

1. Executive Summary: 0-5 years Health Visiting Health Needs Assessment, London Borough of Sutton. May 2015.

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1.1. Introduction

Development during the first critical 1001 days (Leadsom et al, 2013) from conception until aged two years impacts upon health and wellbeing, educational achievement and economic sufficiency as an adult (NHSE, 2014b). Health visiting within the United Kingdom is a service which aims to improve the health and wellbeing of young children, and should serve to reduce inequalities in outcomes (NHSE, 2014b).

1.2. Key Policy Documents

As part of the Health and Social Care Act 2012, commissioning responsibilities for 0-5 year olds will be transferred to the Local Authority on 1 October 2015. The 4-5-6 model of health visiting encompasses four service levels, five mandated universal reviews, and six high impact areas (DH, 2015b):

Service Levels

- 1) Community
- 2) Universal
- 3) Universal Plus
- 4) Universal Partnership Plus.

Mandated Universal Reviews

- 1) Antenatal health promoting visits
- 2) New baby review
- 3) 6-8 week assessment
- 4) 9-12 month assessment
- 5) 2-2.5 year review

High Impact Areas

- 1) Transition to parenthood and the early weeks
- 2) Maternal mental health
- 3) Breastfeeding
- 4) Healthy weight, nutrition and exercise
- 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.

1.3. Methods

A corporate, epidemiological and comparative approach was taken. For the corporate HNA, service descriptions of the health visiting service, Sure Start Children's Centres (CCs) and the Family Nurse Partnership (FNP) were obtained from discussions with the relevant management teams, policy documents and other key stakeholders. Stakeholder feedback on services that are needed was obtained via focus groups, one-to-one interviews, and pre-existing local survey data.

An epidemiological assessment of need was conducted by analysing pre-existing nationally available databases and obtaining locally held data. Data presented for LB Sutton have been compared with other areas where possible.

For service provision, where possible, examples of good practice were sought, and pre-existing HNAs from other localities were examined for comparisons.

1.4. Results

1.4.1. Service Description (Corporate Health Needs Assessment)

A thorough overview and description of the current health visiting service provided by Sutton and Merton Community Services (SMCS) within Sutton is given. This includes an overview of management structure, health visiting localities, workforce and specialist roles within the team. There is also a focus on safeguarding within the health visiting service, in light of anecdotal reports of a high proportion of workload being centred upon safeguarding within Sutton. In addition, summaries of the current status of CCs and FNP within Sutton are given. Areas of particular concern or relevance are discussed within this Executive Summary.

In relation to specialist roles, some concerns were expressed regarding the Paediatric Liaison HV role. Currently this post is 1.0 whole time equivalent (wte) across both Sutton and Merton but this leaves business continuity issues when the post-holder is on leave. SMCS management feel this post should be 1.4 wte in order to ensure adequate provision of this service, particularly given the importance of the post in identifying safeguarding concerns (Laming, 2003). In addition, the specialist HV for haemoglobinopathies was noted to have a number of individuals on their caseload aged over five years old,

including adults, and the current model used within Sutton may differ from other areas.

Other process issues emerged around safeguarding. The Multi-Agency Safeguarding Hub (MASH) is a single point of referral for all safeguarding and child protection enquiries. The health visiting service provides a health navigator within the MASH process whose role is to collate information from allied health professionals. The MASH team determine what (if any) further action is required. Two potential outcomes include a Section 47 Enquiry or a Single Assessment by Children's Social Care. It was noted that, due to information governance arrangements, the same information may need to be resubmitted again as part of these processes, even though it has already been submitted to MASH. In addition, stakeholders reported concerns that the role of the health navigator is more concerned with gathering information rather than truly feeding into decision-making processes.

FNP services within Sutton are currently shared with Merton and there is overall capacity for four 1.0 wte Family Nurses and one 1.0 wte Supervisor. The maximal capacity across the four wte nurses is 100 clients, representing 48 potential Sutton clients, with an additional five clients taken on by the Supervisor (two from Sutton). However, stakeholders have expressed concerns that a caseload of 25 clients per nurse may be unmanageable with current safeguarding responsibilities, and that a caseload of 21 per nurse may be more achievable. It has been suggested that current demand within Sutton could warrant four nurses and a Supervisor for the population of Sutton alone. There are also quarterly FNP Advisory Board (FAB) meetings although, due to capacity and workload issues, Sutton representatives are often unable to attend. Commitment to FNP and the FAB at a strategic level are required within Sutton to ensure the service continues to run effectively. Links between FNP and the health visiting team could be more established and this may be at least in part due to the separate location of these services. Co-locating health visiting and FNP would also enable the management team to provide peer support to the FNP Supervisor.

