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<td>Nursing and Midwifery Council</td>
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<td>Office for National Statistics</td>
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<td>Abbreviation</td>
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<td>Primary Care Trust</td>
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<td>Whole Time Equivalent</td>
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Acknowledgements

Dr Sue Levi (Public Health Consultant, LB Sutton) for all her informative comments and guidance throughout the writing of this HNA.

Sylvia Godden (Principal Public Health Intelligence Specialist, LB Sutton) for all her useful advice regarding data sources, analyses, and maps, and for permission to reproduce some of her graphical representations within this document.

Phillip Giraud (GIS Officer, LB Sutton) for constructing the maps of LB Sutton used within this document.

A special thank you to Nadine Mitchell (Universal Services Manager, Sutton Health Visiting, Sutton and Merton Community Services) for her unending hard work in providing invaluable information, data and contact details which enabled a thorough understanding of the health visiting service within Sutton. An additional thank you to all those who contributed to the needs assessment through the provision of quantitative and/or qualitative data (Anne Howers, Maggie Gairdner, Amanda Sadler, Chris Lovelace, Sarah Duggan, Fran Boto, Anna Cassin, Tracey Bogalski, Patience Ohikhena, Melinda Bird, Brendan Hudson and Helen Wilkinson, all members of the Sutton Health Visiting team who gave up their time to participate in the focus groups).
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1. EXECUTIVE SUMMARY

2. INTRODUCTION

The cornerstone of human physical, cognitive, social and emotional development is laid down in utero and during early childhood, with 80% of neurodevelopment occurring by the age of three years (Field, 2010; NHSE, 2014b; WAVE Trust, 2013). Development during these first critical 1001 days (Leadsom et al, 2013) from conception until two years of age has impacts upon health and wellbeing, educational achievement and economic sufficiency as an adult (NHSE, 2014b).

Thus it is during these crucial early years that early intervention can make the most impact to ensure children reach their full potential as adults, in order to optimise their mental and physical health, educational attainment and employment opportunities, and in order to reduce antisocial behaviour, drug and alcohol misuse and teenage pregnancy (Allen, 2011; Leadsom et al, 2013). Furthermore, it is during this time, particularly the early stages of pregnancy, that women are receptive to receiving information and advice and making any appropriate behaviour changes (DH, 2009).

The Millennium Cohort Study (MCS) is a large-scale cohort study tracking approximately 19,000 children born in the United Kingdom (UK) in 2000-2001, and has revealed strong associations between maternal indicators1 and outcomes at five years old (ChiMat, 2011). For example, low income, poverty, deprivation, ethnicity and lack of maternal qualifications are predictive of poor health, poor learning and development and/or poor behaviour at aged five years (ChiMat, 2011). Thus poor outcomes are not distributed equally within society, but represent unfair inequalities. As in Marmot’s (2010) review, tackling such inequalities requires giving every child the best start in life and enabling children to maximise their capabilities. Further, to do so requires ‘proportionate universalism’ – ie, a universal approach but one that is proportionate in scale and intensity to the level of disadvantage (Marmot, 2010).

Health visiting within the UK is a service which aims to improve the health and wellbeing of young children, and should also serve to reduce inequalities in outcomes (NHSE, 2014b). It takes a universal approach, and is primarily a preventive service, which is usually more effective than taking a purely reactionary approach (WAVE Trust, 2013).

Health Needs Assessments (HNAs) are “...systematic method[s] for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities” (Cavanagh & Chadwick, 2005, p3). This HNA aims to review the needs2 of the 0-5 years population within the London Borough of Sutton (LB Sutton), particularly focusing upon the health visiting service. The aim is to identify areas of need within LB Sutton, as demonstrated via corporate, epidemiological, and comparative assessments (Health Knowledge, 2008).

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1 Measured when the child is nine months old or three years old.
2 The term need is used here as indicating the potential to benefit (Health Knowledge, 2008).
3. KEY POLICY DOCUMENTS

3.1. Health and Social Care Act 2012

As part of this Act, some public health (PH) functions were transferred from the National Health Service (NHS) to the Local Authority (LA) and other organisations on 1 April 2013. The responsibility for the Healthy Child Programme (HCP, see below) passed to NHS England (NHSE) until 1 October 2015 when commissioning responsibilities\(^3\) for 0-5 year olds will also be transferred to the LA.

This final transfer of commissioning responsibilities for 0-5 years services will then allow for integrated commissioning of 0-19 years services\(^4\). As part of the transfer, services that will then become the responsibility of the LA include health visiting and Family Nurse Partnership (FNP). Child Health Information Systems (CHIS) will remain the responsibility of NHSE until at least 2020, as will the General Practitioner (GP) six to eight week infant check.

3.2. The National Health Visitor Plan: progress to date and implementation 2013 onwards (DH, 2013)


In 2010 the UK Government stated, by 2015, it would increase the number of whole time equivalent (wte) health visitors (HVrs) by 4,200. This approximately 50% increase was proposed in order to improve outcomes for young children. During the first phase of this programme in 2011 to 2013, an additional 1,000 HVrs entered the workforce.

A Call to Action (DH, 2011) also discussed the transformation of the health visiting service, established 49 Early Implementer Sites (EIS) as leaders in this transformational change and discussed plans to align delivery with other children’s services such as Sure Start Children’s Centres (CCs). A new model of service delivery was developed which incorporated four components or levels as follows:

- Level 1 – Community offer – developing community resources according to local population needs, and raising their profile amongst local families.
- Level 2 - Universal offer – ensuring every mother and child have a HV and receive developmental reviews and information as detailed within the HCP.
- Level 3 - Universal Plus offer – enabling families to access appropriate advice on specific issues pertinent to them as and when required. Eg, postnatal depression (PND), weaning, sleep management.

\(^3\) This excludes workforce (LGA, 2015).

\(^4\) Or 0-25 years services for individuals with Special Educational Needs and Disabilities (SEND).
• Level 4 - Universal Partnership Plus offer – ongoing support for families with continuing complex needs in a way which brings together relevant local services.

3.3. Healthy Child Programme (HCP) (DH, 2009)

The HCP is an evidence-based early intervention and preventative public health initiative that is provided universally to all children. HVs are the lead practitioner for the HCP, but the aim is that services are integrated across the community and should incorporate general practice and Sure Start CCs. Although the HCP offers a universal service, it utilises the theory of progressive universalism, whereby extra services are offered to families with additional needs and requirements.

Core elements and requirements of the HCP include:
- Early identification and additional services for those with further needs;
- Health and development reviews;
- Screening;
- Immunisations;
- Promotion of social and emotional development;
- Parenting support;
- Promotion of health and behaviour change (including breastfeeding).

3.4. National Health Visiting Core Service Specification 2015/16\(^5\) (NHSE, 2014b)

HVs are specialist community public health nurses (SCPHN)\(^6\) whose role as leaders of the HCP should serve to improve health outcomes in children and reduce inequalities at the individual, community and family level. In order to achieve this, HVs should work across service and organisational boundaries for young children aged 0-5 years. The four strands of modern health visiting were first documented in 1977. These are:

- Searching for health needs;
- Raising awareness of such needs;
- Influencing health policies;
- Facilitating activities that improve health.

Within the HCP HV priorities include safeguarding and the six so-called high impact areas:

1) *Transition to parenthood and the early weeks*. As stated previously, the time from conception until aged two years is the crucial period for neurodevelopment and predicts social, emotional and cognitive outcomes, including health and wellbeing.

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\(^5\) The current National Health Visiting Core Service Specification being used within LB Sutton is the 2014/15 specification (NHSE, 2014a).

\(^6\) HVs have a background in midwifery or nursing, and a further diploma or degree in specialist community public health nursing (NHSE, 2014b).
2) Maternal mental health. Perinatal depression affects approximately 10% of mothers, and has a significant impact upon attachment, mother-infant relationships, and the family as a whole (DH, 2015a).

3) Breastfeeding. Breastfeeding is associated with reductions in infections (of the respiratory tract, middle ear and gastrointestinal system), allergies and Sudden Infant Death Syndrome (SIDS) (DH, 2015a).

4) Healthy weight, nutrition and exercise. The first few years of life are an important time for the formation of healthy eating behaviours (DH, 2015a).

5) Managing minor ailments, reducing hospital attendances and admissions.

6) Health, wellbeing and development at the two to two and a half year (integrated) review. This is in support of achieving ‘school readiness’.

According to the national service specification, the service should be led by HVs but should include a skill mix support staff. Initial assessments should be conducted by HVs, but some re-assessments can be delegated to allied professionals if deemed appropriate by the HV. All children aged less than one years old, and any family with children aged 0-5 years with additional needs, should have a named HV. The overarching aim is early intervention in order to prevent problems from arising or worsening.

Overall, the key objectives of health visiting are:

<table>
<thead>
<tr>
<th>Objective</th>
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<tr>
<td>Improving health and wellbeing of young children and reducing inequalities;</td>
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<tr>
<td>Focusing on prevention, health promotion and early intervention;</td>
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<tr>
<td>Delivering the HCP to all, starting in the antenatal period, and including fathers;</td>
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<tr>
<td>Identifying those with additional needs and those who require targeted interventions;</td>
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<tr>
<td>Promoting attachment;</td>
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<tr>
<td>Promoting breastfeeding and healthy eating;</td>
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<tr>
<td>Promoting school readiness;</td>
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<tr>
<td>Supporting positive lifestyle choices and behaviour change;</td>
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<tr>
<td>Safeguarding young children (this is deemed a PH priority and an essential part of the health visiting service);</td>
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<tr>
<td>Supporting families with complex needs as part of a multi-disciplinary team (MDT);</td>
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<tr>
<td>Delivering services to troubled families alongside the LA and Family Nurse Partnership (FNP);</td>
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<tr>
<td>Improving local services for the local population.</td>
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</table>

In addition, there are supervision and training requirements set out within the national service specification. This includes clinical supervision according to need, safeguarding supervision at least quarterly, and supervision for managers and practice teachers.

The assessments that are incorporated within the universal offer are as follows:
### Universal Review Components

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<th>Antenatal health promoting visits</th>
<th>Should be face-to-face 1:1 interviews?</th>
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<td><strong>New baby review</strong></td>
<td>Face-to-face review by day 14 with both parents; Infant feeding; Parenting; Development; Maternal mental health; SIDS prevention; Safety; Any additional concerns or needs; Promotion of required immunisations for mother and baby; Screening results and referral as appropriate; Newborn blood spot results</td>
</tr>
<tr>
<td><strong>6-8 week assessment</strong></td>
<td>Supporting breastfeeding; Maternal mental health; Promotion of required immunisations for mother and baby; Screening results and referral as appropriate</td>
</tr>
<tr>
<td><strong>3-4 month assessment</strong></td>
<td>Supporting parenting; Immunisation status; Assessing growth as required; Maternal mental health; Infant health; Promotion of development; Accident prevention</td>
</tr>
<tr>
<td><strong>9-12 month assessment</strong></td>
<td>Assessing physical, emotional and social development of the child; Supporting parenting; Monitoring growth; Health promotion (including dental health and prevention, healthy eating, accident prevention, safety in cars, skin cancer prevention); Promotion of immunisations for mother and baby</td>
</tr>
<tr>
<td><strong>2-2.5 year review</strong></td>
<td>Assess physical, social, emotional, behavioural and language development of the child; Parental guidance and responding to concerns; Promotion of language development; Promotion of early years education; Health information; Promotion of immunisations; Health promotion (including nutrition and physical activity, dental health accident prevention, sleep management, toilet training, parenting advice and information)</td>
</tr>
<tr>
<td><strong>4.5 years</strong></td>
<td>Formal handover to school nursing at a time appropriate to the child; Must be a written handover if Universal Plus or Universal Partnership Plus Offer</td>
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</table>

**NB.** All of the universal reviews apart from the 3-4 month assessment and the handover at 4.5 years are mandated for LAs to provide under section 6C of the NHS Act 2006 (DH, 2015b; LGA, 2015).

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7 This face-to-face 1:1 interview is a new requirement within the 2015/16 national service specification.
8 This is a new requirement in the 2015/16 national service specification.
9 Should be integrated with the Early Years Foundation Stage two year old summary (NHSE, 2014b).
10 This can be delayed if the HV is the lead professional and outcomes for the child would be improved by such a delay (NHSE, 2014b).
Thus there is proposed to be a 4-5-6 model of health visiting in which there are four service levels, five mandated universal reviews and six high impact areas (DH, 2015b).

4. METHODS

| CORPORATE HNA | Service descriptions of the health visiting service, Sure Start CCs and the FNP were obtained from discussions with the relevant management teams, policy documents and other key stakeholders. The corporate component of a HNA also involves obtaining stakeholder feedback on services that are needed (Health Knowledge, 2008), and this was achieved via focus groups, one-to-one interviews, and utilising pre-existing local survey data. |
| EPIDEMIOLOGICAL HNA | An epidemiological assessment of the need of the population of LB Sutton was conducted with reference to:  
- Analysing pre-existing nationally available data (eg, Office for National Statistics (ONS), Greater London Authority (GLA), PH Outcomes Framework (PHOF) and Child and Maternal Health Observatory (ChiMat));  
- Obtaining locally held data relevant to the services provided and pre-existing populations (eg, RIO data from Sutton and Merton Community Services (SMCS)). |
| COMPARATIVE HNA | Data presented for LB Sutton has been compared with other areas where possible. The ONS has created area classifications based upon the 2001 census. Within this classification, LB Sutton sits within the 'Thriving London Periphery' ONS cluster that includes LB Bromley, Cambridge, LB Hillingdon, LB Kingston upon Thames, Oxford, Reading, LB Richmond upon Thames and Watford. For comparative purposes within this HNA, LB Sutton has been compared with other LBs within the Thriving London Periphery ONS cluster, but not with non-London LAs. Further, because of the historical link between LB Sutton and LB Merton as a joint Primary Care Trust (PCT), and the current existing link between LB Merton and LB Sutton’s health services, LB Merton has been included as a comparator where possible. Where data on these areas was not available, outer London, London or England were used as alternative comparators. For service provision, where possible, examples of good practice were sought, and pre-existing HNAs from other localities were examined for comparisons. |
5. RESULTS – SERVICE DESCRIPTION (CORPORATE HNA)

5.1. Health Visiting Service

The health visiting service within LB Sutton is currently provided by SMCS, and is delivered by The Royal Marsden (RM) NHS Foundation Trust. Service provision at present is across both LB Sutton and LB Merton due to the historical PCT encompassing both boroughs. For the purpose of this HNA, as well as the future separation of services with the new commissioning responsibilities, an attempt has been made to delineate the service provision across the two LBs, although some posts are shared across both boroughs and, where this is the case, this has been noted. An organogram of the existing overarching management structure is depicted in figure 1.

Figure 1: Organogram of SMCS management structure

*Split posts across LB Sutton and LB Merton.

The LB Sutton health visiting team has two Team Leaders and eight HV localities. One Team Leader is based at Green Wrythe Lane Clinic but covers two bases (Jubilee Health Centre and Green Wrythe Lane Clinic) and leads five teams. Three of those teams are based at Jubilee Health Centre (Stanley Park, Jubilee and Amy Johnson teams), and two are based at Green Wrythe Lane clinic (Circle and Wandle teams). The second Team Leader is

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11 The health visiting service, Sure Start CCs and FNP are described in this section with respect to the services that are provided currently within LB Sutton. Further analyses in terms of quantitative and qualitative feedback are given in sections 7 and 8, respectively.
Based at Priory Crescent Clinic and covers three teams all based there (Green Oak, Robin Hood Lane and Manor Park teams). See table 1 which also details the number of whole time equivalent (wte) HVs per team, and alignment of HV teams with GP practices and CCs.

Table 1: HV team alignment

<table>
<thead>
<tr>
<th>Team Leader A</th>
<th>BASE</th>
<th>TEAM NAME/HV LOCALITY</th>
<th>WTE HVs</th>
<th>GP PRACTICES</th>
<th>CHILDREN’S CENTRES</th>
<th>DAYS &amp; TIMES OF DROP-IN CLINICS¹</th>
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<tr>
<td></td>
<td>Jubilee Health Centre</td>
<td>Stanley Park</td>
<td>1.2</td>
<td>Shotfield Medical Centre; Beeches Surgery; Carshalton Fields Surgery</td>
<td>Stanley Park</td>
<td>Stanley Park CC (Monday 9.00am to 12.45pm)</td>
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<td></td>
<td></td>
<td>Jubilee/Shotfield</td>
<td>1.7</td>
<td>Maldon Road Surgery; Wallington Family Practice; Park Road Medical Centre</td>
<td></td>
<td>Jubilee Health Centre (Wednesday 9.30am to 1.00pm)</td>
</tr>
<tr>
<td></td>
<td>Amy Johnson/Roundshaw</td>
<td>1.6</td>
<td>Manor Practice; Wallington Medical Centre; Beddington Medical Centre</td>
<td>Amy Johnson; High View; Beddington</td>
<td></td>
<td>Amy Johnson CC (Monday 9.30am to 10.45am); Beddington CC (Thursday 9.30am to 12.30pm)</td>
</tr>
<tr>
<td>Green Wrythe Lane Clinic</td>
<td>Circle</td>
<td>3.2</td>
<td>Green Wrythe Surgery; Faccini House Surgery; Bishopford Road Practice; Sutton Medical Centre</td>
<td>Tweeddale</td>
<td>Green Wrythe Lane Clinic (Wednesday 9.30am to 3.00pm); Tweeddale CC (Friday 9.30am to 1.00pm)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wandle</td>
<td>3.3</td>
<td>Wrythe Green Surgery; Wandle Valley Health Centre; Hackbridge Medical Centre; Chesser Practice</td>
<td>Spencer; Muschamp; Victor Seymour</td>
<td>Muschamp CC (Tuesday 9.30am to 3.00pm); Spencer CC (Thursday 1.00pm to 3.30pm)</td>
<td></td>
</tr>
<tr>
<td>Team Leader B</td>
<td>Priory Crescent Clinic</td>
<td>Green Oak</td>
<td>3.6</td>
<td>GP Centre; Well Court Surgery; Manor Drive (Kingston); Cheam Family Practice</td>
<td>Green Oak Children’s Centre</td>
<td>Green Oak Children’s Centre (Monday 9.30am to 3.30pm)</td>
</tr>
<tr>
<td></td>
<td>Robin Hood Lane</td>
<td>4.3</td>
<td>Robin Hood Lane Health Centre; Grove Road Practice; Mulgrave Road Practice</td>
<td>Thomas Wall</td>
<td>Robin Hood Lane Clinic (Monday 9.30am-2.30pm; Thursday 9.30am to 2.30pm)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manor Park</td>
<td>3.2</td>
<td>Dr Grice and Partners; Benhill &amp; Belmont</td>
<td>Manor Park; Shanklin</td>
<td>Manor Park Children’s Centre (Tuesday 9.00am to 2.30pm)</td>
<td></td>
</tr>
</tbody>
</table>

¹Although clients may choose to attend drop-in clinics within or close to their residential locality, they are free to attend any drop-in clinic across Sutton, as are non-residents of Sutton. Equally Sutton residents may attend drop-in clinics run by other health visiting services.
The formation of the eight HV teams/localities as detailed above was a new development as of 1 January 2015 with the national shift of health visiting services from GP registered to resident population. The realignment of the HV service was complex, and a pragmatic decision was made not to relocate staff, but to devise localities based upon:

- The number of new births in the last three months of 2014;
- Team resource;
- Natural pre-existing boundaries;
- And location of GP surgeries and CCs.

The eight resulting localities are demonstrated in figure 2.

**Figure 2: HV team localities (Source: SMCS)**

Preliminary analysis\(^\text{12}\) by SMCS management and monitoring of new births and caseload in the newly devised localities from January to March 2015 has suggested that caseload is not currently equitably spread. For example, Shotfield, a largely rural community, may have potentially been over-

\(^{12}\) This analysis has not been submitted to LB Sutton but was relayed via personal communication.
allocated resource and other areas with a high caseload (eg, Stanley Park, Robin Hood Lane, Manor Park, Circle, Roundshaw and Wandle) may require more HVs. Thus the current localities as depicted here are subject to change, and are likely to evolve over the coming months.

The workforce of the SMCS health visiting service is depicted in table 2. As previously noted, some existing roles are currently shared across LB Sutton and LB Merton. It should be noted that there is a discrepancy between wte HVs in table 1 and table 2. Information on wte HVs was obtained from SMCS management and the discrepancy may be attributed to the difficulties inherent in delineating the workforce for LB Merton and LB Sutton separately.

Table 2: Workforce of SMCS health visiting service

<table>
<thead>
<tr>
<th>Role</th>
<th>WTE</th>
<th>Band</th>
<th>Split across Sutton and Merton</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Visiting Service Manager</td>
<td>1.0</td>
<td>8a</td>
<td>Yes</td>
</tr>
<tr>
<td>Team Leader</td>
<td>2.0</td>
<td>7</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Manager/Domestic Violence Specialist HV</td>
<td>0.8</td>
<td>8a</td>
<td>Yes</td>
</tr>
<tr>
<td>Named Nurse</td>
<td>1.0</td>
<td>8a</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Supervisor</td>
<td>2.0</td>
<td>7</td>
<td>No</td>
</tr>
<tr>
<td>Specialist HV Haemoglobinopathies</td>
<td>1.0</td>
<td>7</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric Liaison HV</td>
<td>1.0</td>
<td>7</td>
<td>Yes</td>
</tr>
<tr>
<td>Specialist HV Children with Disability</td>
<td>0.6</td>
<td>7</td>
<td>No</td>
</tr>
<tr>
<td>Specialist Practice Teachers (full caseload holding)</td>
<td>1.8</td>
<td>7</td>
<td>No</td>
</tr>
<tr>
<td>Caseload Holding HVs</td>
<td>23.55</td>
<td>6</td>
<td>No</td>
</tr>
<tr>
<td>Community Nursery Nurses</td>
<td>7.70</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Administrative Support</td>
<td>1.0</td>
<td>4</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative Support</td>
<td>4.72</td>
<td>3/4</td>
<td>No</td>
</tr>
</tbody>
</table>

*Post holder is 1.0 wte but the remaining funding is from LB Sutton. The information received has revealed uncertainty as to whether the post is 0.5:0.5 or 0.6:0.4 SMCS:LB Sutton.

5.1.1. Specialist HVs

5.1.1.1. Paediatric Liaison HV

The Paediatric Liaison HV is a nationally recognised role that aims to provide seamless links between acute services and primary care/community services. The Laming Inquiry (2003) recommended that such liaison is critical for safeguarding children. This non-client facing post sits within the Safeguarding Team (see figure 1) and is based at St Helier Hospital, but also covers LB Sutton residents who attend St George’s Hospital.
The role involves triaging all accident and emergency (A&E) attendances of children aged 0-18 years according to local criteria such as (SMCS, 2014):
- Non-accidental injury;
- Suspected abuse;
- Children on a Child Protection Plan (CPP);
- Significant burns or scalds;
- Signs of neglect;
- Parents leaving the department prior to assessment;
- Any history which is inconsistent with injury;
- Self-harm;
- Where A&E staff have expressed concerns.

These attendances are then entered onto the RIO monthly planner in order to notify health visiting teams of the need to follow-up these families. Any urgent safeguarding concerns are telephoned through to the relevant HV team.

The second part of the Paediatric Liaison HV role involves providing a liaison between health visiting, acute paediatric teams and midwifery services. If children who live out of area attend St Helier Hospital, the post-holder liaises with health visiting services in other areas.

The post is currently 1.0 wte across both LB Sutton and LB Merton.

5.1.1.2. Specialist HV for Haemoglobinopathies

Within LB Sutton there is currently a specialist nurse (HV) for haemoglobinopathies that sits within the health visiting service. The post is 1.0 wte split across both LB Sutton and LB Merton, and is based at St Helier Hospital. The post-holder works closely alongside a consultant specialising in haemoglobinopathies, consultant paediatricians and midwifery services.

This specialist HV is notified of positive antenatal screening results for haemoglobinopathies, contacts the families concerned, and also provides genetic counselling. They follow the child from the antenatal period through birth and into childhood. Some of the children on their caseload are older than 5 years of age and approximately half their caseload also includes adults. It is unclear whether these adults have been followed through from childhood or are being referred via other routes as adults.

