Health Visiting Rapid Appraisal 2012/2013

Summary Report

Contents

Section 1 – Background and Key Observations

Introduction

Government Policy: Children and Families - Early Intervention

The Government focus on the delivery of "The Healthy Child Programme (HCP) - Pregnancy and the First Five Years of Life" (Department of Health (DH) Oct 2009) and the "Health Visitor Implementation Plan 2011-15: A Call to Action (DH Feb 2011)" is part of its overall plan for improving children and family services and their experiences; a move to a system where quality and outcomes drive everything. In order to drive this plan forward, the DH supported a number of Health Visiting Early Implementer Sites (EIS's) across England to showcase some of the best practice in the country and build on these successes, share expertise and provide inspirational leadership across the whole profession.

The growth and transformation of the health visitor workforce was a key NHS Operating Framework priority in 2012/13.

Regional Strategic Approach

In the first year of the Health Visitor Implementation Plan (HVIP) programme, collectively the regional strategic health authorities (SHAs) (in what became NHS Midlands and East) concentrated on setting targets and trajectories for workforce growth by significantly increasing training and ensuring that jobs were available for all newly qualified health visitors (HVs). They developed an approach with provider organisations to retain and support existing staff and encourage qualified HVs to return to practice.

The start of the second year of this four year programme focused on the need to concentrate on utilising the workforce growth to deliver the full service offer. In response, Kathy Branson, Health Visiting and Midwifery Workforce Programme lead with the newly formed NHS Midlands and East, commissioned Sustain on behalf of the SHAs to jointly develop a diagnostic tool which was based on "what good looks like"; i.e. what a fully implemented, competent health visiting service would look like. This tool, when combined with Sustain's rapid appraisal process, would enable an assessment of the progress made in implementing the full health visiting service offer.

Sustain were subsequently commissioned to undertake an individual rapid appraisal for all 33 of the region's health visiting services. The intention was to review where each organisation and system stood on the continuum of project delivery for workforce growth plans to ensure consolidation of the first year of the programme. In addition, the process would benchmark where providers were in relation to the full service offer and what support was required by them. The process was designed to find evidence against key headings in the HVIP and to triangulate this evidence by speaking with key staff in the commissioning and provider organisations and other stakeholders.

The process used is fully described later in this section.

This Report

Following the completion of the rapid appraisal programme of all 33 organisations Sustain would like to thank all those who participated in the programme. Our belief, supported by the surveys we have completed, is that most participants found the process to be less invasive and adversarial than they had anticipated or perhaps have had experience of before. While the output noted areas where improvement could be made occasionally triggered unwanted behaviours within the organisation most found the reports fair, focused and proportionate. Particular appreciation goes to the Peer Reviewers who came to this style of appraisal, for the first time and where required

to deliver the element at the same level of intensity as the Sustain team. They acquitted themselves well and provided us with valuable input and a very specific professional line of enquiry.

The output report has been produced to provide:
- The key overarching observations from the whole project
- Any key findings within individual dashboard segments, including commentary and relevant graphical output
- Anonymised comparatives by organisation and by NHS Midlands and East cluster i.e the regional SHAs of West Midlands, East Midlands and East of England. We have provided the area teams with the comparative dashboards for their providers as in some cases this has been more difficult to anonymise.

The report has been collated using the output reports written for each organisation and was built on:
- 1,000 review questions asked of 1,229 participants over 33 reviews
- 592 detailed RAG rated observations
- 201 areas of support recommendations
- c.500 headline recommendations.

It is important to note:
1. The rapid appraisal programme took 10 months to complete. The timing of each review therefore does need to be considered when looking at the anonymised comparators.
2. The reports and programme was designed to give very specific feedback and recommendations to individual services. The aim of this report is not to provide that element of detail but instead to provide core themes and comparatives focused towards the Area Teams and at a Local Education and Training Board (LETB) level. The report is not designed to provide recommendations beyond identifying the common themes and within the key observation highlight those elements that where common and of high importance. Some of these elements are undoubtedly suitable to a more collective approach. The RAG status used was purely to identify the level of impact a subject area will/may have on the health visiting service. It was not intended to be a reflection of the service or its performance.
   a. Green identified areas of good practice
   b. Amber indicated areas of note
   c. Red highlighted areas of concern.

Process

Background & Adaptability

The rapid appraisal used for these reviews was adapted from a technique developed and used by a Sustain Director over many years to evaluate businesses within the private sector. It was introduced and honed further for use within the NHS and a clinical environment through Sustain's work on Mental Health Payment by Results.

The project to deliver the rapid appraisal over such a number of sites and deliver a high degree of consistent comparatives required further enhancement, a significant element of formalisation and predefinition of structure, data collection and output.

The final process is now one that is fully adaptable and can be tailored to many situations and provides constructive, usable and relevant output within a realistic time period. In addition, it can be easily designed to deliver comparatives and progress along a journey. In the case of the health visiting review, this has incorporated both.

Key attributes of the process:-
• Provides rapid output reporting - delivered in three weeks from the first day on site
• Requires limited documentary evidence
• Engages appropriately at all levels within the organisation
• Triangulates the enquiry process
• Provides assessment against a set of given criterion
• Monitors change against a continuum
• Delivers qualitative and objective appraisal
• Has a low intensity impact on the organisation compared to other processes
• Facilitates a self-assessment component
• Provides for an optional element of peer review
• Is delivered by appropriately trained individuals with operational experience in the sector
• Delivers a multi-level view across the organisation
• Is completely adaptable and enables an understandable and digestible view of complex areas.

Key attributes of the report:-
• Can be used to benchmark and identify progress
• Is objective, succinct, and impact focused
• Incorporates a self-assessment view of the future
• Identifies good practice
• Provides support area recommendations
• Provides a change management and development planning tool and enables focus on key areas.

Designing the Appraisal

The diagnostic design phase was a co-development with the NHS Midlands and East Health Visiting & Midwifery Workforce Programme Lead. This involved sharing and honing thoughts on the national agenda, priorities and current perceived status of implementation. As part of this process, decisions were taken to refine:
• Requested participants, time required and those requiring a definite follow up
• The sequence of meetings
• Information requests list
• Composition of the dashboard and agreement of "what good looks like", envisaging the expected delivery point at 2015 for the range of deliverables.

Sustain had put together the proposed outputs, styles and content which were not only approved but seen as distinct and positive features of the proposed appraisal process. During the diagnostic development phase, the joint team

started to discuss the options and opportunity presented by the inclusion of a peer review element within the process. While Sustain were keen to achieve this, they also felt that it was best delivered by integrating the peer review element directly into the process. It was agreed that the reviewers would be involved in the process for one of the three days on site and would be integrated into the process alongside the Sustain team.

To our knowledge, this is one of the few occasions where such a peer review element has been directly used and interwoven into a commercially-led process.

Volunteer peer reviewers where selected by most provider organisations and attended a series of half-day workshops to give them a detailed insight into the programme and the areas of enquiry, explain their role, help them understand the approach and meet some of the Sustain team. The allocation of the peer reviewers to appraisals was managed by the regional SHA to ensure that any potential issues which might arise from a visit from neighbouring or directly competing organisation were kept to a minimum.

Delivering the Appraisal

Detailed planning and preparations led by Sustain were carried out with each regional SHA, cluster primary care trusts (PCTs) and, closer to the scheduled dates of the appraisals, with the provider. Scheduled dates for providers after the initial three appraisals were provided significantly in advance and detailed planning discussions commenced with the providers at least six weeks prior to the appraisal date. A list of all the providers and the month that their review commenced is shown as a separate schedule later on in the document.

Prior to the onsite appraisal a limited amount of information was requested (if and only if it was available). The intention was to provide some key insights into the development status of the organisation and team without making this an onerous, paperwork-driven audit exercise. This information requested was:

1. An up-to-date workforce growth plan with a performance report showing delivery against target
2. Turnover statistics for HV workforce
3. Recruitment and retention strategy for HVs
4. Board or senior executive papers that deal with the new HV vision and related plans
5. Copy of the implementation plan and reporting structure
6. A communications plan specific to health visiting
7. A clinical/professional leadership structure chart
8. A training plan (including leadership training)
9. Policy/ies for preceptorship / mentorship / supervision
10. The previous year's staff survey report for health visitors
11. An engagement plan specific to health visiting
12. Output from engagement events/workshops
13. Copies of communication messages
14. Public and user involvement policy
15. Service specification for HV services
16. Commissioners performance report on HV services
17. Directory or map of HV services
18. Monthly performance report
19. FIMS (Financial Information Management System) Return
20. MPET funding plan

This information was reviewed by the Sustain team prior to the appraisal, this allowed them to adapt areas of

discussion. Importantly, this included not spending significant time labouring points and issues in areas where the development of the service was not advanced.

Additional information was requested during the review to further understand some areas in more detail, but the initial list of evidence requirements were felt to be appropriate and manageable, which was a view confirmed by the organisations themselves.

At the same time, the provider submitted a self-assessment of the dashboard to show their view of their position at the time of the appraisal and the predicted position six months later.

The programme entailed three days of on-site presence with a range of fixed slot and flexible meetings across a range of clinical, management and stakeholder personal within the provider, commissioner, Local Authority (LA) and Clinical Commissioning Group (CCG) organisations.

In the first week, two concurrent days were spent on-site, followed in the following week with a further day largely focused on the peer review element with the professional lead, HVs, team leaders and practice teachers.

At the conclusion of the appraisal, the output report was published utilising a tightly managed process. A draft was produced, factually ratified with the provider lead and published by the end of the third week (first day on site being week one).

The Appraisal Meetings and People Met

Meetings took place mostly within the organisation's premises (usually the provider, commissioner or both) within a defined framework. A key factor within the rapid appraisal was that the meetings were undertaken in an informal conversational manner, i.e. a supportive inquiry which was designed to be non-threatening. Whilst there were many detailed questions that the Sustain team were scheduled to ask as part of the appraisal, the style in which the meetings were undertaken meant that the volume of questions and the relevance attached to them was not a barrier to gathering relevant information from those that were seen.

Individual meetings were normally undertaken by one or possibly two members of the Sustain team and group meetings would involve two or three members of the Sustain team (including peer reviewers). Sustain ensured they fielded a clinically qualified team member in the meetings with the professional lead, HVs, team leaders, practice teachers and student HVs.

All regional SHAs provided a representative to attend each of their appraisals and were usually in attendance for one of the first two days and the third day.

It was emphasised during the meetings and maintained throughout the process that all the information shared at the time of the discussions would be held in confidence and, whilst triangulated and possibly used as a basis for the output report, individual responses/comments would not be identifiable. In line with the supportive nature of the review process, there were occasions when Sustain would see that certain information from a previous review could be of use to those involved in the current appraisal This information sharing would only occur with the permission of the initiating provider.

The Sustain team operated within two workstreams for the days on site, occasionally moving to three where required. The Sustain member allocated to each meeting slot was carefully chosen to ensure they had the appropriate specialist knowledge, depending on whether the meeting was clinical or non-clinical or arranged with providers or commissioners. The total number of people seen throughout the reviews was 1,229.

Core Meeting Template

HV Team Meetings		
Roles	**Timing/Sequence**	
HV Professional Lead	Day One	09:00 - 11:00
HV Professional Lead (Follow Up and Peer Review)	Day Three	09:00 - 10:00
Health Visitors	Day One	11:00 - 13:00
Health Visitors (Follow Up and Peer Review)	Day Three	12:00 - 13:30
HV Team Leaders	Day One	13:30 - 15:30
HV Team Leaders (Follow Up and Peer Review)	Day Three	10:00 - 11:30
HV CPTs	Day Two	09:00 - 11:00
HV CPTs (Follow Up and Peer Review)	Day Three	14:00 - 15:00
HV Students	Day Two	11:00 - 12:00

Flexible and Optional Meetings (all one hour)			
Provider Meetings		**Commissioner Meetings**	
CEO (optional)	Day 1 or 2	CEO (optional)	Day 1, 2 or 3
Director of Finance	Day 1 or 2	Director of Finance	Day 1, 2 or 3
Director of Operations	Day 1 or 2	Director of Nursing	Day 1 or 2
Director of Nursing	Day 1 or 2	Director of Public Health or Nominated Representative	Day 1 or 2
Performance Lead	Day 1 or 2	Commissioning Lead	Day 1 or 2
HR/Workforce Planning Lead	Day 1 or 2	CCG/GP Lead for Children's Services	Day 1, 2 or 3
		Lead Commissioner Children's Centres	Day 1 or 2
		County Workforce Lead (where relevant)	Day 1, 2 or 3
		LA Children's Commissioner	Day 1, 2 or 3

The Output Report

Sustain's output report was adapted for the HV appraisal to deliver a focused, objective and independent view in a timeframe which meant the results were still relevant and the output was quickly useable.

