-help groups and work to develop these and

make sure families know about them.

2. **Universal (the 5 key visits)**: health visitor teams ensure that every new mother and child have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation.

3. **Universal Plus**: families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children.

4. **Universal Partnership Plus**: health visitors provide ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition.

The 5 universal health reviews

As part of the transformation of the health visiting service, all families will receive five key visits from their health visitor. Families are also offered a range of advice and support on everything from breastfeeding and weaning to immunisation and minor illnesses.

First visit: Antenatal - When you are around 28 weeks pregnant: This first visit is an opportunity for expectant mothers to meet the health visitor and discuss how they're feeling about having a baby. The baby's father or other parent is very welcome at this visit, which usually takes place in the home.

As part of the visit, the health visitor will ask about plans for having the baby and answer any questions the expectant mothers and partners may have. They will provide you with information on infant development, feeding, parenting, and the Healthy Start Programme. They will also provide their contact details and explain how they can support following the birth of the baby.

The midwife will provide immediate care and support for the first few days after the birth of the baby.

Second check: 10-14 days following the birth of your baby: The health visitor will visit the home to see how the mother is getting on and provide support with feeding and caring for the baby. The baby's father or other parent is very welcome to be present at this meeting.

The health visitor will establish how the mother is feeling and how the family is adjusting to the new arrival. They will also ask if the parents have any questions and listen to any concerns they may have about the baby's health or their own health.

Examples of issues that may be discussed include interacting with the baby (e.g. songs and music, books); feeding; diet and nutrition; colic; sleep; crying; establishing a routine; safety; car seats and the immunisation programme. They may also weigh the baby during their visit.

Third check: When your baby is 6-8 weeks old: At this visit in the home, the health visitor will see how thing are going and how the mother is feeling. This visit is in addition to the GP medical visit, which takes place at around the same time at the GP surgery.

The Health Visitor may weigh the baby, review their general health and discuss their immunisations. They will also provide contacts for local health clinic or children's centre where parents can get their baby weighed and access a range of support.

Fourth check: A review of your child's development at 9-12 months: This visit may take place in the home or in the local clinic and is an opportunity for parents to assess and discuss the child's physical health and development.

This includes lots of things, such as the child's diet, dental health and safety issues. As part of the visit, the health visitor may weigh and measure the child and discuss their immunisations.

If parents wish, the health visitor can also put them in touch with local mother and baby groups, children's centres or activities in their area.

Although the next scheduled visit isn't until the child is 2-2 ½ years, parents can always contact their health visitor or their GP if they have any questions or concerns about the child's development.

Fifth check: A review of your child's development at 2-2½ years: This is the fifth and final scheduled visit from the health visitor or nursery nurse, which can take place at the home, local clinic or children's centre.

This visit is an opportunity to talk about any issues parents may have regarding their child's health. This may include their hearing and vision, language development, behaviour, sleeping or toilet training. The child will also be weighed and measured, and

parents can discuss their immunisations and the various options for childcare and early year's education.

Although this is the last scheduled visit, parents are reminded their health visitor is on hand to offer advice, information and signposting until the child is five years old.

Our Harrow, Our Community

Harrow prides itself in being one of the most ethnically and religiously diverse boroughs in the country with people of many different backgrounds and life experiences living side by side.

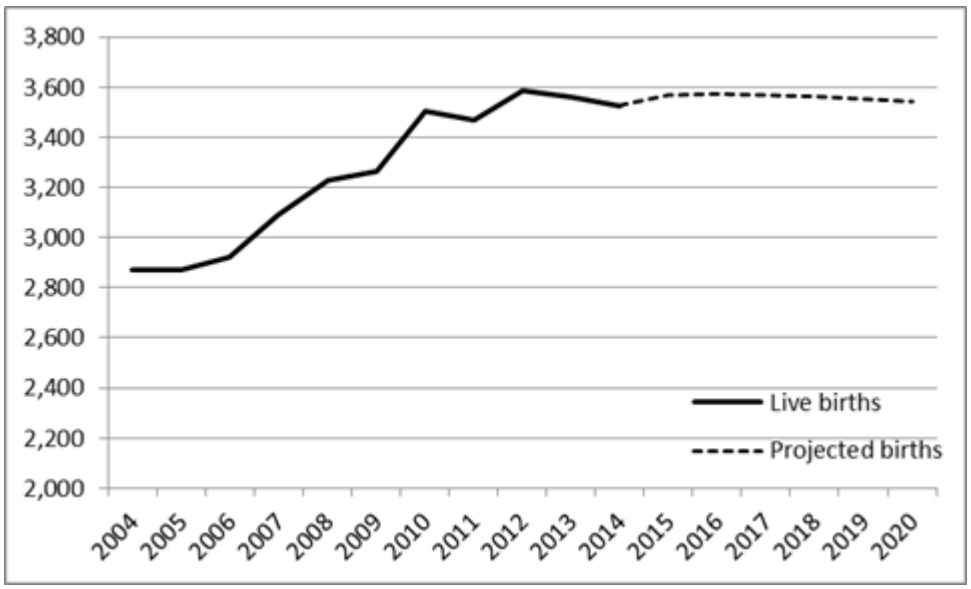
Population: Harrow's resident population is estimated to be 247,130[1]