5.1.1.3. Specialist HV Children with Disabilities

This post is a joint post between SMCS and LB Sutton. There is current uncertainty regarding the specific budget for this post,
but it is thought that either 60% derives from the SMCS budget and 40% from LB Sutton, or 50% from each. The post-holder is 1.0 wte and based within the Early Support Services at LB Sutton in Stonecourt. SMCS and LB Sutton use different caseload systems (RIO and Care First, respectively), but the post-holder can access RIO remotely or via hot desks at Green Wrythe Lane clinic.

The Early Support Service aims to provide advice and support to families where at least one child aged 0-8 years has additional needs or disabilities requiring input from at least two additional specialist services. It is a non-caseload-holding post that historically started as a secondment into the LA as a Key Working Coordinator in 2004 (now known as an Early Support Coordinator). Although the post is non-caseload-holding, the HV does have family contact and undertakes a home visit for all new referrals. Referrals are received via the Early Support referral form or via a Common Assessment Framework (CAF)\textsuperscript{13} form, and can be made by anyone with concerns, such as but not limited to paediatricians, HVs, preschool managers, speech and language therapists. All children who are eligible for the service are included in the CONTACTS system (see below) or a Team Around the Child meeting is held (see below). The aim of both is to produce a multi-disciplinary plan that is regularly reviewed by allied professionals and the family.

Specifically, the post-holder's role encompasses:

a) Co-chair of CONTACTS (Coordination Of Needs Tracking A Child Through Services) group. These are MDT meetings incorporating the family that aim to coordinate and track children's needs to ensure they are accessing the right services in a coordinated manner. A key worker is identified during this process. The specialist HV in this role also represents health at these meetings. The CONTACTS group reviews approximately ten children every two weeks. As of March 2015 there were 116 children in CONTACTS in LB Sutton.

b) Co-chair of Team Around the Child meetings. These meetings are arranged if there are additional needs or concerns not being met by the CONTACTS group. They occur weekly during term time and three children are discussed (in conjunction with their families) at each meeting. As of March 2015 35 children were the subject of Team Around the Child meetings at LB Sutton.

\textsuperscript{13} The CAF allows for the standardised assessment of children and their families in order to promote the early identification of additional needs and to facilitate a coordinated multi-agency response (DfE, 2012).
c) Management of the Key Working scheme. Sutton runs a non-designated scheme whereby anyone working with the child can become their key worker. The key worker is chosen by families and aims to provide emotional and practical support for families, acting as their point of contact. Key workers have in-depth knowledge of the child and their family and this can facilitate the development of a comprehensive MDT plan. Key working is prioritised if children are involved with three or more different specialist services in order to ensure appropriate coordination. As of March 2015 35 children within LB Sutton have a key worker. The efficacy of the scheme for each family is reviewed at Team Around the Child meetings.

d) Sleep services for children aged two to 18 years with disabilities and co-existing sleep problems. The specialist HV is fully accredited by Sleep Scotland and runs morning clinics and home visits with the help of a trained volunteer. As of March 2015, six or seven children are undergoing sleep counselling in LB Sutton, but there is high demand with a nine month waiting list.

e) Parental Early Support Saturday workshops. These are co-delivered by a parent and the specialist HV, and are held as a four week course twice per year at Tweeddale CC. They provide an opportunity for parents to offer peer support and to facilitate understanding of local and national services available. There may be demand to increase this to three times per year, but currently there is not the capacity to do so.

f) Panel member. The current post-holder sits on a panel for allocating short-term respite care within LB Sutton, and also the ICOUNT Register Steering Group. ICOUNT is a voluntary local register which aims to ensure the LA are aware of the prevalence of children with disabilities within the borough, where they live and what services they require.

The Specialist HV for Children with Disabilities encompasses children aged 0-8 years in order to capture the transition of children into school, as this can be an uncertain and problematic time for families with a sudden reduction in support. In addition, the post-holder liaises with schools regarding planning and adaptations required for children with specific health needs. If a family require no additional input, transfer to the school nursing team occurs at five years old but, if additional needs are identified, support is offered until the child is eight years old. Other health visiting teams outside of Sutton (eg, Merton) offer a
different model whereby the role is solely within the health visiting service and is caseload-holding.

5.1.1.4. **Infant Feeding Coordinator**

This post is band 7 0.8 wte shared across both LB Sutton and LB Merton. It is a strategic role, aiming to initiate, maintain and enhance breastfeeding promoting policies throughout the community. Although non-caseload-holding, the HV in post does have telephone contact with parents in a supportive capacity. This role is supported by a 0.4 wte band 3 Breastfeeding Supporter.

The post-holder is currently instrumental in moving SMCS health visiting service towards meeting the UNICEF UK Baby Friendly Initiative standards for health visiting, and SMCS are undertaking their Stage 3 assessment in May 2015.

**5.1.2. Safeguarding within SMCS Health Visiting service**

Safeguarding children can be defined as:

“…[p]rotecting children from maltreatment; preventing impairment of children’s health or development; ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and taking action to enable all children to have the best outcomes” (HM Government, 2015, p5).

A HV literature review revealed that, rather than isolated HV screening contacts, repeated contacts (ideally via home visits) are required in order to identify families about whom there are safeguarding concerns (Cowley et al, 2013). Furthermore they argue that this should be via the universal service given that Serious Case Reviews often report very young children to be the most vulnerable and most at risk of poor outcomes, including death (Cowley et al, 2013).

In order to fulfil their statutory functions under Section 11 of the Children Act 2004 (SMCS, 2013), SMCS have the following safeguarding posts:

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14 The UNICEF UK Baby Friendly initiative (Unicef, 2015) are standards set in place for maternity, neonatal, health visiting and CC services. There are three stages to the assessment process: Creating a foundation (producing written policies and guidelines, auditing and evaluating the standards, and not promoting formula feeding); Educating staff; Reviewing parents’ experiences (helping pregnant women understand the benefits of breastfeeding; supporting women to breastfeed for as long as they require; supporting informed decisions regarding the use of non-breast milk alternatives, and supporting close relationships between parents and child). Meeting these standards is within the 2015-16 National Health Visiting Core Service Specification.
These posts are all currently split across LB Sutton and LB Merton. However, safeguarding is the responsibility of all staff (HM Government, 2015; SMCS, 2013), and thus the responsibility of all members of the health visiting team. As such safeguarding children training is mandatory for all members of staff (SMCS, 2013). All HVs must undergo mandatory safeguarding supervision, as must Specialist Safeguarding supervisors within the Safeguarding Team.

The London Continuum of Need matrix (London Safeguarding Children Board, 2015) is used to guide all professionals across different agencies to establish the level of need for a child. The levels of need map to health visiting service levels as set out in the National Health Visiting Service Specification (NHSE, 2014a):

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>ADDITIONAL NEEDS</th>
<th>ALIGNMENT WITH HEALTH VISITING SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>None identified</td>
<td>Universal services</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Early help required. Low risk/vulnerable. Threshold for initiating a CAF process</td>
<td>Universal Plus services</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Complex multiple needs. Threshold for an assessment required by social care under Section 17 of the Children's Act 1989 (eg, MASH input – see below)</td>
<td>Partnership Plus services</td>
</tr>
<tr>
<td>Tier 4</td>
<td>Acute need. Intensive statutory support required as likely to suffer or are suffering significant harm. Threshold for child protection</td>
<td>Child Protection Plan</td>
</tr>
</tbody>
</table>

The Multi-Agency Safeguarding Hub (MASH) is a single point of referral for all safeguarding and child protection enquiries. LB Sutton MASH incorporates police, social care, probation services, health, education and voluntary services. Anyone (including health visiting staff) with concerns regarding child safety refers the child into MASH via completion of a referral form. If the concern is urgent, this should be preceded (within 24 hours) by a telephone referral. Where possible, consent from the family should be obtained prior to making a MASH referral. Referrals should include a summary of referral reasons, and a Blue-Red-Amber-Green (BRAG) rating15.

15 BRAG rating consists of: blue (no further action); green (action required within 24 hours); amber (action required within six hours); red (action required within two hours).
The health visiting service provides a health navigator within the MASH process, and there is always either a HV or school nurse within MASH. Health navigators sit within the Safeguarding Team and provide cover from Monday to Friday 9am until 5pm\textsuperscript{16}. The model used within SMCS is that seven supervisors (some of whom are from the school nursing service) rotate into the role and cover it as part of a rota. Feedback from stakeholders has suggested that the post should be 1.4 wte in order for annual leave, training and other commitments to be appropriately covered. Splitting the existing service between LB Sutton and LB Merton will result in insufficient capacity to fulfil this role.

The health navigator’s role is to collate information about the family from allied health professionals (GPs, SMCS, St Georges Mental Health Trust, Epsom St Helier, St Georges Acute Trust) for RAG-rated referrals. There are strict information governance requirements, and all agencies who participate must have signed up to and adhere to the Sutton MASH Information Sharing Agreements. Information shared must remain within MASH and should not be shared outside of the process. Limited information regarding the fact a MASH referral has been made may be entered onto RIO, depending upon the rating of the referral.

The MASH team (duty social work manager) determine what (if any) further action is required. Possible outcomes include:

- **Section 47 Enquiry** if a child is suffering or is likely to suffer significant harm. The social worker leads on this assessment and healthcare professionals, including HVs, will be asked to contribute to the assessment. Due to the information governance arrangements surrounding MASH, the same information may need to be resubmitted as part of this process.
- **Single Assessment** undertaken by Children’s Social care in order to determine what services may be of benefit to the child and family. Again, healthcare professionals, including HVs, will be asked to contribute to the assessment and the same information that was provided within MASH may need to be resubmitted.
- **Referral to Early Intervention** such as the Family Intervention Project or Homestart.
- **No further action.**

It is a statutory requirement for the initial referrer into MASH to be informed of the outcome of their referral, but other agencies who have been involved will not be informed.

As well as providing a health navigator, other HVs within the service contribute to the MASH process by collating any information requested by the health navigator, and they may have additional duties depending upon the outcome of the MASH process.

\textsuperscript{16} The post is notionally described as 1.0 wte but must be more to cover periods of leave.
As well as the MASH process, within LB Sutton there are Multi-agency Risk Assessment Conferences (MARAC) which are monthly MDT meetings for sharing information on high risk domestic abuse cases. During these meetings, multi-agency risk management plans are devised for those who are vulnerable. A member of SMCS Safeguarding Team sits on LB Sutton’s MARAC and, in the week prior to the meeting, will research all cases due to be presented. RIO is updated with the relevant information as part of the MARAC process. Other HVs also play a role in that they must make contact with the victim and obtain consent to share information with the GP after MARAC.

If safeguarding concerns are noted during the antenatal period, the HV should undertake a targeted safeguarding visit at 30 weeks gestation (ideally within the home). These referrals are made via the Vulnerable Antenatal Forum, the Paediatric Liaison HV, Social Work teams and/or GPs. The HV should seek consent from the family to share information with the GP and midwives. It is considered best practice for the routine face-to-face antenatal contact in the 2015/16 National Health Visiting Service specification (NHSE, 2014b) to be conducted as a home visit (Cowley, 2015). Repeated home visits have been proposed as a potential means of facilitating the identification of safeguarding concerns (Cowley et al, 2013).

HVs may also be required to participate in Child Protection case conferences which aim to plan how to promote the welfare of the child involved and determine whether a CPP is required. There is a statutory duty for NHS provider organisations to participate in such processes (HM Government, 2015). It is an SMCS workload priority to ensure that someone represents the organisation at all Child Protection case conferences (SMCS, 2013). Notifications of initial case conferences come into the Safeguarding Team via a shared secure inbox, and invitations are then sent to the relevant health visiting team and team manager. If more than one professional is involved with a family (eg, HV and school nurse), only one needs to attend, and a decision should be made regarding who is most appropriate. It is the role of the individual HV (and not the Safeguarding Team) to attend the conferences, unless the case is particularly complex or the HV is newly qualified.

If a child becomes subject to a CPP, a Core Group is convened, consisting of key professionals who take joint responsibility with respect to the CPP. HVs are members of the Core Group if they have children on their caseload who are subject to CPPs, and it is their responsibility to update the Core Group on identified health needs. There are minimum requirements on the number of targeted visits by HVs for children subject to a CPP that are age-dependent. However,

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17 Monthly if the child is <2 years old; six weekly if the child is >2 years old.
individual assessments are required as this may at times need to be more frequent.

According to SMCS Safeguarding Policy, HV attendance at Review Child Protection Case Conferences is required to ensure quoracy of the conference (SMCS, 2013). HVs must also submit reports for each Case Conference, and for each child within a family. These should be prepared in conjunction with other allied health professionals from within SMCS. HVs routinely take case responsibility for all children under five years old subject to safeguarding within LB Sutton (SMCS, 2013). Any children aged under eight years old will remain within the health visiting service remit if they are an only child or if they have younger siblings (SMCS, 2013).

If children for whom there are safeguarding concerns move outside LB Sutton, the existing HV undertakes a verbal telephone handover with the new HV. If a child who is subject to a CPP or Child In Need plan moves into Sutton from elsewhere, the new HV must undertake a home visit ideally within two working days, but no later than five working days.

Looked after children (LAC) fall under the remit of the CCG. Sutton CCG are commissioning a specialist nurse for LAC, with a particular focus upon care leavers given their particular vulnerabilities. There needs to be interdependency and a good relationship between the CCG, HVs and school nurses to help deliver this.

5.2. Sure Start Children’s Centres

The aim of Sure Start CCs are to “…improve outcomes for young children and their families and reduce inequalities, particularly for those families in greatest need of support” (DfE, 2013, p6). Particular outcomes of relevance include those related to child development, school readiness, parenting skills and aspirations, child and family health, and life chances (DfE, p7). CCs deliver community-based services, and are visible and accessible to families who may be less likely to access traditional services (DH, 2009). Statutory guidance stipulates that LAs must attempt to identify prospective parents who are unlikely to engage in early childhood services and encourage them to use the services provided (DfE, 2013). They are managed by or on behalf of the LA and aim to provide integrated early childhood services either on site or via signposting elsewhere (DfE, 2013). Relevant services provided include:

- Early years education and childcare;
- Social services for young children and families;
- Health services for young children and families;
- Training and employment services for parents/prospective parents;
- Information and advice for parents/prospective parents.

Many CCs within Sutton are commissioned to schools to deliver on behalf of the LA, and these CCs have varied structures. The CCs within LB Sutton that
are run by the LA have the ‘preferred’ model of a CC Manager, a Lead Early Years Practitioner, and an administrator. CCs offer a range of services for 0-5 year olds. Within LB Sutton, families must register with CCs.

In order to ensure an integrated service, health services and LAs should share data and information regularly, and this could be facilitated by the development of local agreements or protocols (DfE, 2013). This is one aspect that Ofsted look for during inspection (see below).

CCs should develop links with a range of services, including midwifery, GPs and HVs. Each CC must have a named HV who should work with the management of the CC to ensure appropriate information sharing occurs, and on delivering the 0-5 HCP in collaboration (DfE, 2013).

Section 5A of the Childcare Act 2006 states that LAs must ensure there are enough CCs to meet the needs of the local population and that these are accessible to all families, although there should be some targeting of those with most need (DfE, 2013). There are currently 14 CCs within Sutton split between three localities (see figure 3 and table 3).

Localities were devised in April 2014 on the basis of LSOAs and wards whilst also taking into consideration demographics and transport links. There is current variation in the number of children attached to a CC (eg, Green Oak has 2,604 children versus 658 in Muschamp), but this is due to differences in demographics within an area. Families from outside LB Sutton are free to use CCs within LB Sutton, but some other LAs do prioritise their own residents and may turn LB Sutton residents away.

There is currently a consultation within LB Sutton regarding the future status of CCs in the borough. However, prior to any reorganisation, LB Sutton must demonstrate that this will not adversely impact upon children within Sutton, particularly those with greatest need, and hence “[t]he starting point should…be a presumption against the closure of children’s centres…” (DfE, 2013, p9).

To ensure quality of services provided within CCs, the Childcare Act 2006 stipulates that CCs must undergo Ofsted inspections every five years. These inspections judge how effective a CC is on three key aspects: access to services; quality of services; effectiveness of leadership, governance and management (Ofsted, 2014). After an inspection, LAs must produce a written Action Plan stating their proposed actions in response to the inspection report. In order to achieve a rating of ‘good’, an overall reach\(^\text{18}\) of 65% is required, alongside 65% reach of hard-to-reach or target groups.

\(^{18}\) Reach is defined as one count per child (regardless of the number of times attended) divided by the number of children within the catchment area.
**Figure 3: Location of Children’s Centres and localities**

![Map showing the location of Children's Centres and localities](image)

**Table 3: Children's Centres and localities**

<table>
<thead>
<tr>
<th>Children's Centre Locality</th>
<th>Children's Centres</th>
</tr>
</thead>
</table>
| Green Locality             | *Green Oak Group CC (Stonecot & Worcester Park, and Nonsuch & Cheam)  
Shanklin CC |
| Blue locality              | *Tweeddale CC  
*Muschamp CC  
*Spencer CC  
*Manor Park CC  
Thomas Wall CC |
| Red locality               | *Amy Johnson CC  
High View CC  
*Beddington CC  
*Stanley Park CC  
Victor Seymour CC  
The Grange CC |

*These CCs have HV clinics running from them.

Each CC should also have an Advisory Board (although they may be shared amongst CCs). Chairs of Advisory Boards should be community members or
parents and the Board should be representative of the local community as a whole. Although HVs are not explicitly named within the statutory guidance, there is a requirement for representatives from the health sector to sit on Advisory Boards (DfE, 2013) and, within the National Health Visiting Service specification, a key performance indicator for service delivery is the percentage of Advisory Boards with a HV presence (NHE, 2014b).

5.3. Family Nurse Partnership (FNP)

5.3.1. Background

The FNP is a licensed structured home visiting programme offered on a voluntary basis to first time teenage mothers (DH, 2012a). It was originally developed by Professor David Olds at the University of Colorado (FNP National Unit, 2015a). The programme is delivered by specifically trained family nurses, and provides intensive support to mothers and their families from pregnancy until the child is two years old. This support is achieved via 64\textsuperscript{19} regular structured one to one home visits that last approximately one hour (DH, 2012a; FNP National Unit, 2015b). The three aims of FNP are “...to improve pregnancy outcomes, improve child health and development and improve parents’ economic self-sufficiency” (DH, 2012a, p5).

FNP nurses must have a nursing background with a nursing or midwifery qualification, be registered with the NMC, have a degree or equivalent postgraduate qualification, at least two years’ experience working with families in deprived communities, and two years in public health, home visiting, midwifery or child health. Previous attempts at using less qualified staff as family nurses have resulted in poorer outcomes (Allen, 2011).

The ethos of the FNP programme is enabling the mother and family nurse to build an in-depth therapeutic relationship based upon trust and, furthermore, for the family nurse to model nurturing behaviours in order to facilitate young mothers developing positive relationships with their babies. It is this therapeutic relationship that is fundamental to the programme (Ball et al, 2012; FNP National Unit, 2015b). The idea is to build the mother’s self-esteem and self-efficacy, enabling her to become empowered and look after her family into the future, beyond the FNP programme (FNP National Unit, 2015b). The programme focuses upon positive behaviour change, and builds upon the mother’s inherent motivation to do the best for her child (FNP, 2015). Such outcomes are achieved by employing a range of techniques including behavioural change, motivational interviewing and active learning (Ball et al, 2012). The programme is split into three phases (pregnancy, infancy and toddlerhood) and covers five domains within each (personal health, maternal role, life course, family and friends, environmental health).

\textsuperscript{19} The 64 visits are split into 14 in pregnancy, 28 during infancy and 22 during toddlerhood.
There is a robust evidence base, although the majority of the research emanates from America and is largely based upon three American randomised controlled trials (RCTs). The FNP programme reports positive outcomes in the short-, medium- and long-term, although Ball et al (2012) state there are fewer short-term benefits, which has implications for commissioning. Specifically, American evidence has demonstrated (DH, 2012a):

- Improvements in antenatal health (a reduction in kidney infections and number of cigarettes smoked – Ball et al, 2012);
- Reductions in children’s injuries, neglect and abuse;
- Improvements in parenting practices and behaviour;
- Reduction in subsequent pregnancies and longer intervals between births;
- Improvements in early language development, school readiness and academic achievement (with the largest gain for children of the most vulnerable mothers (Ball et al, 2012));
- Improvements in maternal employment and reductions in welfare use;
- Improvements in fathers’ involvement.

A UK RCT (The Building Blocks RCT) commenced in 2009 looking at approximately 1,600 expectant mothers in 18 areas across England, and is due to publish their findings on the effectiveness and cost-effectiveness of FNP in the UK (FNP National Unit, 2015a). The results are eagerly anticipated in order to demonstrate whether the USA findings are replicable within the UK. For example, it has been suggested that the UK may not see such significant gains in economic welfare given the UK traditionally has more established support systems for families living in poverty (Ball et al, 2012). However, equally, there may be additional outcomes seen in the UK population not evidenced in America (Ball et al, 2012).

Economic evaluations of FNP have also been largely based on findings from America. Conservative estimates of UK economic outcomes suggest that every £1 invested in the programme results in a return of £1.94 (FNP National Unit, 2015b). The economic benefits are thought to be due to crime reduction (although any difference may be reduced beyond the age of 15 years) and a reduction in welfare costs. However, others (eg, Ball et al, 2012) suggest the proposed economic benefits may have been over stated and postulate that more effective targeting is required as, in lower risk families, costs may outweigh benefits. However, even if there are only significant improvements in outcomes for the minority of families, this could still prove cost-effective (Ball et al, 2012). Other potential UK economic benefits include higher earnings and increased tax revenue, lower benefit payments, less conduct disorder, fewer hospital admissions, and less need for foster care (Ball et al, 2012).

The programme is fully licensed in order to ensure ‘fidelity’ with the programme as a means of ensuring promised outcomes are delivered
and achieved (Ball et al, 2012; FNP National Unit, 2015a). It was first rolled out in England in 2006 in ten demonstration sites (Ball et al, 2012; FNP National Unit, 2015a). As of March 2015, the aim is to have 16,000 FNP places in just over 130 LAs delivered by 126 FNP teams, representing coverage of approximately 25% of the eligible population (FNP National Unit, 2015b). Overall there are 900 Family Nurses and Supervisors, all supported by the FNP National Unit which ensures the quality of the service, and organises training, research and development (FNP National Unit, 2015b). Real-time data is captured by the FNP teams and submitted to the National Unit via the NHS Open Exeter information sharing system as part of the licensing agreement.

5.3.2. FNP within Sutton

<table>
<thead>
<tr>
<th>MAXIMUM STAFFING CAPACITY(^{20})</th>
<th>EXISTING STAFFING WITHIN FNP TEAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 x 1.0 wte FNP Supervisor</td>
<td>1 x 1.0 wte FNP Supervisor</td>
</tr>
<tr>
<td>4 x 1.0 wte Family Nurses</td>
<td>2 x 1.0 wte Family Nurses(^{21})</td>
</tr>
<tr>
<td></td>
<td>1 x 0.6 wte Family Nurse due to start</td>
</tr>
<tr>
<td></td>
<td>1 x 0.6 wte vacancy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MAXIMUM CLIENT CAPACITY</th>
<th>EXISTING CLIENTS WITHIN FNP TEAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 clients across Sutton and Merton (48 potential Sutton clients, with five additional clients taken on by the FNP Supervisor, two of whom are from Sutton)</td>
<td>30 clients within Sutton</td>
</tr>
<tr>
<td></td>
<td>20 potential clients on waiting list within Sutton</td>
</tr>
</tbody>
</table>

Mothers-to-be are deemed eligible if they meet the following criteria (SMCS, 2015):
- Aged 19 years or under at last menstrual period;
- First time mothers;
- Less than 28 weeks gestation\(^{22}\);
- Live within LB Sutton or LB Merton;
- Are not planning on having the child adopted.

Notifications into the service are made in a number of ways, often via antenatal record sheets from the Child Health system which have been inputted by midwifery services. Other routes include directly via the FNP website, via school teachers or social workers. All notifications are entered onto the RIO monthly team planner. The FNP team then

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\(^{20}\) Across Sutton and Merton.

\(^{21}\) One is new in post.

\(^{22}\) 60% should be enrolled by 16 weeks gestation.
calculate the gestation of the mother-to-be to ensure they meet the eligibility criteria (see above). If there is capacity to accept another client, the team try to contact the potential client initially via telephone and, if this is not possible, they will send a letter. The mothers-to-be can then refuse or accept an enrolment visit, which is a 15-20 minute home visit informing them about the programme. If the mother-to-be would like to participate, they are then accepted into the service, and an additional visit will be undertaken within the following week.