The core elements where within four key sections:
1. Headlines (usually between eight and 12)
2. The comparative dashboard showing progress towards the 2015 standard and a self-assessment of the organisation's position in six months
3. Key observations defined as good practice, areas of concern and areas to note
4. Areas of support focused on areas where regional resources could assist, particularly where the skills or capacity were not felt to be available in the organisation and/or to the HV service

The final pages of the report identified the people Sustain met during the process.

Participants Feedback

As part of Sustains internal continuous improvement process, and to gain an on-going evaluation of the rapid appraisal process, feedback was systematically sought from the peer reviewers, senior provider and commissioner staff and Health Visiting staff via survey monkey questionnaires. The following section provides a summary of the responses and examples of comments received from all three groups.

Peer Reviewers

Legend: Very Good | Positive

Questions (top to bottom):
- Did participation in this review, stimulate you to reflect on your own organisations approach to implementing the 'Call to Action'?
- How useful did you personally find the Peer review process?
- How much did you feel your input added value to the HV review process?
- Did you feel your views were listened too and influenced the outcomes?
- Did you feel able to ask the questions you wanted without restraint?
- Did you feel adequately supported by the Sustain Team?
- Did you feel adequately briefed, prior to and during the Peer Review Process?

x-axis: % of those surveyed (0.0% to 100.0%)

Overall, how well did you feel the Peer review process went?

Pie chart legend:
- Very Succesfully
- Successfully
- Neither successful or unsuccessful
- Unsuccessfully

"I understand how a review process is implemented, and I appreciate the value of the opportunity to reflect with others how they deliver their service"

"Learned about the importance of evaluation from a "whole service" approach, and a greater understanding of the importance of engagement of professionals at all levels".

"The opportunity to observe the impact of policy at different levels, and how this is translated into practice"

"Insight into own area, opportunities for development and networking with wider range of colleagues, great experience"

"Made me think about developments in our own organisation"

Health Visiting Staff

Very Good **Positive**

Did participation in this review, stimulate you to reflect on your own organisations approach to implementing the 'Call To Action'?

Did you feel the Sustain approach gave you confidence to express your views freely?

Was the Sustain teams approach supportive and non-threatening?

Did you feel the discussions with the Sustain team covered the relevant areas of the Health Visiting Agenda?

At the start of the meeting, did the Sustain team provide you with an adequate expalantion of the review process and purpose?

0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0% 70.0% 80.0% 90.0% 100.0%

% of those surveyed

Overall, how well did you feel the Peer review process went?

Highly valuable
Beneficial
Of some benefit
Not good use of my time

"It was very daunting prior but proved to be a very thought provoking interactive session"

"Non-threatening, allowed freedom of expression"

"Felt we were listened to in the review process"

Senior Provider and Commissioner Staff

"The appraisal process was a really valuable exercise which generated a sense of purpose at every level of the organisation and has galvanised actions required going forwards"

"Sustain were knowledgeable about health visiting, which helped massively as they understood the issues and knew what they were looking for"

"Sustain were empathetic towards us; as a result, the review felt like something constructive which was meant to be a helpful process rather than an inspection"

"The report which Sustain produces is robust and thorough, makes clear recommendations and provides the organisation with a very helpful steer"

Regional Approach to the HVIP

During the review programme the only noticeable differences to NHS Midlands and East approach based on the three regional SHAs were:

Workforce growth rationale - The West and East Midland regions had developed regional growth plans that built in a degree of contingency planning. This necessitated a number of their provider organisations having to train larger cohorts than their requirements. The East of England, with the exception of the Essex providers, based their approach on each organisation building in enough contingency planning to deliver the regional target.

Regional use of MPET monies – The East of England were able to disperse significant training monies to each provider organisation within its area in addition to its regionally funded actions. The other two regions did not take the same level of approach but instead invested mainly in region wide events/resources e.g. HV leadership courses, project management.

Building Community Capacity (BCC) – The East of England set out their expectations regarding the development of BCC projects which were expected to be delivered as part of the preceptorship programme for newly qualified HVs and managed each organisation on the output of these. West and East Midlands sponsored qualified HVs to attend BCC project development courses and monitored the initiation of subsequent projects.

Project set up - All the regions had formed operational lead HV project set up and management support groups or networks:
- West Midlands – had invested in a project lead per cluster PCT to facilitate and monitor individual organisations delivery of the HVIP.
- East Midlands – had collectively developed common tools/models to share across all provider services through their network groups, e.g. standard operating procedure, competency framework, preceptorship model.
- East of England – among other things invested in additional support for EIS sites and six county leads. Within the region Essex County used a county-wide approach and involved partner organisations.

Subsequent use of the output reports

The East of England used the reports to:
- Identify main themes and support the organisation to address the issue if appropriate e.g. knowledge of workforce and growth issues
- Use as a discussion point in SHA assurance visits
- Provide a session to HV operational leads on improving planning processes
- Improve the depth of understanding of distance to full offer for organisations and clusters. This has helped plan the Health Education East of England HV support infrastructure for 2013/14 where the allocation of new locality lead posts will vary according to the amount of support needed.

East Midlands used the reports to:
- Triangulate the findings of regional assurance visits to PCTs and providers, as each of the appraisals concurred with the assurance visit. For two providers extra assurance visits have been scheduled with a view to focusing on the appraisals.
- Effectively engage executive level colleagues, especially where the health visiting service had integrated into a mental health trust

West Midlands used the reports to:
- Support, challenge and question PCTs on their progress against the plan. This was possible as the review offered the SHA both assurance and reassurance at a regional and local level of progress against the 'Call to Action'.
- Share good practice in local meetings with PCTs.
- The plans were also shared at management level with local leads to explore gaps and opportunities. This approach to sharing, developing and learning was particularly helpful with early implementer sites.

Core Observations

From the thirty three reports produced, the background analytics and detailed notes we have identified the Headline observations that were consistent themes found across all of the regions within NHS Midlands and East. As an overriding statement we would say that prior to the reviews the approach to the implementation at cluster and provider level was missing some of the core elements that would ensure the delivery of vision for Families and Children in a sustainable manner. If these priorities are not addressed the programme in some areas risks becoming a project that delivers a lot of newly qualified Health Visitors but losing sight of the vital improvement agenda.

1. System Leadership

In Sustain's view the project's strategic and operational leadership was the single most important factor to have affected the development and management of the HVIP in defining and implementing a changed service model.

The leadership and vision gap between government policy and provider implementation has been marked. This is surprising given the understanding and expectation that leadership for the HVIP at all levels within the health and social care system is crucial if its delivery is to be fully realised with partner organisations.

The Department of health introduced the policy and tools to facilitate the fundamental service change required out of the delivery of the healthy child programme.

The HV Implementation plan: a call to action provided the vision and when combined with the **expectation that commissioners would provide the necessary resource to support workforce growth** provided the outline plan. In order for this to be realised at a local level it was essential that there was robust connectivity up and down the system triangle displayed above.

However this has been shown to be weak in places. Whilst there were supportive mechanisms, networks and monitoring frameworks put in place by the government, SHAs, commissioners and individual organisations, the opportunity for people to be influential and contribute fully to designing the local vision and service development with partners was generally underdeveloped.

In most cases there was whole system and local commissioning drive for development and performance improvement within the health visiting service. However there was varying evidence of provider organisations leading their service teams in the development and delivery of an integrated service with appropriate short and medium term outcomes for children and families.

A great deal of emphasis has been given to the WFG element of the HVIP for obvious reasons. While this would have had a detrimental effect on the development of the service offer in some areas, it was by no means the only reason.

Formal arrangements were in place to monitor the WFG. However less formal arrangements exist for the delivery of the service offer against plan. Consequently, the degree and pace of change needed in some organisations has not been fully embraced or understood. Progress is consequently slow and in some cases compounded or even driven by the fact that some key staff grades do not appear to have the right skill sets or possess the level of understanding to scope and deliver the key outcomes.

Organisations that were ahead of the curve possessed leaders at both a director/directorate level and service level who are visionary with good problem solving skills. They have been able to define their core business for health visiting, understand who their key partners are and set strategic direction, (the vision). With very senior management involvement they have also been able to build and drive a commitment for the vision both internally and externally. Internally they have fostered understanding within the HV teams, gained alignment and "buy in" to the vision and been able to motivate staff through even the most difficult times. Externally they have maximised the benefits that come from a whole system strategic partnership approach.

Where strong leadership skills were combined with strong change management skills there were often more explicit integrated service development plans and service specific communication and engagement plans in place. Staff had been actively involved in the formation of the plans and therefore they were based on operational reality with an understanding of the true risks and opportunities.

These organisations frequently sat in areas that had robust, joint commissioning/planning forums. Organisations that were held back in the development of the HVIP were often going through an organisational change process that did not recognise the future needs and requirements of the health visiting service. They may have been more WFG focused and/or the leadership for the development and implementation of the HVIP was compromised or not in place. Service development plans lacked vision and integration and communication and engagement plans were ad-hoc or underdeveloped.

Whilst staff engagement in service development plans could be identified there was not always a strong drive to implement them or a feeling that they were sustainable.

The joint commissioning/planning forums were variable and ranged between functionally robust to disrupted or under developed.

The key risk appears to be that without a clearly communicated vision, developed plan for the new service, and quantification of benefits that arise from the implementation of the new service offer, the service and the profession will be at risk in the future from a number of areas.

2. Organisational Form and System Instability

The realignment and restructuring of both provider and commissioner service over a short period of time has been a powerful influencer on the development and delivery of HVIP.

Provider

The integration of health visiting services across the region is varied, as demonstrated below.
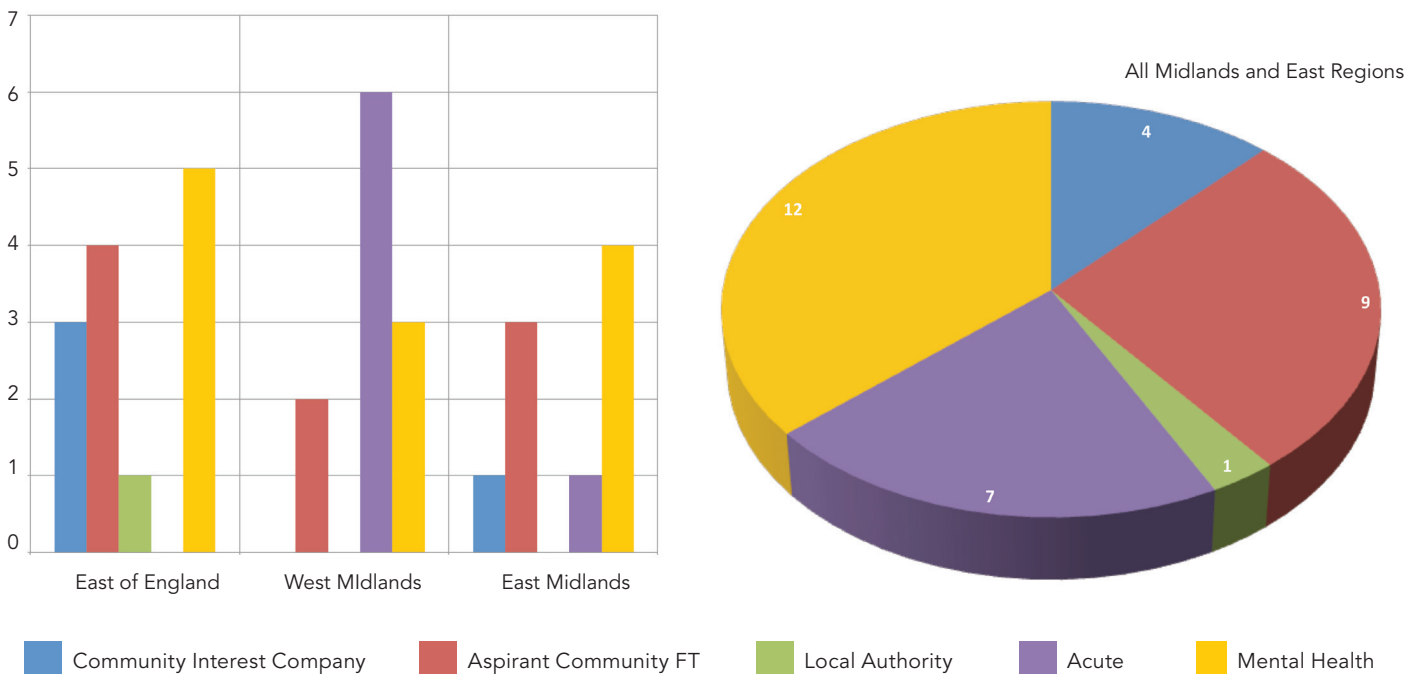
Interestingly, the organisational form of the health visiting service had very little effect on the degree to which the HVIP programme new service offer was successfully rolled-out.