Table 1: Live Births in Harrow – Actual and Projected

Year	Live Births	Year	Live Births
2004	2,870*	2013	3,559*
2005	2,872*	2014	3,525*
2006	2,924*	2015	3,566**
2007	3,088*	2016	3,571**
2008	3,230*	2017	3,570**
2009	3,265*	2018	3,564**
2010	3,503*	2019	3,555**
2011	3,466*	2020	3,543**
2012	3,585*		

* ONS data[2]
** GLA projected figure[3]

[1] At 30th June 2015, Office for National Statistics (ONS) 2015 Mid-Year Estimates
[2] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsbyareaofusualresidenceofmotheruk
[3] http://data.london.gov.uk/dataset/2015-round-population-projections/resource/9af1a907-9546-4018-b27b-7bb6758d96ff?utm_campaign=2015-round-trend-based-population-and-household-projections&utm_source=emailCampaign&utm_medium=email&utm_content=



As can be seen, it would appear that the peak level of new live births has been reached.

Age – 20.6% of Harrow's residents are under 16. 64.5% of Harrow's population are of working age (16 to 64) and 14.9% of Harrow's residents are 65 or older.[4] The average (median) age is 37 years, lower than most other places[5]. As with most areas in the country, the borough has an aging population. It is expected that the number of residents aged 65 plus will increase by nearly 42% and those aged 85 plus could increase by over 62% by 2029[6].

Gender/Sex – 49.8% of the population are male and 50.2% are female[7].

Disability – 15.4% of Harrow's working age population classified themselves as disabled, a total of 24,600 people[8]. 7,690 individuals, 3.1% of the total population, receive Disability Living Allowance.[9]

Race (Ethnicity) – 69.1% of residents classify themselves as belonging to a minority ethnic group. The White British group forms the remaining 30.9% of the population, (down from 50% in 2001). The 'Asian/Asian British: Indian' group form 26.4% of the population. 11.3% are 'Other Asian', reflecting Harrow's sizeable Sri Lankan community. 8.2% of residents are 'White Other', up from 4.5% in 2001.

In percentage terms, in 2011, Harrow had the second largest Indian, the largest 'Other Asian' and the 7th largest Irish population of any local authority in England and Wales.

[4] ONS, 2015 Mid-Year Estimates
[5] ONS, 2015 Mid-Year Estimates
[6] 2014-2029, ONS, 2014 Sub-National Population Projections
[7] ONS, 2015 Mid-Year Estimates
[8] Oct 2015-Sept 2016, ONS, Annual Population Survey
[9] May 2016, ONS/DWP. Rates calculated using the ONS 2015 Mid-Year Estimates

Harrow also had the highest proportion of Romanian (4,784) and Kenyan born residents, the latter reflecting migrants from Kenya who are of Asian descent.[10]

Religion or Belief – Harrow had the third highest level of religious diversity of the 348 local authorities in England or Wales. The borough had the highest proportion of Hindus, Jains and members of the Unification Church, the second highest figures for Zoroastrianism and was 6th for Judaism. 37% of the population are Christian, the 5th lowest figure in the country. Muslims accounted for 12.5% of the population[11].

Sexual Orientation – It is estimated that 10% of the UK population are lesbian, gay and bisexual (LGB), which would equate to approximately 24,713 of our residents.

Civic Partnerships / Same Sex Marriage – As of 31st December 2016, there have been 142 Civil Partnerships in Harrow, 19 of which have been converted to marriage. There have been 32 same sex marriages in Harrow since inception on 29th March 2014.

Our Commitment to Fair and Inclusive Services

In serving a diverse population, the Council aims to ensure there is equality of opportunity for its residents, service users, employees, elected members, stakeholders and partner organisations irrespective of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

As an employer, we are committed to employing a diverse workforce, to help us to understand and relate to the community we serve.

As a service provider, we are committed to ensuring our services are open, fair and accessible by taking into consideration the needs and requirements of our diverse community and service users.

As a procurer of goods and services, we will continue to ensure our commissioning processes are fair and equitable and that service providers delivering a service on our behalf share our commitment to equality and diversity.

Health Visiting Service in Harrow

In October 2015, NHS England transferred the commissioning of services for children between the ages of 0-5 to Local Authorities, including the health visitor service.

[10] ONS, 2011 Census, Table QS203EW
[11] ONS, 2011 Census, Table KS209EW

The idea was that Local authorities know their communities and understand local need so can commission the most vital services to improve local children's health and wellbeing. One of the benefits of councils commissioning health visitor services is that it offers opportunities to link with wider systems, such as housing, early year's education providers. This in turn will provide a more joined-up, cost effective service built around the individual needs, paving the way to deliver across a wider range of public health issues.

Financial Context

This information (Appendix 2) is commercially sensitive and is therefore being treated as exempt information under Paragraph 3 of Schedule 12A of the Local Government Act 1972.

6. FINDINGS AND RECOMMENDATIONS

As part of the review, the group attended various clinics to gain further knowledge and insight, understand how the clinics operated and learn more about the service user experience.