Within the service there is also administrative support provided by a Data Quality Control Officer. This was previously a 0.6 wte substantive post and 0.4 wte bank post. However, the initial post holder has been seconded elsewhere within SMCS, and now there is a bank staff member performing this role as 1.0 wte. This individual's role involves inputting data onto Open Exeter for submission to the National Unit.

Safeguarding supervision for the nurses is provided on a weekly basis by the FNP Supervisor. Safeguarding supervision is provided to the FNP Supervisor by the Merton Safeguarding Supervisor for SMCS on a monthly and ad hoc basis. The FNP Supervisor is also the Named Nurse for the FNP Team. In addition, the National Unit requires the team has monthly supervisions with a psychologist (FNP, 2015). All staff are also required to undergo training as recommended by the National Unit. For supervisors, this includes Extended Practice Days and Quality Improvement Days (eight days per year) which are important for networking and learning from others.

There are also quarterly FNP Advisory Board (FAB) meetings (see table 4 for FAB membership).

### Table 4: FNP Advisory Board Membership

| Director of Children’s Services, LB Merton (Chair) |
| Director of Children’s Services, LB Sutton (Chair) |
| RM/SMCS Clinical Director of Children’s Services |
| Head of Midwifery, Epsom & St Helier Trust |
| Service Development Lead, FNP National Unit |
| Joint Commissioning Manager, Children & Families, LB Merton |
| Public Health Consultant, LB Merton |
| Service Manager, Early Years, LB Merton |
| RM/SMCS FNP Supervisor |
| RM/SMCS Universal Services Manager |
| RM/SMCS – Designated Nurse |
| Public Health Consultant, LB Sutton |

If clients move out of the area, they stay under the care of the FNP team if they are a LAC who has been relocated due to shortage of accommodation in LB Sutton. However, if they have been transferred to an area too distant to enable the FNP nurse to travel to them, they will be offered a transfer to another more local FNP team. If they are not a LAC, whether they stay under the remit of the FNP team depends upon where
they move to. The National Unit would prefer for a single FNP nurse to follow the client through due to the importance of the therapeutic relationship, but the feasibility of this is at the discretion of the FNP Supervisor. However, this situation is relatively uncommon and the majority of clients remain within LB Sutton.

FNP nurses deliver the HCP to mothers on their caseload, and thus no additional health visiting support is required until the child reaches two years old and is discharged from the care of FNP to the health visiting service.

6. **RESULTS – WHAT IS THE NEED? (EPIDEMIOLOGY)**

6.1. **Background**

The indicators used here in order to provide information in relation to need for health visiting services within LB Sutton are largely derived from the outcomes that the 2015-16 National Health Visiting Core Service Specification states should be improved by effective health visiting (NHSE, 2014b), and also those referred to within the HCP as potentially requiring increased resource allocation (DH, 2009).

6.2. **Demographics**

6.2.1. **Population size**

ONS mid-year population estimates for Sutton in 2013 report the total population to be 195,914. GLA population estimates for 2015, estimate the total population in Sutton to be 201,200 (GLA, 2015). Figure 4 is a population pyramid demonstrating the age and sex structure of the population of LB Sutton as compared to England in 2013. This population pyramid indicates a comparatively high proportion of 0-4 year olds within LB Sutton.

**Figure 4: Population pyramid LB Sutton, 2013. (Source: Godden, 2014)**
Table 5 provides ONS 2013 mid-year population estimates (absolute number and percentage) for 0-5 year olds as single age bands in Sutton as compared to Merton, London and England. All four regions are fairly comparable. LB Sutton was estimated to have 16,322 0-5 year olds in 2013, which represents 8.3% of the total population. This is just higher than the England estimate of 7.6%, but just lower than London (8.8%) and LB Merton (9.1%).

Figure 5 demonstrates that resident population estimates of the 0-4 year population have gradually increased over the past decade. However, while the absolute number of 0-4 year olds has gradually increased, the percentage of the total population which is 0-5 years has remained relatively stable (see figure 6). In 1999 8% of Sutton's population were aged 0-5 years old, compared to 8.3% in 2013. Of the compared regions, Merton has had the biggest percentage increase from 8% to 9.1%.

Table 5: 0-5 years population estimates, 2013. (Source: ONS)

<table>
<thead>
<tr>
<th>AGE BAND (yrs)</th>
<th>SUTTON (%)</th>
<th>MERTON (%)</th>
<th>LONDON (%)</th>
<th>ENGLAND (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2,640 (1.3%)</td>
<td>3,406 (1.7%)</td>
<td>130,172 (1.5%)</td>
<td>676,531 (1.3%)</td>
</tr>
<tr>
<td>1</td>
<td>2,924 (1.5%)</td>
<td>3,400 (1.7%)</td>
<td>132,726 (1.6%)</td>
<td>701,281 (1.3%)</td>
</tr>
<tr>
<td>2</td>
<td>2,715 (1.4%)</td>
<td>3,162 (1.6%)</td>
<td>123,448 (1.5%)</td>
<td>688,777 (1.3%)</td>
</tr>
<tr>
<td>3</td>
<td>2,744 (1.4%)</td>
<td>3,079 (1.5%)</td>
<td>119,104 (1.4%)</td>
<td>678,113 (1.3%)</td>
</tr>
<tr>
<td>4</td>
<td>2,678 (1.4%)</td>
<td>2,779 (1.4%)</td>
<td>115,831 (1.4%)</td>
<td>669,428 (1.2%)</td>
</tr>
<tr>
<td>5</td>
<td>2,621 (1.3%)</td>
<td>2,768 (1.4%)</td>
<td>115,877 (1.4%)</td>
<td>676,035 (1.3%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>16,322 (8.3%)</td>
<td>18,594 (9.1%)</td>
<td>737,158 (8.8%)</td>
<td>4,090,165 (7.6%)</td>
</tr>
</tbody>
</table>

Rounded to 1 decimal place.

Figure 5: Resident population estimates 0-4 years, 2001-2012. (Source: ONS)
Overall, the population of Sutton is projected to increase (see figure 7), and this holds true for the under 5 year old population, which is projected to increase from approximately 13,400 in 2012 to approximately 14,800 in 2022 (see figure 8). Again, as can be seen in figure 9, the increase in the 0-4 years population is in line with an increase in the overall size of the population of LB Sutton, rather than a disproportionate increase in the 0-4 years population specifically. However, from a service perspective, the absolute numbers are more important than percentages. It should also be noted that these projections are estimates and do vary. For example, the latest GLA population projections suggest the 0-4 year population within Sutton was 13,700 in 2012 and will decrease to 12,900 in 2022.

At ward level, based upon 2012 estimates, the highest absolute number of 0-5 year olds live predominantly in the northern areas of LB Sutton, in Wandle Valley (1,218), St Helier (1,187), Worcester Park (1,136) and Sutton Central (1,070). These four wards are also the four highest in terms of percentage of 0-5 year olds living within them (again based upon 2012 estimates), as follows:

- Wandle Valley (10.2%)
- St Helier (9.7%)
- Sutton Central (9.5%)
- Worcester Park (9.3%)

The wards with the fewest numbers of 0-5 year olds are Stonecot (673, 6.3%) and Cheam (650, 6.3%). See figures 10 and 11.
Figure 7: Population projections (all ages), 2012-2037. (Source: ONS)

Figure 8: Population projections (0-4 years), 2012-2022. (Source: ONS 2012-based Subnational Population Projections)
Figure 9: Percentage population projections (0-4 years), 2012-2022. (Source: Godden et al, 2015)

Population projections as percentage of whole population aged 0 to 4 years
(Source: ONS)

<table>
<thead>
<tr>
<th>Year</th>
<th>England</th>
<th>London</th>
<th>Sutton</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>6.3</td>
<td>7.4</td>
<td>6.9</td>
</tr>
<tr>
<td>2013</td>
<td>6.3</td>
<td>7.4</td>
<td>7.0</td>
</tr>
<tr>
<td>2014</td>
<td>6.3</td>
<td>7.4</td>
<td>7.0</td>
</tr>
<tr>
<td>2015</td>
<td>6.3</td>
<td>7.4</td>
<td>7.0</td>
</tr>
<tr>
<td>2016</td>
<td>6.2</td>
<td>7.3</td>
<td>7.1</td>
</tr>
<tr>
<td>2017</td>
<td>6.2</td>
<td>7.3</td>
<td>7.0</td>
</tr>
<tr>
<td>2018</td>
<td>6.2</td>
<td>7.2</td>
<td>6.9</td>
</tr>
<tr>
<td>2019</td>
<td>6.1</td>
<td>7.1</td>
<td>6.9</td>
</tr>
<tr>
<td>2020</td>
<td>6.1</td>
<td>7.1</td>
<td>6.8</td>
</tr>
<tr>
<td>2021</td>
<td>6.1</td>
<td>7.1</td>
<td>6.7</td>
</tr>
<tr>
<td>2022</td>
<td>6.1</td>
<td>7.1</td>
<td></td>
</tr>
</tbody>
</table>

Figure 10: Map of number of children aged 0-5 years by ward in Sutton, 2012. (Source: ONS)
6.2.2. Live births

In 2013 there were 2,629 live births in Sutton, which represents a gradual increase from 2,166 in 2000. However, birth rates have fallen, and 2013 had the lowest birth rate in LB Sutton since 2008 (see figure 12). Figure 13 compares the number of live births in LB Sutton with LB Merton, London and England. It can be seen that, for both LB Sutton and LB Merton, there has been a gradual increase in the number of live births, with the trend appearing to be tailing off in recent years. Both LBs appear to be following the same overall trend as England in terms of live births, with London demonstrating a more static absolute number of live births over the past decade. Figure 14 demonstrates birth projections\textsuperscript{23} from mid 2013 to mid 2022. This indicates that the number of births within Sutton is expected to increase from 2,734 in 2013 to 2,860 in 2022. Thus it should be noted that a proportion of the projected growth in the 0-4 year population is due to migration into the borough.

At ward level, the areas with the highest number of live births in 2013 were as follows: Sutton Central (214 live births), Wandle Valley (213 live births), Worcester Park (193 live births) and St Helier (185 live births).

\textsuperscript{23} Based upon assumed LA age-specific fertility rates.
births). These are also the four wards with the highest numbers and percentages of 0-5 year olds (see figures 15, 10 and 11).

**Figure 12:** Live births in Sutton, 2000-2013. (Source: GLA)

![Live Births in Sutton, 2000-2013](source: GLA)

<table>
<thead>
<tr>
<th>Year</th>
<th>Live Births Sutton &amp; Merton</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>2166</td>
</tr>
<tr>
<td>2001</td>
<td>2090</td>
</tr>
<tr>
<td>2002</td>
<td>2131</td>
</tr>
<tr>
<td>2003</td>
<td>2247</td>
</tr>
<tr>
<td>2004</td>
<td>2220</td>
</tr>
<tr>
<td>2005</td>
<td>2325</td>
</tr>
<tr>
<td>2006</td>
<td>2426</td>
</tr>
<tr>
<td>2007</td>
<td>2568</td>
</tr>
<tr>
<td>2008</td>
<td>2605</td>
</tr>
<tr>
<td>2009</td>
<td>2786</td>
</tr>
<tr>
<td>2010</td>
<td>2675</td>
</tr>
<tr>
<td>2011</td>
<td>2756</td>
</tr>
<tr>
<td>2012</td>
<td>2708</td>
</tr>
<tr>
<td>2013</td>
<td>2629</td>
</tr>
</tbody>
</table>

**Figure 13:** Live births in Sutton, Merton, London & England, 2002-2013. (Source: GLA)

![Live Births Sutton, Merton, London & England, 2002-2013](source: GLA)
Figure 14: Birth projections, Sutton, mid-2013 to mid-2022. (Source: ONS 2012-based Subnational Population Projections)

![Births projections, Sutton, mid-2013 to mid-2022. (Source: ONS)](image)

<table>
<thead>
<tr>
<th>Year</th>
<th>Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2734</td>
</tr>
<tr>
<td>2014</td>
<td>2798</td>
</tr>
<tr>
<td>2015</td>
<td>2815</td>
</tr>
<tr>
<td>2016</td>
<td>2831</td>
</tr>
<tr>
<td>2017</td>
<td>2857</td>
</tr>
<tr>
<td>2018</td>
<td>2860</td>
</tr>
<tr>
<td>2019</td>
<td>2866</td>
</tr>
<tr>
<td>2020</td>
<td>2864</td>
</tr>
<tr>
<td>2021</td>
<td>2862</td>
</tr>
<tr>
<td>2022</td>
<td>2860</td>
</tr>
</tbody>
</table>

Figure 15: Map of number of live births by ward in Sutton, 2013. (Source: ONS)

![Map of number of live births by ward in Sutton, 2013.](image)
6.2.3. Fertility

The crude live birth rate\(^{24}\) in Sutton in 2013, was estimated to be 13.4/1,000 population. Table 6 reveals that this is lower than Merton, outer London and London (16.6, 15.1 and 15.2/1,000, respectively), but higher than the England estimate of 12.3/1,000. The general fertility rate (GFR)\(^{25}\) is a better indicator of fertility rates within an area, as it only includes women of child-bearing age within the denominator. In 2013, the GFR for Sutton was 64/1,000. Table 6 and figure 16 demonstrate how this compares to other LBs within the ‘Thriving London Periphery’ cluster, outer London, London and England. In summary, Sutton ranks around the mid-point GFR compared to other ‘Thriving London Periphery’ areas, and this is lower than the outer London GFR (68.8/1,000), slightly higher than the England GFR (62.4/1,000) but in line with London (64/1,000). Figure 17 shows trends in GFR from 2005 to 2013. The GFR in Sutton has remained relatively stable, as it has for London and England. However, GFR is dependent upon the age structure of the female 15-44 year population, and thus total fertility rate (TFR) should also be considered.

**Table 6: Crude live birth rate, general fertility rate and total fertility rate, based upon mid-2013 population estimates.** (Source: GLA)

<table>
<thead>
<tr>
<th>AREA</th>
<th>CRUDE LIVE BIRTH RATE</th>
<th>GENERAL FERTILITY RATE</th>
<th>TOTAL FERTILITY RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUTTON</td>
<td>13.4</td>
<td>64.0</td>
<td>1.85</td>
</tr>
<tr>
<td>MERTON</td>
<td>16.6</td>
<td>70.9</td>
<td>1.87</td>
</tr>
<tr>
<td>OUTER LONDON</td>
<td>15.1</td>
<td>68.8</td>
<td>1.93</td>
</tr>
<tr>
<td>LONDON</td>
<td>15.2</td>
<td>64.0</td>
<td>1.74</td>
</tr>
<tr>
<td>ENGLAND</td>
<td>12.3</td>
<td>62.4</td>
<td>1.85</td>
</tr>
</tbody>
</table>

The TFR is defined as the average number of live children a group of women would bear if they experienced the age-specific fertility rates of the year in question throughout their childbearing years (GLA, 2014). In 2013, within LB Sutton the TFR was 1.85, which is comparable with England (1.85) and Merton (1.87), but slightly lower than outer London (1.93) (see table 6). Of the LBs within the Thriving London Periphery cluster, LB Sutton had the third highest TFR (see figure 18). It should be noted however that population estimates used for calculation of the TFR are generally only reliable in five year age bands and thus these data may not be wholly reliable (GLA, 2014). The TFR in LB Sutton in 2005 was slightly lower than in 2013 at 1.82. However, in the intervening years there seems to be some fluctuation, with a peak in 2009 of 2.02. England appears to show a similar trend, as does London although the TFR for London has decreased over the past few years to 1.74 in 2013 (see figure 19).

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24 Crude live birth rate encompasses all persons and all ages.
25 GFR is the number of live births per 1,000 women aged 15-44 years.
Figure 16: General fertility rate, 2013. (Source: GLA)

Figure 17: Trend in general fertility rate, 2005-2013. (Source: GLA)
Figure 18: Total fertility rate, 2013. (Source: GLA)

Total Fertility Rate, 2013
(Source: GLA)

Figure 19: Trend in total fertility rate, 2005-2013. (Source: GLA)

Trend in Total Fertility Rate, 2005-2013
(Source: GLA)
6.2.4. Ethnicity

Since the 2001 census, LB Sutton has become more ethnically diverse as. In 2001, 89% of the population were white whereas, by the 2011 census, this had decreased to 79% of the population (source: LB Sutton JSNA, 2015). Figure 20 profiles the ethnicity of Sutton’s population in the 2011 census as compared to London and England. It can be seen that 12% of the population within Sutton were reported to be Asian or Asian British, 5% Black or Black British, and 4% of mixed ethnicity. This is more ethnically diverse than England (85% of the population were reported to be White in the 2011 census) but less so than London (60% White). According to the GLA borough profiles, in 2014 26.4% of Sutton’s population were born abroad and in 2013 23.1% were from Black, Asian and Minority Ethnic (BAME) groups (GLA 2015). The GLA borough profiles (GLA, 2015) also suggest that, in 2011, the three largest migrant populations by country of birth within LB Sutton (in descending order) were the Sri Lankan population, Indian population and Irish population, respectively.

Figure 21 profiles ethnicity at ward level within Sutton from the 2011 census. The four wards with the highest percentage non-White UK ethnic population are Sutton South, Sutton Central, Sutton West and Beddington South. With the exception of Beddington South, these are all areas with relatively high new births and 0-4 year populations (see figures 10, 11 and 15). In fact, within Sutton, Sutton Central had the fourth highest number of births in 2013 and the second most ethnically diverse population. Sutton South and Sutton West also had a relatively high number of new births in 2013.

Figure 22 reveals the ethnicity of the 0-5 years population within Sutton. GLA demographic population projections based upon the 2011 census suggest that, in 2015, the 0-5 years population of LB Sutton is 64% white. Furthermore, the BAME 0-5 years population within LB Sutton is projected to increase steadily over the next five years from just over 6,000 in 2015, to 6,600 in 2020, before tailing off to reach approximately 6,700 in 2025 (see figure 23). Historic trends of the percentage of live births to non-UK born mothers from 2002 until 2012 also indicate a steady increase from 20.7% in 2002 to 38.1% in 2012. This trend is in line with LB Merton and London, although both have a higher percentage (58.2% and 57.4% in 2012, respectively). However, the trend is more marked than for England as a whole (26.7% in 2012) (see figure 24).
Figure 20: Population by ethnic group, all ages. (Source: LB Sutton JSNA, 2015).

<table>
<thead>
<tr>
<th>Percentage in each ethnic group</th>
<th>England</th>
<th>London</th>
<th>Sutton</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>3</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>8</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>Mixed</td>
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<td>4</td>
</tr>
<tr>
<td>White</td>
<td>85</td>
<td>60</td>
<td>79</td>
</tr>
</tbody>
</table>

Figure 21: Ethnicity by ward, Sutton. (Source: LB Sutton JSNA, 2015)
Figure 22: Ethnicity of 0-5 years population, Sutton, 2015. (Source: GLA)

Figure 23: Projected 0-5 years BAME population in Sutton, 2015-2025. (Source: GLA)
6.3. Wider determinants of health

6.3.1. Deprivation

The Index of Multiple Deprivation (IMD) 2010\textsuperscript{26} ranks LB Sutton as 196 of 326 boroughs across England (with one being the most deprived and 326 the least deprived). Within Sutton, the Lower layer Super Output Areas (LSOAs)\textsuperscript{27} in the most deprived quintile across England are within Beddington South, Belmont, Wandle Valley, St Helier and Sutton Central (see figure 25). Incidentally the latter three also rank in the top four wards in Sutton for the number of live births and 0-5 year old population (see figures 10, 11 and 15). However, it should be noted that the IMD is due to be updated in the summer of 2015 and the current status within LB Sutton may have changed.

\textsuperscript{26} The IMD 2010 measures 38 indicators of deprivation across seven domains (income; employment; health and disability; education, skills and training; barriers to housing and services; living environment; crime). These are then weighted and combined to give an overall score, which is then used to rank Lower layer Super Output Areas (LSOAs) in England. (DCLG, 2011).

\textsuperscript{27} LSOAs are areas derived from the census and have, on average, approximately 1,500 residents and 650 households.
The Income Deprivation Affecting Children Index (IDACI) is derived from the English Indices of Deprivation 2010, and looks at income deprivation in children aged under 16 years old (GLA, 2012) (see figure 26). Within LB Sutton, there are three Lower Layer Super Output Areas (LSOAs) within the 10% most income deprived LSOAs in England for children, and these are concentrated in the north and east of the borough - specifically within Wandle Valley and Beddington South. There are 11 areas in the most deprived quintile (within Beddington South, St Helier, Wandle Valley, Belmont, Sutton Central, The Wrythe and Wallington North). However, on the whole, LB Sutton has most LSOAs (24) in the least deprived quintile. However, as with the IMD 2010, these figures may change when they are updated, which is anticipated to be in summer 2015.

---

28 Income deprivation is defined as the proportion of people dependent upon Income Support, Income Based Job Seekers Allowance, Pension Credit, Child Tax Credit, and asylum seekers receiving support (GLA, 2012).
Figure 26: Map of Income Deprivation Affecting Children Index (IDACI), 2010, Sutton. (Source: LB Sutton JSNA, 2015)

Source: The English Indices of Deprivation 2010, Department for Communities and Local Government. Map: ©Crown copyright 2014. All rights reserved. ©1994-2014 ACTIVE Solutions Europe Ltd

More recent data from the GLA borough profile suggests that 16.2% of children in LB Sutton in 2013 lived in out of work families (as compared to 18.9% in outer London, 21.5% in London, and 18.2% in England). Similarly, 15.3% of children lived in low income families in LB Sutton in 2012 (compared to 15.9% in Merton, 23.7% in London and 19.2% in England) (see figure 27). At ward level, the highest percentage of children living in low income families are in Beddington South (28.5%), St Helier (25.8%), Wandle

29 Children are defined as <16 years old.
30 Low income is defined as the proportion of children who live in families who receive Income Support or Income Based Jobseekers Allowance, or tax credits where their income is <60% of UK median income.
Valley (25.3%) and Sutton Central (19.6%) (see figure 28). Except for Sutton Central, these are all higher than the London percentage of 23.7%.

**Figure 27:** Percentage of <16 year olds living in low income families, 2012. (Source: GLA)

**Figure 28:** Percentage of <16 year olds living in low income families by ward, 2012. (Source: GLA)
6.3.2. Lone parent households

At the 2011 census, there were 5,545 lone parent households with dependent 31 children in LB Sutton. Of these, 2,231 (40.2%) were not in employment. 453 (8.2%) of lone parent households had a male parent (8.2%).

6.3.3. Homeless families with dependent children

In LB Sutton in 2011/12, there were 1.6/1,000 families with dependent children classified as homeless 32, which equates to 135 families that financial year (FY). This is not statistically significantly different from the England rate of 1.7/1,000 for the same time period. Figure 29 shows Sutton as compared with its statistical neighbours and England.

Figure 29: Family homelessness per 1,000 households, 2012/13. (Source: ChiMat)

6.4. Maternal and infant health

6.4.1. Teenage pregnancies

According to GLA Borough Profiles, the 2013 teenage conception rate 33 for under 18 year olds in Sutton was 17.8/1,000 (as compared to 21.5/1,000 in outer London, 21.8/1,000 in London and 24.3/1,000 in England) (GLA 2015). Figure 30 compares this to other boroughs within London, and figure 31 compares it more specifically to other

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31 Dependent child is aged 0-15 years or 16-18 years if in full-time education.
32 Homelessness is defined as households eligible for assistance according to the 1996 Housing Act who are unintentionally homeless and in priority need (eg, dependent children or pregnant women).
33 Teenage conception rate is defined as conception in those aged <18 years old per 1,000 female population aged 15-17 years or, for those aged <16 years old, per 1,000 female population aged 13-15 years (GLA, 2015).
Thriving London Periphery boroughs and LB Merton, along with the <16 year old conception rate. Figure 30 shows that, across London, LB Sutton compares fairly favourably on <18 year old teenage conception rate, being in the second lowest quintile within London. Equally, figure 31 demonstrates that LB Sutton is not overtly dissimilar from its statistical neighbours and LB Merton in either <18 year old or <16 year old conception rate. This latter figure also demonstrates that, as with other LBs, the majority of teenage conceptions occur in those aged 16 years and older.