1.4.2. What is the Need? (Epidemiology)

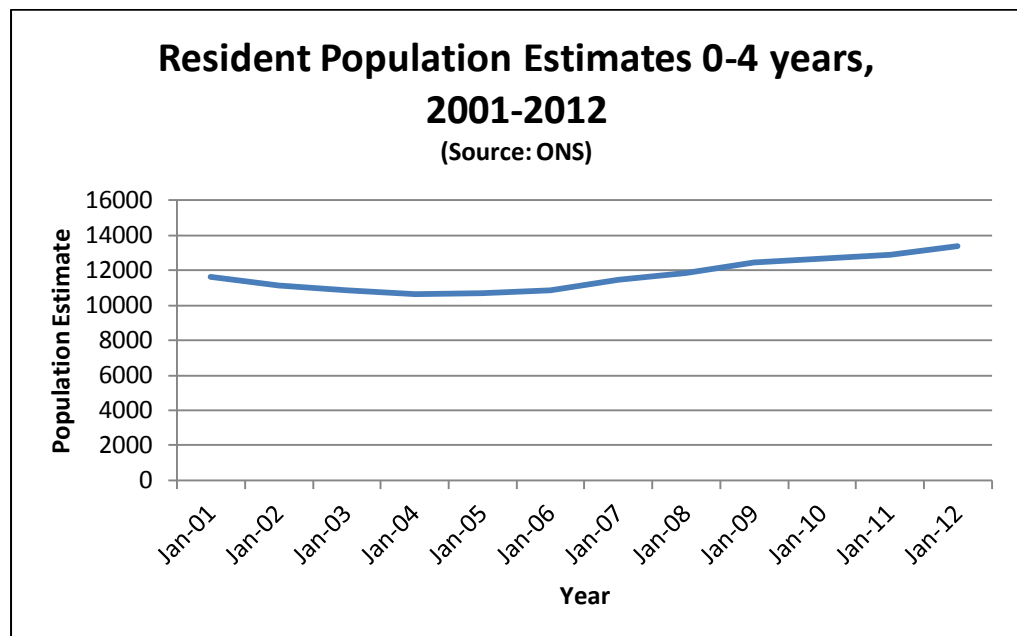
The indicators used to determine *need* for health visiting services were derived from the outcomes that the 2015-16 National Health Visiting Core Service Specification states should be improved by effective health visiting (NHSE, 2014b), and also those referred to within the

Healthy Child Programme as potentially requiring increased resource allocation (DH, 2009).

Greater London Authority (GLA) population estimates suggest the total population in Sutton in 2015 is 201,200 (GLA, 2015). The *absolute* number (16,322 in 2013) of the 0-5 years population within Sutton has gradually increased over the past decade, but the *percentage* of the total population has remained relatively stable (8.3% in 2013). Overall, the under five year old population of Sutton is projected to increase from approximately 13,400 in 2012 to 14,800 in 2022. This 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.

Live births across Sutton have increased over the past decade and, in 2013, there were reported to be 2,629. The four wards with the highest number of live births in 2013 were Sutton Central, Wandle Valley, Worcester Park and St Helier. These are also the wards with the highest numbers and percentages of 0-5 year olds. Projections of estimated number of births suggest they are expected to increase from 2,734¹ in 2013 to 2,860 in 2022.

Figure 1: Resident population estimates 0-4 years, 2001-2012.
(Source: ONS)



¹ NB. The discrepancy between this value (2,734) and the previous value of 2,629 is due to the former being a projected value.