> "I felt very privileged to have had the experience of attending the home visit and clinics"
>
> Chair of the Review

All the members agreed that the visits had been extremely valuable and definitely an important part of the review. A summary of the feedback for each visit is available in **Appendix 3.**

The Challenge Panel invited submissions and heard evidence from Council Officers, the Director of Public Health, service managers from London North West NHS Trust, as well as a representative from Public Health England. The purpose was to understand in depth the Health Visiting service provided in Harrow and the impact of the service on the residents of Harrow.

The evidence gathered from the clinic visits and the challenge panel highlighted the emergence of a number of key themes. The following section therefore looks at these highlighting the evidence provided and recommendations put forward by the Panel.

Staffing Levels and Caseload

The Health Visiting (HV) Service in Harrow is provided by London North West Healthcare NHS Trust for the Council since it was established on the 1st October 2014.

The service is overseen by a General Manager and a Service Manager, with two teams (East and West) beneath them. The East team is based at the Caryl Thomas Clinic building near the Civic Centre (plus sites at Alexander Avenue Health and Social Care building); the West Team is based at Talbot House.

Staffing levels (Full Time Equivalent – FTE) as at July 2016:

31.5 FTE Health Visitors (HVs)
2 FTE Community nurses
4.2 FTE nursery nurses
4.6 FTE HV assistants
1.8 FTE Administration

London North West (LNW) runs a Clinical Academic Hub for Health Visitor training which has been successful in recruiting and training staff: 90+ HVs in the last two years. For this round of training places there have been 30 applications for 20 places.

As a trust LNW has committed to taking on 201 apprentices. They are paid at Band 2 and 80% of their training costs can be recouped. Public Health has linked the Council's apprenticeship lead with the relevant colleagues at LNW and Health Education England to ensure that this opportunity is maximised for Harrow's young people.

Within the HV staff, there are some specialist roles including Paediatric Liaison, Domestic Violence, CONI (Care of the Next Infant – after an infant death), Haemoglobinopathies (e.g. sickle cell) and Breastfeeding.

Local Caseload and Key Activity Measures

Overall numbers as at 1 June 2016

The average Health Visitor caseload size: 645 (The recommended caseload is 300 for an area with Harrow's levels of deprivation. Harrow is in the 65th percentile according to the data for IMD.)

Universal Caseload: 19,000 approx.

Universal Plus: 800 Children approx.

Universal Partnership Plus: 499 Children (of whom 55 children on Child Protection Plan, remaining 442 are CIN and children with complex needs)

Recommendations

1 To ensure the vacancy rate is filled across all the grades and not just he Health Visitors in order to meet the demand of the service, which will reduce the caseload per HV and improve the efficiency of the service.

2 To improve the level of skill-mix within the Health Visiting teams to deliver the Healthy Child Programme focusing mainly on the underperforming 12 months and 2-2.5 year developmental checks while maintaining performance levels for the other mandated checks.

3 To develop and implement a programme to recruit, develop and retain HV staff to meet the demand in service, which will reduce waiting times and deliver a more efficient service.

Training and Staff Development

Training and the development of staff was also highlighted by the review.

All members agreed the HVs seemed very professional, caring and dedicated individuals who built a good relationship with the service users. They covered various topics including family history, family health, mothers wellbeing, breastfeeding (including expressing milk), signposting to other clinics and support groups. However, there was room for improvement in terms of consistency in terms of the information and depth of details provided to parents.

> "The HV went through everything, even though it was a 4th child for one family"
>
> Panel Member

Some HVs stressed at the clinics how important it was to develop floor play, some stressed the importance of the mum doing pelvic floor exercises, and others did not. The need for consistency in terms of the information provided is important.

On one visit, a member picked up how a HV was not aware of the process to book an interpreter. The service confirmed Language Line was available and all staff should be aware of this.

Cultural Differences - During the visits, members also picked up concerns from parents due to differing cultures. Many parents needed information and advice to address behaviour and way of life due to cultural difference. For example, certain cultures believe having coco cola reflects their status and is good for the children.

> "One family told me having coca cola in the house was a symbol of status"
>
> Panel Member

In certain cultures issues such as mental health or post natal depression are not openly discussed, or even acknowledged. The birth of a female child is still frowned upon in many cultures, which put pressure on mothers who are often blamed for this. In such circumstances, mothers may not be able to discuss these issues in a home environment, with family around especially if these family members are relied on to act as interpreters. This was an important issue highlighted by the panel and something which needs to be addressed.

Recommendations

4 That Health Visitors (HVs) are trained to ensure information and advice provided to parents is consistent across the board including knowledge on language line and providing the service in various community languages [state rationale for this recommendation] Recommendation that the service develops and supports five groups for the five most common language groups. The purpose of these groups would be to act as a sounding board for translated documents and invitation letters etc., and be able to support other parents from those communities

5 That HVs undergo diversity and cultural awareness training to develop an

understanding of different cultures and how this impacts on their roles improving the quality of service being delivered.

6 That HVs are trained to recognise cultural pressures and are able to provide the relevant support, information and advice in a confidential and safe environment to mothers/parent, which will help pick up and address potential issues such as depression and domestic violence.

Booking Procedure and No Shows

In Harrow, service users receive three letters reminding them of their appointment followed by a SMS and a telephone call the day before.