**Figure 30:** Map of teenage conception rate in London, 2013. (Source: GLA Borough Profiles)
Figure 32 reveals that the teenage conception rate since 1998 has decreased in both Sutton and Merton, although there were upsurges in Sutton in 2008 and 2011. England has also seen a decline from 46.6/1,000 in 1998 to 27.7/1,000 in 2012. At ward level, the areas with the highest teenage conception rate for under 18 year olds in 2010-2012 were St Helier, Wandle Valley, The Wrythe, Sutton Central and Wallington North (see figure 33).

Not all conceptions result in a live birth and so figure 34 reveals the percentage of new teenage mothers\(^{34}\) for the FY 2012/13 in Sutton compared to its statistical neighbours and England. LB Sutton had 0.6% of its delivery episodes to mothers under 18 years old which is in line with the majority of its statistical neighbours and less than England which had double that at 1.2%.

---

\(^{34}\) New teenage mothers are defined as the percentage of delivery episodes where the mother is aged under 18 years old.
Figure 32: Teenage conception rate <18 year olds, 1998-2013. (Source: GLA)

![Teenage conception rate graph](image)

Figure 33: Map of conception rates for women aged <18 years old by ward, 2010-2012. (Source: LB Sutton JSNA, 2015)

![Conception rates map](image)
6.4.2. Infant mortality

In LB Sutton from 2011-2013, the infant mortality rate\(^{35}\) was 2.5/1,000 live births. This is the second lowest of the statistical neighbours, and lower than the England rate of 4.1/1,000 over the same time period (see figure 35).

---

\(^{35}\) Rate of infant deaths aged <1 year old per 1,000 live births.
6.4.3. Low birth weight

Figure 36 reveals the percentage of all live births at term\textsuperscript{36} with low birth weight (LBW)\textsuperscript{37} in Sutton as compared to statistical neighbours, London and England. Of the LBs within the Thriving London Periphery, LB Sutton, LB Kingston upon Thames and LB Hillingdon all had 2.9\% of births with LBW in 2012. This compares with an England percentage of 2.8\% and a London percentage of 3.1\%.

Figure 36: Percentage of all live births at term with low birth weight, 2012. (Source: PHOF)

6.5. Health improvement

6.5.1. Smoking in pregnancy

In 2013/14, LB Sutton had higher rates of women smoking at the time of delivery as compared to London, and all other statistical boroughs apart from LB Hillingdon (see figure 37). Specifically, the rate in Sutton was 6.1 women per 100 maternities as compared to 5.1/100 in London. However, in England, the rate was almost double that of Sutton at 12/100. Looking at trends since 2010/11 reveals an increase since 2010/11 when the rates were 5.4/100, although overall the rates have been relatively stable since 2011/12 (see figure 38).

\textsuperscript{36} Term is defined as at least 37 complete weeks.
\textsuperscript{37} Low birth weight is defined as <2500g.
Figure 37: Smoking at time of delivery, 2013/14. (Source: PHOF)

Figure 38: Smoking at time of delivery, 2010/11-2013/14. (Source: PHOF)
6.5.2. Breastfeeding

The Public Health Outcomes Framework (PHOF)\textsuperscript{38} has not published data on the initiation\textsuperscript{39} or maintenance\textsuperscript{40} of breastfeeding for LB Sutton in 2013/14 due to data quality issues. Percentage breastfeeding initiation in England for 2013/14 was 73.9\% and was estimated to be 85.5\% in London. Percentage breastfeeding maintenance in England for 2013/14 was also unpublished due to data quality concerns, but was estimated to be 61.9\% in London.

The latest PHOF estimates are for 2012/13 indicate that LB Sutton had a breastfeeding initiation percentage of 85.5\% (higher than England) and a breastfeeding maintenance percentage of 59.6\% (also higher than England) – see figures 39 and 40. The trend in breastfeeding initiation in Sutton seems to be increasing since 2010/11, but has remained relatively static for breastfeeding maintenance.

Despite the issues with the PHOF data, SMCS have submitted breastfeeding data on the percentage of mothers within Sutton who have fully and/or partially breastfed their babies at 6-8 weeks from 2010 to 2014 (see figure 41). Unfortunately, for 18.1\% of mothers in 2014, breastfeeding status was unknown. The percentage not breastfed in 2014 was 34.5\% which is a downward trend since 2010 when it was 41.3\%. The percentage exclusively breastfed in 2014 was 31.6\% which has remained relatively static since 2010 when it was 29.2\%. Combined fully and/or partially breastfed percentage in 2014 was 47.5\%, which is a slight increase of 3.2\% since 2010.

Figures 42 and 43 show the percentage of babies fully or partially breastfed, or exclusively breastfed at six to eight weeks by LSOA and ward within Sutton, respectively. Both maps reveal wide variation in breastfeeding across Sutton, not only at borough level but also at LSOA level. However, it should also be noted that data were not provided for a fairly high proportion of new mothers. Areas with lower percentages (in dark blue) suggest increased need, and are scattered across particularly the north of the borough.

\textsuperscript{38} The PHOF is produced by Public Health England and provides desired outcomes and indicators in order to understand how public health is being improved and protected within an area.

\textsuperscript{39} Percentage of mothers who breastfeed their babies within the first 48 hours after delivery.

\textsuperscript{40} Percentage of all infants at 6-8 weeks who are partially or totally breastfed.
Figure 39: Percentage of mothers who initiate breastfeeding in first 48 hours after delivery, 2010/11-2012/13. (Source: PHOF)

![Percentage of mothers who initiate breastfeeding in first 48 hours after delivery, 2010/11-2012/13](image)

Figure 40: Percentage of women who partially or totally breastfeed their infants at 6-8 weeks, 2010/11-2012/13. (Source: PHOF)

![Percentage of women who partially or totally breastfeed their infants at 6-8 weeks, 2010/11-2012/13](image)
Figure 41: Breastfeeding status at 6-8 weeks, 2010-2014. (Source: SMCS)

Breastfeeding status at 6-8 weeks, 2010-2014 (Source: SMCS)

Percentage fully breastfed
Percentage partly breastfed
Percentage not breastfed
Percentage with unknown breastfeeding status

Figure 42: Map of percentage of babies who are fully or partially breastfed at 6-8 weeks by LSOA, 2014. (Source: SMCS)

Percentage of babies who are fully or partially breastfed at six to eight weeks by LSOA 2014

Percentage of babies who are fully or partially breastfed at six to eight weeks by LSOA 2014

This map was created by the OS Team on 17/04/2015

Find us on Facebook by searching for (section: OS Team). Follow us Twitter by searching for: (section: OS Team)

Email: geo.terrain@national.gsi.gov.uk

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6.5.3. Obesity

In 2013/14, the prevalence of reception aged children (4-5 years) who were classified as overweight\(^{41}\) in LB Sutton was 19.2%, and 7.4% were classified as obese\(^{42}\) (see figure 44). Both of these were statistically significantly better than the England percentages of 22.5% and 9.5%, respectively, and the London percentages of 23.1% and 10.8%, respectively. For Year 6 children (aged 10-11 years), the prevalence increases, with 33.6% classified as overweight in Sutton, and 17.7% classified as obese. Neither of these is statistically significantly different from either the England percentage of 33.5% and 19.1%, respectively, or the London percentages of 37.6% and 22.4%, respectively. Figure 44 reveals the prevalence of obesity in reception aged children as compared to other statistical neighbours. Figure 45 reveals trends in the prevalence of obesity in this age group and it can be seen that there has been a decline in Sutton since 2006/07 when the prevalence was 10.9% and, at that point, was much closer to the prevalence in London as a whole.

At ward level, the prevalence of excess weight and obesity at reception age in 2010-2013 varied from 14.1% (Nonsuch) to 25.7% (St Helier)

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\(^{41}\) Definition of overweight includes obese. Overweight is defined as Body Mass Index (BMI) on or above 85\(^{th}\) centile of British 1990 growth reference (UK90) according to age and sex.

\(^{42}\) Obese if BMI above 95\(^{th}\) centile of British 1990 growth reference (UK90) according to age and sex.
(see figure 46). The four wards with the highest prevalence were St Helier (25.7%), Wandle Valley (23.1%), Sutton Central (21.9%) and Worcester Park (21.7%). This is also demonstrated graphically on the map in figure 47. The wards with the highest prevalence of obesity overlap with the wards with the highest levels of deprivation, as indicated by a moderately negative correlation between the two indicators (see figure 48).

**Figure 44: Prevalence of obesity in reception aged children, 2013-14.**
(Source: NCMP)

![Graph of prevalence of obesity in reception aged children, 2013-14.](image1)

**Figure 45: Prevalence of obesity at reception age, 2006/07-2013/14.**
(Source: NCMP)

![Graph of prevalence of obesity at reception age, 2006/07-2013/14.](image2)
Figure 46: Prevalence of excess weight and obesity at reception age, 2010-2013. (Source: NCMP)

![Bar chart showing prevalence of excess weight and obesity at reception age, 2010-2013.](image)

Figure 47: Map of percentage of children with excess weight at reception age by ward, 2010/11-2012/13. (Source: LB Sutton JSNA, 2015)

![Map showing percentage of children with excess weight by ward, 2010/11-2012/13.](image)

% excess weight ▄ % obese ▄ Sutton % excess weight including obese
6.5.4. Parents in treatment for drug or alcohol misuse

Figure 49 shows the rates\(^{43}\) of parents who are attending treatment for substance misuse or alcohol, who live with their child or children. For both indicators, LB Sutton has higher rates than its statistical neighbours. In 2012/13 there were 151.1/100,000 parents receiving treatment for drug misuse. This is a large increase from 2011/12 when there were 96.9/100,000, and is also higher than the England rate of 107.4/100,000. For parents receiving treatment for alcohol misuse, the rates in LB Sutton were 184.4/100,000 in 2012/13, which is similar to 2011/12 when the rate was 178/100,000, but higher than the England rate of 145.9/100,000. The reasons why Sutton appears to have higher rates of parents receiving treatment for drug or alcohol misuse have not been elucidated and should be explored further. However, it should be considered that higher rates of parents receiving treatment may indicate good access to services and/or high data capture rather than higher rates of misuse per se.

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\(^{43}\) Rate per 100,000 children aged 0-15 years in the area.
6.6. Health protection

6.6.1. Childhood immunisations

The NHS immunisation schedule incorporates a range of different immunisations scheduled to be administered at different times during a child’s life. Two such examples are the Measles, Mumps and Rubella (MMR) vaccination which is given in a two dose schedule at 12-13 months and again at three years and four months or soon after, and the 5-in-1 diptheria, tetanus, pertussis, polio and Haemophilus influenza type b (DTaP/IPV/Hib) vaccine which is given at two months, three months and four months (NHS Choices, 2014). Adequate vaccination coverage in a population is important for ensuring herd immunity and preventing communicable disease outbreaks in susceptible populations.

The benchmark for achieving coverage with both of the vaccines above is 90%. Public Health England (PHE) has set vaccination coverage targets of at least 90% locally, with an aspiration of 95% coverage to be achieved nationally to ensure herd immunity for some childhood communicable diseases. In 2013/14 within Sutton, 87.9% (95% confidence interval (CI) 86.6-89.1%) of children received their first dose
of MMR by the time they were two years old\textsuperscript{44}. This is below the England level of 92.7\% but just above the London level of 87.4\%, and statistically significantly lower than the benchmarking criteria of 90\%. For achieving two doses of MMR by aged five years, LB Sutton performs even worse (80\%, 95\% CI 78.5-81.5\%) and thus, again, statistically significantly lower than the benchmarking criteria of 90\%. Comparisons with other statistical neighbours are made in figures 50 and 51.

Figures 52 and 53 demonstrate the trend in these two indicators from 2010/11 until 2013/14 and show that, for coverage of first dose by two years old, the percentage coverage has increased from 81.6\% to 87.9\% and, for coverage of two doses by five years old, despite a dip in 2012/13, the percentage has remained static (79.8\% and 80\%, respectively).

Figure 54 reveals the percentage coverage of a completed primary course (three doses) of DTap/IPV/Hib by two years old in 2013/14. It can be seen that LB Sutton has the second lowest coverage of 87.1\% (95\% CI 85.8-88.3\%), with LB Merton having the lowest with 86\%. Thus Sutton is statistically significantly lower than the benchmarking criteria of 90\%. Coverage across London was 93.1\% and 96.1\% in England. Figure 55 reveals trends in this indicator from 2010/11 until 2013/14 and shows there has been an ongoing decline in coverage since 2010/11 when the percentage was 91.8\%. In comparison, coverage in England has remained relatively static over the same time period.

\textbf{Figure 50: Percentage of children receiving first dose of MMR by 2 years old, FY 2013/14. (Source: PHOF)}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{percentage_first_dose_mmr}
\caption{Percentage of children receiving first dose of MMR by 2 years old, FY 2013/14. (Source: PHOF)}
\end{figure}

\textsuperscript{44} Percentage receiving first dose of MMR by two years is defined as percentage of children who received one dose of MMR on or after their first birthday, and at any time up until their second birthday.
Figure 51: Percentage of children receiving two doses of MMR by 5 years old, FY 2013/14. (Source: PHOF)

Figure 52: Percentage coverage one dose MMR by 2 years old, 2010/11-2013/14. (Source: PHOF)
Figure 53: Percentage coverage two doses MMR by 5 years old, 2010/11-2013/14. (Source: PHOF)

Figure 54: Percentage coverage completed course of DTap/IPV/Hib by 2 years old, 2013/14. (Source: PHOF)
6.7. Child development

6.7.1. School readiness

In 2013/14, 59.6% (95% CI 57.7-61.5%) of children at the end of reception within LB Sutton achieved a good level of development\textsuperscript{45} (see figure 56). Out of the six statistical neighbours (including LB Merton) utilised here, LB Sutton is fifth (LB Bromley is highest with 67.2% and LB Hillingdon is the lowest with 52.5%). LB Sutton is just lower than the percentage across England (60.4%), and lower than the percentage across London (62.2%), although differences are not statistically significant. However, this does represent an improvement since 2012/13 when Sutton achieved 40.8% on this indicator. Figure 57 also shows the percentage of children achieving a good level of development at the end of reception in 2013/14 who also have free school meal status. In this indicator, LB Sutton achieved 40.4%, which is lower than that achieved in London (52.3%) and England (44.8%), but not statistically significantly different.

\textsuperscript{45} A good level of development is achieving at least the expected level in the early learning goals within personal, social and emotional development; physical development; communication and language; mathematics; and literacy.
Figure 56: Percentage of children achieving a good level of development at the end of reception, 2013/14. (Source: PHOF)

Figure 57: Percentage of children with free school meal status achieving a good level of development at the end of reception, 2013/14 (Source: PHOF)
6.8. Healthcare

6.8.1. Accident and Emergency attendances

In comparison to other statistical neighbours and to England, LB Sutton has a relatively high accident and emergency (A&E) attendance rate in the 0-4 years population (see figure 58). In 2011/12, there were 733.8/1,000 0-4 year olds who attended A&E. This compares with England as a whole which had 510.8/1,000 over the same time period.

Figure 58: A&E attendance rate 0-4 years, 2011/12. (Source: ChiMat)

6.8.2. Hospital admissions due to unintentional and deliberate injuries

As with A&E attendances, LB Sutton has the highest rate of hospital admissions due to unintentional and deliberate injuries in the 0-4 years old population (see figure 59). In 2012/13 the rate was 133.3/10,000. This was just below the England rate of 134.7/100,000, but higher than the London rate of 104.9/100,000.
6.9. Children with disabilities

It is difficult to accurately identify the children within Sutton who have disabilities as there is no accurate objective register of all such children (LB Sutton JSNA, 2015). One way this can be estimated is via self-reported activity limitation. In the 2011 census, 3.4% of the 0-15 year population within LB Sutton reported that their activity was limited a lot (1.4%) or a little (2%). This was the third highest amongst LB Sutton’s statistical neighbours, and was equivalent to London (3.4%) but slightly lower than England (3.7%) (see figure 60). However, this is obviously self-reported data and, as such, is subject to bias.

Figure 60: Prevalence of activity limitation 0-15 years, 2011 (Source: ONS)

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*aUsing age-specific and not age-standardised rates.*
An alternative means of estimating the prevalence of children with disabilities within Sutton is via ICOUNT, the statutory register within LB Sutton, but this is voluntary and incomplete (LB Sutton JSNA, 2015). Potentially the most objective estimate that can be used is the register of children with statements of Special Educational Needs (SEN)\textsuperscript{46}, although this too has methodological constraints as it only provides information about those children who require additional support in the context of education, and not necessarily all children with disabilities, and can be subjective (LB Sutton JSNA, 2015).

In 2014 there were just over 1,080 children with a statement of SEN in Sutton (see figure 61). Over the preceding ten years there have been fluctuations in these numbers, from approximately 1,070 in 2006 to approximately 1,125 in 2010 at its peak. Figure 62 reveals the subcategories within the statements of SEN from 2005 until 2014, and table 7 shows the absolute and percentage change over the past decade. Both of these figures demonstrate that there have been the biggest increases in Autistic Spectrum Disorder (ASD) (104% increase in ten years), and profound and multiple learning disabilities (21% increase in ten years), although some of these changes may be due to increased awareness and diagnoses, including changing thresholds (LB Sutton JSNA, 2015). The three most prevalent primary special needs in absolute terms in 2014 were ASD (319 children), speech, language and communication issues (229 children), and moderate learning disabilities (150 children). It has been crudely estimated within LB Sutton that future need for statements of SEN may increase by approximately one third to approximately 1,440 children by 2020 (LB Sutton JSNA, 2015).

Figure 61: Number of children with a statement of SEN in Sutton, 2005-2014. (Source: LB Sutton JSNA, 2015).

\textsuperscript{46} The Children and Families Act (2014) contains changes to support children and young people with SEN, whereby Education, Health and Care (EHC) plans will be used instead of SEN statements.
Figure 62: Numbers of children and young people with statements of SEN, Sutton, 2005-2014. (Source: LB Sutton JSNA, 2015)

Table 7: Changes in numbers and percentages of children with subcategories of SEN (Source: LB Sutton JSNA, 2015)

<table>
<thead>
<tr>
<th>Prime Special Need</th>
<th>Numbers of children, 2014</th>
<th>change over 10 years/children</th>
<th>% change in numbers of children over 10 years</th>
</tr>
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<tbody>
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<td>-25</td>
<td>-32%</td>
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<tr>
<td>Moderate LD</td>
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<td>-120</td>
<td>-44%</td>
</tr>
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<td>Severe LD</td>
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<td>-28%</td>
</tr>
<tr>
<td>Profound &amp; Multiple LD</td>
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<td>8</td>
<td>21%</td>
</tr>
<tr>
<td>Speech, Language &amp; Comm</td>
<td>229</td>
<td>24</td>
<td>12%</td>
</tr>
<tr>
<td>Autistic Spectrum Disorder</td>
<td>319</td>
<td>163</td>
<td>104%</td>
</tr>
<tr>
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<td>-7%</td>
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</tr>
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<td>Other</td>
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</tr>
<tr>
<td>Total</td>
<td>1087</td>
<td>9</td>
<td>1%</td>
</tr>
</tbody>
</table>
6.10. Safeguarding (vulnerable children)

6.10.1. Looked after children (LAC)

In LB Sutton in 2014 there were 45/10,000 children classified as LAC (compared to 48 in outer London, 54 in London and 60 in England. This represents an actual number of 200 LAC in Sutton in 2014 (compared to 170 the previous year, and 155 in 2005). These rates (from 2005-2014) are depicted in figure 63 which demonstrates that rates of LAC within LB Sutton are increasing. In comparison, rates in other areas appear to be decreasing, apart from England as a whole which is rather static.

Figure 63: Rates of LAC, 2005-2014. (Source: GLA)

6.10.2. Child protection plans (CPP)

Figure 64 shows rates of children who were subject to a CPP from 2005 to 2014 in LB Sutton as compared to LB Merton, London and England. In 2014, LB Sutton had the highest rate of children subject to a CPP in comparison to these other areas (with a rate of 55/10,000 children aged <18 years). This compares to a rate of 37/10,000 in London and 42/10,000 in England. Figure 64 suggests that rates are increasing within LB Sutton.
6.10.3. Health of vulnerable children

Figure 65 reveals the proportion of children in care for at least 12 months whose immunisations were up to date in 2013. Within LB Sutton 90.9% of these children had up to date immunisations (higher than London (76.5%) and England (83.2%)).

As of 31 March 2014, there were 115 children looked after continuously in Sutton for at least 12 months and, of these:
- 110/115 (95.7%) were up-to-date with their immunisations.
- 110/115 (95.7%) had their teeth checked by a dentist.
- 115/115 (100%) had their annual health assessment completed.

As of 31 March 2014, 20 of these 115 children (17.4%) were aged five years or under. All 20 of these (100%) had their developmental assessments up-to-date.

Figure 65: Proportion of children in care for at least 12 months whose immunisations are up to date, 2013. (Source: DfE)
7. RESULTS – PERFORMANCE

7.1. Health Visiting Service

The performance of the health visiting service was based upon activity data submitted by SMCS to LB Sutton. The provider performance framework report within the national service specification does not set targets for indicators, suggesting these should be approved via local agreement. A HNA for LB Richmond in 2013 detailed targets for some of these indicators and thus, where provided, these have been illustrated for comparison purposes.

Figure 66 demonstrates the percentage of babies who received a new birth visit (NBV) from a HV within 14 days of birth between 2010 and 2014. This demonstrates that percentages have remained fairly static over time and, in 2014, 82.3% of babies received a NBV within 14 days. The target set by LB Richmond according to their 2013 HNA is 95%. It is unclear why Sutton is achieving fewer than this, but it may be at least in part due to difficulties in seeing all new mothers and babies within the allotted 14 days as, for example, some may remain in hospital and others may go and stay with relatives for a period after the birth. This probably needs further analysis to determine why the indicator was not achieved for 17.7% of new births.

Figure 66: Percentage of babies receiving a new birth visit from a HV within 14 days of birth, 2010-2014. (Source: SMCS)

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The data were resubmitted three times over a three month period to LB Sutton and, each time, as a result of data quality checking by SMCS, the activity data reported were slightly different. The graphs are based upon the latest data submitted but the maps are based upon the first set of data submitted, and thus there are slight discrepancies between them. These differences were most pronounced for the 2.5 year review data, and thus the maps should be interpreted with caution.
In 2014, 86.8% of babies received a 6-8 week review by a HV. Again, this has remained relatively static since 2010 (see figure 67). No targets were set by LB Richmond within their HNA for this indicator, but SMCS management suggested a target of approximately 90% may be realistic and achievable. Data were also submitted on the percentage who were invited to and received a six to 12 month review. This is a service delivery target within the service specification and is probably trying to capture the review by nine months and 30 days referred to in the 2014/15 national service specification (NHSE, 2014a). Figure 68 demonstrates the percentage invited, and those who were reviewed. It can be seen that, in 2014, 89.5% were invited to a review and, of these 65.21% received a review. This is an increase in percentage invited from previous years (eg, 83.2% in 2010) but fewer are accepting the review (eg, 79.4% in 2010). The reason for this reduction in numbers accepting the review needs to be explored further. It should also be noted that, within LB Richmond, the target set for receiving the review is 80%.

Figures 69 and 70 reveal the data referring to the six to 12 month review in map format. Specifically, figure 70 is looking at percentage of infants invited to this review by LSOA and figure 71 is looking at percentage of infants who received this review by LSOA. Areas in dark blue represent areas of higher need (ie, lower percentages invited to and receiving their review). These maps reveal that the wards of Nonsuch, Worcester Park and part of Carshalton South and Clockhouse seem to have a lower percentage both being invited and receiving the 6-12 month review. In addition, parts of Beddington South, Cheam, the centre of Sutton and Beddington North appear to have a higher percentage of invites but a lower percentage of uptake. These discrepancies need to be explored further as a concern would be that those in most need may be less likely to take up the review.

**Figure 67: Percentage receiving 6-8 week review from a HV, 2010-2014.**
(Source: SMCS)
Figure 68: Percentage invited to and receiving 6-12 month review, 2010-2014. (Source: SMCS)

Figure 69: Map of percentage of infants invited to take up a 6-12 month review by LSOA, 2014. (Source: SMCS)
The 2.5 year review is a new requirement of the universal service as of the 2014/15 service specification. Sutton and Merton were designated an EIS for the two year review (DH, 2012b). Prior to this, the historical uptake across both boroughs was approximately 4%, and the review was only offered to those on an enhanced service (DH, 2012b). Thus the data submitted from SMCS pertaining to this review are only since 2013. In 2014, 85.5% were invited to attend the review and, of these, 55.8% accepted the offer and received the review (see figure 71). This is a substantial increase from 2013, but the review is still in its relative infancy. Figure 71 also reveals the 70% target set out in the HNA of LB Richmond, which is for percentage receiving the review. Also of note is the fact that SMCS management suggest a target of 75% may be realistic and achievable.