Nevertheless, the differing philosophies of the organisations, the implementation of the initial transformation plans and degree of integration within the host organisation has had both positive and negative effects on the service. In some organisations a number of care pathways, such as midwifery and infant and maternal mental health, were in the process of being formed. However there was a common belief that these pathways were not transferable to other organisations as the partnership approach would need to be negotiated separately.

Some services had flourished:
*   Within a strong culture of communication and engagement with its staff
*   Within an organisation that valued and promoted the embedding of continuous improvement models with an emphasis on user and public involvement
*   As the result of expertise and resource available from a strong PMO within a large Trust

Others have found that their pace of change has been inhibited and the clash of cultures has resulted in a lack of understanding about the granularity of the health visiting service and consequentially inadequate staff support systems.

A consistent theme throughout the review programme was provider service restructuring; services have just been through it, are in the middle of it or are out to consultation. This has inevitably added more stress into the service and in a lot of cases has moved the focus away from the delivery of the HVIP.

Commissioner

Commissioner restructuring has been prevalent within the timeframe of the review. PCTs have clustered; CCGs have formed and latterly gained authorisation; area teams and LETBs have recently been established.

While there were some very good quality HV service specifications seen at the beginning of the review these were focused within systems with good HV leadership and robust commissioning and were in the minority. The standard and the quality in general improved throughout the duration of the programme. The national core HV service specification provides an opportunity for all systems to have a robust base specification but needs to be localised according to regional priorities and demographics.

Public health engagement has been disrupted in most areas because of the recent restructuring arrangements. Nevertheless, high level strategic commissioning engagement via public health has been consistently good. Operational engagement with public health specialists has been varied, often due to historical patterns of working as well as organisational restructuring. Where it was in place and the relationship with the HV lead were good, there was evidence of proactive development, targeting of services, more frequent reviews of staff deployment and a greater appreciation of the HV service and benefits achieved through working with stakeholders.

Local/unitary authorities have been in the process of undertaking fundamental service reviews and developing new operating models. This has resulted in a change (or proposed change) to the children's centres contract which often resulted in a reduction in universal support for families with an emphasis on more targeted services for troubled and vulnerable families. Given the policy direction for the future health visiting service, there is a clear potential for this to cause increased pressure and expectation on service.

This period of restructuring, implementing new operating models and service offer change in both the provider and commissioner services has had varying effects on the pace of change within the health visiting service. For example:
* In the area of integrated service provision with children's centres
* In service specification development continuity
* The prioritisation of the children's agenda
* The engagement of public health specialists in service redesign and the formation of local deployment models

3. Workforce Growth (WFG) and Workforce Development Planning

A comprehensive amount of work had been undertaken in setting WFG targets and trajectories for each organisation with the regional SHA and local commissioners to ensure that national targets were met and adequate funding was available for the scheduled newly trained HVs. Nevertheless a range of issues still existed:

- The rigor within the organisations by which the WFG plan was formulated and managed though, governance structures and exception reporting mechanisms
- Plans did not consistently include turnover rates, estimated retirement rates, student attrition/failure rates and newly qualified HV retention rates
- Some organisations have factored the main WFG in the last two years of the programme which will entail increased risk and stress on the system
- WFG figures were not consistently tracked to 2015
- Debates regarding the accuracy of the HV growth numbers for some organisations and accuracy of the Electronic Staff Record (ESR) data in each organisation
- Deployment – range of models used, with and without public health involvement. There were some poorly constructed models which in turn generated inadequate service resource requirements

The development of more robust policy and mechanisms to retain and support existing staff and encourage qualified HVs to return to practice was evident. However, there were a number of common themes that needed to be addressed:

- In a number of organisations skill mix was a significant element of the workforce mainly relating to high numbers of nursery nurses. In some systems (though by no means all) this was causing difficulties in the delivery of the workforce growth for a number of reasons.
- Management of vacancies
- Recruitment and retention difficulties in some areas were extreme and mostly caused by:
    - Neighbouring organisations being able to apply London weighting
    - NHS pension rights affecting recruitment into community interest companies
    - Pool of acceptable applicants too small to cover the regional demand
    - Workload issues caused by high vacancy rates compounding a vicious circle
- The current capacity to train the WFG needs is compromised especially where the growth was over 100%
- Management of novice to expert HV, which in some areas equates to 50% of their HV workforce having less than two years' experience at April 2015, is likely to provide a significant challenge. In the majority of cases, plans had not been developed to address this. This dynamic will represent both an opportunity, in terms of fresh ideas and new thinking, and also a risk from the safety/quality aspects of service delivery

4. Vision

A clearly articulated Vision for the future of the local service offer was rarely seen.

Commonly HV service developments had been advanced by using the national vision set out in the guidance documents and therefore some plans missed the opportunity to:
- Work with key stakeholders, partners and potential partners, users and the public to provide a basis on which to build the service offer taking into account the operating models of key partners e.g. local authority
- Describe and market the added value that health visitors as leaders of the HCP 0-5 years bring to the delivery of the programme and its outcomes
- Define the enhanced role of the HV required to deliver the universal plus and universal partnership plus service
- Explore in depth, the possibility of Building Community Capacity projects using a wide partnerships base and thereby incorporating partners outside of those traditionally used
- Engage and enthuse staff with the service model that they were designing and would be delivering

EISs tended to have a vision for the areas of service development they were focusing on as part of their EIS plan but rarely for the whole service.

5. HVIP

A detailed and comprehensive project plan for the delivery of the HVIP was not commonly seen. However in a small number of organisations and particularly where the PMO framework provided resource and expertise to the project, the HVIP was beginning to take a more robust form. Of the remaining organisations most had some form of programme with the development of individual plan areas, and in some cases individual leads to deliver task focused elements of the HVIP e.g. WFG and WFP; sections of the new service offer; support for staff. These lacked a coherent approach to comprehensive planning and project management.

The governance framework that supported this approach was not always robust or consistently linked into the organisations quality and assurance structures.

The robustness of the plans was variable and reliant on the:
- Degree to which it was deemed core to the organisations business planning
- Internal leadership skills and vision for the service
- Project management allocation
- Management structures and processes
- Robustness of commissioning plans

The appraised EISs (both first and second wave) had the benefit of strategic leadership and project planning, early training opportunities e.g. in restorative supervision, and peer support. Nevertheless none of the EISs in the review area had a fully implemented HVIP across all of their service bases/areas and in several cases the formality and structure in place through EIS had been discontinued.

6. Professional Leadership

Professional leadership – The professional lead role was not always in place, secondment opportunities were common or elements of the role were delegated to other members of the team e.g. service manager, team leaders. Where leadership was having a positive effect, the role was clearly defined and usually taken forward by one

individual, there was a clear vision, (in line with the comments made above in number four) wide networking and a strong partnership focus.

Where leadership was less effective, the role was more likely to be disseminated across a range of individuals, most frequently at team manager level with often inadequate coordination. This gave the impression to staff that professional leadership was fragmented and sometimes being lost completely because of the pressures of operational management.

HVs as leaders for the HCP – There was a general understanding by HVs that they were the professional leads for the 0 - 5 year old HCP, but this has not translated in most cases to the development of a vision for the local service.

Leadership training to specifically develop HV capacity and capability in the context of the HCP was limited but where it was available it was highly regarded by those who attended.

7. Communication Engagement and Marketing

Communication and engagement plans in the main were generic for the provider organisation and very few services had developed a specific plan for health visiting. The inclusion of a marketing plan for the service was rare.

Nevertheless there was some evidence of operational communication and engagement activity and the formation of individual strategic relationships with positive outcomes for partnership working. For example with:
* General practice and the development of link systems
* Children's centres and the exploration of further integrated working
* User engagement in certain aspects of service delivery improvements

It was generally accepted that the development of a formal plan would facilitate real improvements in:
* The level of understanding and 'buy-in' from partners and stakeholders
* The level of integrated service delivery and the interdependencies of key stakeholders set alongside the unique role of the HV in delivering the HCP
* The sustainability of the service post 2015
* The benefits analysis and description and how they will be measured and reported
* User and public engagement which appeared to be an underdeveloped subject especially in the area of user/public engagement in new service delivery models.

This is fundamental in assisting the service to manage expectations and market the benefits of change to all stakeholders during the implementation. This will help facilitate a system-wide ownership and appreciation of the value of the service, in turn protecting its future standing and investment within the host organisation and the wider system.

8. Service Delivery

A comprehensive understanding and mapping of the current service delivery was growing and this was one factor that had become more developed through time. Defining the future service offering and planning its implementation was in progress in all organisations. The level of staff involvement and engagement in this process was variable and because of this for some health visiting teams the plans have not felt understandable, acceptable or sustainable.

The service offer was rarely innovative except in areas where partnership development was very actively sought and joint commissioning opportunities were being realised. Nevertheless, good practice was found in every health visiting service.

None of the 33 organisations reviewed were delivering the full service offer across all of their service teams. The main reason for this was capacity as in most organisations the WFG had not been fully realised. For other organisations it was because the service vision was not tightly defined and the HVIP was not robust enough to deliver the changes required.

Towards the end of the programme there was more of a standardised approach across the organisation, both in infrastructure and for the service offer requirements. However the success of such an approach would always be restricted whilst the vision and articulation of the new service offer is still under development.

Mechanisms to share good/best practice were generally speaking significantly under developed. Whilst area and regional forums were in place, "communities of practice" were not developed in every area. It was also evident that the sharing of innovation and good practice was not disseminated across service teams in a way which brought about meaningful and consistent change. The pursuit of good practice as the driver for continuous improvement was rarely understood and more often perceived as a "nice to do" and therefore often further inhibited by the lack of service capacity.

User engagement activity was found in every service but traditionally was focused on client satisfaction and rarely on the demand, design or introduction of new service offers. However, where BCC projects were being taken forward, in some cases these were instigated by users of the service.

9. Post 2015

Concerns regarding the sustainability of the future service were only explicitly expressed by a handful of organisations. Nonetheless, this remains an important underlying matter which needs to be addressed through the realisation of a benefits analysis and the development of detailed communication, engagement and marketing plans.

There is anxiety that the increased level of funding for health visiting will not be sustainable post March 2015 and may become the subject of ongoing disinvestment. There was also a genuine concern that having developed the clear service model/offer and the unique role performed by HVs this would be eroded in order to cover other gaps within the overall provider, health and local authority systems.

The role of the provider and the service in addressing and mitigating this risk should not be underestimated. We also found examples where the investment within the service was being viewed as an opportunity for delivery of services and activities outside of the HV core expectations. In other cases full delivery of the service offer was still some way away.

What Good Looks Like

As noted earlier in this report one of the key components of the diagnostic development was to identify "What Good Looks Like" and the categorisation that should then be incorporated into the Sustain Dashboard. The Dashboard itself is intended to reflect the journey that services are on and their progress from Red to Green indicating the transition from Significant Support Needs to a High Performing service. Throughout the appraisal and in reading this report it must be understood that the intention is to track the development of a service through to 2015 and full implementation – there was no expectation that services in general would demonstrate full delivery at this stage in the overall HVIP.

The dashboard is split into the focus areas used within the appraisal report, namely:
• Plans for Workforce Growth
• Supporting Health Visitors
• Improved Support to Families 1
• Improved Support to Families 2

Reported on the Sustain Dashboard against these notes are the maximum, average and minimum attainment across the whole of the NHS Midlands and East area for each detailed dashboard item.