The evidence highlighted a significant number of parents not attending and therefore wasted appointments. Members who attended clinics also reported a number of 'no shows', which obviously has an impact on the performance.

Table 2 below shows the number of parents who did not attend their appointments per clinic.

Table 2: Did Not Attend (DNA) rate for the different clinics
Apr16 - Feb17

Count of Outcome Equivalent	Column Labels			
Row Labels	Attended	DNA	Grand Total	DNA Rate %
Clinic Alexandra Avenue	273	12	285	4.2%
Clinic ASQ Alexandra Avenue	150	62	212	29.2%
Clinic Caryl Thomas	180	53	233	22.7%
Clinic Caryl Thomas 2	615	432	1047	41.3%
Clinic Cedars Children's Centre	253	7	260	2.7%
Clinic Chandos Children's Centre	92	81	173	46.8%
Clinic Elmgrove Children's Centre	23	28	51	54.9%
Clinic Gange Children's Centre	333	90	423	21.3%
Clinic Gange Children's Centre 2	76	16	92	17.4%
Clinic Hillview Children's Centre	298		298	0.0%
Clinic Honeypot Lane	998	655	1653	39.6%
Clinic Kenmore Park Children's Centre	316	116	432	26.9%
Clinic Pinner Wood Children's Centre	221		221	0.0%
Clinic Stanmore Park Children's Centre	566	172	738	23.3%
Clinic Stanmore Park Children's Centre 2	138	91	229	39.7%
Clinic Stanmore Park Children's Centre 3	94	25	119	21.0%

Clinic Wealdstone Centre	909	302	1211	24.9%
Grand Total	**5535**	**2142**	**7677**	**27.9%**

What further action is being taken to address the DNAs?

- Health Review clinics with high DNA rate such as Chandos , Elmgrove Children Centres and Honeypot Lane Clinic are under review. Due to poor attendance some sessions will be relocated to Health Centres and Children centres sessions, where there is a good uptake.
- Audit to establish reasons for DNA appointments to improve service delivery.
- Saturday clinics appointments to accommodate those parents / antenatal clients who are unable to attend appointment during week days.
- Booking system allowing parental choice of venue and time to reduce DNA.
- Centralised administration process to follow up DNA appointments and offer second appointments
- Clients who DNA 6 – 8 weeks clinics appointments are followed up at home by health visitor.
- Reminder text messages sent out to all appointments.

The service already offers a Saturday clinic to address issues of parents working and encourage fathers to attend. Although this is a step in the right direction, it was noted that more Saturday clinics can be provided and publicised.

Publicising and Promoting the Service: A theme which emerged from the review was the importance of publicising and promoting the service across the borough. Due to various reasons including cultural differences, not understanding the importance of the clinics and language barrier, members agreed it was important for the service to be promoted not only through posters and leaflets, but word of mouth, engaging with local community groups, places of worship, schools and partners. This will not only educate parents on the importance of the visits but potentially increase the take up and reduce non-attendance.

> "In one clinic, the walls were empty with no posters and also no literature to hand to parents. Instead they were advised to go onto a website for the information" Panel Member

Lack of information – it was noted that there was a lack of information including posters on walls and information leaflets to hand to parents at a couple of clinics. Members agreed it was important for the clinics to be welcoming, publicising and promoting relevant services to parents and ensuring literature is available for parents to take away.

Recommendations

7 To further and promote appointments within dedicated Saturday clinics to address the low take up of Antenatal and 12 months and 2-2.5 year Health Reviews to reduce the number of parents not attending.

8 To undertake a publicity campaign (including posters, social media, engaging with the voluntary and community sector, faith groups, schools and partners) to raise awareness and educate parents on the importance of the clinics, which will educate parents on the importance of the clinics and could reduce the no shows.

9 To ensure adequate information (posters) is displayed at all clinics and also available to provide to parents, as lack of information was available at a number of clinics.

Performance

Table 3 below provides our performance on the five checks in the last 21 months.

		15/16				**16/17**		
	KPI	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
1	Number of mothers who received a first face to face antenatal contact with a	13	17	18	5	94	163	243

		15/16				16/17		
	KPI	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	Health Visitor.							
2	Percentage of births that receive a face to face NBV* within 14 days by a Health Visitor	90.9%	90.0%	88.4%	91.0%	90%	96%	94%
3	Percentage of children who received a 6-8 week review by the time they were 8 weeks.	3.2%	2.3%	64.9%	86.8%	63%	66%	70%
4	Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months.	4.9%	14.9%	4.8%	7.6%	22%	40%	60%
5	Percentage of children who received a 2-2½ year review	3.3%	3.2%	2.1%	8.4%	14%	25%	31%

Table 4 below provides an overview of our performance against other London Boroughs, for Q1 2016/17.