Figures 72 and 73 map uptake of the 2.5 year review by LSOA in 2014. Figure 72 reveals the percentage invited to the review and areas with LSOAs with low percentages include Nonsuch, Worcester Park, Cheam, Beddington North and Carshalton South and Clockhouse. Perhaps unsurprisingly these also correspond with areas of low percentages receiving the review, but uptake seems particularly poor in Beddington North, and there are also parts of the centre of Sutton which have poor uptake. As noted previously, the maps were based upon data submitted in January 2015 and there has been some data cleaning since then. Thus the maps should be treated with caution, but do reveal areas where further analyses could prove useful in determining the reasons behind low uptake. Further, interestingly, neither maps of uptake of development reviews (figures 70 and 73) clearly align with...
maps of deprivation, births or 0-4 years population within Sutton (see figures 10, 11 and 15).

**Figure 71: Percentage invited and receiving 2.5 year review, 2013-14.**
(Source: SMCS)

![Percentage invited and receiving 2.5 year review, 2013-2014](chart1)

**Figure 72: Percentage of children invited to take up a 2.5 year review by LSOA, 2014.**
(Source: SMCS)

![Percentage of Children Invited to take up a 2.5 Year Review by LSOA](chart2)
SMCS also submitted data on percentage of achieved contacts that are non-face-to-face from 2010 to 2014 (see figure 74). This reveals that the majority of contacts within the health visiting service are face-to-face (92.2% in 2014). Figure 75 demonstrates the percentage of families who had a CC promoted to them either by 14 days or at their NBV. In 2014, the figures were 43.3% and 52.7% respectively. It can be seen from figure 75 that there has been wide variation in this activity since 2010, with a particular low in 2013 of 8.6% and 6.9% respectively. The reasons behind this variation are unclear and the relatively low figures need to be explored further to determine whether this is a data issue.

In terms of safeguarding and enhanced caseloads, 4.6% of the total health visiting caseload were receiving an enhanced service within 2014 (see figure 76). This has remained relatively static since 2010. Figure 77 reveals the composition of the enhanced caseload from 2011 to 2014. Proportionally there has been more than a doubling of the percentage of children on an enhanced caseload who are subject to a CPP from 6.9% in 2011 to 15.1 in 2014%. There are also increases in LAC as a percentage of the enhanced caseload from 2.9% in 2011 to 4.6% in 2014.
Figure 74: Percentage of achieved contacts that are non-face-to-face, 2010-2014. (Source: SMCS)

Figure 75: Percentage of families to whom a CC was promoted by 14 days or by NBV, 2010-2014. (Source: SMCS)
Figure 76: Percentage of total HV caseload on an enhanced caseload, 2010-2014. (Source: SMCS)

![Percentage of total HV caseload on an enhanced caseload, 2010-2014](image)

Figure 77: Enhanced caseload composition, 2011-2014. (Source: SMCS)

![Enhanced caseload composition, 2011-2014](image)
7.2. FNP

The following data has been requested from the FNP service:

- Total number of referrals (Sutton Vs Merton)
- Number of eligible clients (Sutton Vs Merton)
- Number who accept the service (Sutton Vs Merton)
- Number who drop out (Sutton Vs Merton) and whether this is in the antenatal/infant/toddler period.

Of clients enrolled in the service in Sutton alone:

- Age at enrolment
- Ethnicity
- Ward where they live
- Smoking status
- Employment status
- Safeguarding involvement.

The FNP team are retrieving the data for this report but this has not yet been received at the time of writing.

8. RESULTS – STAKEHOLDER AND CLIENT VIEWS

8.1. Health Visiting

8.1.1. Health visiting focus groups and stakeholder interviews

Two focus groups were held in January 2015 with the health visiting team, excluding senior management. In total, 32 people attended the two focus groups (15 on day one and 17 on day two). The groups comprised 28 HVs (including specialist HVs and Team Leaders), representation from FNP, and four community nursery nurses (CNNs). The average age was 48 years (range 30 to 63 years)\(^{48}\) and all attendees were female. Focus groups were audio-recorded and transcribed, and analysis was conducted using the framework approach\(^{49}\) (Pope et al, 2000).

The other stakeholders were interviewed individually either in person or over the telephone, with notes made by hand. A list of these interviewees is in table 8.

\(^{48}\) Four declined to answer this question.

\(^{49}\) The five stages of the framework approach to qualitative analysis are: familiarisation with the data; identification of a thematic framework; indexing the data; charting the data; mapping and interpretation of the data (Pope et al, 2000).
Table 8: List of stakeholders interviewed

<table>
<thead>
<tr>
<th>Interviews with other stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair, Sutton Clinical Commissioning Group (CCG), and Sutton GP</td>
</tr>
<tr>
<td>Designated Nurse Safeguarding Children and Adults, Sutton CCG</td>
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<tr>
<td>Family Information and Development Manager, Children Young People and Learning Directorate, LB Sutton</td>
</tr>
<tr>
<td>FNP Supervisor/Service Manager, SMCS</td>
</tr>
<tr>
<td>Lead Midwife for Antenatal &amp; Community Midwifery Services, Epsom &amp; St Helier University Hospitals NHS Trust</td>
</tr>
<tr>
<td>Public Health and Children’s Information Manager, SMCS</td>
</tr>
<tr>
<td>Universal Services Manager, SMCS</td>
</tr>
</tbody>
</table>

8.1.1.1. Role of the HV

Overall, key themes that emerged regarding the role of the HV were: Delivering the HCP; Prevention; Supporting parents and families; Identifying needs.

These are listed in more detail in table 9.

Table 9: Key themes on the role of the HV

<table>
<thead>
<tr>
<th>Key themes on the role of the HV</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivering the HCP</td>
<td>Promoting immunisations</td>
</tr>
<tr>
<td></td>
<td>Promoting breastfeeding</td>
</tr>
<tr>
<td></td>
<td>Health promotion</td>
</tr>
<tr>
<td>Prevention</td>
<td>“Being proactive rather than reactive”</td>
</tr>
<tr>
<td></td>
<td>“…I think health visiting is all about prevention and building a relationship with a family and you just feel you can’t do that so well anymore”</td>
</tr>
<tr>
<td>Supporting parents and families</td>
<td>Positive parenting; attachment parenting</td>
</tr>
<tr>
<td></td>
<td>“Work with families to try and support them”</td>
</tr>
<tr>
<td></td>
<td>“Using their strengths as a family”</td>
</tr>
<tr>
<td></td>
<td>“…that’s what makes us HVs, that’s what makes us different from other services, that we have that relationship”</td>
</tr>
<tr>
<td>Empowering clients</td>
<td></td>
</tr>
<tr>
<td>Identifying needs</td>
<td>“Looking for deviations from normal practice”</td>
</tr>
<tr>
<td></td>
<td>Targeted health needs</td>
</tr>
</tbody>
</table>
8.1.1.2. Corporate caseload

A recurring theme was that health visiting had shifted towards more of a business approach in which HVs were working in corporate teams and where it was additionally important to look at data and demonstrate efficiencies. Specifically it was noted that it was:

“Increasingly necessary to demonstrate what we do.”

Another individual commented that:

“I think we accept that there’s a change in the culture in that we have to prove our worth. It’s just the method of doing that is causing all of us problems really…”

It was felt that there was some interference with the role of the HV in that it was:

“…more of a business model and because we are seeing so many different clients.”

Specific negative themes that emerged when discussing corporate caseloads were a loss of continuity, covering large areas (in terms of both population and distance) and a loss of control. However it was noted that corporate working was not necessarily all bad, and that there were positives such as the provision of a more equitable and even workload, working within a team, and opportunities.

Loss of continuity

This was the biggest issue in terms of a move towards a more corporate caseload, and has also been suggested within the health visiting literature (eg, Cowley et al, 2013).

“We used to have defined caseloads as well, I think corporate has made a change. So everybody actually knew and had the opportunity to develop relationships with families on that basis and if they went away they got a colleague to cover…[now] [y]ou’re on a rota to cover clinics, they can be mornings or afternoons, so you can’t say to somebody, I’m always in the Monday morning clinic, please come and see me there, so we just lose that opportunity for that.”

“Whereas you used to be able to say, oh I know her…I’ll see her at clinic, let’s catch her on the way home…because people…especially harder to reach families…they’re going to trust perhaps someone that they have seen before…and you
might... have a better chance of a decent outcome for that child I think.”

Thus two of the biggest concerns associated with this loss of continuity were a reduction in efficiencies and also potential safeguarding concerns:

“And also with not having relationships like we used to, we can’t pick up the conversation where it was last left. If you don’t ask the right pertinent questions, you might waste a lot of time faffing around the edges, before you get to know somebody because you don’t know what their history is.”

“I think because you don’t know the clients, if you’ve got somebody that comes into a base where you haven’t got access to their records, there can be safeguarding issues, you can miss things…”

Covering large areas (population and distance)
The move towards a corporate caseload was acknowledged to mean that HVs and teams are seeing clients from all over the borough in drop-in clinics, and that many of these will be individuals that the HVs and CNNs do not know.

Loss of control
A theme was that there was a general reduction in control and loss of autonomy over the working week with the introduction of rotas for clinics and fixed appointments for developmental reviews, and that this resulted in a:

“Definite loss of autonomy I think, to some extent.”

“And the set sessions, obviously they also...impact on that because we haven’t got the freedom so much now in our diaries to be able to...what we feel is prioritising our caseload...I’m not talking about safeguarding because we have to prioritise that, but all the rest of the stuff. You know...years ago, if I felt that a certain family needed a little bit more input, it was okay to go and do a few more home visits. We couldn’t do that now.”

“I feel like that we are not allowed to think anymore, you know, we can’t think at all, we have to react. It’s a reactive world we are living in at the moment, not a thinking world so.”

Equitable workload
On a positive note it was felt that a corporate caseload had been crucial in evening out the workload:
"Also, the work can be divided up very evenly because in the past there have been situations where you've had people on their knees and people with less work...so you can spread things out more evenly. If you're particularly heavy, or have particular problems working with a family, you can say, right...I've done that for the last five years, maybe that's your chance to give it a go."

**Working within a team**

One comment was that working in a team with individuals of different strengths was beneficial.

**Opportunities**

One comment noted that there were more opportunities provided for students within the current system.

### 8.1.1.3. Shift from registered to resident population

It was recognised by members of the focus groups that working on the basis of the resident population was how services used to be delivered many years ago. Many felt that the shift had resulted in net gains of children onto the caseload within Sutton, with obvious resultant issues in relation to workload:

"There was a significant difference in what was transferred out from what was received in. So received in was disproportionately higher. So actually, for the ladies in this room, that does have an impact for them, because they've actually, the move to geographical has increased their workload, when they're already stretched probably."

"So there has been a big influx of clients, which we've seen in the local child health clinics already."

Another comment was that the shift to resident population may negatively impact upon liaison with GPs, although one individual commented that it could be used as an opportunity to look at local pressures unique to different teams and devise local solutions, although it was felt there probably was insufficient time to do this effectively. One individual felt that it merely represented a different way of working and had no specific concerns.

Other stakeholders felt the move from registered to resident population was not a good idea, and may be more beneficial for rural areas rather than urban areas such as Sutton. Regarding the named HV per GP practice, there was the feeling that this individual should know the clients attached to the practice rather than being solely a link HV. It was felt that this move may serve to increase the sense that the service is becoming more reactive.
rather than proactive and preventive. There was also the view that it would be important to have a telephone number for the link HV and not just a generic email address.

8.1.4. Developmental reviews

Overall the developmental reviews were felt to be done well:

“[A]nd I think that is one of the things that we do well, is monitor the child’s development and identify any deviations from the norm and support them and put them onto the correct service if that’s required.”

Antenatal review
The antenatal review was felt to be very valuable but that, in practice, it was difficult to achieve and as a result coverage was patchy across Sutton. However, it was seen to be an invaluable opportunity to introduce the health visiting service:

“You can ask difficult questions because the baby’s not there. It’s much easier to ask the difficult questions because the focus isn’t on the baby. They are good contacts but, then…you know, if six new births come in then you have to…prioritise things. So they then get, oh I’ll do that next week, and then the next week comes and a case conference comes in, and the next week comes…they’re just at the bottom of the pile all the time…It’s a bit of a shame because they’re really positive contacts 90% of the time.”

“It is a shame because it really raises our profile as well because not very many people know what we do and so. Everyone knows what a midwife and a GP and a nurse does. But what does a HV do? So it’s a really good opportunity to sell the service but…if you can’t actually get in there in the first place, because other things take over, it does go down the bottom of the pile. It’s a real shame really.”

The fact that the woman is on her own usually during this visit was felt to be critical in terms of issues around safeguarding as the partner or other family members are often present at the NBV. In addition, the absence of the baby was felt to be important as, when the baby is there, the focus obviously shifts. It was also felt to be a crucial opportunity to promote breastfeeding in particular:

“And it’s really important for the PH agenda as well, the antenatal check, because then you can get in with your breastfeeding speaking and hopefully that will raise a bit of awareness, you can explore the whole concept and, you know, that gets mum thinking about things a bit more, if you can get in
there between 28 and 32 weeks, because after that time she’s only going to have birth on her mind and she might not be thinking about it. But…it’s just getting in there at the right time. But there’s so many really positive things that can come from that contact...”

In terms of linking this check with the midwifery service, it was not evident exactly how the two could be linked as community midwives do not see mothers at home. Current community midwifery clinics are very busy, although theoretically it could be possible for HVs to attend the midwifery clinic to see first-time mothers. Another possibility would be via parent education classes as, traditionally, HVs do week four and many attendees are first-time mothers. However, HVs are not always involved in these classes and it was reported that they are not run across the whole borough.

2-2.5 year development review
The 2-2.5 year review was also felt to be a very important check although, again, concerns were expressed about how to fit it into already heavy workloads:

“I would entirely endorse that because when the two year check went, for many, many years, I was finding four year olds with incredible problems who really, you know, ended up...going to special schools and...since it’s been reinstated...I’ve noticed an enormous difference because they are getting done, mostly getting done, because I’m getting to know about the children...where there’s concerns. It’s a really important check.”

“[I]t’s such an important check because, prior to that, some children weren’t being seen between eight months and school entry. So...all the difficulties that...arise, speech and language, any developmental delays, anything like that, there wasn’t an actual professional seeing the child. And if you’re a first time parent you haven’t got anything to compare it to. So it’s a really important visit but I’m still baffled as to how we’re supposed to see all these people, the antenatals and the two years without any increase in hours.”

Choose and Book system
Previously, different teams within the health visiting service were responsible for organising and delivering their own developmental reviews. With the shift of working towards a more corporate system and more geographical-based working, this was deemed less possible, and a centralised Choose and Book system was implemented for some developmental reviews such as the 2-2.5 year review. The feeling amongst the members of the focus groups was that this had resulted in less ownership amongst teams. In addition, it was felt that, whilst
there may be increased numbers of clients taking up their 2-2.5 year developmental review, this was associated with a corresponding drop in other elements of the service such as the six to 12 month review.\(^{50}\)

“…[W]here you used to have maybe an uptake of, across the whole Trust, maybe between 75% and 85% of the six to 12 month check, all you’ve done is increased the two year check to 40 to 50% and the six to 12 month check has gone down. So I don’t think you’ve necessarily increased the contacts by that much because some areas were operating at…almost 100% because we owned them. We owned them. Whereas, by taking it away, you took the ownership away but, at the time, it was the best…[option]…that we could think about…”

Previously, when there was more flexibility in the system, and less fixed rotas, HVs reported fitting in developmental reviews amongst their other priorities, and organising them for times they knew fitted with families. They even talked about doing a number of different contacts and reviews at one time – eg, if a family had two siblings of aged six to 12 months and two years, they would be able to do two reviews in one visit, and thus the shift in working has reduced some of these efficiencies.

It was also acknowledged that it may be harder to reach more vulnerable populations as those who are taking up the Choose and Book offer may be those with less need:

“I think there’s quite a lot of geographical variation and obviously the point of moving it over to the central system, whereas, you know, some…areas tend to…[have] higher uptake like with any drop-in sessions. The point of moving it over to the central booking system was so that, if one session was booked in one area, a woman could be offered a session in another area. But it’s always the same with drop-ins isn’t it…where a woman’s got to self-present, there will be quite a lot of variation.”

There was also reported to be patchy attendance at different times of the week for certain groups (eg, weaning groups) at some (but not all) locations. However, it was felt that, overall, with the advent of Choose and Book, non-attending rates had decreased.

\(^{50}\)This was demonstrated in the HV activity data. There was an increase in 2-2.5 year reviews conducted but, correspondingly, the percentage who received a 6-12 month review decreased from 79.4% in 2010 to 65.2% in 2014. It should be noted however that there was an increase in percentage invited for the 6-12 month review during this time period. See figures 69 and 72.
8.1.1.5. Teaching

It was reported that the teams spend a large part of their time on teaching others such as student health visitors, student nurses and midwifery students. The increase in workload that this had resulted in was felt to be due to the HV Implementation Plan. It was felt that this was an expected:

“…part of our brief.”

“Each team is a learning environment and a practice placement so... everybody’s involved in it. So it has an impact on everybody.”

However, it was also felt that this had increased workload considerably:

“But it is just another strand that, you know, I think the workforce has been coping with, as well as delivering the service to the clients as well.”

8.1.1.6. Data collection and information technology (IT)

Part of the acknowledgement of a more business approach towards health visiting, was the acceptance that there was more of an emphasis on looking at data and quality and demonstrating efficiencies:

“[You]...[c]an’t just be out there delivering a high quality service if you’re not showing in the performance data back on base.”

“And actually, in a way, the data has kind of taken over…”

Although there was an acceptance that data collection was an expected part of their role, there were some specific concerns noted regarding outcomes being notoriously difficult to measure within health visiting, the fact that the goals often change, issues around feedback, and the time-consuming nature of data collection.

Difficult to measure

It was acknowledged that outcomes within health visiting have always been recognised to be difficult to capture and measure, due to health visiting being largely a preventative service.

“These things that are more intangible about the difference you make; it’s never been easy in public health; so they look at other things (key performance indicators, KPIs) to measure us and it’s tricky.”
Overall it was felt that current means of monitoring outcomes were not a good way of measuring the service and the effectiveness of the service. Instead, people wanted to see a shift towards more qualitative data capture that tried to measure quality:

“Getting some qualitative data from families – that’s got to be the focus.”

“Capturing the quality of what we do. When out there in practice...some of the practice is fantastic and you can see the difference but it’s about how do you capture that in the future?”

“And are the outcomes right? I mean if the outcome for a visit is that the visit was achieved...that’s not a proper outcome is it?”

It was acknowledged that one of the difficulties is that current commissioning concentrates on quantity delivered rather than quality.

“We’re not commissioned anymore for that. That’s the key thing, it’s about the commissioning. What are you commissioned for?”

Changing goals

Some people reported that the goalposts of which data needs to be collected and which targets need to be achieved often change, resulting in a complete change of focus of the team.

“And the goalposts change as well. And we don’t really know why they’ve changed, so for ages we get emails saying you’ve got to do this, and then all of a sudden that’s gone, we’re not doing that, and then we’re doing this, and you’re thinking well I was collecting that, so why am I, you just don’t quite know! You’re collecting one thing and then all of a sudden no one wants to know that piece of information and you think well I’ve actually put quite a lot of hard work into that and now nobody wants it and I’ve got to do something else.”

Feedback

It was felt that it was variable as to whether data ever gets fed back to team members. Breastfeeding statistics were reported to have been fed back, but it was felt that negative feedback was more likely to occur than positive feedback, in that people were informed when they hadn’t completed their data or met their target(s). However, weekly internal updates were also acknowledged and these were felt to be a good way of reporting
back about specific pieces of work or outcomes within the service.

Time-consuming

Finally, data capture was felt to be time-consuming:

“"The more data you’re recording the less time you’re spending with children or their parents.""

“It does take a lot longer to record very simple processes. And that’s not just in the records but in the recording of the appointment itself and outcome of the appointment itself, and there’s a lot of focus from our team leaders chasing us on bits of data that then become more time-consuming and it’s got to be done but it is frustrating that it takes such a long time, and that does take away from client contact.”

Two issues seemed to be particularly related to time. These were duplication of data recording (in that one contact may need to be recorded in many different places), and also the IT systems themselves, both the software (eg, RIO) and the hardware:

“Plus there’s nowhere to put the length [of the baby], you have to go into the progress notes just to record the length.”

“I think we worked it out that there were nine different things you needed to do for a new birth visit on RIO. So, health review screen, breastfeeding screen, progress notes, and that’s just for the baby. And then you’ve got the mother’s NBV screen, then you’ve got their progress notes, then you’ve got breastfeeding assessment, BCG referral...I think we worked it out that there were nine separate different processes, and that is for one visit, and actually the one visit might take an hour and a half, and if you keep getting interrupted, the actual recording of that can be quite, nearly as long.”

“I think the computers themselves are out of date as well. It’s not just the system, the actual computers, the hardware, they’re acknowledged to be out of date, so I think we could be moving faster but we haven’t got the equipment to move faster.”

“So you actually, you just can’t...do it, you look at the time and you think, I’ve got...ten minutes I could just get this done, yeah you could get it on in a normal world if you’re at home, but on a RIO system because everybody else is trying to get it on and it just freezes, it’s bizarre, it just can’t cope.”

“It’s not fit for purpose.”
There were many concerns about the IT system, and not just about it being slow and laborious. There were particular issues around the (lack of) remote working due to connectivity issues. This was true for the FNP team as well as the health visiting team. Firstly, very few people had access to remote working laptops. For those that do, they often failed to work:

“…[S]ome of us have got laptops. They’re lovely but they don’t work. You cannot get…3G, it’s awful. You cannot get it…it doesn’t work in a Children’s Centre. The best place for it to work is when you’re doing a clinic because you can put the person on and fill in the data as they’re leaving but you just cannot get a…3G signal, the mobile broadband doesn’t work…So they’re there, they are used, but only when you are in a place where you can get a signal, which is either in your office, or not at all.”

“…[W]hereas with our laptops, I’ve actually given mine back, because I’ve only got three hours to do a clinic, and the computer didn’t come on, I didn’t have any internet in that time, so I just can’t live with it…so I’ve given it back.”

It was reported that, within other areas, HVs did have remote IT access that worked effectively, but this was often due to investment and appropriate IT support.

As a result of IT issues, people often reported that they could not enter all their contacts on the day of occurrence, and would have to come back into work another day to complete these. This is obviously an issue for data recording in that records should ideally be contemporaneous. In addition, it leaves a potential gap for safeguarding issues.

It was also noted that (lack of) data sharing between organisations was an issue. For example, this was particularly noted between health visiting and CCs:

“It’s a disaster. It just does not happen. Our systems don’t talk…there’s a lot about in the future doing maybe joint stuff on the two year developmental check, so if somebody was attending daycare that people from…the community or the nursery nurses there would do the two year check, but their system doesn’t talk to our system. You know, when you go to an Advisory Board, you’re given this data, and they’re sort of like, well this is our data, you can’t really take that data away…So there is definitely a big gap. Now…our boss and their boss, they’re constantly complaining that data isn’t shared. So, like, the Children’s centres at one point didn’t know where children with safeguarding plans were…[T]here is a constant problem with data sharing, and all the CCs moaning at us
because we’re not sharing our data, and we’re moaning at them because they’re not sharing but somehow, at some big committee, it has to be sorted out.”

“I think for that we need more joint working with…the CCs because actually they have the data on where…there are specific pockets of deprivation or specific needs, and I don’t think that we have that data. So I think more joint working with them and, you know, it’s amazing the maps, the resources that LB Sutton have that we don’t have access to.”

Part of the issue with data sharing may be around information governance and data protection. However, lack of data sharing does have an impact upon outcomes for families and also, for example, with CCs Ofsted note there is a lack of real-time sharing of health data. The data is shared, but often only just as an Ofsted inspection is imminent, rather than on a regular basis so that it can feed into services. Other areas are reported to be able to access this data from their partners.

Within LB Sutton, data is not well shared between CCs and health visiting services or health as a whole. This is partly due to concerns over data protection and sharing of information across different organisations. This is one aspect that Ofsted look for during inspection (see below), and Ofsted have been critical in reports about the lack of real-time information sharing. Data that would be of particular pertinence include registered births, obesity in children, teenage parents, and breastfeeding.