Plans for Workforce Growth

Dashboard Area	Dashboard Detail	Average			Maximum			Minimum			
		Significant support needs		High Performing	Significant support needs		High Performing	Significant support needs		High Performing	
Delivery	Training capacity and commissions		■			■				■	WFG plans have been formulated which contain: • Growth trajectories that include turnover rates, estimated retirement rates, student attrition/failure rates and newly qualified HV retention rates • Agreed commissions for training places with relevant HEI's • Sufficient PTs and mentors • Details of flexible HR practice to enable appropriate recruitment and enhance the retention of the existing HV workforce • Medium to long term workforce analysis and strategy formation will deliver the sustained service. There is an identified programme lead and robust plan management governance structures and processes in place. Appropriate levels of multi-disciplinary engagement and planning which incorporates provider and commissioner strategic leaders, LETB and HEI representation, internal provider HR and finance engagement and service delivery professional lead and clinical input.
	Plan Reporting and Management		■			■			■		
	Engagement	■				■			■		
	Capacity and Recruitment		■			■			■		

Supporting Health Visitors

Dashboard Area	Dashboard Detail	Average			Maximum			Minimum			
		Significant support needs		High Performing	Significant support needs		High Performing	Significant support needs		High Performing	
Organisational Alignment	Board Engagement										There is evidence that Boards are fully engaged and aware of the HV agenda and the local service vision evidenced by papers/presentations that provide members (were appropriate) with an understanding of the WFG plan and performance against it, status of investment, a broad understanding of the HVIP and exception reporting against its key milestones. The organisations have appropriately outlined the vision for Health Visiting services within their Business Plans and strategies, and identified the necessary actions and investments. The HVIP has been comprehensively scoped to deliver the local service vision and has the necessary project management and reporting framework. Assurance mechanisms and structures with formal links into the existing corporate performance regime and commissioning structures are in place and fully functional. There is an allocated resource for the project which includes a project lead and professional lead to facilitate effective delivery of the HVIP.
	Core To Organisational Strategy										
	Delivery Structure and Management										
Staff & Workforce	Communication and Engagement										There is a detailed internal Communication and Engagement Plan which enables robust communication channels across the Health Visiting teams and with other divisions of the organisation. Multi-disciplinary engagement of staff is seen within sub-groups, task and finish groups and the development of new processes. The HVIP will include all aspects of the following within a Workforce Development Plan: • The effect that partnership working will have on workforce planning and development of the service • The management of Novice to Expert HV's • Leadership development opportunities • Professional and HR support • Mechanisms and processes to source, communicate and implement evidence based good practice. Support systems are embedded within the wider organisational structure. In particular there is evidence of: • A range of relevant supervision models which are regularly used by staff • A strong culture of continuous improvement in which learning from external sources can be captured and internal innovation projects can flourish and be celebrated • Robust supportive HR policy.
	Availability and Access To Training										
	Professional Support										
	Leadership Development										
	Evidence Based Good Practice and EIS										
	Staff Wellbeing and Support										
	CPT and Student Wellbeing and Support										

Improved Support to Families 1

Dashboard Area	Dashboard Detail	Average		Maximum		Minimum		
		Significant support needs — High Performing		Significant support needs — High Performing		Significant support needs — High Performing		
Users & Partners	Commissioning framework and outcomes							The HV service specification to April 2015*, has been agreed and is based on the HV as the lead for the delivery of the HCP 0-5 and A Call to Action, an integrated service delivered in partnership to form robust pathways of care and user and public involvement in the design and improvement of the service offer. The specification will include trajectory for the full achievement of outcome measures and the effects of new operating models of the Local/Unity Authorities
	Public Health involvement/direction							Public Health has been strategically involved in the development of the service specification and in setting the vision for the new service. Public Health involvement at a service level is strong and they have played a key role in developing the HV deployment model and the localised service offering. Provider, Public Health and the Local/Unitary Authority are developing a strong strategic relationship in preparation for the transfer of commissioner responsibility.
	General Engagement							A HV service specific Communication, Engagement & Marketing Plan (inclusive of users and the public) has been formulated and is in the process of implementation. The messages and media are appropriate to the level and the key interests of the stakeholder/recipient. Its success can be measured through:
• The level of understanding and 'Buy-in' from partners and stakeholders
• The degree to which the vision for the local Health Visiting service was formulated with key partners and stakeholders and their level of understanding
• The level of integrated service delivery and pathways of care
• The level of understanding of the benefits to children and families obtained through the new service offer
• The implementation and development of new services and the mode of delivery as a result of user and public engagement.
	Partnership Working							
	User Engagement and Use to Design and Inform							

*This was the expectation at the commencement of the reviews and was used throughout the appraisal process. The publication of the National Core HV Service Specification 13/14 became available at the latter end of the review process. It will however remain important that the core specification is supplemented by the local needs driven priorities so that local issues are addressed)

Improved Support to Families 2

Dashboard Area	Dashboard Detail	Average		Maximum		Minimum		
		Significant support needs	High Performing	Significant support needs	High Performing	Significant support needs	High Performing	
Defining the Service Offering	Understanding current and future service offering							The HVIP is driving the changes to the service offer and its success is measured through: • The new service offer is defined and aligned to the four levels of the service model (Building Community Capacity; Universal; Universal Plus; Universal Partnership Plus). • A directory of services has been developed to underpin each element of the service vision and the new service offer. • The level of service delivery is consistent and measured against the SOP with activity mapped down to individual practitioner level. • There is consistency in the working relationships with partners with a high level of integrated service delivery. Detailed, time limited plans are in place to implement the new service offer with clear description as to how the differing levels of service build on the Universal service offer. Transition plans are detailed and prevention and early intervention services clearly stated. Key partners and stakeholders are identified and pathways of care are formulated when working with vulnerable and troubled families.
	Universal							
	Universal Plus							
	Universal Partnership Plus							
Delivering the Service	FNP Expansion							FNP programmes are commissioned and running effectively. Where the programme is not commissioned other options, for example; the Early Start Programme and MESCH have been fully considered. There is evidence that learning from FNP sites has been considered and implemented into the core service offer where appropriate.
	Building Community Capacity							A comprehensive programme of projects have been developed and formulated at individual team level in partnership with relevant partners, the public and users. Monitoring of the effectiveness and sustainability of the projects is undertaken at service level. BCC training is co-ordinated through the workforce development plans.
	Deploying HV Growth							Robust deployment plans are in place which have been formulated with the support of Public Health, shared with local stakeholders and mapped to 2015. These plans are used to allocate the workforce growth and at least an annually used to refresh the appropriate allocation of the entire HV workforce.
	Supporting the Change							Staff are fully supported in change management activity, their role as a leader as opposed to that of a manager and continuous improvement methodologies. Evidence based, personal behaviour and service change management mechanisms/courses have been prioritised. There are full IT and estate programmes to support the development of plans for agile working across the service.

Detailed Observations

In this area of the report we provide comments that relate to the detailed dashboard areas of enquiry and as a comparative show a scatter diagram representation for each site within each SHA area. In common with other diagrams the representation from red to green represents a progression of the HVIP implementation. The spread provides a good indicator of the degree of consistency of attainment in areas.

Delivery Workforce Growth

Training capacity and commissions

Significant support needs — **High Performing**

The numbers of students per cohort per organisation were defined but frequently revised.
The most common reasons for this were:
- Requirements to meet regional WFG figures
- Individual organisation adjustments due to changes in estimated figures.

Commissions were not always sought from one HEI provider when large numbers of students were required or large geographical distances needed to be taken into account. This presented:
- Logistical issues for the service
- The need to accommodate different curriculum programming, teaching & support methodologies.

There was concern expressed by both PT's and students that some HEI establishments were struggling to accommodate and adequately support the requisite number of students for each provider organisation.

Plan Reporting and Management

Significant support needs — **High Performing**

WFG plans were monitored by the provider, commissioner and SHA HV Programme lead.
The consistent main issues were:
- Contention regarding the final WFG figures nationally allocated to each Provider.
- The effect the growth of HV staff had on the skill mix of the teams.
- Plans did not consistently include turnover rates, estimated retirement rates, student attrition/failure rates and newly qualified HV retention rates.
- WFG figures were not consistently tracked to 2015.
- The rigor by which the WFG plan was formulated and managed, governance structures and exception reporting mechanisms.

Engagement

Significant support needs — **High Performing**

Multi-agency/disciplinary engagement in the formation of the WFG plans was initially sought most commonly between commissioners, workforce leads at local and regional levels and relevant HEI's; internally with the HR and finance departments and key members of the HV workforce.

On-going mechanisms for engagement where through formal assurance monitoring structures.

While growth figures were regularly shared with the whole Health Visiting team and communicated across the wider staff groups through formal communication mechanisms the implications of them were not always understood.

The full details of the plan, assumptions and amendments where not usually widley known beyond the the core group.

Legend: ■ East of England ■ West Midlands ■ East Midlands

Delivery Workforce Growth

Capacity & Recruitment

Significant support needs — High Performing

Recruitment - organisational systems that were initially put in place were found to be insufficient by many organisations.

There were higher than expected levels of struggling students and attrition rates.

Some areas adopted a regional approach to recruitment led by the HVIP Programme Leads in cluster PCT's which was seen as successful by some organisations but not all.

Retention issues for some organisations presented a real challenge for the following reasons:

- Neighbouring organisations appeared to offer more opportunities e.g. paying higher levels of remuneration - London Weighting; better terms and conditions; caseload mix and size.
- Newly qualified HV's took jobs nearer to home.

Organisational Alignment

Board Engagement

Significant support needs — High Performing

In many organisations there was high level understanding at Board/Senior Management Team level regarding the amount of investment in their Health Visiting service with exception reporting against the WFG plan and a small range of KPI's e.g. levels of breast feeding.

Where skill-mix was an issue commissioning negotiations and the relevant service redesign process were broadly understood.

The degree to which the required service change was understood as identified in HVIP - A Call to Action alongside the need for the HV to lead the HCP for 0-5 year olds was nominal.

Core To Organisational Strategy

Significant support needs — High Performing

In a lot of cases the expansion of the HV workforce was highlighted in the organisations business plans. However the vision for the service and wider service change issues requiring a partnership/integrated approach for the delivery of the HCP was rarely fully articulated.

■ East of England   ■ West Midlands   ■ East Midlands

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Organisational Alignment

Delivery Structure & Management

Significant support needs — High Performing

A comprehensive and detailed project plan and robust processes for the delivery of the HVIP was rarely seen. Often plans were fragmented, incomplete and silo managed. However the majority of organisations had individual plans to deliver the WFG and certain elements of the new service offer.

The robustness of any plans was variable and reliant on the:

- Degree to which it was deemed core to the organisations business planning
- Internal leadership skills and vision for the service
- Project Management skills and resource being available
- Management structures and processes
- Robustness of commissioning plans
- Quality and performance mechanisms already in place internally and between external commissioners/ organisations.

Whilst the EIS's had programme plans they did not cover all the elements required to deliver the full HVIP.

Staff & Workforce

Communication and Engagement

Significant support needs — High Performing

Formal internal communication and engagement plans for the development and delivery of the HVIP were in their infancy or not evident. Nevertheless, in organisations/service teams where workforce involvement was very important in service re/design, communication and engagement structures and processes where in place and being used effectively.

The major constraint for effective staff engagement was often sighted as workforce capacity. However the leadership style and organisational culture were also a major factor.

Availability and Access To Training

Significant support needs — High Performing

Workforce development plans were not consistently available. Nonetheless Health Visiting team workforce development opportunities were being commissioned and undertaken.

Funding was available directly from MPET monies or through the organisation's allocation of educational funding for the service. Some multi-agency training was undertaken between Children's Centre's, the Local Authority and some voluntary/charitable organisations.

The capacity of the workforce to attend all the necessary training, both mandatory and service specific was proving exceedingly challenging for some service teams.

■ East of England   ■ West Midlands   ■ East Midlands

Staff & Workforce

Professional Support

Significant support needs — High Performing

Professional support mechanisms were in place in all organisations. There was a general understanding that these were important however the level of investment in some programmes e.g. restorative supervision was not fully realised.

Clinical and safeguarding supervision, mentorship and preceptorship models were in place. The effectiveness of their application was cited as variable by the HV workforce and where there appeared to be constraining issues this was highlighted to the organisation and written in the individual output report.

Mechanisms to support innovative practice and continuous improvement were apparent but the celebration of subsequent successes was not consistent seen.

Leadership Development

Significant support needs — High Performing

The Professional Lead role was not always in place, secondment opportunities were common, or elements of the role were delegated to other members of the team e.g. service manager, team leaders.

There was a general understanding by HV's that they were the professional leads for the 0 - 5 year old HCP but this has not translated in most cases to the development of a vision for the local service.

Leadership training to specifically develop HV capacity and capability in the context of the HCP was limited i.e. it was often focussed on staff leaders. However where it was available it was highly regarded by those who attended.

Evidence Based Good Practice & EIS

Significant support needs — High Performing

Evidence based good practice was generally cited as that outlined in the HCP and the learning from EIS programmes where it had been shared. On the whole organisations were generally inward looking and had little external focus.

The mechanisms adopted by organisations to identify, share and embed good practice were limited, diverse and not always effective. In general there was little evidence of formal processes to support good practice dissemination and implementation.

Each regional SHA held forums where there was an opportunity to share good practice and innovation however these forums were not cited as examples by service staff or HV leads.

Legend: ■ East of England ■ West Midlands ■ East Midlands

Staff & Workforce

Staff Wellbeing & Support

Significant support needs   High Performing

HR policy to support sickness, a flexible approach to work-life balance, terms and conditions and a good occupational health service were variable. Good HR policy and benefits were commented on by the workforce as being strong retention motivators.Evidence of good workforce planning for the Health Visiting service was inconsistent. The multi-disciplinary approach to the management of vacancies, turnover rates and retirements, set alongside the current WFG targets and management of skill mix was generally underdeveloped.