Figure 2: Population projections (0-4 years), 2012-2022. (Source: ONS 2012-based Subnational Population Projections)

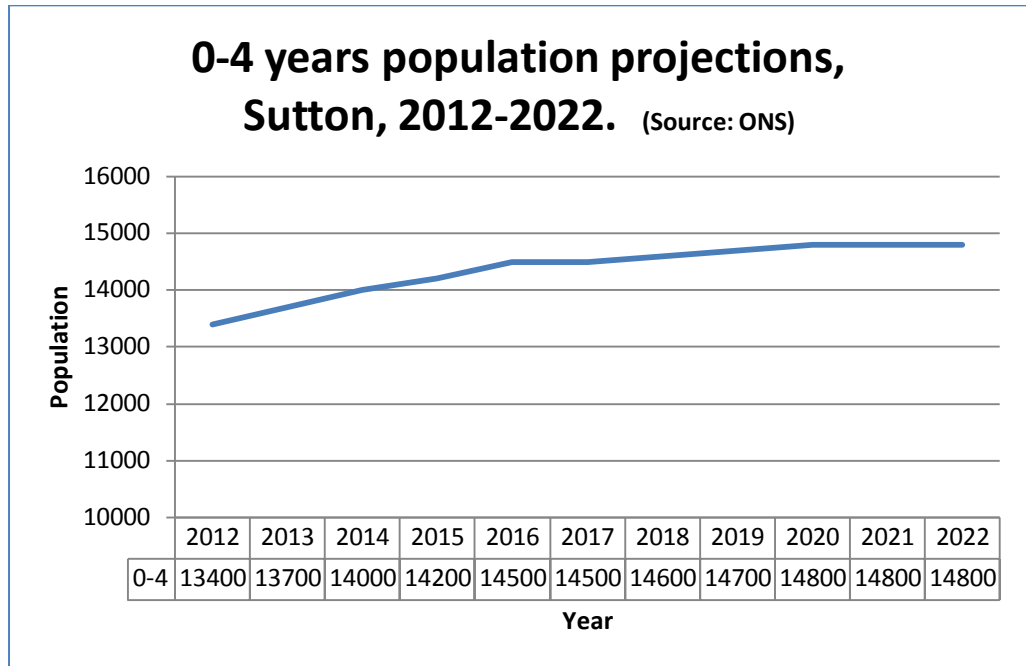


Figure 3: Map of number of children aged 0-5 years by ward in Sutton, 2012. (Source: ONS)

Number of children aged 0-5 years by ward in Sutton 2012

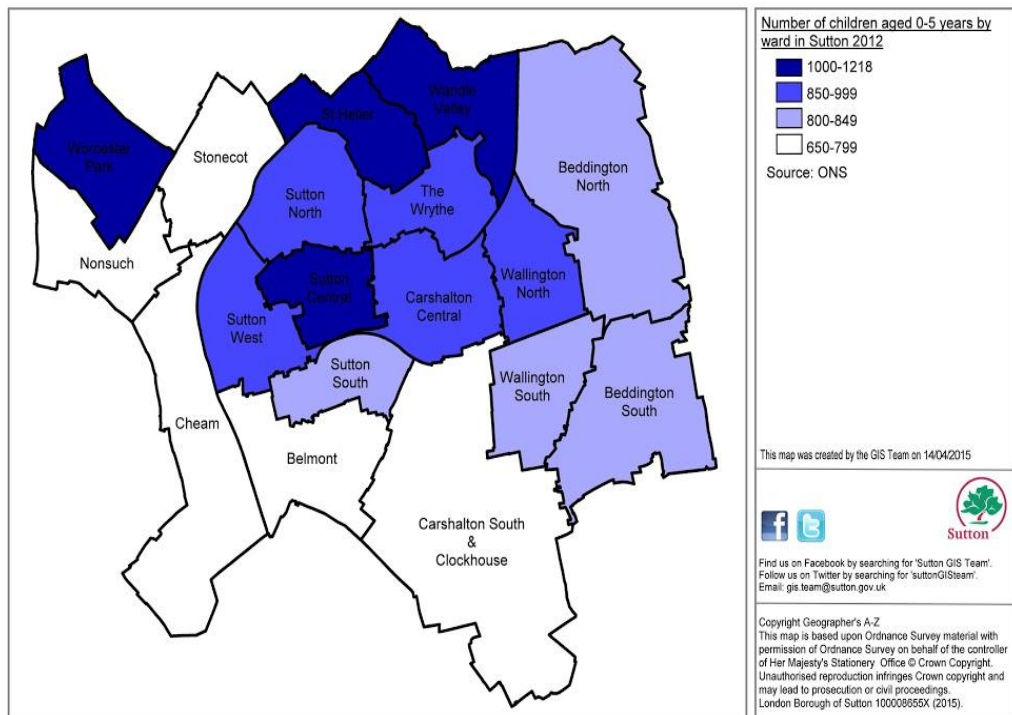


Figure 4: Live births in Sutton, 2000-2013. (Source: GLA)