In addition, data sharing issues were noted within FNP. Due to information governance concerns, the FNP team have been advised not to enter data onto Open Exeter for individuals who have not agreed to participate in the FNP programme. However, as a result, Open Exeter reporting states there is 100% uptake of the eligible population, which is not correct. Of interest is the fact that other areas do enter this data onto Open Exeter and thus SMCS appear to be operating in a different manner in terms of information governance.

8.1.1.7. Safeguarding

As mentioned above, the shift to a corporate caseload in combination with the IT issues experienced by the health visiting teams contribute to concerns around safeguarding:

“I think because you don’t know the clients, if you’ve got somebody that comes into a base where you haven’t got access

51 Includes registered births, obesity, teenage pregnancy and breastfeeding.
to their records, there can be safeguarding issues, you can miss things…but you’ve got no way of checking…So access to IT in the venues where we’re delivering the clinics, and they could be CCs, I think that really needs strengthening a lot.”

“If there’s no access to clinical records…safeguarding is a real concern, which I have highlighted over and over again because people aren’t working with access necessarily.”

“I think the other thing is it’s a risk. So many of the places where we do clinics are in CCs. Now we can’t access their LB Sutton stuff, we can’t access our stuff either. So we’re basically, a mother presents to you in a CC, you’ve got no way of knowing is that child subject to a CPP, is there a history of domestic violence or PND or anything. You literally are standing there and you are working on your own assessment. Then you come back to the clinic, open up RIO and think, oh my God, I wish I’d done this and I wish I’d done that. Actually it is a risk to the organisation the fact that we do not have access to our…information systems when we’re doing child health clinics in CCs, and even in clinics really…”

“Other health professionals don’t work like that do they?”

“I mean for home visits it’s simple, you look up the records before you go, you’ve got a new birth you check it back, but, clinics, anybody could walk in from anywhere and you are literally flying by the seat of your pants. You can get it really right or you can get it really wrong.”

The only sites for child health clinics that offered access to RIO during clinics were reported to be Robin Hood Lane, Green Wrythe Lane, Jubilee CC, Jubilee Health Centre and Amy Johnson CC. However, even at sites where access was possible, it was reported that connectivity issues meant access was too slow and not feasible within the timeframe of the clinics, with such high volumes of clients. There was the acknowledgement that this represents a real organisational and personal risk.

The sheer workload associated with safeguarding was a prominent theme within the focus groups and it was noted that there were discussions around potentially centralising the safeguarding service to ensure the workload was more equitably spread in terms of children who are subject to a CPP.

“I mean just numerically the numbers are significantly higher. They’re at an all time high. If we look at the number of children who are looked after in the borough…they’re almost double…what they were five or six years ago. So actually the
volume on the ground has increased for the staff and to fulfil your commitments under safeguarding and to work effectively with those families is a challenge, and it’s a high risk environment for the workers to be in, and I think they do that well. But I do think it’s a tension with those numbers increasing, and the universal agenda. How do you get the balance that you do both really effectively and well?”

And this wasn’t limited to children on a CPP, but also those who sit just underneath the radar:

“I mean I do 20 hours a week and I’ve got three children on a CPP, and that’s my limit but I also have two child in need families that actually generate a lot more work than the children on plan.”

“It’s a significant proportion of your working week…it means the time that’s not allocated to safeguarding…becomes very pressurised, and there’s then obviously less time available to support vulnerable families who haven’t met that threshold.”

“That’s right. Apart from safeguarding, we have got loads of vulnerable families who we can stop going into that category, you know, so because we spend so much time on the safeguarding issues…we are unable to protect the families who we really should be protecting...or being proactive towards…”

And because of the need to prioritise safeguarding work, it means other important parts of the health visiting role are being reprioritised:

“I think it takes us away from our bread and butter stuff, the stuff we were trained to do. You know like delivering weaning talks and postnatal groups and kind of, you know, building those relationships and encouraging peer support with other mums, especially new mums. If you have four families on a plan then you have to factor in the core groups, your own monthly contact, everything else that goes on with it, and actually it does prevent you from doing the job you were trained to do in some respects I think.”

“I think it skews our ability to be primary preventers. Just because of the numbers.”

However, there was agreement that it was completely appropriate to be prioritising safeguarding as these families have higher levels of need. The issues however were felt to be insufficient members of staff to deal with the increasing workload:
“Because that’s the bottom line, if you have more staff, if money wasn’t an object and there were more health visitors employed, we could probably get that balance better, and do a better job…”

“But within, you know, this current economic climate, where we have lots of considerations to make, it’s about how do you get the balance where the targets for the universal managers are met and the targets within safeguarding are met. And, more importantly, beyond the targets, that the children and families critically get the service they require to be healthy and well. That’s the most important thing. But I think it is a big challenge.”

Reasons why safeguarding workload has increased significantly were postulated:

“[T]he changes to government…like changes to housing benefit, mean that…a lot of extra money and staff were in central London because the caseloads there were seen to be more vulnerable. Obviously a lot of those vulnerable families can’t afford the rents in central London so they’re all out here in the suburbs so, whereas, you know, all that extra money and support went in there, actually now it needs to be here because that’s where they are. I think it is that just a…huge government changes isn’t it?”

And there were concerns that HVs did not want to have their workload becoming solely about safeguarding with non-safeguarding responsibilities being shifted onto CNNs, as it was reported to be in some other LBs.

It was also felt there were certain inefficiencies within safeguarding in Sutton and that, if these were addressed, they would help mitigate the increased workload associated with safeguarding.

“It’s safeguarding. And the relationship with social services in Sutton. It’s not only…the incidence, the numbers but, due to I think internal issues with social services, and their own difficulties, sometimes, just the practicalities of liaising with social workers, trying to get them back, then every time you make a…failed phone call to a social worker who doesn’t respond, putting it on four people’s records to…make sure that your records are contemporaneous. And, actually, just the whole process I think could be streamlined…but it could be eased I think if the whole business of liaising with social services was more effective.”
Included in these inefficiencies was the fact that HVs are often the only constant presence within case conferences, and this was at least in part thought to be contributed to by the fact that HVs were the most stable workforce and there was a high turnover of staff within social work, including many being employed by agencies.

“Yes. We’re stable. So...sometimes there’s a sense that we’re almost that social worker as opposed to the social worker being the social worker...”

“Well, absolutely. I mean I’ve kept families who should have moved on because I have known that nobody else has the full picture, and I’ve turned up at meetings where the social worker has been allocated the case the day before and the file’s that thick. Turned up at conferences where they, sort of, you know, they’ve had no preparation. So you feel personally obliged to turn up because then if something comes up you can say, hang on a minute, I know that happened three years ago or two years ago, and you can go back through your notes and wade through it so that there’s a full picture of what’s happening. And if I didn’t do it and handed that to somebody else, they’d be coming in and it would be a superficial conference and not in the best interests of the child.”

“And that probably isn’t helped with the way that social services have their referral and assessment team, so the family stay with the referral and assessment team for two or three months and when it’s something longer term, another change of social worker, and moving into a longer thing, and then that social worker goes on annual leave, and it just snowballs a little bit so the HV’s the only consistent form of contact for that family, which is what you were saying about, you know, often being told things they’re not willing to share, the families aren’t willing to share with the social worker. So you do feel very responsible at a conference actually, more responsible than the social worker in some respects because you have a much better insight into what’s going on, or what has gone on...”

In addition it was reported that case conferences were often cancelled at the last minute, or HVs were often communicated with about changes at the last moment, if at all. Furthermore, it was frequently noted that social workers or other key members of the conference often would not turn up, and this was frustrating for both HVs and families.

“Or they have a meeting without you, and you say, oh when’s the next core group. Oh it was this morning. Oh we didn’t tell you? That happens quite a lot as well.”
However, on a positive note, it was noted that the new case conference structure ('Strengthening Families') was clear, with a clearer plan of what’s going well, what’s not going well, actions and who takes responsibility for them. This was clearer both for HVs and for families. The Chair was also thought to be crucial to whether decisions were made in a timely manner. However, these conferences were also noted to be very time intensive (lasting approximately three hours), although subsequent record keeping was felt to be shorter as a result of the new structure.

Other stakeholders who it was thought could play more of a role were GPs who were repeatedly noted to not attend core groups and case conferences, often thought to be due to a lack of time.

“They don’t attend core groups and case conferences when they’ve been invited which is a shame, because you find that when you go to a GP meeting and discuss safeguarding families, they want to know why this family’s not on a plan, why this is not happening, but they’ve been invited to the groups but they never actually attend. So but they sort of see it as very much our role to instigate that and get that into place, where actually we would like another voice because we’re one voice at those types of events, and they’re quite valuable because, quite often with some families, they have background information that we don’t have access to, and they often know all the family, whereas we perhaps just know the child and the mother...And I think that...lets us down.”

“We actually begged one GP to go to a case conference. My colleague’s not here yet but she’s the person that asked him, desperate for him to go, and he just wouldn’t go, he just wouldn’t go, he just wouldn’t go. And his answer was, we get three days’ notice, and I said well sometimes we get two days’ notice, it’s you know, it has to be done, you know. So that’s a let down really, I think.”

However, it was thought that lack of time may not be the whole issue as sometimes there is sufficient warning of case conferences. It was commented that the perception was that some GPs did not see it as part of their role, otherwise they would be prioritising attendance. However, GPs were reported to provide information requested by the HVs for those case conferences and core groups.

The issue of GPs not always attending case conferences or submitting reports is acknowledged by the CCG who has initiated a financial incentive scheme to encourage GPs to do both. This scheme was developed at least in part due to the fact that it was acknowledged that GPs often have difficulties attending for the following reasons:
Poor timing of meetings (ie, clash with surgery times);
Insufficient notice;
Length of meetings;
Other competing commitments;
Other time pressures.

Previously it’s reported that the LA used to pay for GPs to attend but this does not happen anymore. However, it is hoped that the situation may well improve in the near future with the CCG financial incentive scheme, although there is still the issue of engaging with social care to negotiate changes in processes around timeliness of invites and reports.

Overall HVs were felt to be key to the safeguarding agenda:

“The other thing I’d like to say is that I think HVs are crucially important in terms of safeguarding, because the families, and primarily I’m talking about mothers, may have a very different conversation, or confide and talk to the HVs in a way that they won’t with the social worker, because they perceive the social worker to have the authority around removal of the child. And we see that all the time where things might be said in one instance to any of you that are not said to the social worker. And obviously things are shared, but in terms of supporting families, or having a conversation with those mothers to understand the role of the social worker more, or to understand how she can more effectively safeguard her child, or weigh up the risks when it’s about staying with an abusive man or leaving him for the sake of the child, I think HVs are pivotal to that role. So, again, it’s about how you get that balance. I think, you know, schools have an important role to play, but I think the HVs are really, you know, there’s a lot of stuff out there that shows that families will say that a health professional, they see as a supportive professional, and that is who they will connect with and confide in. And that’s what health visiting provides really.”

In addition, home visits were thought to be pivotal to this:

“Because we’re actually in the position where this, say with something like child protection, we’re actually in the house, so we’ve actually got an insight that they haven’t got.”

8.1.1.8. Strengths of the health visiting service

Overall, members of the focus groups felt the health visiting team were working well together and were very complimentary about the management and other staff within the service. Overall the team and management were felt to be supportive and the management team’s open door policy was valued. The
management were also felt to be flexible in terms of employee’s non-working commitments.

“And I think that...there is an enormous amount of goodwill amongst the HVs....every HV and nursery nurse will go the extra mile...I think we’re lucky to have a fantastic staff really”

Associated with this is the fact that staff turnover within the health visiting service is low. It was felt this resulted in a wealth of experience within the team which was an invaluable asset. Further a specific example was given whereby this ‘institutional memory’ was felt to have significantly strengthened the input the organisation made into a specific safeguarding concern. An additional positive aspect of management that was reported were the HV updates. These are weekly internal updates that report back on ongoing work and developments relevant to the health visiting service.

“And we do get these updates which is really good because, in the past...you often get information going up and not coming down but I feel, and also with the use of emails, we literally get updated from up to down quite regularly and that is very positive, I think.”

In terms of the service offered and provided, it was felt that the drop-in clinics provided an invaluable service:

“...there’s not many places where you can go for a drop-in. And there’s one every day in Sutton where you can walk in and see a HV if you’ve got concerns about anything which is excellent.”

“[a]nd I think the...clinics offer a good service. You know...where do you get access to a health professional without an appointment? Who can either help you on the day or guide you to the person that can help you. That’s why they’re so well attended.”

“We’ve got a very clear leaflet about where they are, and once people start coming they...never get cancelled, they’re always running. Christmas Eve...New Year’s Eve, they just run.”

Overall this was thought to compare favourably with other areas, and the drop-in clinics were reported to be extremely well attended, with one comment that a recent clinic had seen 70 children at one session in the previous week. Equally, this high turnover of children was felt to be challenging in terms of workload:
“I think it’s hard on the staff though…because you’re doing long…sessions…”

And it was postulated that such high turnovers could potentially adversely affect the quality of the service offered by the end of an extremely busy clinic.

Safeguarding supervision was another area in which the service was thought to be running well. It was acknowledged that the safeguarding workload was high but, despite this, the HVs and the team contributed positively to the safeguarding agenda:

“…I think supervision…is delivered quite well…for the ladies here to work with a number of families involved with children on a plan…and…they go the extra mile and they’re forever chasing up on absent other members of the network who perhaps haven’t turned up or things haven’t been done. So…what I hear is that they’re very good advocates for the children in those families, and I think that’s a strength.”

“I think we do go the extra mile, all the time…[F]or people who…don’t turn up at meetings or close cases and not tell you. We act in chasing those up all the time and it’s not in our role, and I don’t want it to be, that’s not what I came into health visiting for. I came in for prevention and supporting families…”

Overall, and probably linked to the fact that the staff turnover is low, was the feeling that LB Sutton compared favourably to other areas:

“…what we get here…is largely a supportive environment to work in…I mean I’ve trained and never left.”

“It’s a good borough I think for general services isn’t it, so that you feel that you have got a sort of a network so that, with your family…you can kind of…signpost…to other services.”

The specialist HVs for the homeless were also felt to be a valuable asset in reaching families in refuge or temporary accommodation, travellers, asylum seekers, and very hard-to-reach families with multiple problems.
8.1.1.9. Gaps within the health visiting service

Despite the fact that it was felt that LB Sutton compared favourably to some other areas in terms of services provided, it was acknowledged that there were a number of services and groups that are no longer in existence\(^{52}\). Examples include PND groups, Incredible Years parenting; childhood obesity; baby massage; Parentcraft education classes; toddler groups; smoking cessation. By far the most commonly mentioned gap in terms of a specific service were those for PND. This shift of services out with health visiting is connected to another perceived gap – that of skill loss by HVs:

“...I just feel that all the things that I enjoyed about health visiting have been taken away. A lot of the things that are done in the groups that are run in the CCs, ie postnatal support group, weaning group...minor illnesses...the nurturing groups, we used to run. But because it’s so much safeguarding, there’s so much note keeping, RIO is a whole process within itself...it takes a lot of time to do...”

“...you always have to refer on. I think we’re still finding the need and identifying it but actually following that through...we haven’t got the time for that anymore.”

“We can’t use our expertise at the moment.”

“We used to do toddler management as well...[t]oddler groups...And I think a lot of those have gone over to the CCs and...you would hear debates about that. About the erosion of the role of the HV...they’re highly skilled practitioners with specific training in child development, yet some of the services which they are best placed to deliver are being delivered by people with more generic and watered down qualifications. It would be a lovely research piece to look at the quality around, and the long-term outcomes, but I think it’s a sad day when that came out of health visiting, because it’s not just about the

\(^{52}\) Some of these services may be being run by services outside of health visiting such as CCs.
delivery of the group, it’s about the connection the HVs have with those families and the type of disclosures they get and how they get a wider support into families in need. Because when families trust them they make those disclosures. So I think the group work’s critical."

The lack of a skill mix within the health visiting team was also a theme that emerged during discussions about gaps in the service or possible areas for improvement. It was noted that some other areas (eg, Croydon and Kingston upon Thames) had more band 5 staff nurses as part of the team. In contrast, in Sutton, the team largely comprises CNNs and HVs, and a lot of the former’s workload is taken up with developmental reviews as fixed sessions such that they had little time for anything else. Generally there was agreement that people would welcome more of a skill mix within the team:

“…if you have a skill mix then you can delegate…and you can bring in team members who are stronger in some areas or...have particular skills...So it’s crucial to have a skill mix within a team I think.”

However, there was also caution on two aspects. Firstly, some disagreed that band 5 staff nurses were required and felt that they would not offer much, if anything, in addition to CNNs because the latter have skills more relevant to health visiting. There was however concern that the existing CNNs could not really progress within the current system, and more should be done to recognise the skills that CNNs develop and allow for career development and progression. Secondly, caution was noted that employing more of a skill mix should not be used as an excuse to move more services away from HVs inappropriately:

“…[H]Vs have huge experience, excellent training and…I am concerned that in some areas band 5 staff nurses do some of the things that HVs do without any training. Come straight off the wards and they’re expected to do NBVs. I very, very strongly believe that there are some things that should be the remit of properly trained community public health nurses as HVs…I do think that in some areas they are just using them as HVs and HVs just do safeguarding…[T]hat is my concern about band 5 staff nurses [t]hat, used properly, they’re fine, but used instead of HVs, I think it’s very poor.”

“I would agree with that because I worked…previously where there were band 5’s and there were a lot of issues and litigation issues…around that…So you’ve got to be ever so careful.”
Another major theme with respect to gaps in the service was the workforce in that it was felt the workload was exceeding the capacity within the current service:

“I think the teams generally...have a huge pressure, we have an increase in the birth rate, we’ve had no increase in staff and we’ve had an increase in safeguarding in Sutton in the last year...So we’ve got huge pressures on our time...Sutton has changed in...ten years...it’s much more multi-cultural, there’s different challenges, trying to work through interpreters, people moving in and out of the area much more quickly...a much more mobile client base. So there are huge...extra stresses on the health visiting service that maybe there weren’t ten years ago...[T]hey would know...their HV, see the same HV regularly, there were more home visits. Now...if we’re lucky the same person does the antenatal and the NBV...So I think we do seem to have lost that relationship that we had in the past...And we have huge...amount of stress within the health visiting team...you know...people on annual leave, and we have a couple of people go sick, disaster!...So we haven’t had additional resources which is what we need.”

This long extract demonstrates a number of factors that are proposed to have increased the workload within Sutton: increased birth rate, safeguarding, ethnicity, migration, loss of continuity, less home visits. Another additional factor that was felt to contribute was the introduction of new routine checks such as the antenatal visit and the two year developmental review without additional resources:

“So it’s a really important visit but I’m still baffled as to how we’re supposed to see all these people, the antenata1s and the two years without any increase in hours.”

Finally, the lack of administrative support was felt to be a large gap within the current health visiting service. In particular the issues alluded to earlier regarding the data entry responsibilities and IT issues were thought could be mitigated by some administrative support:

“[A]nd if we had, we had admin support until, whenever long ago it was that that was removed, and if we still had that and it was focused on helping us record things, like synchronising the data on RIO so that...could probably take half the time to record a very simple contact if the data had been synchronised, and it used to be done by Child Health but that doesn’t exist anymore. So...some admin support and better IT hardware I think would make this run more smoothly...”
HVs reported they were spending a lot of their time doing administrative work and felt it was inefficient in terms of time and money for them to be spending their time doing that:

“It can’t be cost-effective can it?”

“But, so, if we could have that back, it would be fantastic, but you know, I’m probably living in cloud cuckoo land, but it would be really nice because everywhere I’ve worked before, we’ve always had admin support and, to not have it, it has a real impact on what you can actually deliver because you’re having to do so much admin before you actually get out over someone’s door.”

The overarching theme was that doing administrative work meant that HVs could not do health visiting.

Another theme that emerged in one of the focus groups in relation to gaps within the service was that of HV prescribing for certain conditions such as head lice, candidiasis, dermatological conditions etc:

“...[W]hen you look at other areas, they do prescribe, generally. And I think we’re all trained, or have been trained, and it’s just never really managed properly I don’t think, because it was so bureaucratic trying to prescribe, it put everybody off. All the paperwork that you had to then duplicate into the GP surgery within a certain amount of time, but it would be a really valuable thing to be able to do easily, and save a lot of time for everybody I think.”

“And we all give the advice, so actually in effect we do prescribe because we diagnose, we recommend the treatment, and then we say, and then go to your GP or go to a chemist. And actually we could...”

However, others within the health visiting service were not convinced that prescribing was a gap in the service and were concerned that, with the high volume of clients at baby clinics, there may be insufficient time to prescribe. In addition there were recognised logistical issues that made it difficult now that HVs were no longer co-located with GPs:

“Well it’s writing your prescription and then making sure that that’s then recorded on the GP records, and then...you had to demonstrate that you’d followed it up afterwards, so that’s another kind of record keeping implication and I think...the theory is great but the reality just didn’t work for us and it’s a shame.”
“Some people still do I think, don’t they, I don’t know, but most of us, it’s too much hassle actually.”

One proposed solution was:

“In other boroughs they have independent nurse prescribers so they…don’t have to run to the GP and do all that, so they’re a level up with the prescribing.”

Overall there was disagreement whether this was a true gap or need. It was acknowledged that some HVs had stopped prescribing because they did not feel safe doing it in terms of supervision, and that this would be an important consideration. Some felt that the service was managing without this and others felt that it could work in some areas.

During the interviews undertaken an additional gap identified was childhood immunisations. There have been reports of HVs not performing immunisations despite taking part in anaphylaxis training. Within other LBs (eg, Wandsworth), undertaking immunisations is apparently within their Terms and Conditions of employment. However, it should be noted that administering immunisations is not within the national HV service specification. It was acknowledged that the low immunisation rates within Sutton may at least in part be due to reporting issues, but there may be a truly low uptake rate too. Ideas for how immunisation rates could be improved within Sutton included a central drop-in immunisation clinic or establishing a task force.

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8.1.1.10. Important services

Some services that were mentioned within the health visiting focus groups as being of importance for residents of Sutton include those listed below:

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53 This is not a complete list and some of the services listed here may no longer be offered.
Children’s Centres

Home-Start
This is a national family support charity that helps to support parents and families with young children. This service was valued but there were concerns that funding had been cut. However, it was commented upon that funding had been re-established, although from a different source and not from LB Sutton.

Breastfeeding

Weaning and healthy eating
Infant feeding services are run from CCs. CNNs do weaning talks. Clients can book onto them via a centralised Choose and Book service, although some clinics are very well attended and others less so – even if clients book on to them they do not attend in some areas.

Sleep management
This is in progress, and some members of the team are going on Millpond sleep training. The plan is for those who attend the training to then run groups on sleep management.

PND
This was repeatedly referred to as a large gap as it was reported there is no current PND group.

Domestic violence

Portage

Special needs
It was felt that the provision for special needs within Sutton were very good, and that the links between the health visiting service and the special needs service were excellent.

Voluntary sector
Generally the voluntary sector and local church groups were felt to be very vibrant with a multitude of activities for children and families.

Duty line
This open access line for parents was felt to be well-used. However, there had been some concern that social care were using it somewhat inappropriately to speak to specific HVs, rather than being used exclusively as a parental advice line.

Incredible Years Parenting
This encompasses a series of training programmes for parents, teachers and children. The aims are to improve parent-child and teacher-child relationships, and to prevent, reduce and treat early-onset behavioural and emotional problems. This still exists within LB Sutton but it was felt that HVs no longer were able to input into it as they once had, and that the service was very oversubscribed. Also these groups tend to be reserved for the most vulnerable, and the thresholds for referral are increasing such that there are less primary prevention opportunities for less vulnerable families who could still benefit.

*Childhood obesity*

*Postnatal groups*
There used to be postnatal groups for all new mothers that would link them with other new mothers, enabling them to access peer support, but this is no longer offered. It was felt that, if groups such as this were still running, it could effectively reduce PND within LB Sutton.

*BCG clinics*
These were felt to be currently working well. Previously there had been issues with clients not receiving letters or no one available to answer the phones when clients were ringing to make appointments. However, although this has been improved, it was noted that some areas are still short-staffed.