Table 4: Health Visitor Service Delivery Metrics 2016/17 Quarter 2

Area	PHE Centre	C2: Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days by a Health Visitor %	C8i: Percentage of infants who received a 6-8 week review by the time they were 8 weeks %	C4: Percentage of children who received a 12 month review by the time they turned 12 months %	C5: Percentage of children who received a 12 month review by the time they turned 15 months %	C6i: Percentage of children who received a 2-2½ year review %
England (aggregate value of local authorities passing Stage 1 validation)		88.5%	81.9%	75.3%	82.5%	78.1%
North East (aggregate value of local authorities passing Stage 1 validation)		91.0%	92.9%	89.5%	96.2%	89.9%
North West (aggregate value of local authorities passing Stage 1 validation)		88.5%	88.9%	83.4%	90.2%	86.9%
Yorkshire and The Humber (aggregate value of local authorities passing Stage 1 validation)		85.1%	86.1%	81.6%	88.8%	82.6%
East Midlands (aggregate value of local authorities passing Stage 1 validation)		90.4%	91.7%	83.4%	91.3%	84.1%
West Midlands (aggregate value of local authorities passing Stage 1 validation)		91.9%	88.3%	85.3%	84.1%	83.2%
East of England (aggregate value of local authorities passing Stage 1 validation)		93.9%	90.8%	87.7%	92.4%	86.1%
London (aggregate value of local authorities passing Stage 1 validation)		91.1%	54.1%	47.3%	64.0%	57.4%
South East (aggregate value of local authorities passing Stage 1 validation)		85.0%	83.5%	74.7%	79.2%	78.2%
South West (aggregate value of local authorities passing Stage 1 validation)		78.8%	81.8%	74.1%	79.7%	74.8%
Barking and Dagenham	London	90.8%	47.2%	23.9%	57.4%	41.9%
Barnet	London	95.5%		65.1%	77.2%	71.9%
Bexley	London	94.8%	13.1%	16.7%	69.8%	81.6%

Brent	London	88.9%	66.2%	27.0%	35.0%	23.4%
Bromley	London	94.2%	83.7%	86.7%	90.4%	80.0%
Camden	London	93.5%	66.3%	66.7%	86.0%	
Croydon	London	49.7%	9.2%	2.9%	23.3%	25.0%
Ealing	London	93.1%	56.7%	36.4%	52.1%	44.1%
Enfield	London					
Greenwich	London	91.7%	41.0%	33.8%	81.5%	80.2%
Hackney and City of London*	London	95.6%	23.9%	90.8%	94.1%	86.6%
Hammersmith and Fulham	London	95.7%		78.7%	77.3%	75.8%
Haringey	London	92.8%	0.0%	42.2%	55.1%	39.7%
Harrow	London	96.0%	66.0%	18.4%	40.1%	25.1%
Havering	London	91.3%	43.5%	52.6%	84.2%	70.5%
Hillingdon	London	93.0%	94.4%	84.3%	59.0%	74.5%
Hounslow	London	97.2%	91.3%		27.1%	29.3%
Islington	London	93.3%	46.9%	16.0%	62.7%	77.9%
Kensington and Chelsea	London	98.2%		69.9%	73.8%	74.3%
Kingston upon Thames	London	82.9%	93.8%	52.6%	17.2%	52.2%
Lambeth	London	96.2%		83.4%	84.9%	84.2%
Lewisham	London	98.5%	75.2%	75.2%	78.2%	73.4%
Merton	London	98.2%	85.4%	54.7%	63.5%	
Newham	London		28.4%	31.8%	73.0%	34.2%
Redbridge	London	90.6%	83.0%	40.5%	53.3%	55.9%
Richmond upon Thames	London	98.7%	93.6%	48.7%	66.0%	39.8%
Southwark	London	94.2%	0.0%	80.2%	80.2%	
Sutton	London	90.7%	84.6%	66.5%	81.7%	66.0%
Tower Hamlets	London	86.9%	78.0%	60.2%	70.7%	70.6%
Waltham Forest	London	91.1%		14.3%	57.4%	36.6%
Wandsworth	London	91.9%	74.4%	45.1%	71.7%	54.1%
Westminster	London	96.0%		84.4%	87.0%	
Slough	South East	94.1%		82.4%	82.5%	83.1%

Harrow's statistical neighbours

Notes:

	No submission
	Does not pass Stage 1 validation
	Does not pass Stage 2 validation
DK	Local authority entered 'Don't Know'
	Blank cells (with no colour highlight) show where data does not meet validation criteria, therefore values can not be published
*	joint submission

Source: Public Health England

As you can see from the table, Harrow's performance is considerably poor for the last three visits compared to its statistical neighbours. It is also worth highlighting that the Health Visiting Service for Brent, Ealing and Harrow is delivered by LNW.

1-year and 2-year checks

In terms of performance regarding the 1-year and 2-year checks, the provider has stated that the workforce identified to deliver the 1-year and 2-year checks are currently running at 35% vacancy. Two staff nurses, and one community nursery nurse posts were vacant. One community nursery nurse was on maternity leave. One staff nurse is currently being recruited; one community nursery nurse has been recruited.

50% of clients are Did Not Attend (DNA) so the service in now implementing a new offer/access process including SMS reminders/more clinics/phone call follow-up that should see rates increase. There was also insufficient capacity in the children's centres. Those clinics have now been booked.

The links with Private, Voluntary or Independent (PVI) nurseries has improved so that they are referring when they complete their 2.5yr check if the child has not already seen the health visitor for their 2.5yr check.