The wider impact on the workforce of training substantially larger amounts students than in previous years and supporting a significant percentage of newly qualified HV's on the continuum from novice to expert was not robustly addressed

Practice Teacher (PT) & Student Wellbeing & Support

Significant support needs   High Performing

Whilst the role of the PT was formally recognised by each organisation the remuneration and protected time (if any) allocated to the role varied.

PT models of delivery were mostly consistent with the development of long-arm mentoring. The responsibilities of both the PT and mentor were well defined. However the role of the HEI and the PT in supporting the development of the mentor was not clearly delineated. On the whole support for new mentors was not adequate but broadly recognised; the biggest issue being the capacity of the PT.

Students' experience of PT and mentor support was generally good even when the student numbers were high in placement. Students reported HEI support was mixed and in some establishments under resourced for the size of cohorts.

HEI support for the PT was generally good.

Most of the WFG plans included the growth of PT's but few of the plans discussed the PT role post 2015.

Users & Partners

Commissioning framework and outcomes

Significant support needs   High Performing

The service specifications for the Health Visiting service based on the HV being the lead for the HCP 0-5 and the roll-out of A Call to Action were variable. Every service had a current service specification although some were still in draft. The majority of services were in the process of agreeing a trajectory for the attainment of the KPI's however the development of outcome based performance indicators was not well developed.

East of England   West Midlands   East Midlands

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Users & Partners

Public Health involvement/direction

Significant support needs   High Performing

The involvement of Public Health in the development of the Health Visiting Service Specification and outcomes was evident in almost every area. However the direct engagement of Public Health at a service level was variable and therefore a strong public health focus in service development and delivery was in some areas not developed to the level we would expect.

Many provider organisations noted the fact that since the transfer of the Public Health service to the Local Authority the level of engagement had (hopefully) temporarily declined.

General Engagement

Significant support needs   High Performing

Communication and Engagement Plans in the main were generic and traditional for the whole provider organisation, showing little sign of innovative engagement ideas. Very few services had developed a specific plan for the Health Visiting service. The inclusion of Marketing Plans for the service was rare; service leads had generally not thought past the need to communicate and engage.

Engagement with General Practice was variable and rarely described as good by GP's. CCG engagement was also variable.

Partnership Working

Significant support needs   High Performing

There was an acceptance within the service that the full delivery of the HCP could only be delivered through working in partnership with other agencies. Most organisations had strong working relationships with the Local/Unitary Authorities and were exploring a range of integration options with Children's Centre's. A GP link system had been set-up between General Practice and the Health Visiting service with varying degrees of success. With some notable exceptions most partnerships arrangements that were in place were traditional and currently lacked the ambition to extend beyond the norm.

The importance of partnership working was generally promoted within the service specifications. However the potential effect of the changing strategic plans of the Local/Unitary Authorities and in some areas disinvestment in children's services on the future delivery of the Health Visiting service have not been fully factored into the Health Visiting service specifications.

Partnership working with midwifery and mental health services was also presenting a challenge and pathways of care have been more successfully implemented when the service is integrated with acute and mental health care trusts.

■ East of England   ■ West Midlands   ■ East Midlands

Users & Partners

User Engagement & Use to Design & Inform

Significant support needs — High Performing

There were some good examples of user engagement activity which was predominantly at service delivery level through direct contact or questionnaire when auditing current service delivery or following the introduction of new/enhanced services.

Nevertheless this appeared to be an underdeveloped subject especially in the area of using patient/public engagement in new service delivery models.

Defining the Service Offering

Understanding current and future service offering

Significant support needs — High Performing

Understanding the current service offer and the development of the new service offer were key components of the project plans under development by the service. Task and Finish groups were mostly utilised to drive forward the agenda.

The new service offer and its alignment to the four components of the service model (Building Community Capacity; Universal; Universal Plus; Universal Partnership Plus) appears to have been widely understood by HV staff.

The level of service delivery was found to be inconsistent within and across teams and activity was generally mapped down to individual team level.

There was also inconsistency in the working relationships with partners i.e. Children's Centre's, midwifery services, General Practice which affected the level of integrated service delivery. Integration pathways with mental health services were generally not as developed as others.

The development of SOP's in order to standardise practice were beginning to be seen as important. Some organisations had already developed a SOP and their work has been shared with other organisations within the system.

Universal

Significant support needs — High Performing

The Universal service offer was not being fully delivered by any service. The main reason for this was the WFG figures had not yet been achieved; where organisations were close to their target figures the service offer change plans were not always robust enough to realise the changes in a timely manner.

Antenatal services were the most common element of the service to be underdeveloped.

■ East of England ■ West Midlands ■ East Midlands

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Defining the Service Offering

Universal Plus

Significant support needs   High Performing

Planning for the delivery of Universal Plus services was not well defined and because of workforce capacity inconsistently delivered. Nevertheless evidence based good practice was understood and there was general agreement regarding who within a skill mix team was the appropriate individual to undertake the intervention.

Universal Partnership Plus

Significant support needs   High Performing

Universal Partnership Plus services were usually well defined and implemented. Partnership formations were generally consistent in nature across the whole of the SHA area with little local variation.

In many areas, especially where the WFG is high, the service delivery focus was on Universal Partnership Plus provision and therefore was restricting the ability to deliver best practice HV led Universal service and consistent Universal Plus services.

Delivering the Service

FNP Expansion

Significant support needs   High Performing

The FNP programme was in place and closely monitored where the demographics of the region matched the qualifying criteria for implementation. Some areas were in the process of expanding the programme and most of those areas that did not qualify to run the programme were implementing or considering the implementation other options, for example; the Early Start Programme and MESCH.

There were various challenges by some stakeholders about the return on investment from the wider benefits of the FNP programme and discussions in some areas about the appropriate level of investment for the local area were hotly debated.

■ East of England   ■ West Midlands   ■ East Midlands

Delivering the Service

Building Community Capacity

Significant support needs   High Performing

In some organisations BCC had been embraced by the Health Visiting service and a structured approach was established to lead their development. Many organisations were struggling to develop projects because of workforce capacity issues.

Most organisations were actively training small numbers of qualified staff.

However it was generally acknowledged that this component of the service model was under developed and required increased focus. As a result the regional SHA areas have developed plans to facilitate the development of BCC projects.

Deploying HV Growth

Significant support needs   High Performing

Not all services saw the necessity of developing a deployment model. Where they had been developed a variety of models were used to rationalise the alignment of HV resource in geographical regions. Some services had used Public Health expertise but few saw the opportunities to use an independently validated method and tool to deal with old deployment models often implemented through differing historic commissioning approaches. The need for staff engagement in the process was rarely seen as a necessity.

Supporting the Change

Significant support needs   High Performing

Change Management Activity – There was little evidence that staff had been fully engaged in the visioning and benefits analysis of large service change. Continuous improvement methodologies and their use within the service were inconsistently used. The celebration of successes, where it was done well, was highly regarded by staff, however in most cases was underdeveloped. Personal behaviours and service change management mechanisms/courses had not been prioritised.

IT - The development of IT systems to support effective record keeping, plan work schedules, improve communication with partners, demonstrate activity against performance standards and longer term outcomes for children and families has often not been given a high priority within the service. Paper based records continued to be completed alongside electronic systems in a proportion of organisations

Agile working – The mobile technology required had been trialed and implemented in some areas although problems remain, such as connectivity. The estates requirements were not consistently aligned with the agile working developments for the service.

■ East of England   ■ West Midlands   ■ East Midlands

Section 2 – Benchmarking and Comparatives

Introduction

The following pages are intended to provide some comparative benchmarking within each of the SHA Regions and where feasible a comparison between each region or the overall average of the whole NHS Midlands and East area. In these schedules the reference allocated to a site bears no relationship to the order in which the appraisal was completed. In reviewing this data it is important to keep in mind the earlier health warning provided in that the rapid appraisal programme was completed over a period of ten months.

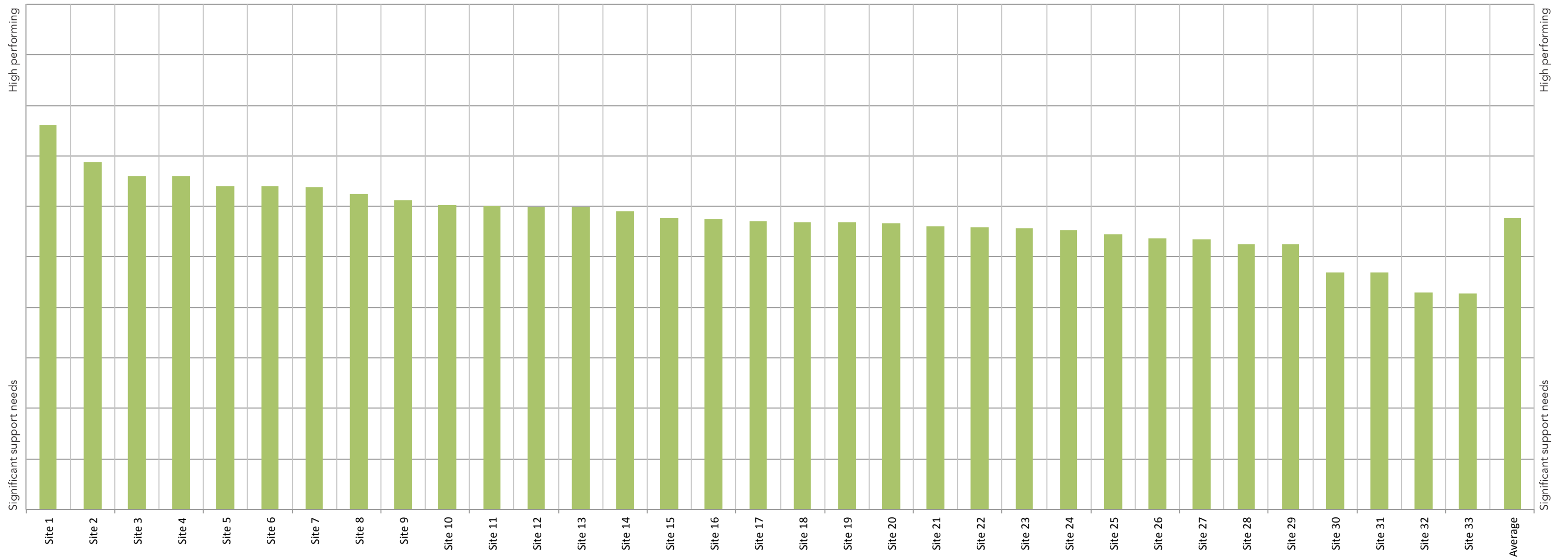# Comparative all Sites – Higher Level Dashboard Areas

The following graphs show all thirty three sites in descending order of their overall attainment. The vertical axes while not specifically designated is linked to the report dashboards with the base line depicting "Significant Support Needs" and the top of the axes defined as "High Performing" and thereby attaining the expectation for fully delivery of the service – which is expected to happen by 2015.

Rather than showing attainment by each individual line of the dashboard the outputs have been grouped within the higher level dashboard areas defined.