### 8.1.1.11. Links with other services

#### 8.1.1.11.1. Links with primary care

The shift from GP registered to resident population for the health visiting service means all the 0-5 year olds within a GP practice will not necessarily have the same HV. In addition, one GP practice (particularly those on the boundaries of Sutton) may have children from different LAs, and hence different areas providing the Health Visiting services for their children. No national communication was sent to GPs regarding this change, and some GPs may have been unaware that this was occurring. SMCS sent communication to GPs within Sutton in March 2015 explaining the change, and providing them with information about each practice’s link HV. It is proposed that each link HV will meet lead GPs for children’s safeguarding on a quarterly basis. Should GPs wish to communicate with HVs, they can email the

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54 According to the National Health Visiting Core Service Specification 2015/16, HVs work in partnership with maternity services, early years services, voluntary sector, private and independent services, primary and secondary care, schools, health improvement teams, FNP and social care (NHSE, 2014b).
generic email inbox for the relevant health visiting team, and they will receive a response within two working days providing them with the correct contact details for the relevant HV. This communication is also going to be delivered in person to Sutton's GP practices by SMCS from April to June 2015.

There was concern from outside the health visiting service that there was a lack of clarity about who the link HVs are, and also how HVs would link with GPs, and that this may represent an area of risk in terms of safeguarding. In addition, communication links with the CCG could be improved as, for example, no liaison with the CCG occurred before writing to all GPs within the area.

Additionally, some GPs would like a telephone number for their link HV and would like HVs to attend their practice MDT meetings. However, amongst the health visiting team there were concerns that there are sometimes peripheral people involved in MDT meetings and thus safeguarding concerns could not be freely discussed. In contrast, other stakeholders felt this was usually not the case, and that, in the main, doctors and nurses are the only team members present.

Amongst the health visiting team, links with GPs were felt to be variable and patchy depending upon the practice, the GP and the HV involved. Certainly it was felt that the effectiveness of the links between them were very much dependent upon individual working relationships between HVs and GPs, and this was attributed due to reorganisation and restructuring of the service. The workload pressure of GPs was acknowledged by HVs, and they felt that some as a result did not view health visiting as a priority due to these competing pressures.

“I think there is good liaison where it’s easy and feasible, but where it’s more difficult and it’s going to take a bit more effort, I think that’s sort of fallen to one side a bit.”

Others within the health visiting service felt that links were more positive:

“But we are all aligned. Each GP practice has a named professional linked to their practice so, to me, that’s a good standpoint to have. So they know who you are and you know who you are aligned to and that does
enable communication somewhat. So I don’t think it’s all bad there.”

Where the links were felt to be good, it was often due to co-location of GPs and HVs and, conversely, where links were poor or patchy it was because of the move of HVs away from GP practices:

“We’re on a patch...where we’ve got one GP at one end and one GP that we work for at the other end, so we do have very close links. But I do agree…it is patchy. But then they’re like, literally they’re in front of us, we’re driving past the surgery daily. So we can have those links. And they’re very good as well. I mean we have meetings with our GP, you know, possibly I would say every three months to four months. So I suppose it just depends on the surgery really. And I would admit they don’t come to case conferences at all.”

“We actually have a good relationship with our GPs...but then we are based there and have rooms that are based there, our baby clinic’s there, our checks are there, so we actually have a very good relationship.”

“It just depends what their experience is because I’d worked for years at a GP’s practice where we had the baby clinic every Tuesday in their waiting room. And course then there were naturally links because you could just catch them...and they just valued your service and we just worked well together but we were on site, only for two hours every Tuesday afternoon, and that worked really well. So we really got to know each other well but once that, once we moved out of that and moved into a health centre for the baby clinic it just, that just sort of vanished.”

“I think communication was easier with GPs when we were...GP attached and certainly when we...used to go in every week to do...baby clinics based in the surgeries and, or we used to meet quite regularly didn’t we with GPs, or were based in the surgery there totally. And that change has gone on over a few years really, gradually and I think, now our contact with GPs is not the better for it.”

Others were more negative in general about the links:

“I don’t think it’s ever been particularly, well in my experience...if there’s a problem they’ll come and find you but I think the general links, for me, have never really
been there. I've tried to get in with practice meetings, they're not really interested in us being there.”

It was felt however that, if links could be improved, it could potentially positively impact upon the workload of the GPs:

“Because we’re actually in the position...say with something like child protection, we’re actually in the house, so we’ve actually got an insight that they haven’t got. So if we actually worked really well together, we would be helping them rather than being seen as, or rather than being sort of a bit sidelined.”

“I've always felt though that if they used us properly, we'd actually take some work away from them...”

Traditionally, GPs and HVs would regularly meet to discuss children for whom there were safeguarding concerns, but also those families in which there were children in need. These proactive discussions around such families enabled preventative work to occur. GPs found this invaluable due to learning about the family dynamics from HVs given the latter’s unique position of conducting home visits. However, part of the issue in not being able to discuss families at length may be due to a loss of continuity within the health visiting service such that HVs no longer know their families like they used to. Furthermore, there is more to child development than safeguarding, and some GPs may like to engage more with HVs to discuss other behavioural and developmental issues, and not just focus upon safeguarding concerns.

These poor links may well be exacerbated by uncertainties around communication:

“I think, from personal experiences, only speaking for my own GPs that I work with, our details change quite a lot. So there's hubs popping up, phone numbers changing, email addresses are changing, and it's impossible for them to keep on top of who to contact and where to get hold of people, and so, you might give, you know, your generic email address to that particular GP, but they're not very good at updating their records and even though, you know, we inform them of who to contact and, I think some of the GPs do know who their named health visitors are and who works in their team but I have one GP surgery that I don't think that they have any idea who, you know, who we actually are.”
It was also proposed that perhaps GPs were unaware of the role of the HV and what service they offered, and that could be an area of potential improvement:

“And that’s our fault I think, probably. Well I think we ought to tell them what it is [the role of the HV] and promote our role more. I think we need to be a bit more forceful and a little bit more up front about it rather than, I think, maybe in the past we’ve always tried to make lots of accommodations, but actually I think we’ve got a lot to offer and I think we should make a strong case.”

From a primary care perspective, GPs may well be forgetting about the role of the HV if they are having less and less contact with them. GPs feel HVs are an invaluable asset, and many would love to have them back within their service as many HVs are seen to be very competent, well trained and confident. Furthermore, mothers often report back to GPs that they have only positive words to say about the health visiting service.

Overall HVs and GPs want to use each other and work together, and it is important to tackle issues together such as PND. It should be noted however that the opinion of a range of GPs has not been sought for this HNA, and more will need to be canvassed for confirmation of the themes that have been discussed here.

8.1.11.2. Links with midwifery

Community midwifery services are employed by Epsom and St Helier NHS Trust, and cover both LB Sutton and LB Merton. The majority of midwifery clinics have been moved to CCs (Nonsuch & Cheam, Amy Johnson, Muschamp, Thomas Wall and Stanley Park CCs) but some do still occur in GP practices\(^{55}\) and in Green Wrythe Lane clinic.

Links between midwifery and health visiting were also felt to be an area that could be improved, although, at a managerial level, these links were reported to be good. At an operational level, links were thought to be somewhat disjointed, partly because HVs and community midwives often do not see each other. It was reported that, where the two professionals knew each other, the

\(^{55}\)GP practices where community midwife clinics are held are: Chesser Surgery; Mulgrave Rd; Ben Hill Surgery; Jubilee Health Centre; Green Wrythe Surgery; Belmont GP Centre; Cheam Family Practice; Grove Road Practice.
client care was more seamless. Again, the workload of the midwifery service was felt to be a significant contributory factor. Within the focus groups, some HVs talked about differences in other areas they’d worked where the two teams had more informal links and would liaise more frequently. It was felt that, if the teams had the opportunity to link together more, they would work well together, but that it was the system that was not allowing or facilitating joint working. A big concern was safeguarding repercussions of poor links:

“Very poor. From my experience. There...doesn't seem to be the structures to have good liaison with midwives. I mean you can get hold of a midwife or pass information through the midwifery office...Sometimes we walk into quite vulnerable NBVs having not received information about a certain family and, I mean that, I think that's possibly changing because we are getting more information now about antenatals, but we still find, well I certainly do, lack of information.”

When HVs were linked with GP practices, community midwives were also based there, and the move of HVs away from GP practices resulted in that link between HVs and community midwives being lost. There is some uncertainty around who community midwives should link with, and often they phone the HV office and leave a message, but these messages may not always be dealt with in a timely manner as it is unclear that the correct numbers are being used.

Conversely, if HVs want to speak to a community midwife, they can ring the central office (Monday to Friday) and there will always be somebody to answer the telephone who can answer initial (administrative) enquiries. That individual can then take a message to pass on to the relevant community midwife if required.

HVs also reported they felt efficiencies would be gained if links were improved, and current duplication of work could be avoided too:

“And also you could avoid some duplication if there was better communication, which I think would benefit the midwifery service probably more than our service, but quite often they’re duplicating things like just weighing a baby after 14 days, and that’s the only reason they’re seeing them, calling them into a clinic when we’re actually going home that same week or that same day or the next day, and really we could do that. I think the duplication
could be avoided. And also the clients have then got, you know, someone else, they’re thinking, well why has this woman come to see me, I’ve been to see the midwife this morning. Especially a lot of them, you know, English is not their first language, they don’t understand our system. It’s, I think it could be better, and it could save resource, if it was better.”

In fact, where goals of the two services could be aligned (eg, infant feeding), working collaboratively was thought to potentially offer better outcomes for families:

“...there are lots of ways...with feeding that we could work together that would improve it for us all in general and it really needs to happen in unison to make...a real difference...”

“...[T]he Baby Friendly Initiative...there are two separate initiatives, the hospital and the community, the standards are a little bit different and I think sometimes people just think about their own Initiative, but if you’re hoping to support women more effectively in feeding choices, and certainly with their breastfeeding, that needs to be done gently and not in isolation. So I think some of it is that but, again, ideally for a hospital and community to work towards that Initiative together, and not in isolation because that’s how you really make a difference.”

However, with respect to feeding, things have never really become established:

“Like I’ve said we’ve looked at ways of exploring having joint training, looked at setting up a tongue-tie service jointly, looked at recruiting and training and supporting breastfeeding volunteers jointly, having an overarching agreement. There’s been lots and lots of work done behind the scenes but it’s never ever progressed, and at the breastfeeding steering group meeting, there is midwifery representation on it at a senior level, so people are sat around the table but nothing to date has ever really come from that.”

“...[I]t is really poor, the communication between the midwifery and health visiting services, and behind the scenes there’s been quite a lot of effort and work done to try and improve that. I’m talking specifically around infant feeding and the handovers. And, you know, there’s been so many opportunities that we’ve tried to explore with running joint training between midwives and the HVs, with
having an overarching agreement with the infant feeding volunteers and setting up a joint tongue-tie service, and we've made absolutely no progress. And about 18 months ago, PH commissioned a review of the infant feeding services across Sutton and Merton in general, and that was highlighted as one of the main issues...that we were working in silo. It was actually two years ago I think that report was commissioned. But nothing at all has moved forward since that, and since then we've had a breastfeeding steering group established that's being run by a PH consultant, and it is constantly raised but nothing...ever seems to improve to be honest...[B]ut it's a major issue with feeding because, of course, it's very much when the HV goes in at two weeks, the feeding assessment, the history is so important as part of that assessment, and there's never any handover...or communication and it should really be something that's a continuum. And there's so many opportunities to work together that would make a difference but there doesn't seem to be the...will there.”

The Paediatric Liaison HV who is based at St Helier Hospital was one area in which there were felt to be good links between health visiting and midwifery:

“I think in the...antenatal period we have had some progress, we have a liaison HV who’s excellent, who works up in and goes to the antenatal risk forum at St Helier’s, and she has excellent liaison with us, she will identify for us vulnerable antenatals and she puts her information on the RIO system and puts it on our monthly team planner. So I think that is huge, is much better in the antenatal period but, postnatally, it's poor.”

Potential ideas for improving links included liaison meetings or joint training between the two services – any means that encouraged HVs and community midwives to spend time together. Previously there used to be a quarterly meeting but this had been stopped for uncertain reasons. It was thought that meetings could be used to discuss feeding initiatives, other concerns, safeguarding issues and families antenatally so that everyone knew what to expect.

“But I think also it’s about building relationships with the midwives as well, and perhaps maybe twice yearly having a kind of, with CCs and midwives and HVs, kind of like a liaison lunch or something for two hours like twice a year, just so that you can build relationships with those other services...so that we all have a better
understanding of what we all do and how we can interlink and work more cohesively because I don’t think that happens with maternity services at the moment, and it’s just that kind of making those steps to building that relationship with them I think.”

“…[I]t would be good to have...good liaison, regular meetings, even if it’s just maybe once every three months, just touching base, HVs and midwives together.”

In addition it was commented that joint antenatal groups (eg, Parentcraft) between the two services used to run previously and would provide good informal links between HVs and community midwives.

The main barrier to more joint-working was reported to be workload (particularly within community midwifery services), and this was perceived to be due to increasing birth rates and a more ethnically diverse population. Another barrier was perceived to be that HVs are not commissioned to develop these informal links between the two services. As with GPs, it was felt that links were better were services were co-located:

“For our team we have midwives...at the...CC, so we use that to our advantage...I’ve...had phone calls from them about vulnerable families, they’ve also...left messages for us at the CC, or while we’re in the CC, they’ve sort of curtailed us...into talking about a new birth that we might be visiting that...there could be a problem with so, I think them being on site at the CC...at least we can actually address...trying to have contact with them that way.”

The FNP team were felt to have good links with the teenage pregnancy midwives (probably facilitated by a smaller caseload), but postnatally, communication with community midwifery was also thought to be poor.

Handovers between midwifery and health visiting
There are no routine handovers between the two services – neither service has a formal handover policy. The only time formal handovers occur was reported to be if a child was subject to a CPP. Notifications of birth are entered onto the monthly RIO planner, and that is where health visiting work is allocated from. In addition there is a discharge summary left in the mother’s notes by the midwifery team, but this was reported by the HVs to only really contain information about the baby’s weight and generic advice given. Community midwives do not use
RIO. Community midwives leave a discharge summary sheet with the mother to give to the HV if there are particular concerns. If there are no concerns, the mother is discharged from the community midwifery team and the red book is completed.

However, for vulnerable antenatals, there is a monthly forum and the Paediatric Liaison HV notifies the health visiting team of specific concerns. This was agreed to be a strength of the service. However, this tends to only flag any antenatal issues and issues that arise around the time of the birth are not passed on and handed over via this route. Within the focus groups some examples were given of specific instances where no handover was received but, when the HV attended the NBV, there were specific medical problems that the baby and/or mother had which the HV should have known about in advance. Indeed, others commented that, previously, this sort of information would have been communicated. At present this handover seems to be patchy and dependent upon the individuals in the neonatal or paediatric teams, rather than any robust processes per se.

“But it’s almost down to the individual isn’t it? It’s down to the individual neonatal nurse to actually bother, on discharge, to phone.”

8.1.1.11.3. Links with social work

Links between HVs and social workers were perceived to be somewhat one-sided at present, although it should be noted that, due to time constraints, no representatives of children’s social services were interviewed during this HNA process. Perceived barriers include the high staff turnover and reliance upon agency staff within social care, and the fact that social workers sometimes do not turn up for core groups or case conferences, something which obviously also affects relationships with families too. It was acknowledged that a large contributory factor was the heavy workloads of social workers within LB Sutton.

“But there’s no kind of pride in…keeping the families and doing a good job, it’s just they…don’t enjoy it and they’re off. And they’re all…saying it, you know, every single social worker you work with are all agency and…you get to know them and then they say, well I’m leaving in two weeks.”
8.1.11.4. Links with CCs

Some stakeholders have reported that, within LB Sutton, not all CCs have a named HV. However, other stakeholders have reported that some CCs do work well in collaboration with HVs. At a strategic level, there is commitment to improving links between health visiting and CCs but, at an operational level, it has been suggested to vary. However, it has been reported that CNNs within health visiting teams do tend to have good links with CCs across LB Sutton.

Links were felt to be area-dependent although, overall, they were thought to be good or very good. It was noted that, at a strategic level, there is a commitment to good working relationships between HVs and CC staff but that, operationally, this can vary and can be very dependent upon individual relationships. One person reported that CCs provided a:

“Fabulous service.”

It was acknowledged by HVs that, if problems were identified by the health visiting team, the CCs would identify those and engage those families in programmes or groups to support them, or refer them back to health visiting for further support.

One of the reasons why links were felt to be good was due to the co-location of services, given that many child health clinics were run from CCs. It appears beneficial for both HVs and CC staff to co-locate:

“…[W]ell we work really closely with the CCs and…some of us are on their Advisory Boards…and a lot of the things that we do are actually in the CC…[W]e have a really good relationship with the CCs, we do our child health clinics in there, we do our developmental checks in there, and try and signpost parents to the activities within the CCs, and especially more vulnerable clients.”

“Yes, there are good links where we are based. We’ve got two or three, I don’t know what their title is, family engagement support workers, and if they have any concerns they just email the team, and when we go to clinic there they talk to us about clients of concern. They can refer to speech therapy, I think audiology as well. So it works well because they may pick up things that we haven’t.”
“They’ll do home visits as well, so say if we’ve got a concern, and they’ll say, oh well we’ll give mum a ring and we’ll go out, and then they’ll do a home visit and then you kind of liaise and kind of work out what you need to do between you, and that works really well where we are.”

“They have actually done joint home visits with…[CNNs]…as well, which has worked quite well. And we fill out a recommendation for support, so if we feel like a family would really benefit from baby massage or any of the groups that they run, we fill out a recommendation for support so that they know that they’re targeting that specific family and then…we can liaise regarding the family.”

“I think as well we’re there almost every day of the week, if it’s not for checks, for reviews, it’s for clinics, and they know us all by name, they’ve got our phone numbers, it’s as if we work in, we don’t work in the same building but it’s as if we do. It’s communication.”

“I think because the HVs go to the meetings at the CCs we have really good links there, so they can talk about the needs of the families in that specific area and then make links as to what…groups…they would run in that specific CC. So it’s very area specific.”

Thus the relationship was felt to be a reciprocal beneficial one. Comments were made by the health visiting team that the CCs are really open to suggestions to adapt local services in a way relevant to their local populations. It was felt that CCs wanted HVs within their centres just as much as HVs wanted to use their space. In addition, it was felt that working alongside the CCs could help compensate for some of the reported loss of continuity within the health visiting service, as relationships could still be formed with families. Equally, if HVs were having difficulty getting hold of a family, they could often use the CC as a resource to help locate them, or drop in to see them while they were accessing groups. It needs to be ensured that the reciprocity of this relationship is maximised, and that the health visiting service also feeds into the relationship - eg, by sharing information on the population (see later) or by ensuring all children are registered with a CC at the NBV.

However, it was noted that, where there should be a named HV for each CC, this does not always occur,
possibly due to the recent reorganisation and structuring within the health visiting service. Despite this, it was also felt that most CCs would probably know a HV to contact should they need to.

**Advisory Boards**

It was acknowledged that all HVs have the opportunity to sit on Advisory Boards, but that not everyone takes up that opportunity. Barriers to HVs attending included the timing of meetings (evening meetings can often not be attended by the HVs), a lack of clarity regarding roles and responsibilities of board members, and insufficient time given their workload.

"Yeah it’s a whole other part to the role and...for us our time is extremely precious. Everybody has a huge amount of fixed responsibilities for clinics and...some people just feel that they can’t fit it in to their ever expanding diaries I think.”

Other comments included that the focus of the meetings tended to be financial rather than health.

**Closure of CCs**

Amongst the health visiting service there was much concern about the possible future closure of CCs:

"I think the relationship with the CCs works really, really well, however I think all of us in this room know that there is a question mark over the CCs in Sutton. It’s been in the local papers and it would be a total travesty if a large amount of the CCs are closed, and would hugely affect the services for under fives in this area...I think there’s not one of us that don’t think that they’re extremely valuable and we work brilliantly together, and they’ve made a huge impact on the health and wellbeing of children of Sutton.”

There were also concerns amongst different stakeholders that, with closure of CCs, safeguarding would potentially increase, and that the impact would affect children within Sutton in an inequitable way:

"But it would be the vulnerable families that would be really hit, because the other families who can access all the other services and can pay will just carry on doing the other groups but it’s the, yeah, it would be vulnerable families.”
Further the impact of the closure of CCs on health visiting could be a corresponding increase in workload:

“But I think...[home visits]...will have to increase with the loss of the CCs, and that’s where a lot of our time is going to be taken, because you can...signpost three or four vulnerable families to a Stay and Play session at a CC where they’re attending every week and you can just drop in and you can see all three or four...[but...when...they don’t have those sessions and nobody is going to be seeing them, then that’s going to create a lot more of the need for home visits and meeting in other areas, so that...is going to put a lot more pressure I think on the teams.”

“And from a selfish point of view, we run so many services within CCs, what will we do with all of those services?...If there is no CC, I think we would, might have to go back working in church halls, which is what we did 25 years ago.”

For midwifery services, closure of CCs would mean that community midwives would have to move back into GP surgeries. This is despite the fact that women are reported to like attending clinics at CCs as they tend to be closer to where they live and more convenient, and give them an opportunity to see what services are available and access other relevant services.

8.1.11.5. Links with FNP

There were some concerns that there were insufficient links and integration between HVs and FNP. The FNP team do attend HV updates, but it was felt there could be more opportunities for transferrable learning between the two – eg, FNP nurses do a lot of work around attachment, and this could be of interest to HVs. Some of the issues with the links may be due to their separate locations – FNP are based at the Wilson Hospital, away from the rest of the health visiting team. It was felt that co-locating the services could possibly improve integration, and would also enable the management team to provide peer support to the FNP Supervisor.

In terms of the FNP Advisory Board (FAB), currently there is more representation from LB Merton as compared to

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56 The learning disabilities specialist HV for LB Merton is the only HV also co-located at the Wilson Hospital.
LB Sutton and, due to capacity and workload issues, Sutton representatives are often unable to attend. This also appears to be borne out at an operational level, whereby the links between LB Sutton and the FNP team are not as well established. For example, communication is not optimal and the FNP team are not aware of who to refer to in relation to the Early Intervention and Prevention Strategy and Troubled Families. In contrast, in LB Merton there are excellent communication links, and the FNP Supervisor has recently received a staff excellence award for contribution to the community. Commitment to FNP and to the FAB at a strategic level are required within Sutton to ensure the service continues to run effectively.

Finally, in terms of FNP workload, stakeholders expressed concerns that a caseload of 25 clients per nurse may not be manageable with the current amount of safeguarding involved, and that a caseload of 21 per nurse may be more achievable. Prior to the recent staff vacancies which arose in December 2014, there were 45 clients in LB Sutton, but there was still a demand for the service. It has been suggested that the current demand within LB Sutton could warrant four nurses and a Supervisor for the population of Sutton alone.

8.1.2. Client views

There was insufficient time and resource to canvass opinion from client groups specifically during this HNA, but recent surveys already in existence were utilised to gather information on client opinions.\textsuperscript{57}

8.1.2.1. Well Child Clinic Survey\textsuperscript{58}

There were 365 responses to this survey. 237/365 (65\%) responses were within Sutton clinics or CCs. However, it should be noted that responses captured within Sutton were not necessarily from Sutton only residents, although they are more likely to be. Within LB Sutton, respondents were from the following sites:

- Green Wrythe Lane Clinic (46 responses; 13\%);
- Robin Hood Lane Clinic (34 responses; 9\%);
- Manor Park CC (31 responses; 8\%);

\textsuperscript{57} NB. Information has not yet been received as to the exact timing of these surveys, and also information regarding response rates. Further, they cover the populations of both Sutton and Merton given the current health visiting service encompasses both. Where available, responses for Sutton only residents have been presented.

\textsuperscript{58} All responses rounded to nearest whole number, and thus categories of responses may not add to 100\%. 

125
Stanley Park CC (31 responses; 8%); Muschamp CC (28 responses; 8%); Jubilee Health Centre (16 responses; 4%); Beddington CC (14 responses; 4%); Cheam Resource Centre CC (14 responses; 4%); Spencer CC (10 responses; 3%); Tweeddale CC (7 responses; 2%); Amy Johnson CC (6 responses; 2%).

SMCS have only provided summary scores for this survey and thus all 365 responses need to be analysed as a whole.

