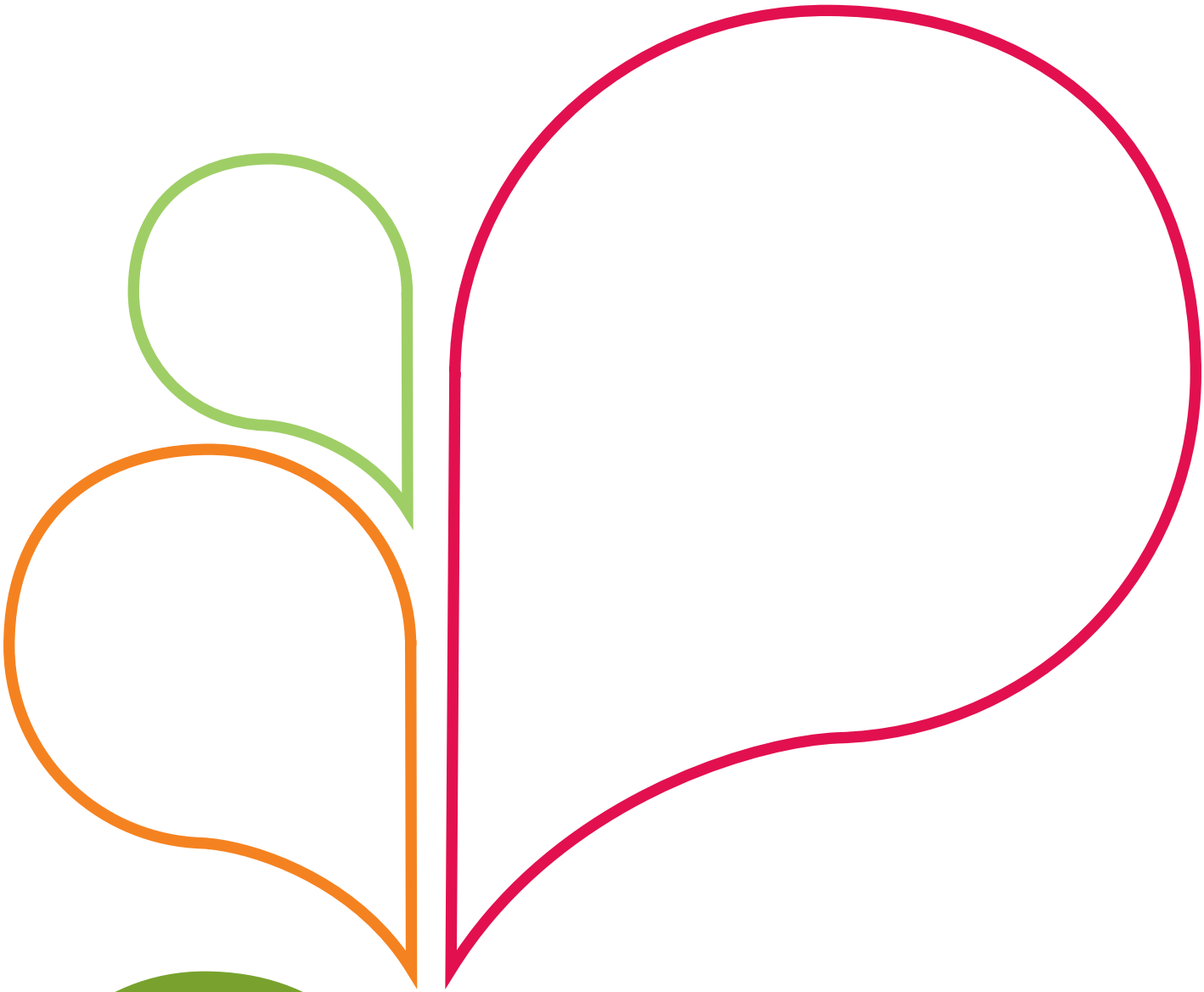
Central and North West London NHS
NHS Foundation Trust



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Hillingdon Community Healthcare Services Report

2015-16

Contents

Dear Colleague,

At CNWL Hillingdon we are incredibly proud of the work we do in supporting our resident families, patients and carers with their community healthcare needs. It is with great pleasure that I present a review of 2015-16 to show you some of our highlights from our community health services over the last year.

We have worked to strengthen our links and partnerships with primary care, the Hillingdon Hospitals NHS Foundation Trust and the third sector. Together we have formed Hillingdon Health and Care Partners and are now on a journey to transform how we collectively deliver care to the residents of Hillingdon.

We have also extended our links with the third sector so more patients can be cared for in their own home through the use of services such as night sitting. We continue to work in collaboration to deliver on the 7 day working initiative to enable patients to access services equitably across the week. Introducing 7 day therapy to our inpatient unit has meant that patients are able to spend less time in hospital.

We are now looking at how we can embed more community expertise within GP practices. Working with our partners we have supported a pilot in 4 GP practices with a specialist nurse and care co-ordinator helping to embed skills, expertise and capacity within practice to anticipate care needs and therefore avoid unnecessary trips to hospital for our more vulnerable residents. This is something we hope to roll out across the whole Borough over the next year.

We were delighted to be asked to lead the Diabetes Pathway in Hillingdon and have worked closely with our partners to review the pathways and make sure we provide care in the right place at the right time. We are also working with Hillingdon Hospital to develop a new Cardiology pathway and have expanded our own capacity to deliver more enhanced cardiology services within the community.

In March this year our Health Visiting service received confirmation of Stage 1 Baby Friendly Initiative for breastfeeding - a big achievement for the teams and we are working to gain Stage 2 accreditation now.

Our Children's Community Nurse Team are now offering IV therapy to children at home to reduce hospital stays and admissions.

We want to concentrate our services on fewer but larger sites. This will be more convenient for our families, patients and service users as they can go to 'one-stop shops' for all their care and treatment needs. It will mean that how we configure some of our services will change but it also means we can start to offer appointments at more convenient times such as evenings or weekends.