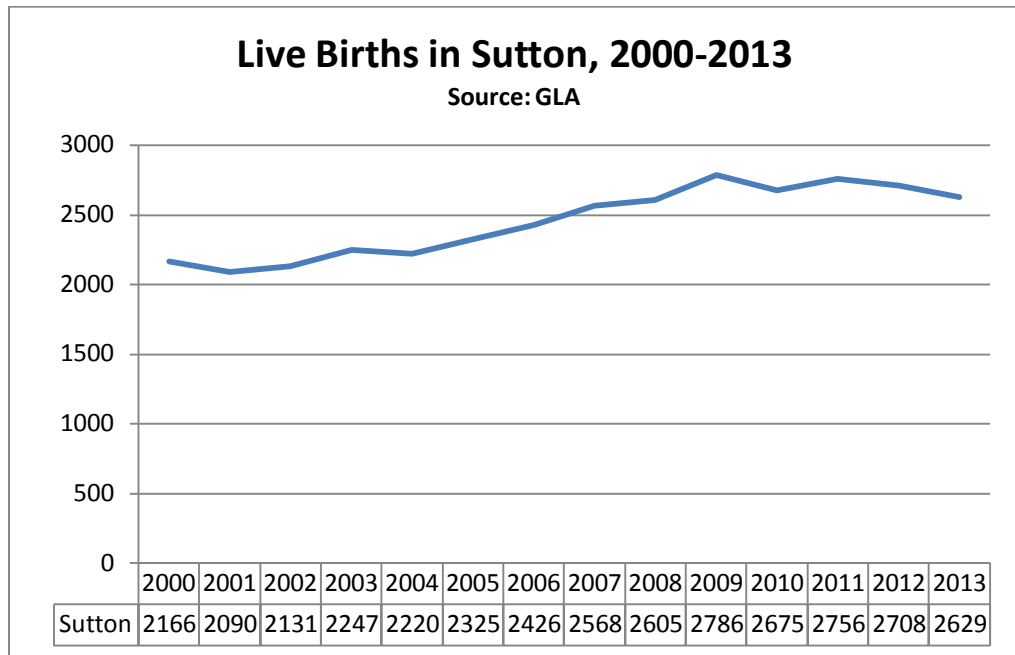


Figure 5: Birth projections, Sutton, mid-2013 to mid-2022. (Source: ONS 2012-based Subnational Population Projections)