The service has said that performance for 1- and 2-year checks should be up to 35% in Q1. We are currently looking at the targets for the new specification. These targets will be at least 65%.

Recommendations
10 **[for the Council]** To agree targets (comparative to neighbouring boroughs) and include these as Key Performance Indicators (KPIs) within the contract to be monitored on a regular basis, which will help to improve performance.

An Accessible and Inclusive Service

In general the feedback was the clinics were accessible, inviting and with friendly reception staff. Only one clinic was hard to find as the postcode was not recognised on the GPS.

Staff have also been provided with devices which has helped them to work more flexibly and save time by inputting information and updating the accounts straight after the visits.

One of the biggest (if not the biggest) issue witnessed by members attending the clinics and highlighted by the review was ‘language barrier’. A significant proportion of parents visiting the clinics found it difficult communicating with the HVs and understanding the conversation. Although the HVs tried their best to try and get the information across, in some cases members realised this was not being understood. In one case the HV had to find a picture online and show this to the parent. This not only questions the quality of service provided but highlights important and vital information relating to the child and parents health being lost in communication.

In another case, the HV kindly offered to help the parent with various queries and promised to get back to them. The member present asked how they would communicate the information to the parent who had difficulty speaking and understanding English, and the HV responded ‘I don’t know’!

> “Language barrier was a big concern witnessed in almost all the visits, which can result in information lost in communication and service users not understanding vital information”
>
> Panel Member

It also seemed the onus was on service users to arrange for interpreters (family members, relatives and friends) to accompany them to the visits. The concern raised here by members was that, in some cases parents may not wish to share or discuss certain information with HVs via family, relatives or friends.

> *“HVs seemed very professional and engaging at all times, even when there were language barriers and on one occasion a mother did not seem to engage”*
>
> Panel Member

Confidentiality – at one clinic, a member witnessed two visits being conducted in one room which runs the risk of confidentiality issues and service users reluctant to openly discuss issues of concern. It is therefore important to review this and ensure customer confidentially is maintained at all times.

Harrow is one the most diverse boroughs in the country, and therefore services need to cater for all service users addressing issues such as language barrier, access and taking into consideration cultural and religious requirements.

Recommendations

11 To change the way ethnicity and mother tongue/language competence are recorded on patient records. At the moment the Health Visiting patient record system records 132 different ethnicities. It is recommended that ethnicity is simplified and the Council's Diversity Monitoring categories **(Appendix 4)** are used and a separate record is kept of language and language proficiency.

12 To review the contact material (letters) to ensure they are inclusive and incorporate a strap line offering the information in alternative formats and community languages, which will contribute to addressing the language barrier.

13 To ensure all staff are aware of and trained to arrange for interpretation services if required to address the issue of language barrier.

14 To undertake a review of the set-up of all clinics to ensure customer confidentiality is maintained at all times so that no more than one visit is conducted in the same room at any one time.

15 **[for the Council]** That a fully comprehensive Equality Impact Assessment is undertaken to highlight potential barriers and identify ways to improve the service. The findings and requirements of this to be incorporated in the service specification of the new contract.

16 That the service develops and supports five groups for the five most common language groups. The purpose of these groups would be to act as a sounding board for translated documents and invitation letters etc., and be able to support other parents from those communities

7. CONCLUSION

The Panel appreciate the financial pressures on Local Authorities and the Public Sector as a whole. However, Local Authorities do have a duty to ensure services delivered meet the needs

of its service users and are fair, equitable and accessible. This also applies to services commissioned out to external providers.

Despite limited budgets and many competing priorities, Members have put forward a number of recommendations to help improve the Health Visiting Service in terms of improving our performance and providing an accessible and inclusive service to some of our most vulnerable residents.

Appendix 1: Scope of the Review

HARROW COUNCIL

OVERVIEW AND SCRUTINY COMMITTEE

DATE: 8 November 2016

REVIEW OF HARROW HEALTH VISITING - DRAFT SCOPE

1	**SUBJECT**	Review of Harrow Health Visiting and proposals for new 0-19 service
2	**COMMITTEE**	Sub-committee or O&S
3	**REVIEW GROUP**	**Councillors – Chair – Cllr Janet Mote** **Membership to be confirmed** **Co-optees: Potentially could be one or more representatives from CCG, service users, representative from Health watch. This would be for the Members to decide.**
4	**AIMS/ OBJECTIVES/ OUTCOMES**	To understand the current service performance and how it compares to other London Boroughs To make recommendations for a service specification for new 0-19 service
5	**MEASURES OF SUCCESS OF REVIEW**	To have an understanding of the Health Visiting Services performance and have made recommendations for 0-19 service.
6	**SCOPE**	The suggestion is that it includes: • Understanding the service on the ground through work-shadowing, meeting parents and meeting London North West service managers. • Understanding how other boroughs' HV service works. • Understanding how it fits with LBH Early Years Service • Understanding the current budget • Examination of the expenditure involved in provision of the service • Meeting national representative of e.g. PHE or Institute of Health Visiting to understand the national picture.
7	**SERVICE PRIORITIES (Corporate/Dept)**	Harrow's Health and Wellbeing Strategy 2016-2020[12] sets out the Council's commitment to enabling children to "Start Well" so that "children from the womb to adulthood [can] be safe, happy and