Our Annual Patient Survey told us that 95% of respondents would be extremely likely or likely to recommend community Services. This is up from 93% in 2014. 99% told us they were treated with dignity and respect and 97% felt they were appropriately involved with their care. The Paediatric Speech and Language Team received excellent user feedback results for 2015/16; including 100% of parents within the pre-school children caseload reporting that their therapist was kind and caring and had a good relationship with their child.

All this is a credit to the hard work of all of our

staff who day in day out deliver high quality patient focused care to patients and their families or carers.

Whatever the service being delivered, our staff pride themselves in putting the needs of patients first. This year we will launch the #hellomynameis… campaign across our Trust. Delivering compassionate care starts with an introduction and we are encouraging our services and teams to adopt the principles behind Dr Kate Granger's campaign as a way to ensure we are always putting the needs of our families, patients and service users first.

We value feedback in whatever form it is received. Enshrined within everything we do is a system promoting safe and effective care through reflective practice and learning to ensure when lessons from incidents or complaints and positive patient feedback is identified, they are put into practice not only in the service concerned, but across the Trust as a whole.

Each service report highlights their achievements for the year which include a variety of service improvements, patient engagement projects and delivery of key performance targets and outcomes. All pivotal to maintaining a healthy organisation that is looking forward to delivering even more service transformations in partnership with our patients and their families or carers.

We appreciate your feedback and comments. If you would like to discuss anything in this report then do contact me directly. My number is 020 7685 5806 or email Graeme.caul@nhs.net.

Yours sincerely,

Graeme Caul
Community Services Director

Vision

What we are working towards – Wellbeing for life

To work in partnership with local people to improve their health and wellbeing. Together we look at ways of improving an individual's quality of life, through high quality healthcare and personal support.

Values

What we believe in

Compassion:
We all contribute to a compassionate environment for everyone here; what we say and do helps make the lives of others better

Respect:
We will respect and value the diversity of our patients, service users and staff, to create a respectful and inclusive environment, which recognises the uniqueness of each individual.

Empowerment:
We will involve, inform and empower our patients, service users, carers and their families to take an active role in the management of their illness and adopt recovery principles. We will ensure our staff receive appropriate direction and support, to enable them to develop and grow.

Partnership:
We will work closely with our many partners to ensure that our combined efforts are focused on achieving the best possible outcomes for the people we serve.

Year in numbers

91% of mothers received a new birth assessment in 14 days

99% of height and weight checks completed

237 referrals from enuresis support by School Nurses

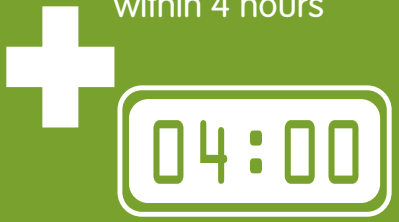
100% of our Looked After Children assessments undertaken on time

92% of patients using District Nursing, Rapid Response and Case Management screened for dementia

87% of palliative patients were able to die in their preferred place of care

88% of District Nursing referrals contacted within 24 hours of referral

99% of District Nursing urgent referrals seen within 4 hours



93% of children received an audio and vision check

4% identified with vision issue and referred on
8% identified with hearing issue and referred on
650 referrals on made

Service reports

Hillingdon children's services

Community Paediatric Nursing

Summary of service

The Community Paediatric Nursing Team is comprised of qualified children's nurses working in the community, special schools and GP surgeries. The Community Children's Nursing Service provides nursing care for children from 0-18 years of age with acute, chronic or complex conditions. Care may be provided in children's own homes or in other community settings, seven days a week.

All children/young people referred to the service are contacted by a trained children's nurse within 48 hours of receipt of referral. Urgent cases are contacted and a visit arranged within 24hours. At first assessment a care plan is developed in partnership with the family.

The team provides structured education and training to children/young people, their carers, statutory and voluntary organisations.

A paediatric dietician is working in the team until November 2017 to support children who receive enteral feeding.

Community Paediatric Matron Service - The paediatric community matron provides minor illness clinics in four GP practices in Yiewsley, five days a week.

Special School Nurses - This service provides resident nursing support to three special schools within the borough: Grangewood, Sunshine and Moorcroft, for children aged 4-19 years.

Activity

The CCNT covers the borough of Hillingdon. The current number of children on caseload is in excess of 200.

The service received 1,855 referrals, with 11,049 appointments or visits made over the course of the year. The Community Children's Matron sees approximately 16 children per day, five days a week.

The CCNs based in the borough's three special schools see children/young people on a daily basis. They deliver training to education staff, administer feeds and medication and compile health care plans with school and the CDC consultant.

New developments this year

The team has recently increased its provision of ambulatory care for children requiring IV therapy at home. This means care can continue at home following either a short hospital admission or actual prevention of admission.

A nurse with specialist training in epilepsy management has started working in partnership with a Consultant Paediatrician at the Child Development Centre. The nurse reviews children/young people, monitors their medication and liaises with parents, carers and paediatricians.

Plans for 2016-17

Two special school nurses are undertaking the Nurse Prescribing course. This will enable families to discuss and agree potential medication changes directly with the nurse.

Hillingdon Health Visiting Service

Summary of service

The Health Visiting Service promotes the health and wellbeing of families with children under five. The team includes health visitors, community staff nurses, nursery nurses, health visitor assistants and administrative staff. The team works closely with Children's Centres, social care and other healthcare professionals, including GPs.

The Health Visiting service is commissioned to deliver the Universal and Targeted elements of the Healthy Child Programme. This includes provision of a named contact for all children and families under the universal services contract, and a named health visitor for all children and young people who require extra support or whose needs are more complex and enduring.

Hillingdon has health visitors specialising in maternal and infant mental health, domestic violence, breastfeeding, hospital liaison and marginalised communities (the Community Engagement Programme).

The team offers expecting mothers and families support before birth, in the early weeks following birth and as the child develops.

The service offers a Saturday morning service at two sites across the borough, enabling easier access for parents and carers who work Monday to Friday.

Activity

The service received 13,292 referrals, with 93,082 appointments or visits made over the course of the year.

New developments this year

The Health Visiting service achieved level 1 in the UNICEF baby friendly breastfeeding award and is working towards reaching level 2 in the coming year.