- Organisational Alignment
- Staff and Workforce
- Users and Partners
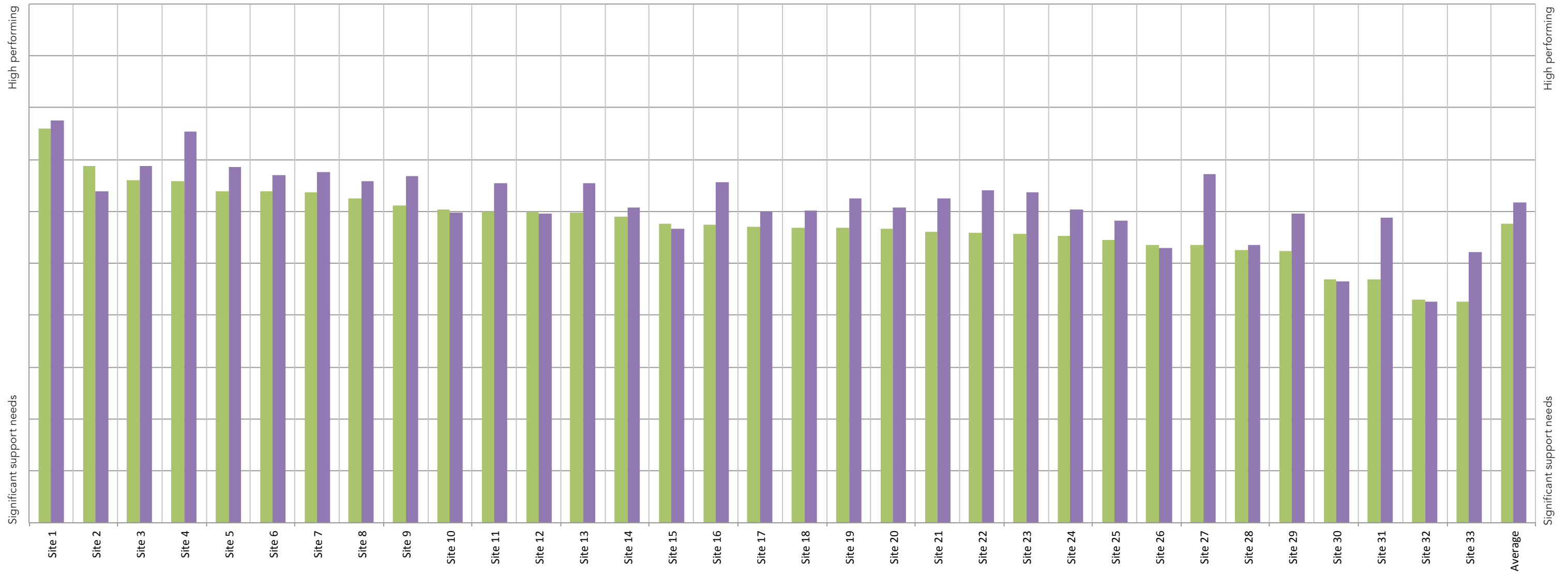- Defining the Service Offering
- Delivering the Service Offering

Overall

Organisational Alignment

Overall   Organisational Alignment

Staff & Workforce

Staff & Workforce bar chart comparing Overall (green) and Staff & Workforce (orange) scores across Site 1 through Site 33 and Average, with vertical axis from "Significant support needs" (bottom) to "High performing" (top).

Users & Partners

Legend: Overall | Users & Partners

Y-axis (left and right): High performing ... Significant support needs

X-axis: Site 1, Site 2, Site 3, Site 4, Site 5, Site 6, Site 7, Site 8, Site 9, Site 10, Site 11, Site 12, Site 13, Site 14, Site 15, Site 16, Site 17, Site 18, Site 19, Site 20, Site 21, Site 22, Site 23, Site 24, Site 25, Site 26, Site 27, Site 28, Site 29, Site 30, Site 31, Site 32, Site 33, Average

Defining the Service Offering

Legend: Overall (green), Defining the Service Offering (blue)

Y-axis (left and right): High performing ... Significant support needs

X-axis: Site 1, Site 2, Site 3, Site 4, Site 5, Site 6, Site 7, Site 8, Site 9, Site 10, Site 11, Site 12, Site 13, Site 14, Site 15, Site 16, Site 17, Site 18, Site 19, Site 20, Site 21, Site 22, Site 23, Site 24, Site 25, Site 26, Site 27, Site 28, Site 29, Site 30, Site 31, Site 32, Site 33, Average

Delivering the Service

Legend: ■ Overall ■ Delivering the Service

Y-axis (left): High performing ... Significant support needs

X-axis: Site 1, Site 2, Site 3, Site 4, Site 5, Site 6, Site 7, Site 8, Site 9, Site 10, Site 11, Site 12, Site 13, Site 14, Site 15, Site 16, Site 17, Site 18, Site 19, Site 20, Site 21, Site 22, Site 23, Site 24, Site 25, Site 26, Site 27, Site 28, Site 29, Site 30, Site 31, Site 32, Site 33, Average

Y-axis (right): High performing ... Significant support needs
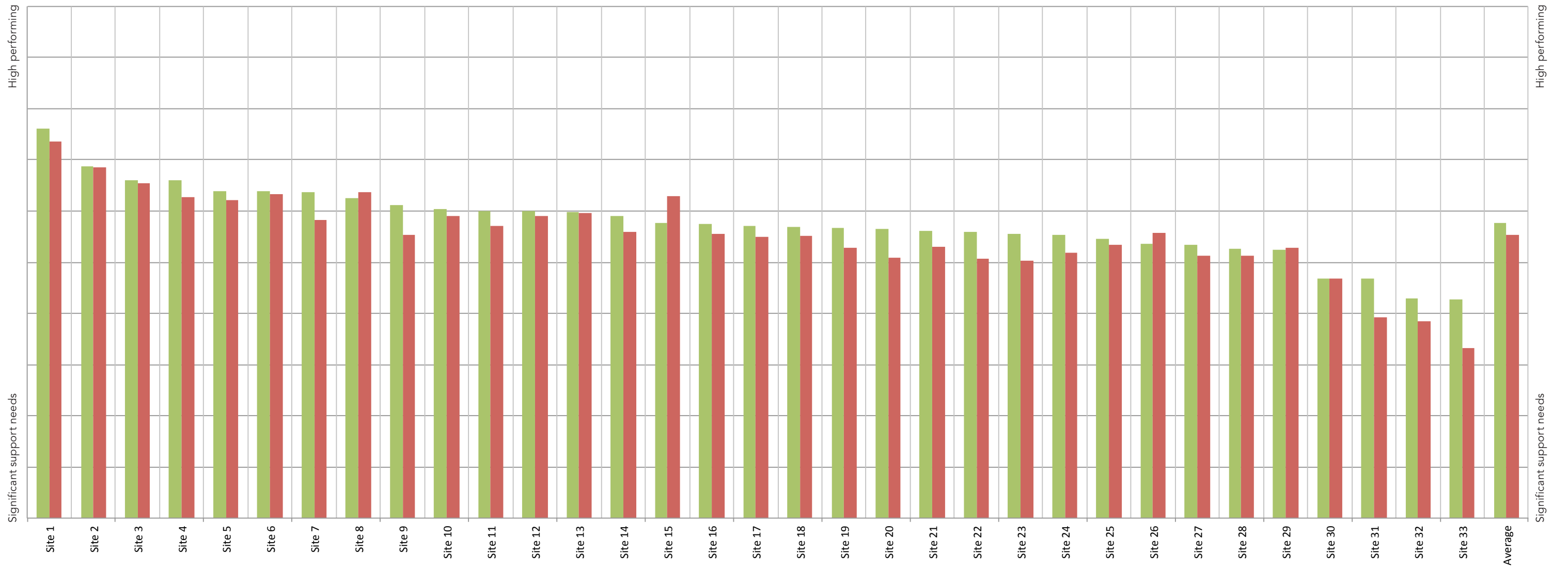
Comparatives all Sites within SHA Region – Detailed and Higher Level Dashboard Area

We have introduced the report dashboard style showing the anonymised scoring for all sites within that region. This style of presentation is the output we have provided to each Area Team Director of Nursing – but naming the individual sites within the dashboard.

In a similar style to the previous section then we show the attainment for each site for each higher level dashboard group with a comparative both against its overall attainment and that for the average of its SHA region as a whole.
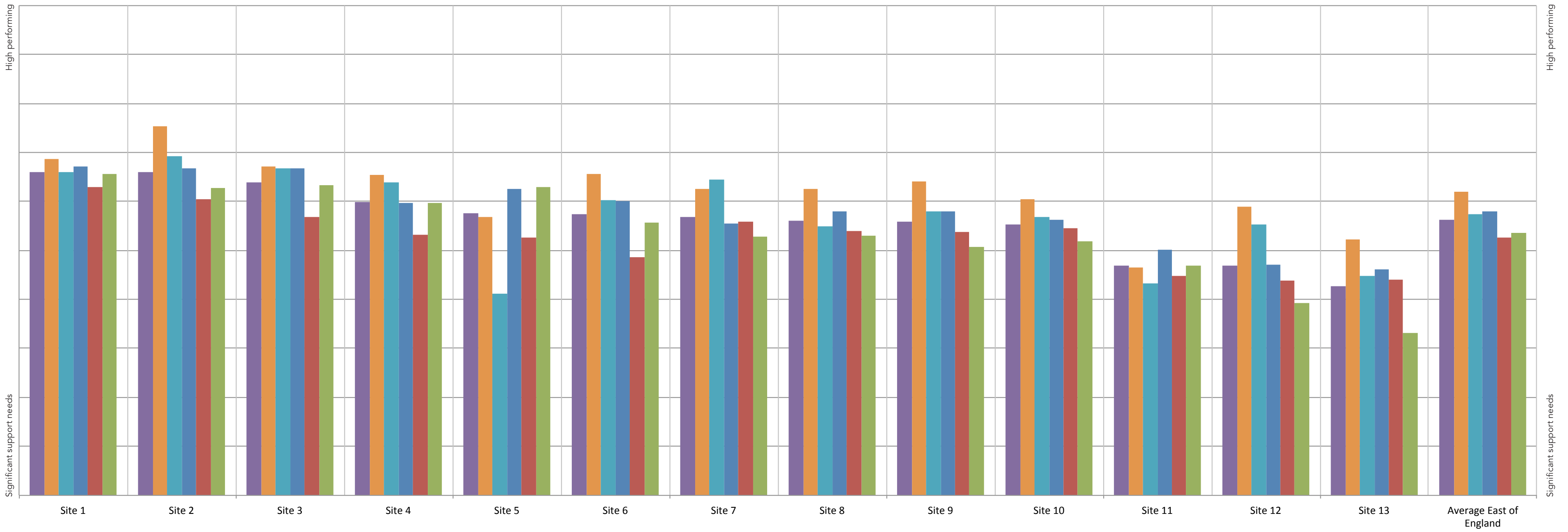
Comparative NHS East of England – Site Comparative – Detailed Dashboard

		Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8	Site 9	Site 10	Site 11	Site 12	Site 13
Delivery	Training capacity and commissions													
	Plan Reporting & Management													
	Engagement													
	Capacity & Recruitment													
Organisational Alignment	Board Engagement													
	Core To Organisational Strategy													
	Delivery Structure & Management													
Staff & Workforce	Communication and Engagement													
	Availability and Access To Training													
	Professional Support													
	Leadership Development													
	Evidence Based Good Practice & EIS													
	Staff Wellbeing & Support													
	CPT & Student Wellbeing & Support													
Users & Partners	Commissioning framework and outcomes													
	Public Health involvement/direction													
	General Engagement													
	Partnership Working													
	User Engagement & Use to Design & Inform													
Defining the Service Offering	Understanding current and future service offering													
	Universal													
	Universal Plus													
	Universal Partnership Plus													
Delivering the Service	FNP Expansion													
	Building Community Capacity													
	Deploying HV Growth													
	Supporting the Change													

Comparative NHS East of England – Site Comparative – Higher Level Dashboard Area

- Overall
- Organisational Alignment
- Staff & Workforce
- Users & Partners
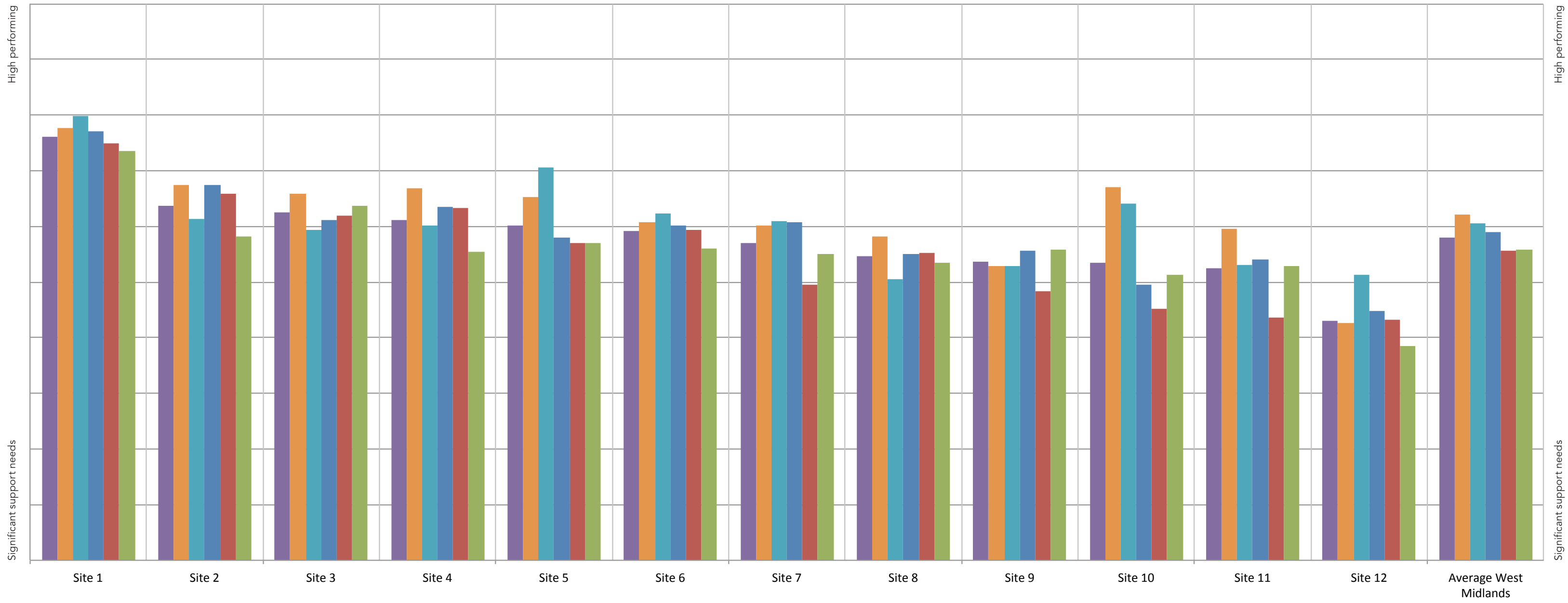- Defining the Service Offering
- Delivering the Service