The first question related to how long the client had waited to be seen. 357/365 respondents answered this question. The results are detailed below:

<table>
<thead>
<tr>
<th>Waiting time</th>
<th>Percentage response</th>
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<tbody>
<tr>
<td>&lt;15 minutes</td>
<td>54%</td>
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<tr>
<td>&lt;30 minutes</td>
<td>25%</td>
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<td>&lt;45 minutes</td>
<td>9%</td>
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<td>&lt;1 hour</td>
<td>6%</td>
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<tr>
<td>&gt;1 hour</td>
<td>9%</td>
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</tbody>
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Thus, although the majority of clients waited for less than 30 minutes, 18% waited for over 30 minutes, possibly reflecting the high demand for these services.

The next question asked whether clients felt they had enough time to discuss their child’s health with the health professional. Responses are demonstrated graphically in figure 78. It can be seen that no-one disagreed with this statement. In addition, 98% of the 353 clients who responded either strongly agreed or agreed that the consultation met their child’s needs. In contrast, only 3 (just under 1% of respondents) disagreed or strongly disagreed.

Overall, the care received was rated highly by the 352 individuals who responded to this question (347 clients (99%) rated it as excellent/very good/good). Only 3 (1%) rated it as poor or very poor. This was reflected by the high number of the 348 who responded to the question stating they would probably or definitely recommend the clinic to others. Only 7 (2% of respondents) said they would not.

Clients also appeared satisfied with the confidential nature of the environment. 9 failed to respond, but 337 (95%) either strongly agreed or agreed. Only 11 (3%) disagreed or strongly disagreed.
Clients were also asked what would be their ideal clinic opening times in the future. 345 responded to this question. Again, there appeared to be satisfaction with drop-in sessions as opposed to appointments, with the majority 187 (54%) preferring morning drop-in sessions, followed by afternoon drop-in sessions (64, 19%). In contrast, 45 (13%) wanted morning appointments and only 11 (3%) wanted afternoon appointments. 11 (3%) expressed a preference for drop-in sessions in the evening, and only one client said they felt an appointment in the evening would be ideal. Equally, there was not a high demand for Saturday appointments, with only 19 (6%) favouring drop-in sessions and 7 (2%) favouring appointments, respectively.

8.1.2.2. Your Health Visiting Service Survey

There were 105 responses to this survey. 103 answered the question where their GP surgery was located (50% in Sutton; 46% Merton; 6% elsewhere). Again, summary responses were given for Sutton and Merton combined. The majority had one (50%) or two (44%) children, with none having more than four children. Figure 79 reveals responses to how the client accessed their health visiting team. It can be seen that the predominant means was via child health clinics, closely followed by CCs, and then routine NBVs.

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59 All responses rounded to nearest whole number, and thus categories of responses may not add to 100%.
Figure 79: Responses to how clients accessed their health visiting team. (Source: SMCS)

Of the 103 that responded to the question, 35% last had contact with their health visiting team within the last month, and 22% had contact more than one year ago. 42% of respondents had contact 1-12 months ago. The preferred means of contact for the future were as follows:

- Drop-in child health clinic (77%)
- Phone line (58%)
- Face-to-face booked appointment (42%)
- Email (29%)
- SMS (15%)
- Local website/app (9%)
- Twitter/facebook (7%)
- Other (1%)

98 responded to the question ‘How has your health visiting service already helped you?’ The top seven responses were:

- General advice at child health clinics (80%)
- Routine healthy child programme (60%)
- Infant feeding support (42%)
- Weaning advice (38%)
- Sleep management (27%)
- Advice on immunisations (24%)
- Contraceptive advice (21%)
8.1.2.3. Reintroduction of the 2-2.5 year review survey\textsuperscript{60}

There were 333 respondents to this survey and, again, these respondents were across both boroughs. The proportion of Sutton residents cannot be estimated from the data provided.

Satisfaction with the review was high 325/332 (98\%) were very satisfied or satisfied. Only 7 (2\%) were not satisfied. 330 responded to the question of whether they completed an ages and stages questionnaire prior to the review, and 97\% said they did. 96\% of the 332 who responded said they found this questionnaire very useful or useful. 91\% of respondents said the booking process met their requirements, and 94\% of respondents reported that the initial invite letter provided the information needed to encourage them to book the developmental review. 95\% of respondents felt the review provided them with information about their child’s developmental progress. 93\% reported they were given age appropriate health promotion advice and 78\% were given age appropriate leaflets and ideas to promote their child’s development.

However, it should be noted that only limited information about the process of this survey was received and thus it cannot be determined whether a response bias is contributing to some of the results.

9. RESULTS – COMPARATIVE ANALYSIS

Throughout the HNA, where possible, specific comparisons have been cited as examples of good models of practice in other areas. In addition, where possible, data have been interpreted in relation to comparator areas (see section 3.3).

9.1. LB Richmond

LB Richmond is an affluent outer London borough in South West London. The ONS have classified it within the ‘Thriving London Periphery’ cluster alongside Sutton and, as such, is a statistical comparator. In 2013 LB Richmond conducted an Early Years Needs Assessment (2013) and, prior to that, a health visiting service review in 2011. Of relevance to Sutton is the fact that the latter document led to the revision of their local health visiting service specification with the development of new KPIs in order to monitor performance. These have already been referred to and were discussed in section 6.1.

\textsuperscript{60} All responses rounded to nearest whole number, and thus categories of responses may not add to 100\%. 
In addition, LB Richmond report incorporating a skill mix since 2004 as an appropriate means of diversifying their workforce. The skill mix they introduced incorporated CNNs and staff nurses as well as HVs, although they found other stakeholders (eg, GPs, allied health professionals and commissioners) did not fully understand the roles of the other members of the team.

10. CONCLUSIONS AND RECOMMENDATIONS

10.1. Strengths of the health visiting service within Sutton

10.1.1. Management team

Feedback across a range of stakeholders is that the management team are supportive, open and accessible and, as a result, staff feel valued. The regular feedback and updates provided to staff is welcomed.

10.1.2. Workforce

The workforce within the health visiting service has remained remarkably stable, and this has resulted in a wealth of experience and institutional memory within the team. Furthermore, there is a high degree of dedication within the team, with the needs of the families and children of Sutton prioritised.

10.1.3. Development reviews

These were felt to be an area of the existing service that is currently working well. Indeed, Sutton and Merton were a designated EIS for the two year review (DH, 2012b).

10.1.4. Paediatric Liaison HV

This role was frequently mentioned by a range of stakeholders as invaluable in addressing safeguarding concerns but also in helping establish and maintain links with other services, particularly midwifery.

10.1.5. Safeguarding supervision

A range of stakeholders reported that safeguarding supervision was done well within Sutton, and that HVs, including newly qualified HVs, felt well supported in their safeguarding work. This is a notable achievement, particularly given the high safeguarding workload within Sutton.
10.2. Areas for future work

10.2.1. IT

It is important that remote access and reliable, fast access to RIO at the point of client contact are provided in order to ensure staff have contemporaneous access to notes (in order to mitigate the danger of unaddressed safeguarding issues), and such that synchronous record keeping can occur. **Recommendation:** Investment in IT software, hardware and infrastructure support is required in order to mitigate organisational and personal risk.

10.2.2. Information/data sharing

The sharing of information and data within and between organisations is critical to the effective working of the health visiting team and in order to optimise outcomes for young children. Leadsom et al (2013) recognise that maternity services, health visiting, social care, mental health services and CCs should work closely and share data as required in order to ensure children and families receive the support they require in a timely manner. In particular, where there are safeguarding concerns, sharing of information becomes even more critical.

Within LB Sutton, data is not well shared between CCs and health visiting services or health as a whole. This is partly due to concerns over data protection, and there is a resultant hesitancy in sharing information across organisational boundaries. **Recommendation:** In order to ensure an integrated service, health services and LAs should share data and information regularly, and this could be facilitated by the development of local agreements or protocols (DfE, 2013). Responsibility and ownership for this needs to be accepted at a strategic level across all agencies involved.

10.2.3. Alignment of localities

In order to aid meaningful comparisons of data across disparate organisations, it would be helpful if there could be some alignment in the localities employed by the LA, health visiting service, CCGs and CCs. Presently different organisations use different localities or catchment areas across the borough for analysing data. This could theoretically be feasible if all localities employed by different organisations align to existing LSOAs, and if information regarding the alignment were shared. **Recommendation:** Organisations should work together to ensure localities are aligned in terms of LSOAs such that meaningful comparisons across organisational boundaries can occur.
10.2.4. **Inter-agency working and communication**

It is acknowledged that "[p]artnership, integration, communication and multi-agency working are key to improving outcomes" (DH, 2014, p2). Furthermore, the Childcare Act 2006 places a duty on commissioners of local health services to ensure early childhood services are integrated effectively (DfE, 2013).

Links and communication between health visiting and other services need to be improved. These other services include CCs, GPs, FNP, children’s social services, community maternity services and the CCG. Whilst there were some individual examples of how things are working well, these tended to be associated with co-location of services. With the recent and ongoing restructuring of services, it is unclear what the service will look like in the future but co-location should be attempted where possible, as co-location does appear to be key.

Where co-location is not feasible, good communication between teams is vital for safeguarding and efficiencies, including preventing duplication, whilst also serving to improve outcomes for children and families within Sutton. Examples of initiatives that may work include regular joint team meetings, joint training and joint running of services such as Parentcraft. Commitment to this needs to be realised at both a strategic and operational level.

Some specific ways in which links could be improved include:

- **Ensuring HVs register children with their local CC during the NBV.** Qualitative feedback was that this is not occurring and, indeed, HV activity data suggests there is room for improvement (see figure 75);
- **Ensuring all CCs and GP practices have a named HV and that the relevant organisations are informed of appropriate communication methods.** Attempts should be made to not alter these communication channels where possible;
- **Obtaining further feedback from GPs in Sutton to confirm their perceptions and experience of the health visiting service thus far, and to obtain information on how to shape the service in the future;**
- **Liaising with individual GP practices regarding their specific requirements -** eg, some may value more than quarterly meetings, and may also value attendance of a HV at their MDT meetings, as long as HV concerns regarding safeguarding information and confidentiality are addressed;
- **Strengthening informal links such as joint services and training between services.**

Furthermore, improving links and communication between services should extend to ensuring there are robust handover processes in place between services.
Recommendation: Improving inter-agency collaboration and communication between health visiting and CCs, GPs, FNP, children’s social services, community maternity services and the CCG. Where feasible, co-location should be considered optimal in promoting collaborative working. Commitment to improving links between services needs to be realised at both a strategic and operational level.

10.2.5. Caseload and skill mix

Given that HV caseload and safeguarding responsibilities within Sutton are high, consideration should be given to incorporating more of a skill mix into the existing team. Certainly this was something that the qualitative feedback suggests would be welcomed by the current team, as long as it was not used to allocate tasks inappropriately to staff members without the requisite competencies. Indeed, Fisher (2009) makes the distinction between a ‘grade mix’ that is concerned with overall costs of a service and a ‘skill mix’, which is concerned with skills of the staff in relation to local population needs. However, McKnight (2006) do report cost efficiencies as being a potential benefit of employing a skill mix team (cited in Cowley et al, 2013).

There is currently insufficient evidence relating to what an appropriate skill mix team looks like. Cowley et al’s (2013) review of health visiting revealed that, in a survey of 980 HVs conducted in 2007, more than 73% worked in a skill mix team of varying composition, including nursery nurses, trained family support workers, clinic assistants and registered nurses. They found some evidence for this being associated with a reduction in stress associated with staff shortages, but there were concerns surrounding reduced quality of service provision. Furthermore, the assertion of a reduction in stress and reduction in workload is not proven, and others propose there may be an increase in stress associated with increased supervisory responsibilities, which are particularly challenging in a community service provision setting (Fisher, 2009; Cowley et al, 2013).

Additionally, Cowley et al’s (2013) review found that others (eg, Gibbings 1995) had suggested a skill mix results in an overall reduction of skills and negatively impacts upon continuity of care. Further potential issues identified include concern around missing health promoting opportunities (eg, Carr & Pearson, 2005, cited in Cowley et al, 2013), and structural barriers resulting in differing career patterns between skill mix members. Indeed, this latter factor was discussed by some stakeholders as a concern for CNNs within Sutton.

Overall, the literature review’s conclusion was there is a lack of literature surrounding appropriate skill mixes and how this relates to outcomes (Cowley et al, 2013). They state: “[o]verall, issues of accountability, quality and safety of services appear to be largely
absent from the limited amount of research concerning skill mix and team organisation in health visiting services” (Cowley, 2013, p112). Prior to implementing any skill mix within Sutton, other areas that have already successfully implemented a skill mix should be liaised with, and lessons learned from their experiences. **Recommendation:** The health visiting service may benefit from increasing the skill mix within it, but lessons should be learned from other areas who have already implemented a skill mix regarding structures and processes.

In terms of caseload, there is a proposed minimum floor standard of one wte HV to every 300 children aged under five years old within an area (Cowley, 2015). However, in terms of the nationally proposed health visiting service 4-5-6 model (see section 3.4), this minimum floor standard only provides sufficient resource for delivery of the five mandated contacts (Cowley, 2015). Within Sutton, in 2013 there were estimated to be 13,701 0-4 year olds. This would equate to a HV workforce requirement of 45.67 wte within Sutton alone using the minimum floor standard. In contrast, the latest figures provided by SMCS suggest the current number of wte HVs within Sutton is 32.85 (see table 2).

However, it should be noted that it has been proposed that HV caseload should vary according to deprivation and, if this were the case, Sutton’s proposed caseload size should be one wte HV to 400 children aged under five years old (Cowley et al, 2009). On this basis, Sutton should have 34.25 wte HVs which is much closer to the current size of the workforce. Rounded population projections for 2015 (see figure 8) suggest the 0-4 year old population size in Sutton is approximately 14,200. On this basis, the current number of HVs, should be 35.5-47.3 wte, depending upon whether deprivation is taken into account. Thus the current number of HVs within Sutton lies just under this range, which probably reflects a shortage in the number of HVs when considering that it has been proposed the 1:300 minimum floor standard is only sufficient for delivery of the universal service, and given the high safeguarding workload within the borough. In terms of planning for the future, ONS population projections predict the 0-4 year population within Sutton will reach 14,800 by 2022 (see figure 8). These figures would suggest the HV numbers within Sutton should be 37-49.3 by 2022. However, it should be noted that GLA population predictions for 2022 suggest a reduction in 0-4 years population within Sutton to 12,900. If this were the case, Sutton’s HV numbers should be 32.25-43 by 2022. **Recommendation:** Current HV numbers within Sutton should increase in order to at least meet the minimum floor standard. If the 0-4 years population does increase over the next five years, there may be a requirement to increase the numbers further.
10.2.6. **Business continuity**

Related to appropriate workloads is that there should be sufficient capacity within the service to cover certain posts when members of staff are on leave or fulfilling training requirements. The Paediatric Liaison HV is a post that has been particularly mentioned as invaluable to the health visiting service. However, there is concern within the management team that this post should be 1.4 wte in order to ensure continuity. Given the key role of this post in safeguarding, it is important to ensure there is appropriate cover for this post at all times (Laming, 2003).

*Recommendation:* There should be sufficient capacity provided within the service to cover key posts during periods of leave. This is particularly relevant to the Paediatric Liaison HV post.

10.2.7. **Administrative support**

*Recommendation:* In order to increase efficiency within the service, further administrative support would seem warranted.

10.2.8. **Structure of the service**

An element of restructuring may be required given the imminent split of services between Sutton and Merton, and the requirement that existing provisions cover both areas. Special consideration needs to be made about how to structure the service to ensure maximum efficiency. There is a case for further work to determine whether the service would benefit from restructuring and, if so, how. For example, it is recognised that the specialist HV roles do invaluable work across Sutton, but there may be scope for reconsidering the current service configuration.

For example, the specialist HV for haemoglobinopathies may be more appropriately aligned with other non-health visiting services. In order to answer this question, further comparisons with other models in other areas needs to be made, and more in-depth analysis of the need within Sutton is required. It has been mentioned that LB Croydon may operate an alternative model whereby the specialist nurse sits within the specialist haemoglobinopathy service, although the effectiveness of this service is not known in comparison to Sutton. Given that it is reported that approximately half the current caseload includes adults, and some children on the caseload are older than five years old, it can be reasonably questioned whether this role falls outside of the scope of the current health visiting service. It has been reported that not all other areas align this specialist role within health visiting, and in some areas the specialist nurse is employed by the Acute Trust and sits within the specialist haemoglobinopathy service61.

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61 This was reported via personal communication and needs to be corroborated.
Similarly, the specialist HV for children with disabilities is providing an invaluable service within Sutton but consideration needs to be given to how this role should look in the future, and whether the current model of split between the LA and the health visiting service should be continued. These considerations are important, particularly given that stakeholder feedback suggests there may be sufficient demand within Sutton for 2.0 wte HVs for children with learning disabilities. Further, there would seem to be a current high demand for sleep services and parental support for families with children with disabilities, and consideration needs to be given as to how to increase capacity for these.

If the role were to reside solely within health visiting, this could result in an unmet need for families with children aged 5-8 years whose child is transitioning into school. The Merton post-holder takes all children with complex disabilities onto their caseload, but this could theoretically result in other HVs deskillling in these areas due to a reduction in exposure to children with complex disabilities. Furthermore, there may be an additional gap in sleep counselling services for children with disabilities as a caseload-holding HV may not have time for this additional work, and there is already high demand for this service. In addition, moving the post solely within health visiting may result in a gap within Sutton’s Early Support services, although any HV within this role could potentially feed in to Borough processes. Although the post-holder does not have to be a HV, having a health professional in the role does facilitate good links with paediatric services.

Another pre-existing gap in the current service identified by stakeholders is toilet training support for families with children with disabilities. Previously a school nurse was providing some support with this, but this has now been withdrawn such that there is no school service either. Currently the only support offered is via CNNs or HVs.

Some stakeholder feedback has also suggested there could be scope for restructuring the safeguarding service. For example, potential options include combining the named nurse and safeguarding manager roles, although there would need to be business continuity plans in place to ensure one post-holder was sufficient. There are also currently seven safeguarding supervisors across both boroughs, and these supervisors are responsible for the supervision across teams. Consideration could be given to having fewer safeguarding supervisors but training others within existing teams to also conduct supervision. However, it should be noted that other stakeholders acknowledged that other areas’ safeguarding supervisors have a dual role (ie, caseload and supervision), but it was felt that one of the reasons why supervision within Sutton was rated so highly by staff was because having a dual role may dilute this supervision. It should also be considered that there is currently a certain amount of slack in the system afforded by having cross-cover between the boroughs when members of the team are away. Splitting of the service with the
transfer of commissioning responsibilities will necessarily reduce this which may be a risk to the service.

Some other areas do use a different model whereby the health navigator post is covered by one individual, but stakeholders have expressed concerns that this role would not be insufficiently varied resulting in the HV deskillling and potentially not meet current Nursing and Midwifery Council (NMC) revalidation requirements.

**Recommendation:** More work is required to determine appropriate models of specialist health visiting and what has worked well in other (similar) areas.

10.2.9. Safeguarding

The HVs and other members of the health visiting team within Sutton contribute enormously to the safeguarding agenda, and their commitment to the welfare of the children on their caseload is admirable and duly noted. Safeguarding responsibilities in Sutton do appear to be increasing, and are high when compared to other statistical neighbours (see figures 63 and 64). The qualitative work suggested this was at least in part due to a shift of vulnerable children from inner to outer London as a result of central government policies. However, the data do not necessarily support this assertion as rates of LAC in outer London are also generally decreasing (see figure 63).

There have also been increases in the relative percentages of children on an enhanced caseload who are subject to a CPP (see figure 77). The reasons behind this are uncertain and need to be explored further, but it has been postulated to include a lack of Early Years support. Prior to a child being referred into MASH, there seems a lack of joined up services when children are deemed vulnerable. If Team Around the Family meetings and Early Help assessments were working efficiently, there would be fewer numbers referred into MASH, and thus fewer numbers of children subject to a CPP. Additionally there may also be other factors at play such as tolerance to risk.

The move towards geographical working may increase further the safeguarding caseload for some HV localities more than others. It is acknowledged that demographic profiles across Sutton vary and, as such, some areas may have a higher caseload in terms of safeguarding than others. It needs to be assured that cases are allocated in an equitable manner across Sutton, whilst not disrupting continuity of care.

Further engagement with social services within Sutton could prove invaluable in helping to streamline the service, and increase efficiencies and inter-agency working. Engagement could also contribute to improving the role of the health navigator such that it
becomes more integral to the decision-making process rather than merely gathering information.

In addition, information sharing around safeguarding could be improved. Current information governance arrangements advise that information provided by professionals as part of the MASH process must remain within MASH and thus, should further information be required for a Section 47 Enquiry or a Single Assessment, the same information may be re-requested by social services, resulting in duplication of work for the healthcare professional(s) involved. Consideration should be given to whether local agreements could be devised whereby this duplication of work is avoided, and information from MASH could be appropriately shared where necessary, obviously whilst taking into consideration data protection and information governance requirements.

Furthermore, it has been reported that the referrer into MASH is not always informed of the outcome, despite this being a statutory requirement. In addition consideration should be given to whether other professionals who have contributed to the process could be advised of the outcome in some capacity as it has been reported that some would, understandably, like feedback on outcomes.

**Recommendation:** A review of safeguarding within Sutton across organisational boundaries is warranted in order to streamline safeguarding services and make the processes more efficient, whilst not compromising child safety.

10.2.10. **Activity and performance**

Activity and performance data submitted by SMCS have revealed three specific areas for improvement or further analyses. Firstly, the A&E attendance rate in 0-4 years population is relatively high in Sutton as compared to other statistical neighbours and to England. Further analyses need to be performed to determine the reasons behind these attendances and whether they were potentially avoidable. Last winter the health visiting service did some work around A&E attendances and appropriate use of out-of-hours services with clients, so it needs to be determined whether this has been effective in reducing this rate. Further joint collaboration between the CCG and the health visiting service is required. **Recommendation:** Further analyses of A&E data to determine if A&E attendances are potentially avoidable, alongside evaluation of the recent health visiting intervention is required in conjunction with the CCG to better understand the reason behind the high rates.

This indicator may also link with a perceived gap within the current service – prescribing. Some HVs reported this to be a gap, but there was disagreement on this. Although it will depend upon the reasons behind the high A&E attendance rates within Sutton, the 2015/16
national service specification states that HV prescribing should act on the high impact area of minor illness and reducing A&E attendances (NHSE, 2014b). **Recommendation:** Comparative work with areas that utilise HV prescribing is required to evaluate whether this can impact upon A&E attendances and/or use of other health services.

The second area for improvement is breastfeeding status. In 2014 this was unknown for 18.1% of mothers, and this percentage has increased. **Recommendation:** The reasons behind high unknown breastfeeding status need to be reviewed and methods of capturing this indicator integrated into the working of HVs without putting additional burden on their workload. It may be that joining with GPs in ascertaining this information as part of the 6-8 week review could be one way forward in improving performance on this indicator.

Thirdly, 17.7% of NBVs do not appear to be conducted within the required 14 days. **Recommendation:** Future data collection on the NBV should incorporate the reason why a certain percentage are not conducted within 14 days, in order to ascertain where potential improvement may lie and the proportion that are unavoidable (eg, remain in hospital or staying out of area temporarily).

10.3. **Future considerations**

10.3.1. **Closure of CCs**

Current health visiting services are somewhat reliant upon CCs both in terms of location and services provided. With the potential imminent closure of CCs across Sutton careful consideration needs to be given to the appropriate relocation of services, costs associated with this, where families will be signposted to if services cease and any resultant effects this may have on workload for the health visiting team.

10.3.2. **Integrated commissioning**

With the move of commissioning responsibilities to the LA, and the restructuring of the health economy generally, it is important to ensure commissioning in the future is integrated, and encourages providers to work together.

There is also a requirement to consider long-term gains from investments made now - eg, in terms of administrative support, appropriate IT infrastructure and preventative services such as FNP. With respect to the latter, it has been acknowledged that “[c]entral government…[should]…take a lead in recommending the service and perhaps in guiding local health commissioners to it, because preventive commissioning is easy to over-look when there is pressure on resources” (Ball et al, 2012, p51).
Future local targets and indicators should focus on quality of service delivered and not just quantity, which is often the focus currently.

Further, there is a requirement for commissioning to promote collaboration – a major barrier to joint working was perceived to be that HVs are not commissioned to develop informal links between services when both services would benefit in terms of improved efficiencies, reduced duplication and better outcomes for children and families. Leadsom et al (2013) discuss how pooling of commissioning budgets can promote joined-up working, and other stakeholders have referred to the importance of joint commissioning in ensuring services work well together.
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