Health Visitors are reviewing the antenatal programme 'Your Bump and Beyond' with the Children's Centres: this is a universal, ante natal programme delivered in Children's Centres along with children centre staff and the midwifery service.

Uma Purohit, specialist HV for community engagement, was awarded CNWL employee of the year for her work with the Afghan women's community to support them with parenting issues.

Plans for 2016-17

There are plans to review the service and management structure for the health visiting service teams, to meet commissioning requirements and ensure effective and efficient delivery of the service.

We are planning user feedback surveys for our families to comment on the service currently offered to them and how it could be improved.

The service plans to review its child health clinics and will look to improve delivery and quality of the experience for service users.

The service plans to share best practice in Hillingdon between Hillingdon, Camden and Milton Keynes for all Health Visitors.

In 2016 a professional practice day with speakers from the Local Authority and the Institute of Health Visiting is planned. This will discuss future service developments around the six early years high impact areas.

Hillingdon and Harrow Looked After Children Health Team

Summary of service

The Hillingdon and Harrow looked after children health team provides health services to children who have entered the care system. They ensure that all those involved in the care of these children are able to promote positive health, are aware of and address relevant health issues. The team:

- Ensures children have a comprehensive and high quality assessment of their health needs, by undertaking statutory health assessments which contribute to the child's health care plan
- Ensures that the child's immunisations and dental checks are up to date
- Provides advice and information to foster carers to promote health and wellbeing and provides advice relating to child development, emotional difficulties, and common health problems
- Trains colleagues working with looked after children, their families and carers, social workers, foster carers and staff/children in residential establishments
- Reviews the health needs of care leavers
- Advises and supports the Adoption and Fostering Panel
- Liaises and advises hospital trusts, independent contractors and other agencies such as social services, education, police and voluntary services
- Works with partners to address teenage pregnancy and the sexual health of young people and address emotional health issues such as self-harm
- Works directly with young people to actively involve them in the development of services, such as meetings with the Children in Care Council.

Activity

The looked after children (LAC) caseload fluctuates on a weekly basis, as children enter and leave the care system. Data from January/February 2016 show that Hillingdon's LAC population was 361 and Harrow's LAC population was 184. There are additional LAC who are placed within Hillingdon by other Local Authorities, and although the overall statutory responsibility remains with the placing authority, the LAC team may be asked to undertake health assessments on their behalf.

During 2015/16 Hillingdon received 554 requests for health assessments, 240 of which were for initial health assessments (IHAs) and 314 for review health assessments (RHA, of which 506 assessments needed to be completed.

From June 2015 to March 2016 Harrow received 254 requests for health assessments (109 IHA and 145 RHA requests) of which 202 were required to be completed.

Total activity for both teams was 708 assessments.

New developments this year

The main change this year has been the newly commissioned Harrow Children Looked After Service from June 2015. In order to ensure smooth transition and implementation of the new Harrow contract the team:

- Held a launch event for Harrow Service with all partners in June 2015
- Spends one day a week with the Local Authority, meeting senior managers to monitor health assessments and being available to social workers
- Attends meetings and links made with key partners – health visitors, school nurses, Youth Offending Team, Child and Adolescent Mental Health Services, and sexual health
- Implemented a programme for foster carer training
- Provided induction training for new social workers and partners
- Successfully applied for and awarded TB grant for £500 which was used for the production of leaflets and posters delivered to all Harrow schools and GPs in consultation with Children Looked After (CLA)/Unaccompanied Asylum Seeking Children (UASC) team
- Hosted a visit from Swedish school nurses interested in our work with UASC and CLA
- Delivered a presentation at the care leavers' forum, attended by over 40 carer leavers
- Attended a corporate parenting board and corporate parenting managers meeting
- Attended a Children Looked After celebration in Harrow
- Attended a foster carer's award ceremony. This event provides recognition to foster carers who have provided services to Harrow and delegates awards for long service
- Developed a 'Handy Hints' leaflet in conjunction with Children Looked After

Other developments were:

- Designated nurse asked to deliver a teaching session at Oxford Brooke's University
- Team members have implemented new ideas including sexual health packs in all Hillingdon residential homes, and presenting at men's health week
- New consent form and parent information leaflet introduced
- Introducing a 'crib sheet' to help interpreters at health assessments
- Development of written health assessment for non-attenders/refusers.

Plans for 2016-17

During 2016-17 the Hillingdon Looked After Children Health Team will continue to provide a health service to looked after children, as outlined within statutory guidance, working with our health and social care partners. The Harrow Children Looked After Health Team will continue to review existing processes to ensure they are as streamlined as possible, including the introduction of:

- A new way to request adoption medicals and providing medical advice
- Health passports for our care leavers

The team will continue to build upon the success of its first year, working in close partnership with Harrow CCG and Harrow Local Authority.

The joint team to develop an annual client satisfaction audit for 2016-17.

Safeguarding Children

Summary of service

Section 11 of the Children Act (2004) places duties on health organisations to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. These organisations should have in place arrangements that reflect the importance of safeguarding and promote the welfare of children. Health professionals are in a strong position to identify welfare needs or safeguarding concerns regarding individual children and, where appropriate, provide support. This includes: understanding risk factors, communicating effectively with children and families, liaising with other agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews.

Activity

There are over 69,000 children and young people aged under 18 years in Hillingdon. The number of children subject to a Child Protection Plan ranged from 350-390. This number would be in line with what would be expected in the context of the child population size.

New developments this year

- National mandatory reporting of Female Genital Mutilation (FGM) in children was introduced 31 October 2015
- Children's services staff received bespoke training on child sexual exploitation
- Multi Agency Child Sexual Exploitation panels are now well established and information is shared widely across the health partners in Hillingdon
- A full time health practitioner with access to SystmOne is working in Hillingdon's Multi Agency Safeguarding Hub (MASH). The team use their shared knowledge and skills to ensure that children and families have access to the right services at the right time

Plans for 2016-17

- Focus on neglect – it is planned to include it in CNWL's 2016/17 Trust-wide safeguarding children work plan and it is a priority for Hillingdon's Local Safeguarding Children Board in 2016/17
- Bespoke training for children's services staff from Hillingdon's Serious Case Reviews and Domestic Homicide Reviews to be rolled out
- Development of a Trust-wide safeguarding children strategy
- Revise the Trust-wide safeguarding children training strategy

Community Paediatricians Service

Summary of service

Hillingdon Community Paediatrician Team works with children who have complex additional needs, disabilities or long term conditions, enabling them to achieve their maximum potential.