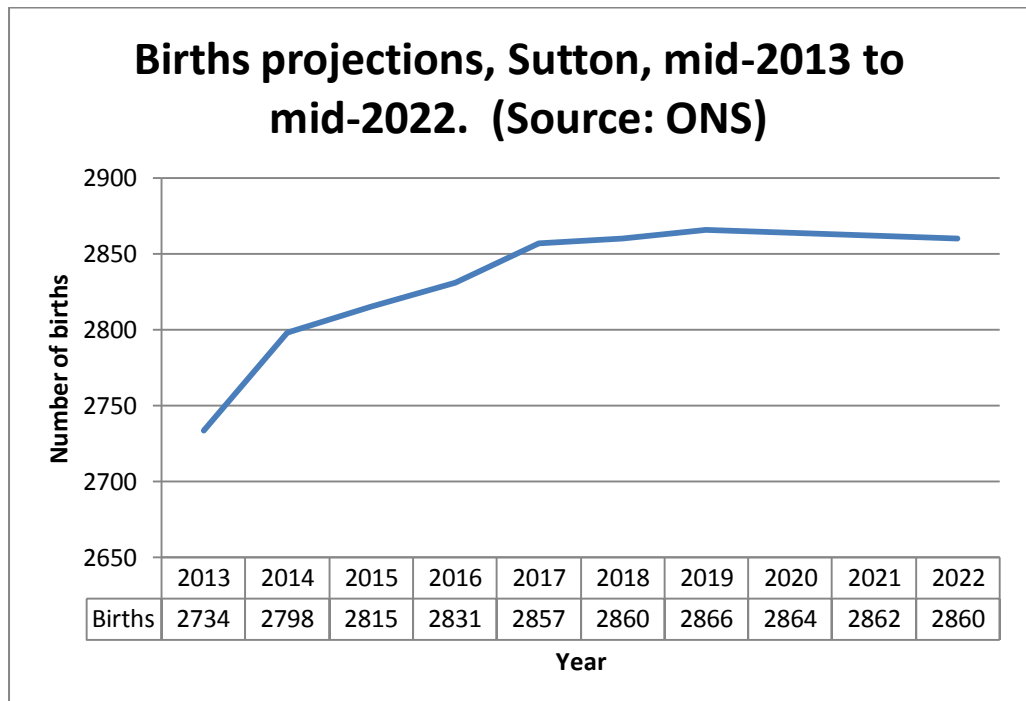
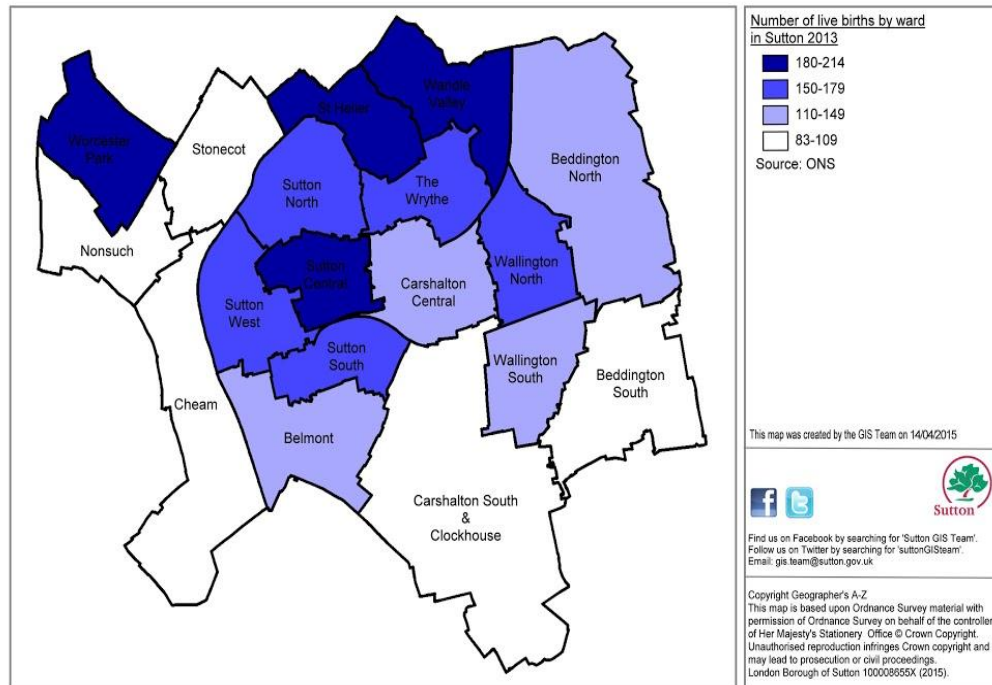


Figure 6: Map of number of live births by ward in Sutton, 2013.
(Source: ONS)

Number of live births by ward in Sutton 2013



Since the 2001 census, Sutton has become more ethnically diverse. In 2001, 89% of the population were white whereas, by 2011, this had decreased to 79% (source: LB Sutton JSNA, 2015). In the 2011 census 12% of the population were reported to be Asian or Asian British, 5% Black or Black British, and 4% of mixed ethnicity. According to 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 also suggest that, in 2011, the three largest migrant populations by country of birth were the Sri Lankan, Indian and Irish populations (GLA, 2015). 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 numbers of new births and 0-4 year populations.

The Index of Multiple Deprivation 2010 ranks 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 in the most deprived quintile in England are Beddington South, Belmont, Wandle Valley, St Helier and Sutton Central. The latter three areas of relative deprivation also rank in the top four Sutton wards for number of live births and numbers of children aged 0-5 years. The Income Deprivation Affecting Children Index (IDACI) is derived from

the English Indices of Deprivation 2010. Within Sutton, there are three Lower Layer Super Output Areas (LSOAs) within the 10% most income deprived ISOAs in England for children, and these are concentrated in the north and east of the borough. However, overall, Sutton has most LSOAs (24) in the least deprived quintile.