12 https://www.harrow.gov.uk/www2/documents/s130914/DRAFT%20Harrow%20Health%20and%20Wellbeing%20Strategy%202016-20%20FINAL%20UPDATED.pdf

		have every opportunity to reach their full potential.”
8	**REVIEW SPONSOR**	Andrew Howe, Director of Public Health
9	**ACCOUNTABLE MANAGER**	Rachel Gapp. Head of Policy Audrey Salmon, Head of Public Health Commissioning
10	**SUPPORT OFFICER**	Mohammed Ilyas, Policy Officer
11	**ADMINISTRATIVE SUPPORT**	Policy Team
12	**EXTERNAL INPUT**	Could come from: Health Visiting Service, School Nursing Service, Maternity services, social care, LSCB, early years/children’s centres, parents, PVIs/nurseries, childminders, PHE London, Institute of Health Visiting, other LAs that have a 0-19 service
13	**METHODOLOGY**	1) Research and evidence gathering phase • Public Health Commissioning Manager (November 2016) • Meet/shadow health visitors and talk with mums on a new birth visit and the clinic sessions for the 12/24 month checks. (December 2016 – day-time visits) • Meet Harrow HV service manager(s) (December 2016) • Meet managers from other high-performing LAs (December 2016/January 2017 – day-time visits) • Meet national expert(s) (January 2017) 2) Challenge Panel The evidence from these meetings and visits would feed in to a challenge panel to take place in February 2017.
14	**EQUALITY IMPLICATIONS**	This is a universal service. Members might like to look at how to target resources best and in the most equitable manner if it is not possible always to offer a universal service.
15	**ASSUMPTIONS/ CONSTRAINTS**	Member/officer time. Need to complete review by end March 2017.
16	**SECTION 17 IMPLICATIONS**	The challenge panel will have regard to the possible community safety implications of any recommended changes to policy or practice.
17	**TIMESCALE**	In order for recommendations from the review to be taken into account in the tender process the review needs to be completed – or an interim report needs to be produced by end March 2017. 1) O&S 8th Nov 2016 agree scope and panel members 2) Research and evidence gathering – Dec 2016/Jan 2017 3) Challenge panel – late Feb – early March 4) Panel agree report by March 2017 5) O&S agree report and forward to Cabinet 6th April 2017 6) Cabinet receive report 27th April 2017 7) Response to report at the June Cabinet

18	**RESOURCE COMMITMENTS**	Support from Public Health Commissioning Manager is only possible till end March 2017. During that time 5-7 visits/meetings can be supported by Public Health.
19	**REPORT AUTHOR**	Jonathan Hill-Brown, Public Health Commissioning Manager.
20	**REPORTING ARRANGEMENTS**	Outline of formal reporting process: To Divisional Director [✔] throughout the course of the challenge panel and when developing recommendations and as a witness at the challenge panel To Portfolio Holder [✔] as a witness at the challenge panel and when developing recommendations To CSB [✔] TBC To O&S [✔] TBC To Cabinet [✔] TBC
21	**FOLLOW UP ARRANGEMENTS (proposals)**	Are these proposals required at this stage of approving the scope?

Appendix 2: Financial Context CONFIDENTIAL

Appendix 3: A summary of the feedback from the visits

First Visit: Antenatal – when you are around 28 weeks pregnant	
Positive	**Areas of Concern**
• One member received a leaflet about the clinic beforehand, which was very useful • The Health Visitor (HV) covered various topics including family history, family health, mothers wellbeing, breastfeeding (including expressing milk), signposting to other clinics and support groups available, recommendation of first aid course and completion of the red book • HVs enquired about the mothers health and wellbeing, allowing time for questions and answers • Overall very comprehensive visits covering topics and areas which members had not expected • HV's seemed very professional, caring and dedicated individuals who built a good relationship with the service users • Willingness of HVs to make follow up calls and visits if necessary • Offered Saturday visits to encourage fathers attendance	• Average time of visits varied from 30-45 minutes, policy document states 60-90 minutes • Language barrier was a big concern witnessed in almost all the visits, which can result in information lost in communication and service users not understanding vital information • It seemed the onus was on service users to arrange for interpreters (family members, relatives and friends) • Service users may not be willing to share/discuss certain information in the presence of family members, relatives and neighbours who have been brought along as interpreters due to cultural issues. • 3 out of the 5 parents invited did not attend.

Second Check: 10-14 days following the birth of the baby	
Positive	**Areas of Concern**
• The Health Visitor (HV) covered various topics including family history, family health, mothers wellbeing, breastfeeding (including expressing milk), signposting to other clinics and	• One service users had a midwife visit the day before, so not enough time between visits • Language barrier was a big concern

support groups available • The HV went through everything, even though it was a 4th child for one family • Also provided information on living environment, room temperature, financial support, relationship support and sibling rivalries • HVs seemed very professional and engaging at all times, even when there were language barriers and on one occasion a mother did not seem to engage • Parents spoke highly of the breast-feeding peer support group	witnessed in almost all the visits, which can result in information lost in communication and service users not understanding vital information • Some visits seemed more thorough e.g. one HV asked about the health of the grandparents, others did not touch on this. • Some HVs stressed at this stage how important it was to develop floor play. Some stressed the importance of the mum doing pelvic floor exercises. Other HVs did not. What is in place to ensure greater learning and consistency of message – while maintaining each professionals' clinical responsibility and integrity?