High performing

Significant support needs

Site 1 Site 2 Site 3 Site 4 Site 5 Site 6 Site 7 Site 8 Site 9 Site 10 Site 11 Site 12 Site 13 Average East of England

Comparative NHS West Midlands – Site Comparative – Detailed Dashboard

		Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8	Site 9	Site 10	Site 11	Site 12
Delivery	Training capacity and commissions												
	Plan Reporting & Management												
	Engagement												
	Capacity & Recruitment												
Organisational Alignment	Board Engagement												
	Core To Organisational Strategy												
	Delivery Structure & Management												
Staff & Workforce	Communication and Engagement												
	Availability and Access To Training												
	Professional Support												
	Leadership Development												
	Evidence Based Good Practice & EIS												
	Staff Wellbeing & Support												
	CPT & Student Wellbeing & Support												
Users & Partners	Commissioning framework and outcomes												
	Public Health involvement/direction												
	General Engagement												
	Partnership Working												
	User Engagement & Use to Design & Inform												
Defining the Service Offering	Understanding current and future service offering												
	Universal												
	Universal Plus												
	Universal Partnership Plus												
Delivering the Service	FNP Expansion												
	Building Community Capacity												
	Deploying HV Growth												
	Supporting the Change												

Comparative NHS West Midlands – Site Comparative – Higher Level Dashboard Area

- Overall
- Organisational Alignment
- Staff & Workforce
- Users & Partners
- Defining the Service Offering
- Delivering the Service

High performing

Significant support needs

High performing

Significant support needs

Site 1 Site 2 Site 3 Site 4 Site 5 Site 6 Site 7 Site 8 Site 9 Site 10 Site 11 Site 12 Average West Midlands

Comparative NHS East Midlands – Site Comparative – Detailed Dashboard

		Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8
Delivery	Training capacity and commissions								
	Plan Reporting & Management								
	Engagement								
	Capacity & Recruitment								
Organisational Alignment	Board Engagement								
	Core To Organisational Strategy								
	Delivery Structure & Management								
Staff & Workforce	Communication and Engagement								
	Availability and Access To Training								
	Professional Support								
	Leadership Development								
	Evidence Based Good Practice & EIS								
	Staff Wellbeing & Support								
	CPT & Student Wellbeing & Support								
Users & Partners	Commissioning framework and outcomes								
	Public Health involvement/direction								
	General Engagement								
	Partnership Working								
	User Engagement & Use to Design & Inform								
Defining the Service Offering	Understanding current and future service offering								
	Universal								
	Universal Plus								
	Universal Partnership Plus								
Delivering the Service	FNP Expansion								
	Building Community Capacity								
	Deploying HV Growth								
	Supporting the Change								

Dashboard template and style ©Sustain

Comparative NHS East Midlands – Site Comparative – Higher Level Dashboard Area

- Overall
- Organisational Alignment
- Staff & Workforce
- Users & Partners
- Defining the Service Offering
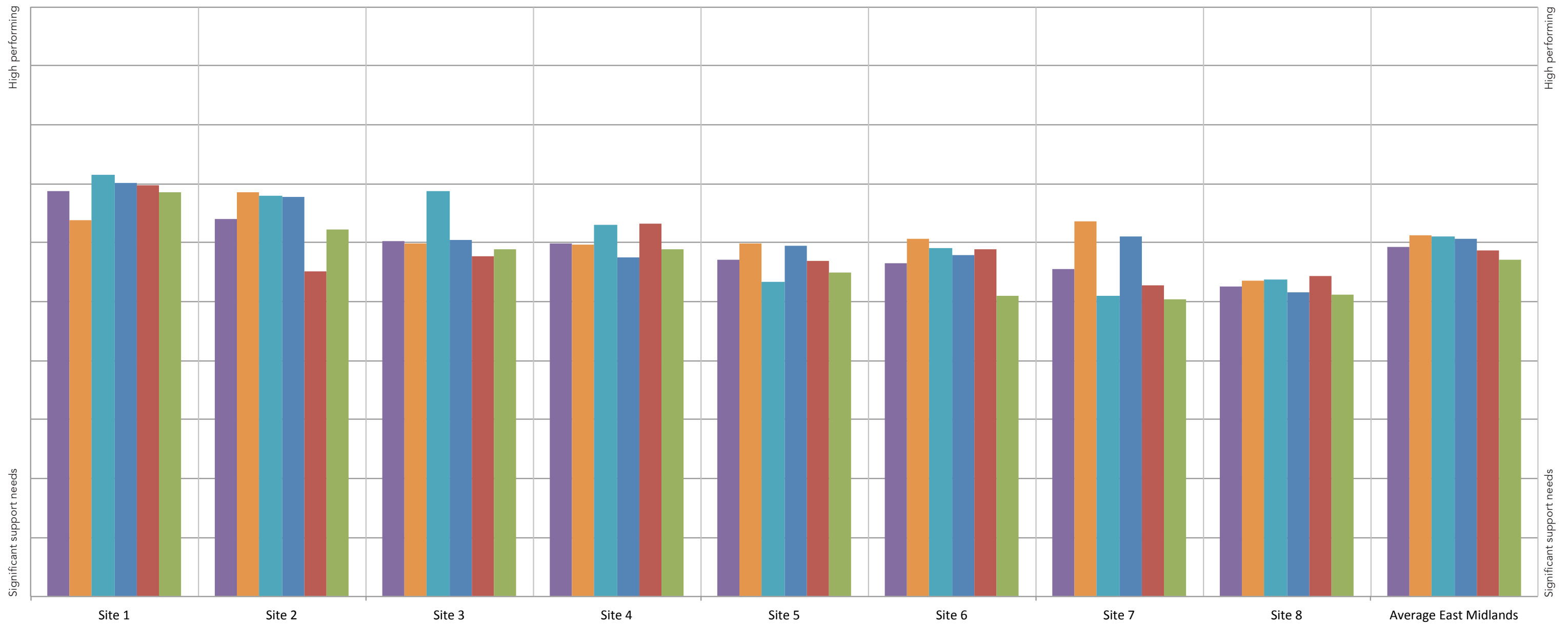- Delivering the Service

High performing

Significant support needs

Site 1 Site 2 Site 3 Site 4 Site 5 Site 6 Site 7 Site 8 Average East Midlands

Comparative NHS Midlands and East and SHA Regions – Observations

Good Practice (Green Rated on Individual Output Reports)

The outputs report the relevant observations (green) that were classified within the area defined (e.g. BCC) as a percentage of all green observations for the region. This is compared to the same measurement for the NHS Midlands and East overall.

East of England – Good Practice

Legend:
- All Midlands and East Regions Good Practice
- East of England Good Practice

West Midlands – Good Practice

Legend:
- All Midlands and East Regions Good Practice
- West Midlands Good Practice

Y-axis: % of Good Practice Observations (0.00% – 12.00%)

Categories: Recruitment & Retention, Partnerships, BCC, General Service Delivery/Offer, Continuous Improvement Culture, Sharing Best Practice, Deployment, User Engagement, SOP & Consistency, CPT, Breast Feeding, Induction & Preceptorship, Service Specification, Staff Engagement, Maternity, Childrens Centres, SystmOne, Mobile Working, HVIP Plan, Professional Leadership, Organisational Culture, Use of Information, Supervision, CCG & GP Engagement, Learning and Development, Strategic Engagement, Safeguarding Supervision, Public Health, Integration, User Culture Awareness, Restorative Supervision, EIS, Vision, Workforce Growth, Strategic Partnerships, FNP, Communication Engagement & Marketing, IT Systems, Staff Support, Training and Development, Service Structure, Commissioner Relationship, Engagement

East Midlands – Good Practice

Legend:
- All Midlands and East Regions Good Practice
- East Midlands Good Practice

Y-axis: % of Good Practice Observations (0.00% – 12.00%)

X-axis categories: Recruitment & Retention, Partnerships, BCC, General Service Delivery/Offer, Continuous Improvement Culture, Sharing Best Practice, Deployment, User Engagement, SOP & Consistency, CPT, Breast Feeding, Induction & Preceptorship, Service Specification, Staff Engagement, Maternity, Childrens Centres, SystmOne, Mobile Working, HVIP Plan, Professional Leadership, Organisational Culture, Use of Information, Supervision, CCG & GP Engagement, Learning and Development, Strategic Engagement, Safeguarding Supervision, Public Health, Integration, User Culture Awareness, Restorative Supervision, EIS, Vision, Workforce Growth, Strategic Partnerships, FNP, Communication Engagement & Marketing, IT Systems, Staff Support, Training and Development, Service Structure, Commissioner Relationship, Engagement