The team are highly skilled clinicians who also lead in the following areas for Hillingdon:

- Designated Doctor and Named Doctor for child protection
- Designated Doctor for Adoption and Fostering for looked after children
- Designated Medical Officer - provider link for education

The services provided are for:

- Children with disabilities and complex health needs
- Children undergoing an assessment of their special educational needs, where medical information is provided to support multi professional assessment
- Children with developmental concerns such as social communication difficulties, autism spectrum disorder (ASD), developmental delay or motor co-ordination difficulties
- Babies who are at high risk of developmental difficulties, transferred from the neonatal team
- Looked after children, as part of the statutory requirement for all children in care
- Safeguarding and protecting children

Paediatricians see children with one or more of the following conditions:

- Developmental delay
- Epilepsy
- Cerebral palsy
- Chromosomal disorders
- Neuromuscular conditions
- Neurodevelopmental disorders such as Developmental Co-ordination Disorder and ASD

Activity

The service received 1,582 referrals, with 4,292 appointments or visits made over the course of the year.

Patient experience measures during 2015-16 were met or exceeded:

- 98% of patients were contacted within one week of receiving their referral
- 100% of child protection referrals for medical assessment were responded to within 24 hours
- 100% of medical assessment requests for children with SEN were responded to within six weeks
- 100% of patients who were in transition had a written child development report provided to their adult GP service by the agreed date of transfer.

Comments from Friends and Family Test include:

'I got very helpful and caring treatment for my son. Thank you all for your help. Also my opinion is heard and a solution is always found.'

'Always helpful, always greet you.'

'Nothing could have been done better.'

New developments this year

Review and streamlining of appointments for multidisciplinary team (MDT) assessments in order to deal with increased number of children referred with suspected ASD. This resulted in 235 children being seen, a 20% increase on 195 seen the previous year.

Launched Child Development Centre (CDC) all staff work streams in October 2015 focusing on staff engagement: staff feeling valued and included and service improvement work streams – including strengthening of patient, parent and carer involvement. This has been well received and feedback from patient and carers is informing service improvements.

Plans for 2016-17

The Child Development Centre (CDC) is continuing to develop several workstreams to improve patient experience and allow the wider staff group, parents, carers, young people and our partners in the community to take a more active role in service planning and delivery. Some of the workstreams being developed over the next year include:

- Patient/parent/carer involvement and feedback – focus event in May 2017
- Working through the 15 Step Challenge to look at care in our settings through the eyes of patients and service users, to help capture what good quality care looks, sounds and feels like
- Review of multi-disciplinary diagnostic pathway for children under five – this included involvement from a parent/service user who is also a member of Hillingdon Parent Carer Forum steering group
- Improving processes to support parents when completing questionnaires

A new post has been created for a clinical psychologist who will work closely with the community paediatricians and therapy teams at the CDC, including supporting the diagnostic pathway for ASD and provide invaluable support to the young people and their families who use the service.

Paediatric Physiotherapy

Summary of service

The Paediatric Physiotherapy Service provides a specialist service including assessment, diagnosis and therapy for children and adolescents who have movement disorders as a result of injury, illness or disability. In addition, the service supports children under five who present with musculoskeletal/ orthopaedic problems. The service is open to children aged up to 19 years of age and registered with a Hillingdon GP. The service is delivered from the Child Development Centre and also in Children's Centres, schools (special and mainstream) and in the child's home.

Activity

The service received 628 referrals, with 6,516 appointments or visits made over the course of the year. Referrals come from health visitors (26%), GPs (23%) and other sources including parents and schools (51%). The maximum wait for an initial appointment is five weeks. This is a key target and has been 100% achieved.

New developments this year

The service had identified the need to improve communication and links with the adult physiotherapy service. The transition pathway from paediatric to adult services was a key area for improvement. The service is now working closely with adult physiotherapy to develop a joint pathway, to ensure an effective transition process is developed to support patients. The outcomes of this work include joint handover appointments with the CNWL Community Adult Rehabilitation Team, and agreed to run a jointly-held clinic with the Alderbourne Rehabilitation Unit at Hillingdon for next year's cohort. These measures will support a whole-system, integrated approach.

Multidisciplinary assessments (OT and PT) for children referred for motor co-ordination difficulties. Children and families benefit as this saves them attending multiple appointments (and having to 'retell their story'). Treatment is also improved resulting from co-ordinated care.

Development of a joint exercise group for children with motor co-ordination difficulties.

Setting up the Ponseti Pathway with the orthopaedic consultant at Hillingdon Hospital (THH) for babies born with structural talipes. Through this service time has been saved, stopping families having to travel long distances to tertiary centres to access treatment, and bringing care closer to home. This approach was set up following feedback from parents to Paediatricians who had sought care to be delivered closer to home.

Whole system working has been supported by the service working with the orthotics service at THH which has reduced the waiting times for orthotics from eight weeks to four to six weeks.

The service is actively supporting work streams across the CDC including the development of increased patient/parent/carer involvement in service review and new developments.