According to GLA Borough Profiles, the 2013 teenage conception rate for under 18 year olds in Sutton was 17.8/1,000. Sutton's rate compares fairly favourably within London for the under 18 year old teenage conception rate, being in the second lowest quintile within London. As with other London boroughs (LBs), the majority of teenage conceptions occur are to females aged 16 years and over. Overall, the teenage conception rate has declined since 1998 in Sutton, although there were upsurges in 2008 and 2011. At ward level, the areas with the highest teenage conception rates for under 18 year olds in 2010-2012 were St Helier, Wandle Valley, The Wrythe, Sutton Central and Wallington North. However, not all conceptions result in live births. In 2012/13 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%.

In Sutton from 2011-2013, the infant mortality rate was 2.5/1,000 live births, which is the second lowest when compared to its statistical neighbours². In contrast, Sutton has a relatively high percentage (2.9%) of live births at term with low birth weight as compared to its statistical neighbours. This also compares with an England percentage of 2.8% and a London percentage of 3.1%.

In 2013/14, LB Sutton had higher rates of women smoking at the time of delivery as compared to London, and all other statistical neighbours apart from Hillingdon. Specifically, the rate in Sutton was 6.1 women per 100 maternities. However, in England, the rate was almost double that of Sutton at 12/100. There has been an increase since 2010/11 when the rate was 5.4/100, although overall there has been a gradual decline since the high of 6.6/100 in 2011/12.

The Public Health Outcomes Framework (PHOF) has not published data on the initiation³ or maintenance⁴ of breastfeeding for Sutton in 2013/14 due to data quality issues. The latest PHOF estimates for 2012/13 reveal Sutton had a breastfeeding initiation percentage of 85.5% and a breastfeeding maintenance percentage of 59.6% (both higher than England). The trend in breastfeeding initiation seems to be increasing since 2010/11, but has remained relatively static for breastfeeding maintenance. SMCS have submitted breastfeeding data

² The ONS has created area classifications based upon the 2001 census. Within this classification, LB Sutton sits within the 'Thriving London Periphery' ONS cluster. Within this HNA, LB Sutton has been compared with other LBs within this cluster, but not with non-London local authorities. Within this HNA LB Sutton has also been compared with LB Merton given their historical link.

³ Percentage of mothers who breastfeed their babies within the first 48 hours after delivery.

⁴ Percentage of all infants at 6-8 weeks who are partially or totally breastfed.

on the percentage of mothers within Sutton who fully and/or partially breastfed their babies at 6-8 weeks from 2010 to 2014. However, breastfeeding status was unknown for 18.1% of mothers in 2014. In 2014 the profile by percentage was as follows: not breastfed 34.5%, exclusively breastfed 31.6%, and combined fully and/or partially breastfed 47.5%. There is wide variation in breastfeeding across Sutton and this is true at both borough and LSOA level.

In 2013/14, the prevalence of reception aged children who were classified as overweight⁵ or obese⁶ in Sutton were 19.2% and 7.4%, respectively. For year 6 children, the prevalence increases, with 33.6% classified as overweight, and 17.7% classified as obese. Overall there has been a decline in the prevalence of obesity in reception aged children since 2006/07. The four wards with the highest prevalence of excess weight and obesity at reception age are St Helier, Wandle Valley, Sutton Central and Worcester Park. 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.

The rates of parents attending treatment for substance or alcohol misuse who live with their child/children are higher in Sutton 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. 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. 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.

There appear to be problems with vaccination rates for most childhood vaccines. The Measles, Mumps and Rubella (MMR) vaccination and the 5-in-1 diphtheria, tetanus, pertussis, polio and Haemophilus influenza type b (DTaP/IPV/Hib) vaccine are incorporated within the routine NHS immunisation schedule (NHS Choices, 2014), and uptake of these vaccinations represents quality of vaccination provision in the first two years of life. 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, 87.9% of children received their first dose of MMR by the time they were two years old and 80% received two doses by five years of age. These are both statistically significantly lower than the benchmarking criteria of

⁵ Definition of overweight includes obese. Overweight is defined as Body Mass Index (BMI) on or above 85th centile of British 1990 growth reference (UK90) according to age and sex.