Third Check: Antenatal – when the baby is 6-8 weeks old	
Positive	**Areas of Concern**
• Kenmore, very good clean and accessible clinic but not very good signage in the street • Children of all ages attending the clinic and the HV responded to questions and queries from walk in mothers/parents • Mother and baby health covered • Weight checks done and the red book completed • Provided various information including breastfeeding, benefits of solid foods, parental hygiene, support clinics and network groups	• ASQ under pressure due to reduction of HVs • Health Assistants have no nurse training and mainly administrative • Not enough leaflets and information available at a number of children centres to give to parents • Kenmore – a long wait for some parents • Kenmore – it was difficult to find your way round. Signage was not great. • Communication barriers came up again

Fourth Visit: A review of the child's development at 2-12 months	
Positive **Honeypot Clinic**	**Areas of Concern**
• Generally went well with key topics including feeding, sleeping patterns, safety tips around the home and the	• Two visits being conducted in one room which runs the risk of confidentiality issues and service users reluctant to openly discuss

mothers/baby's health covered • Also provided information on vitamins and encouraged to take Vitamin D supplements • HV picked up missed information in the red book and promised to follow this up with the GP **Kenmore** • Clinics near fully booked, so some (walk in) parents waited to be seen • Child was quite sick, and the HV was very calm, professional and encouraging at all times • Referred to key professionals but 2-3 months wait! • Good IT systems, which allow remote working.	issues of concern • Language barrier – reliant upon service users to bring an interpreter with them • Questionnaire was sent back but HV not aware of where it was or returned to, so another one had to be completed • HV promised to follow up and get back to the service user, but how will the language barrier be addressed? • A few non attendees – more could be done to promote the service • Long waiting times for professionals **Alexandra Clinic** • No posters on walls or information about clinic or key information • Lack of information leaflets to provide to service users

Fifth Check: A review of the child's development at 2-2.5 years	
Positive	**Areas of Concern**
• The Health Visitor (HV) covered various topics including family history, family health, mothers wellbeing, breastfeeding (including expressing milk), signposting to other clinics and support groups available, recommendation of first aid course and completion of the red book • HVs acquired bout the mothers health and wellbeing, allowing time for questions and answers • HV completed forms for mother who experienced difficulties due to language barriers	• Issue with service users not turning up • Language barrier was an issue again with the husband interpreting, potentially an issue as mother may be reluctant to discuss certain issues due to personal and cultural reasons

Appendix 4 – Harrow Council's Diversity Monitoring Categories

Why do we monitor?

Harrow Council is committed to making sure people are treated fairly. We recognise that our job applicants, employees, our community and service users have different backgrounds and/or needs and we continuously work towards creating a culture and practices that recognise, respect, value and harness difference for the benefit of all.

This equalities monitoring form is used by service users/residents, employees and job applicants. By completing this form you are helping us to:

- Understand the demographics of job applicants and employees to ensure we are applying equality of opportunity for all, including those with criminal records
- Better understand our service users / residents and shape services to meet their specific needs
- Identify and address any barriers / issues individuals may experience when accessing our services (including information about our services)
- Ensure our policies, processes and services are accessible to everyone who uses them

Data Protection – it is your choice whether you provide this information. Your replies will not be used in a way that identifies you or used for any other purpose.

Age - What is your age group?

Under 16		16 – 24 years	
25 – 44 years		45 – 64 years	
65 & over			

Disability – Are your day-to-day activities limited because of a health problem or disability which has lasted or is expected to last at least 12 months?

Yes		No	
Prefer not to say			

Ethnic origin - What is your ethnic origin?

Asian or Asian British

Afghan		Bangladeshi	
Chinese		Indian	
Pakistani		Sri Lankan	
Any other Asian background – please specify			

Black or Black British

African		Caribbean	
Somali			
Any other Black background – please specify			

Mixed background

White and Black African		White and Black Caribbean	
White and Asian			
Any other mixed background - please specify			

Other ethnic background

Arab		Iranian	
Any other Ethnic group – please specify			

White or White British

Albanian		English	
Gypsy / Irish Traveller		Irish	
Polish		Romanian	
Scottish		Welsh	
Any other White background - please specify			

Marriage or Civil Partnership

Are you married?	Yes		No	
Are you in a Civil Partnership?	Yes		No	

Pregnancy or Maternity

Have you been pregnant and / or on maternity leave during the past 2 years?	Yes		No	

Religion and belief - What is your religion?

Buddhism		Judaism		
Christianity (all denominations)		Sikh		
Hinduism		Zoroastrian		
Islam		No religion / Atheist		
Jainism		Other -please specify		

Sex - Are you?

Male		Female	

Is your gender identity the same as the gender you were assigned at birth?

Yes		No	
Prefer not to say			

Sexual orientation - What is your sexual orientation?

Bisexual		Gay Man	
Gay Woman / Lesbian		Heterosexual	
Other; please specify		Prefer not to say	