Plans for 2016-17

- Phase two of the transition pathway from paediatric to adult services which will see the jointly-run clinic set up with the Alderbourne Rehabilitation Unit

- Set up and implement the Cerebral Palsy Integrated Pathway, currently being established across London. This aims to provide a high quality, standardised follow-up programme for children/young people with Cerebral Palsy that will identify musculoskeletal problems through regular physical and radiological examinations. This will allow for effective management of musculoskeletal problems throughout the course of childhood

- Explore a potential opportunity to support the developmental screening of High Risk Children. Currently children who present with motor disorder risk factors receive developmental screening assessments by paediatricians at Hillingdon Hospital. Elsewhere paediatric physiotherapists carry out these assessments, providing advice and intervention and only when necessary refer on for further advice e.g. to paediatricians. This has significant cost saving implications in addition to moving care outside of hospitals. This would involve identifying the numbers of children not already known to the CDC who would require follow up. The level of additional resource required could then be identified

- Explore extended service provision to support young adults (19-25) who present with impairments of motor function in line with SEND reforms. The Paediatric Physiotherapy service could provide a specialist key working role/function for young adults up to 25 years

- Develop existing treatment pathways and MDT working, in response to feedback and changes from service users in line with patient/user involvement work streams at the CDC.

Paediatric Occupational Therapy

Summary of service

The Community Paediatric Occupational Therapy Service (OT) provides assessment of function, mobility, gross and fine motor skills, sensory processing, perception and development. The service assesses the daily functional impact of any impairment, providing strategies in partnership with parents and children/young people, to modify sensory processing difficulties.

This includes providing splinting and equipment to improve function, prevent deformity, control tone and encourage successful performance of everyday tasks.

The service supports partnership and integrated working, and the education of professionals, parents and carers. The service provides intervention within individual and group settings, as appropriate to the child's needs.

Therapy activities support the child/young person's neurological functioning, including attention and concentration, sensory processing, perception, development of physical abilities including fine and gross motor skills, activities of daily living such as dressing and using cutlery.

Paediatric occupational therapeutic interventions support the child/young person's development through the use of purposeful activity and play, to help them achieve their potential. The service provides input according to the each child/ young person's stage of development and specific needs, and with consideration of the social, cultural and family background.

Therapy is delivered in a variety of settings including the Child Development Centre, two specialist sensory exploration rooms (one in the south and one in the north of the borough located within local authority schools), Children's Centres, schools and home visits.

Activity

The service received 759 referrals, with 4,767 appointments or visits made over the course of the year.

Feedback:

- Parents reported progress in 97% of usable targets across all groups and sensory exploration sessions
- 100% of parents reported that staff were kind and caring, had a good relationship with their child/ young person, and had a good understanding of their child's needs
- 100% of all parents reported that staff listened to their concerns, were kind and caring, explained to them what was happening in the session and gave them ideas about how to help their child at home
- In a user satisfaction survey 93% of parents stated that they found the OT session useful or very useful
- 100% rated the OT service excellent or good

New developments this year

The introduction of the new Education, Health and Care Plans (EHCPs) has resulted in a shift towards increased child/young person/family centred way of working which is reflected in the new report format, which includes the child/young person/ family's aspirations, which link with the agreed outcomes.

OT statutory report formats have been reviewed and amended to support efficient working and further develop the quality of reports.

The service has been awarded a new borough-commissioned OT school contract, which will provide OT reviews/programmes and some direct interventions for school age children/young people with an EHCP, largely attending mainstream schools

Paediatric Speech and Language Therapy (SLT)

Summary of service

The Paediatric Speech and Language Therapy (SLT) service aims to provide accurate and timely assessment and therapy for children and young people identified as having moderate-severe speech, language, communication needs or eating, drinking and swallowing difficulties (dysphagia).

Interventions ensure children and young people's communication/ feeding needs are identified, and they are supported to develop and achieve academically, socially, and emotionally to reach their full potential.

The children and young people the Service works with typically have difficulties with one or more of the following areas:

- Speech difficulties
- Language difficulties
- Social Communication difficulties
- Stammering/dysfluency
- Voice difficulties
- Selective mutism
- Eating, drinking and swallowing difficulties

The SLT service is delivered in the following range of locations, dependent on the needs and age of the child or young person:

- Clinic settings
- Child Development Centre (CDC)
- Children's Centres
- Home
- Hillingdon mainstream state schools
- Hospital wards (ABI and dysphagia)
- Nurseries

Activity

The service received 1,417 referrals, with 24,646 appointments or visits made over the course of the year.

Feedback:

- A survey of school special needs co-ordinators (SENCOs) showed that 88% are happy or very happy with the Service that they receive. SENCOs commented on how helpful advice and strategies are, as well as the support and training provided for school staff. They felt therapists communicated well and provided a helpful and creative service with good support for parents. They also commented that children had made good progress and staff felt confident on how to follow up on SLT advice.

- 100% of parents with pre-school children considered that therapists working with their children had been kind and caring and had a good relationship with, and understanding of, their child.

- 99% of parents reported that the strategies they were given by the SLT would help develop their child's communication at home.

- 68-82% of teachers rated that their knowledge of how to support the child's communication skills in class had developed over the academic year. New classroom SLT strategy advice sheets have been developed in order to support teachers with using strategies to support children in their class across the school day.

New developments this year

- Funding for three new posts within the mainstream schools service will help to meet the increased demands for school based SLT support – numbers have more than doubled since 2010. In addition funding for a part time new post to support the ASD diagnostic pathway has been secured for children with complex additional needs.

- A new development screening tool to support early identification and appropriate referrals to the pre-school team has been developed, resulting in increased appropriate referrals to 92.5%.

- The introduction of EHCPs has resulted in a shift towards a more child/family centred way of working, which, as with other services, is reflected in a new SLT report format which includes the child/family's aspirations which aim to link with the agreed outcomes.

- In response to feedback from the local authority and the increase in the number of tribunals the service is being asked to support, the service has further improved the quality and detail contained in recommendations for EHCP reports.

- The service has developed new care plan and target sheet templates to ensure that children have an identified care plan which is shared with school, nursery and the family. A recent audit showed that 100% of audited children in the pre-school teams had an up to date care plan.

- The service has actively supported the CNWL-initiated partnership review of the ASD diagnostic pathway and support with partners (including LBH, Children's Centres, HVs and Paediatricians) for children under five and their parents/carers.

Plans for 2016-17

- A new leaflet is being developed which will be given to families of pre-school children already in therapy and about to start school and will be expected to transfer to the mainstream schools' speech and language therapy team in September 2016. This explains SLT service which is offered in the mainstream schools.