⁶ Obese if BMI above 95th centile of British 1990 growth reference (UK90) according to age and sex.

90%. For a completed primary course (three doses) of DtaP/IPV/Hib by two years old, in 2013//14 Sutton had coverage of 87.1%. This is also statistically significantly lower than the benchmarking criteria of 90%.

In comparison to statistical neighbours and to England, Sutton has a relatively high accident and emergency (A&E) attendance rate in the 0-4 years population. In 2011/12, there were 733.8/1,000 0-4 year olds who attended A&E. This compares with England which had 510.8/1,000 over the same period. In 2012/13 the rate of hospital admissions due to unintentional and deliberate injuries in the 0-4 years old population was 133.3/10,000, which is the highest rate in comparison to statistical neighbours.

In Sutton in 2014 there were 45/10,000 children classified as Looked After Children (LAC) which represents an actual number of 200 LAC in Sutton (as compared to 155 in 2005). In comparison, rates in most other areas appear to be decreasing. In 2014, Sutton had the highest rate of children subject to a child protection plan (CPP) in comparison to Merton, London and England (with a rate of 55/10,000 children aged <18 years). These rates also appear to be on the increase within Sutton.

1.4.3. Performance

The performance of the health visiting service was based upon activity data submitted by SMCS. The National Service Specification does not set targets for these indicators. In 2014, 82.3% of babies received a new birth visit (NBV) within 14 days, which has remained relatively static since 2010. It is unclear why the indicator was not achieved for 17.7% of new births, but it may at least in part be due to difficulties in accessing new mothers within the timeframe as, for example, some may remain in hospital and others may stay with relatives after the birth.

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 Early Implementer Site for this review (DH, 2012b). In 2014, 85.5% were invited to attend the review and, of these, 55.8% received the review. This is an increase from 2013, but the review is still in its relative infancy. At a LSOA and ward level, Nonsuch, Worcester Park, Cheam, Beddington North and Carshalton South and Clockhouse have relatively low percentages of clients invited to this review. Perhaps unsurprisingly these areas also have low percentages receiving the review, but uptake seems particularly poor in Beddington North, and there are parts of the centre of Sutton which have low uptake.

SMCS data also revealed that 43.3% and 52.7% of families had a CC promoted to them either by 14 days or at their NBV, respectively. There has been wide variation in this activity since 2010. 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. This has remained relatively static since 2010. 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.

1.4.4. Stakeholder and Client Views

1.4.4.1. Health Visiting Focus Groups and Stakeholder Interviews

Two focus groups were held in January 2015 with the health visiting team, excluding senior management. Other stakeholders underwent individual interviews in person or over the telephone.

Overall, key themes that emerged during the qualitative interviews were regarding corporate caseloads; the shift from registered to resident population; developmental reviews; teaching; data collection and information technology (IT); and safeguarding.

In terms of corporate caseloads, specific negative themes were a loss of continuity, covering large areas (both in terms of population and distance) and a loss of control. However it was noted that corporate working did allow for the provision of a more even workload, team working, and additional opportunities.

Overall the developmental reviews were felt to be a positive aspect of the service. Both the antenatal and 2-2.5 year reviews were felt to be valuable but there were concerns expressed about how to fit them into already heavy workloads without additional capacity.

Although there was an acceptance that data collection was an expected part of the HV's role, there were some concerns regarding the difficulty in measuring outcomes, changing goals and the time-consuming nature of data collection. There were

also many concerns about the IT system, which was perceived to be slow and laborious. In particular there is a lack of remote working and an inability to enter and/or access records contemporaneously, representing a real organisational and personal risk, particularly with regards to safeguarding. There also appeared to be a lack of data sharing across organisations, partly due to concerns around information governance and data protection.

A number of factors seem to be associated with an increase in workload: an increased birth rate, safeguarding, changing ethnicity, migration, loss of continuity, a reduction in home visits, and the introduction of new routine contacts without additional resources. In addition, the sheer workload associated with safeguarding alone was a prominent theme and it was also felt there were certain inefficiencies within safeguarding in Sutton that needed to be addressed.