- Development of ways to obtain feedback from school aged children receiving speech and language therapy.

- The increase in staffing in the mainstream schools team will be used to close the gap between the level of service and packages of care offered to children with an EHCP and those without.

- Charitable money has been sourced to develop a video providing useful tips and strategies for parents to support their child's early language and communication development. This is to raise awareness for parents/communities in areas of higher social deprivation where there are known to be higher levels of speech, language and communication needs (SLCN).

- A nursery pack is being finalised to provide school nurseries with useful strategies to promote the development of speech and language skills in all children.

- The multi-disciplinary ASD diagnostic pathway for under-fives is being reviewed to improve quality.

- A new ASD pathway for children over five is being developed at the CDC

- Multidisciplinary workstreams have been identified at the CDC including strengthening and developing patient/carer involvement: the SLT service is collaborating with this work.

School Nursing

Summary of service

The School Nursing team comprises qualified nurses with specialist training in the health needs of school aged children. Some are specialist public health nurses. There are three teams in Hillingdon: Eastcote Team covers North Hillingdon; Laurel Lodge team cover Uxbridge and West Drayton; and Minet Team covers Hayes and Harlington.

The school nursing service delivers the healthy child programme from the age of 4-19.

Universal Services

- Health Screening of vision and screening to all reception children
- National Child Measurement Programme for reception and year six children
- Junior Citizenship – partnership working with local community agencies promoting better understanding of accident prevention and risk with children aged 10-11 before starting secondary school
- Neonatal BCG programme in three clinics

Universal Plus Services

- Nurse-led enuresis clinics – children are seen from the age of five. The Service follows the NICE guidelines for children with bedwetting. Children are seen with a parent and followed up with face to face and telephone contacts
- MEND programme interventions for overweight and obese children. The programme targets children at ages 5-7 and 7-13. These programmes are run twice weekly at schools or leisure centres
- Annual asthma and EpiPen training is provided to all primary and secondary schools for teaching and support staff. All schools have an annual audit

Specialist (Universal Partnership Plus)

- Safeguarding – child protection, child in need. School nursing has a key role in implementing health outcomes and a child's developmental and emotional wellbeing
- Early intervention – early help assessments and interventions for families in difficulties
- Drop-in clinics in secondary schools: a recent audit highlighted that the young people valued the service and felt that they were treated with dignity and respect
- School nursing works closely with the Looked After Children team and the immunisation Task Force

Activity

The service received 1,958 referrals, with 11,955 appointments or visits made over the course of the year.

New developments this year

- The service set up an immunisation team following a successful tendering process to provide school aged immunisations to schools in Hillingdon, Brent and Ealing
- Secured a tender to provide outstanding neonatal BCG vaccinations to babies in Brent, Ealing and Harrow.

Plans for 2016-17

The school nursing service is working to become more closely aligned with the Health Visiting service, to ensure seamless delivery of care to children aged 0-19.

School Immunisation Team

Summary of service

The School Immunisation Team was set up in September 2015 and began vaccination sessions in schools on 2 November 2015. The team has been immunising secondary school age children across Brent, Ealing and Hillingdon in line with the routine childhood immunisation schedule.
The team covers 89 secondary schools and has been vaccinating year 8 girls (HPV vaccination), year 10 children (Td/IPV, Meningitis ACWY, and MMR catch up) and year 11 children (Meningitis ACWY). Termly catch-up immunisation clinics have been set up within Brent and Ealing for those who missed their vaccinations in school. Hillingdon children have been accessing existing catch up clinics in Hillingdon.

Activity

Brent:

- 69 school visits.
- 5,228 individual contacts with young people.
- 13 contacts with young people at 3 catch-up clinics.

Ealing:

- 98 school visits.
- 5,976 individual contacts with young people.
- 70 contacts with young people at 3 catch-up clinics.

Hillingdon:

- 22 school visits.
- 2,183 individual contacts with young people.

New developments this year

- This newly commissioned service was set up in November 2015 for Brent and Ealing schools.
- Termly catch up clinics in Brent and Ealing have been set up for young people who have not received their vaccinations in school; and for those children who are not currently accessing mainstream education.

Plans for 2016-17

- The team will be focusing on Brent and Ealing secondary school age immunisations from September 2016.
- The existing school nursing service in Hillingdon will be undertaking vaccination sessions in Hillingdon schools.
- The team are planning to provide education assemblies for young people (commonly provided in Hillingdon) in Brent and Ealing; giving information on the vaccinations they are due to receive in order to improve the uptake.
- The team is planning to set up a new immunisation catch-up clinic more centrally in Ealing, taking into account the views of parents and children attending the current clinics and feedback from the commissioner.

Immunisation Task Force

Summary of service

The Immunisation Task Force offers a catch up childhood immunisation service to babies and young people, more than 12 weeks behind with immunisation. A one-day Fundamentals of Immunisation training is delivered to all new nurses giving immunisations and to practice nursing, twice yearly.

A half-day Fundamentals of Immunisation catch up training is delivered to all nurses giving immunisations, to update their knowledge of immunisations, also twice-yearly.

Activity

2,371 referrals received and 3,255 contacts achieved.

Three catch up clinics a month are offered across Hillingdon at the Minet, Uxbridge and Eastcote Health Centres. An average of 20 patients per clinic attend monthly. On average, 25 immunisations are given per clinic.

Two monthly clinics for unaccompanied asylum seekers are run at residential homes, where an average of six young people are seen and 18 immunisations given monthly.

Home visits are offered for those families who are unable to attend clinic and have been referred through routes including GPs, social services, the LAC and HV service.

New developments this year

The team hosted a series of catch up clinics at the end of each month for young people who missed the MenACWY and HPV Vaccine at school.

Plans for 2016-17

The team plans to target semi-independent accommodation for looked after young people and offer them an immunisation catch up service.

Hillingdon Tuberculosis(TB) Nursing Service

Summary of service

The Hillingdon Tuberculosis (TB) Nursing service provides tuberculosis prevention, control and treatment in patients' home and community settings. The service aims to prevent, control and treat TB across Hillingdon.

The team comprises three specialist nurses, who work in partnership with the Respiratory Team at the Hillingdon Hospital, attending and reviewing patients in clinic.

The service primarily provides case management, outbreak management, treatment and community support, including:

- Supporting patients with TB and their partners and families in a community setting, offering health promotion advice and treatment
- Following up patients during treatment for medicine adherence (including directly observing therapy), side effects, symptoms, and drug interactions. The team sees patients in their own homes and at other locations as appropriate, this is to help with coherence of their medication regimes and to offer support as required
- Contact screening from active TB cases, to check for latent or active TB.

The service also provides ad hoc health screenings, one of which is conducted annually at a temporary homeless shelter in Hayes.

The service provides assistance with the BCG programme in Hillingdon for babies alongside school nurses.

Activity

In 2015 the team had 79 active TB cases in Hillingdon (equating to 33.1 people per 100,000 population) as well as a number of latent TB cases. 99 new referrals were received in year and 2,343 contacts were achieved.

The service completes on average 140 patient visits each month.

New developments this year

- The service is the Clinical Project Lead for the 'Latent TB Testing and Treatment for Migrants' initiative, in conjunction with Hillingdon CCG and Public Health England.
- The service has attended community health promotion events to raise awareness of TB and the services available.

Plans for 2016-17

- Preparing to offer health promotion sessions at Heathrow Airport following a case of smear-positive TB in an airport worker.
- The service has been invited to give a live radio interview as part of live broadcast to include a focus around TB. This is for a new radio station called 'Voice of Islam' on their 'Drive Time Show' which covers current affairs and health topics. The script for this show covers education on the signs and symptoms of TB, its treatment and prevention, and how to reduce risk of contracting the disease.

Hillingdon adult services

District Nursing and Community Matrons Service

Summary of service

District Nursing services support housebound patients, by providing nursing care in their own homes. Services work in partnership with specialist community nursing and therapy services, patients, carers, GPs and other social care teams to provide high-quality nursing care and advice. The service offers professional advice, support, teaching and skilled nursing care to enable people with an acute or chronic illness or disability and who have a nursing need to live as independently. District nurses assess the healthcare needs of patients and families, monitor the quality of care that they receive and are professionally accountable for delivery of care. District Nurses also provide an Ambulant Wound Clinic linked with GP referrals at designated sites throughout the borough. Community matrons provide proactive management of long-term conditions, enabling and educating patients to help them live with and manage their disease. They develop tailored packages of nursing care and work to keep hospital admissions or readmissions to a minimum.

The Service has five main functions:

1. Clinical: community matrons have advanced nursing assessment skills and knowledge in managing long-term conditions
2. Care Co-ordination: the service help co-ordinate the patients' care centrally
3. Communication: the service provides timely and on-going communication with the patient, their GP and their family
4. Coach: community matrons empower the patient to self-care and help them to understand their conditions
5. Care Champions: the service helps patients to plan and achieve their care preferences and goals, and teach family members how to give care to their relatives.

Activity

District nursing received 24,751 referrals and achieved 192,820 contacts in-year. The Ambulant Wound Care clinic received 247 referrals with 4,347 contacts in year. The community matrons received 649 referrals and had 6,848 contacts.

New developments this year

- A community matron and a senior community staff nurse were seconded to lead the 'Care Connection Team' pilots in the north of the borough. This is part of the Whole Systems Integrated Care programme being driven by the CCG.

- Improved integrated working with other services such as Tissue Viability and Palliative Care.

Plans for 2016-17

Planned changes / service improvements:

- New IT project to incorporate mobile working, allowing community nursing to access patient records at any site or location

- Review of the service as part of a three-year QIPP Programme for community services

- Working to support the End of Life Strategy, by being an active member of the End of Life Forum.

Hillingdon Twilight Service

Summary of service

Twilight is an out-of-hours District Nursing Service. The service visits people across the borough of Hillingdon who have a Hillingdon GP.

The service runs seven days a week between 16:30 and 00:30 and also responds to SOS calls such as palliative care, blocked catheters or wound issues.

Activity

The service received 2,222 referrals, with 15,472 appointments or visits made over the course of the year.

Plans for 2016-17

The Twilight Service is planning to perform a specific patient satisfaction audit.

Twilight will also undertake an audit to establish the number of patients seen, who have a blocked catheter, that require a prescription for bladder maintenance fluid.

Rapid Response

Summary of service

Rapid Response is a multidisciplinary team aiming to prevent hospital admissions across Hillingdon. The team accepts referrals from the Ambulance Service, A&E, the Hillingdon Urgent Care Centre, the Clinical Decision Unit, the Acute Medical Unit, care homes and specialist nurses. The team responds within two hours of referral.

Rapid Response also provides early supported discharge service to support the Home Safe Team at Hillingdon Hospital. The team in-reaches to Hillingdon Hospital, supporting early discharge for people admitted under 24 hours.

Rapid Response also offers a non-urgent phlebotomy service, provides community intravenous antibiotics via the ambulatory care pathway and provides access to nightsitting. The service includes experienced clinicians who have developed overlapping skills, registered Mental Health Nurses and, through them, access to the Hillingdon Home Treatment Mental Health Team.

Activity

The service received 7,124 referrals, with 29,342 appointments or visits made over the course of the year. Of these, Rapid Response had 3,621 referrals and 23,669 contacts; Phlebotomy had 3,426 referrals and 4,690 contacts, and Rapid Response IV had 77 referrals and 983 contacts.

A recent peer review rated the service as 'Outstanding' in responsiveness and 'Good' overall.

New developments this year

- Expansion of the Home Safe partnership with Hillingdon Hospital: following a trusted assessment by a Consultant Geriatrician, Rapid Response to provide treatment and care in the community to facilitate early discharge
- Access to Rapid Access Clinic, a Consultant Geriatrician-led clinic run twice a week

Plans for 2016-17

The team is considering new referral pathways:

- Trusted assessment and referrals from Ealing Rapid Response Team
- COPD outreach joint working
- Referrals from Fracture Liaison Nurse
- Potential pathways from Ambulatory Care

Community Cardiac Service

Summary of service

The Community Cardiac Service has two elements: Cardiac Rehabilitation and Heart Failure. These consist of specialist nurses and a specialist physiotherapist, clinically supported by a consultant cardiologist.