Strengths of the health visiting service were perceived to be the management and staff; low staff turnover; HV update sessions; drop-in clinics; safeguarding provision; positive comparisons to other areas; and access for homeless families. Gaps within the health visiting service were perceived to be skill loss; lack of skill mix; workload capacity; lack of administrative support; the lack of some public health interventions and services; prescribing; and childhood immunisations.

Links with other services (eg, GPs, midwifery, social services, CCs and FNP) were also considered. Amongst the health visiting team, links with other services were overall felt to be variable and patchy, and dependent upon individuals involved. Where links were felt to be good, it was often due to co-location of services and providers. Future proposals for working alongside GPs were also considered – eg, it is proposed that each link HV will meet lead GPs for children's safeguarding on a quarterly basis. However, there were concerns outside of the health visiting service that there was a lack of clarity regarding linkage of HVs with GPs, and some GPs may like to engage more with HVs. It was thought that improving links between all services (not just primary care and health visiting) could result in improvements in efficiency, and avoidance of duplication of work.

1.4.4.2. Client Surveys

Recent health visiting surveys were utilised to gather information on client opinions. Overall there was a positive response in terms of client feedback regarding drop-in clinics, and most people felt the consultation met their child's needs and the care received was excellent/very good/good. Waiting times were predominantly less than 30 minutes, but 18% did wait longer than this, possibly reflecting high demand. There appeared to be satisfaction with drop-in sessions as opposed to appointments, and most clients were happy with daytime, weekday clinics/appointments. The predominant means of accessing HVs was via child health clinics, followed by CCs, and then routine NBVs. Preferred means of future contact were drop-in child health clinics (77%), telephone (58%), and face-to-face booked appointments (42%). The main ways in which the health visiting service was perceived to have helped families was via general advice given at child health clinics (80%), the routine healthy child programme (60%) and infant feeding support (42%). 98% were very satisfied or satisfied with the 2-2.5 year review. 95% of respondents felt the review provided them with information about their child's developmental progress and 93% reported they were given age appropriate health promotion advice. 78% were given age appropriate leaflets and suggestions to promote their child's development.

1.5. Conclusions and Recommendations

Strengths of the health visiting service within Sutton include the supportive nature of the management team; the stability of the workforce; developmental reviews; the role of the Paediatric Liaison HV and Safeguarding Supervision. Areas in need of more work and/or resource include IT; information/data sharing across organisational boundaries; alignment of localities used by disparate organisations in order to aid meaningful analyses and comparisons of data; inter-agency working and communication; determination of appropriate skill mix; caseload concerns; business continuity arrangements in relation to key specialist roles; lack of administrative support; appropriate models of specialist HV roles and appropriate structuring of services; safeguarding; A&E attendance rates, and whether HV prescribing could impact upon this; and why breastfeeding status is unknown for a relatively high proportion of women.

Key recommendations are as follows:

- 1. Investment in IT software, hardware and infrastructure support in order to mitigate organisational and personal risk.**
- 2. Regular sharing of data and information between health services and LAs. Responsibility and ownership for this needs to be accepted at a strategic level across all agencies involved.**
- 3. Organisations should work together to ensure localities are aligned according to LSOAs such that meaningful comparisons across organisational boundaries can occur.**
- 4. Improving inter-agency collaboration and communication between health visiting and other services. Where feasible, co-location should be considered optimal in promoting collaborative working.**
- 5. 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.**
- 6. 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.**
- 7. There should be sufficient capacity to cover key posts during periods of leave, particularly in relation to the Paediatric Liaison HV.**
- 8. In order to increase efficiency within the service, further administrative support would seem warranted.**
- 9. More work is required to determine appropriate models of specialist health visiting and what has worked well in other (similar) areas.**
- 10. A review of safeguarding within Sutton across organisational boundaries is warranted in order to streamline safeguarding services and make processes more efficient whilst not compromising child safety.**
- 11. Further analyses of A&E attendances to determine if they are potentially avoidable and reasons behind high rates.**
 - a. Comparative work with areas that utilise HV prescribing to evaluate whether this can impact upon A&E attendances and/or use of other health services.**
- 12. 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 workload. Further, breastfeeding data capture needs to improve so that routine, national data analyses are validated and meaningful for Sutton.**
- 13. 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).**