The Cardiac Rehabilitation team provides specialist nursing and specialist physiotherapy exercise advice in the management of adult patients who have suffered MI, ACS, have undergone valve surgery or CABG.

The Heart Failure services manage and treat heart failure for Hillingdon residents in community and clinic settings.

The objectives are:

- Empowering self-management via health education and health promotion
- Engaging patients and their carers in decisions about the care options available to them, including the development of individual care plans and long-term management plans
- Optimisation of evidence based therapies
- Hospital admission avoidance and reduce use of GP time
- Provide a point of escalation for patients with deteriorating disease in services including access to palliative care
- Working in collaboration with secondary care trusts and other agencies.

Activity

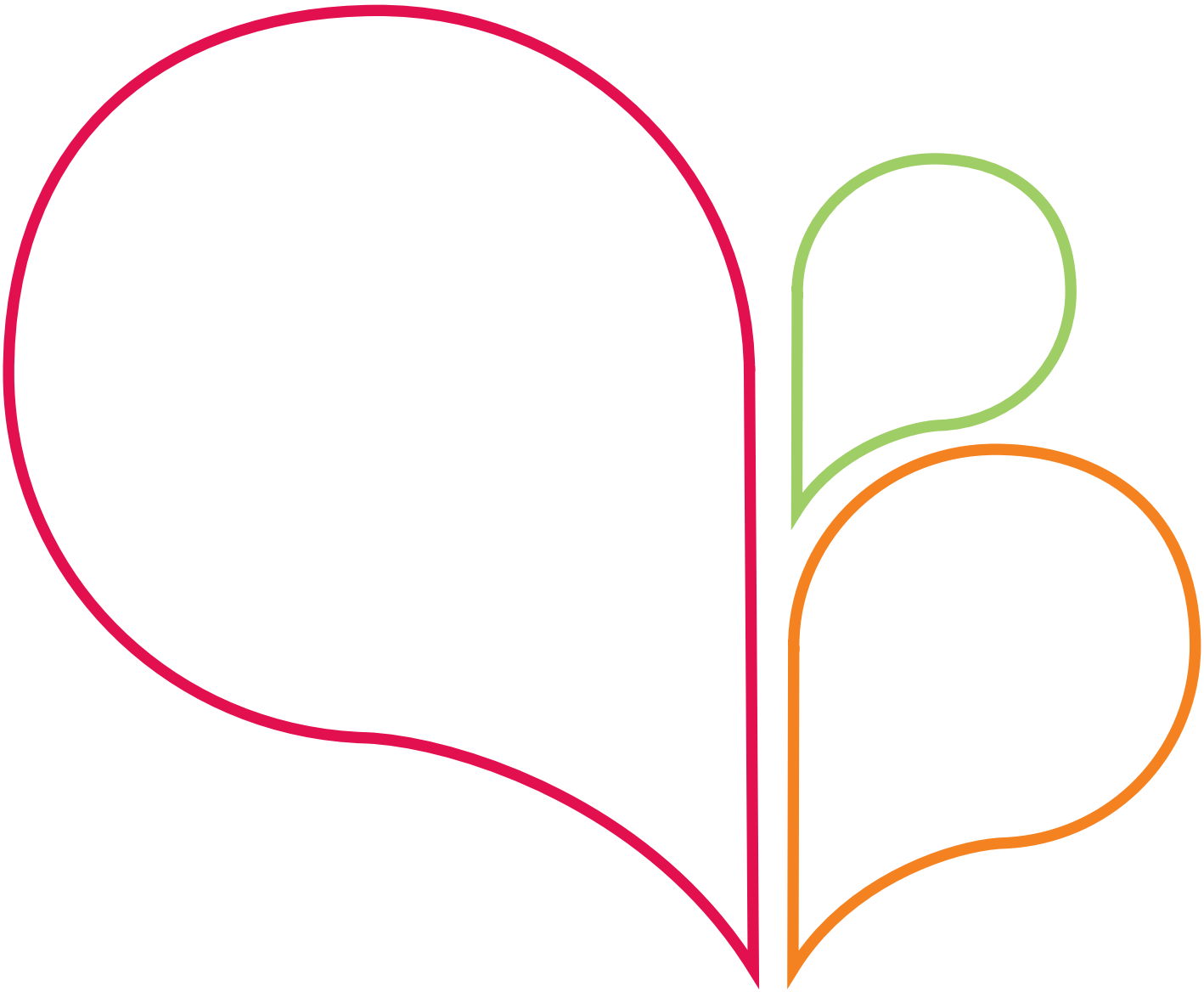
- The Community Cardiac Service performance activity exceeded target by 35%
- Two week wait times were met for the year
- The targets for number of admissions prevented (28) and number of saved GP visits (25) has been met and exceeded year to date
- Cardiac Rehabilitation received 117 referrals and had 1,065 appointments and visits. Heart Failure nursing received 124 referrals and undertook 2,914 appointments and visits.

New developments this year

- Addressing data issues has enabled the team to better track its performance
- Purchase of an ECG machine has enabled cardiac nurses to take ECGs as part of their service
- Arrangements are in place for cardiac nurses to receive supervision from a Hillingdon Hospital cardiologist to ensure they receive the appropriate clinical support and advice
- Community cardiac rehab classes have commenced, with up to eight patients attending weekly
- One of the cardiac nurses successfully completed an adults physical assessment course
- New investment for cardiac service was agreed by commissioner, resulting in the successful recruitment of 2.4 clinical staff to enhance the service

Plans for 2016-17

- A new integrated cardiac service to be launched
- The Service will develop new leaflets and presentations will be given about the new cardiac service at GP network meetings to improve skill base within primary care and to promote the service
- More nursing students to undertake placements within the service



Central and North West London NHS Foundation Trust
Stephenson House, 75 Hampstead Road, London, NW1 2PL

www.cnwl.nhs.uk