Areas of Concern and Areas to Note (Red and Amber Rated on Individual Output Reports)
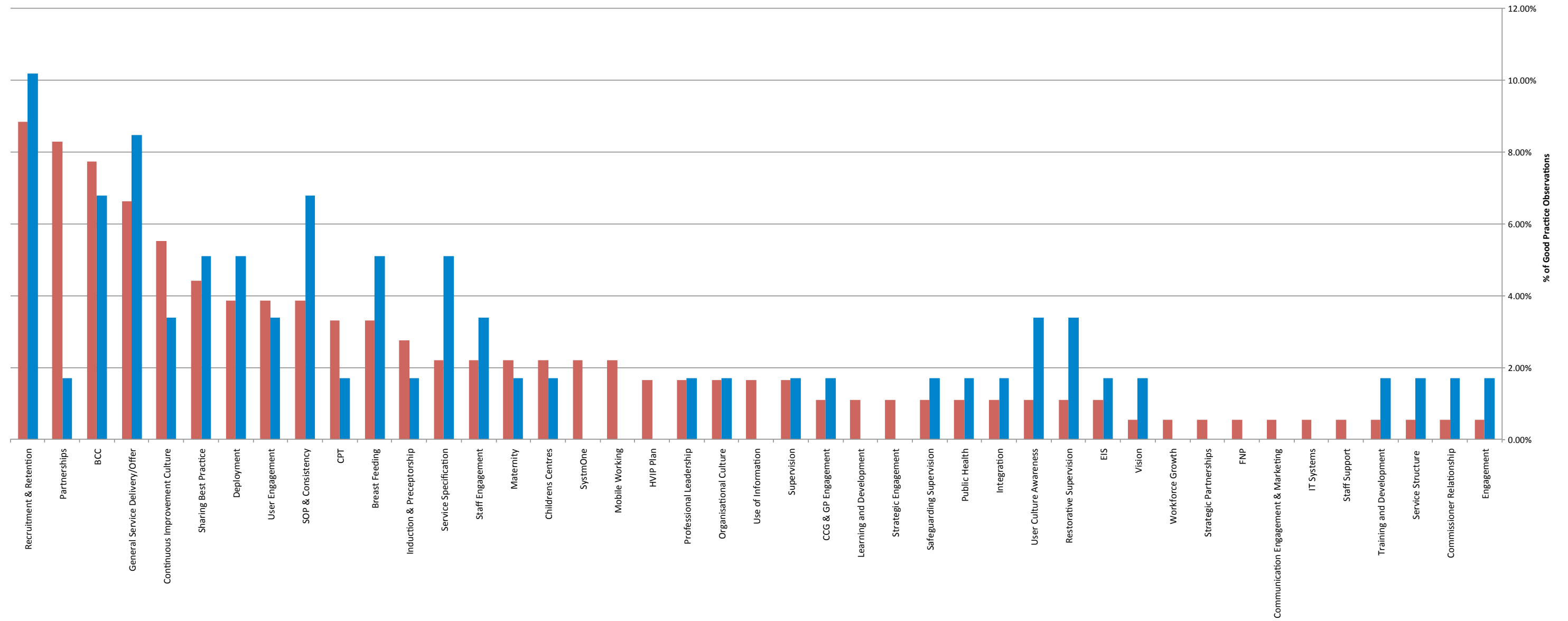
The outputs report the relevant observations (Red and Amber combined that were classified with the area defined (e.g. BCC) as a percentage of all red and amber observations for the region. This is compared to the same measurement for the NHS Midlands and East overall.
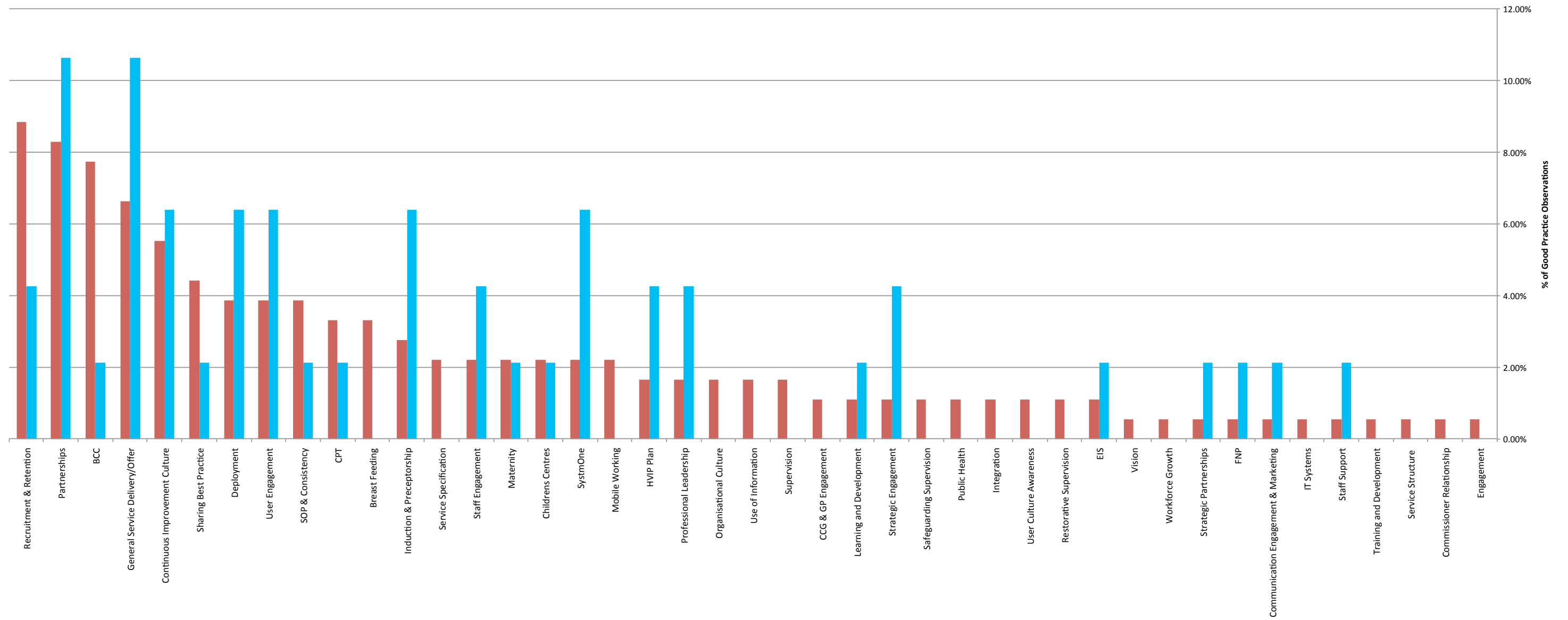
### East of England – Areas of Concern and Areas to Note

Legend:
- All Midlands and East Regions Areas to Note and of Concern
- East of England Areas to Note and of Concern

West Midlands – Areas of Concern and Areas to Note

Legend:
- All Midlands and East Regions Areas to Note and of Concern
- West Midlands Areas to Note and of Concern

% of Red and Amber Observations

Categories (x-axis): HVIP Plan, General Service Delivery/Offer, Vision, Sharing Best Practice, Deployment, CPT, Workforce Growth, Strategic Partnerships, Service Specification, CCG & GP Engagement, Professional Leadership, User Engagement, Recruitment & Retention, FNP, Organisational Culture, Learning and Development, Strategic Engagement, Clinical Supervision, Safeguarding Supervision, Communication Engagement & Marketing, Staff Engagement, SOP & Consistency, IT Systems, Partnerships, Public Health, Staff Support, Maternity, Use of Information, Childrens Centres, BCC, Supervision, Training and Development, CIP, HV Team Capacity, SystmOne, Sustainability, Induction & Preceptorship, Continuous Improvement Culture, Mobile Working, Service Transition, Service Structure, Mentorship, Managing Change, Integration, User Culture Awareness, Commitment to Growth, Commissioner Relationship, Engagement, Breast Feeding

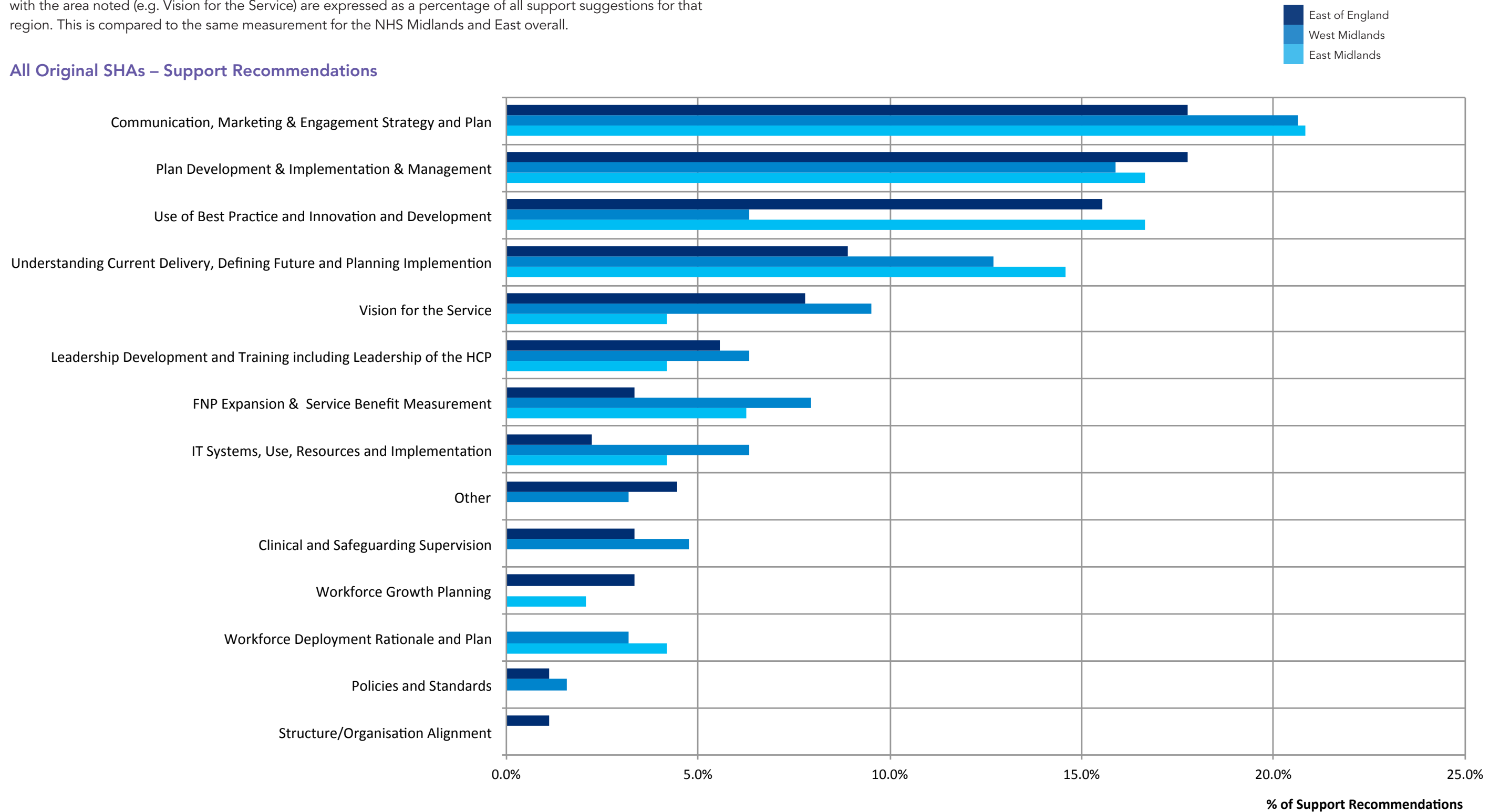## East Midlands – Areas of Concern and Areas to Note

Legend:
- All Midlands and East Regions Areas to Note and of Concern
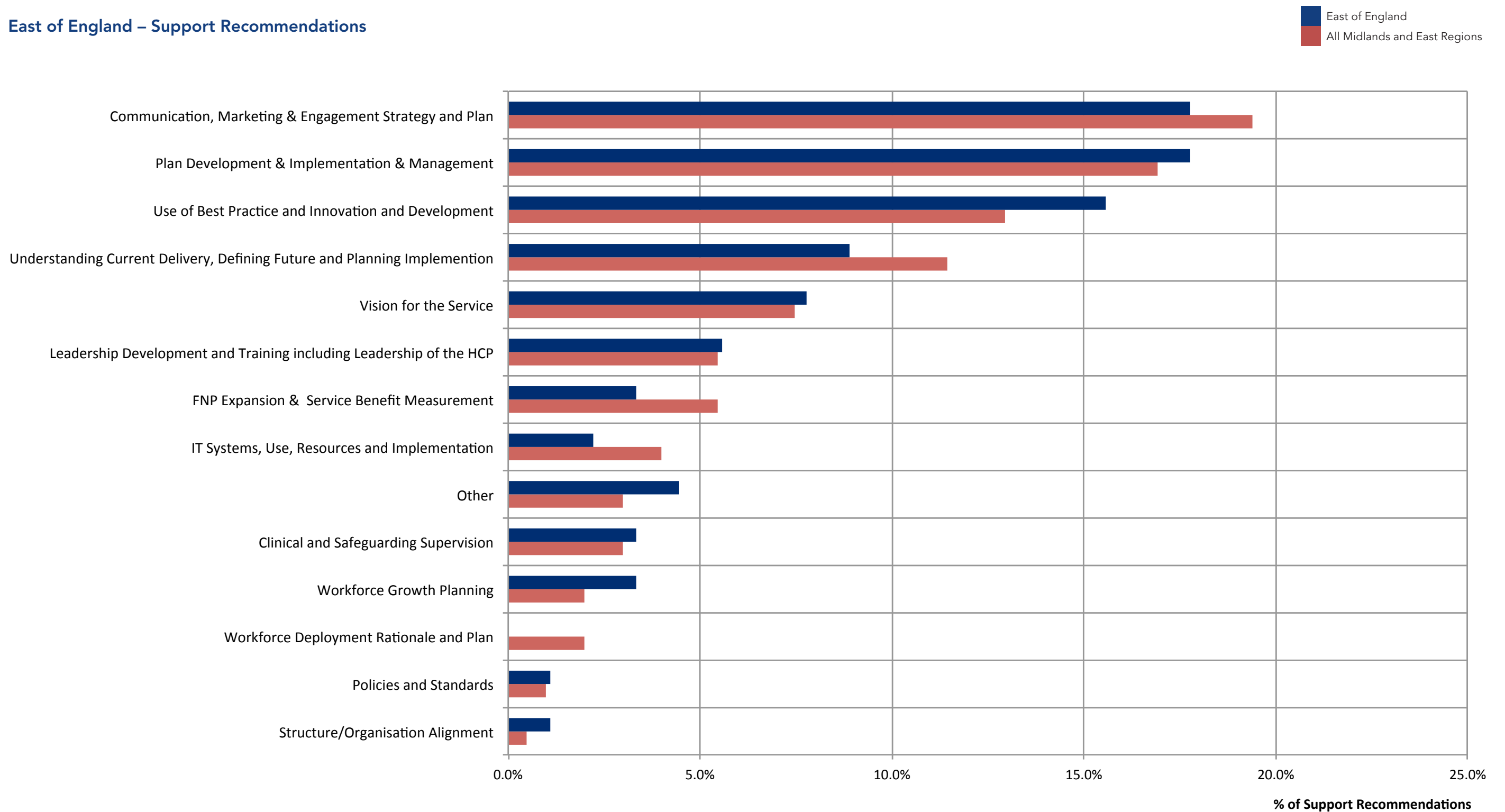- East Midlands Areas to Note and of Concern
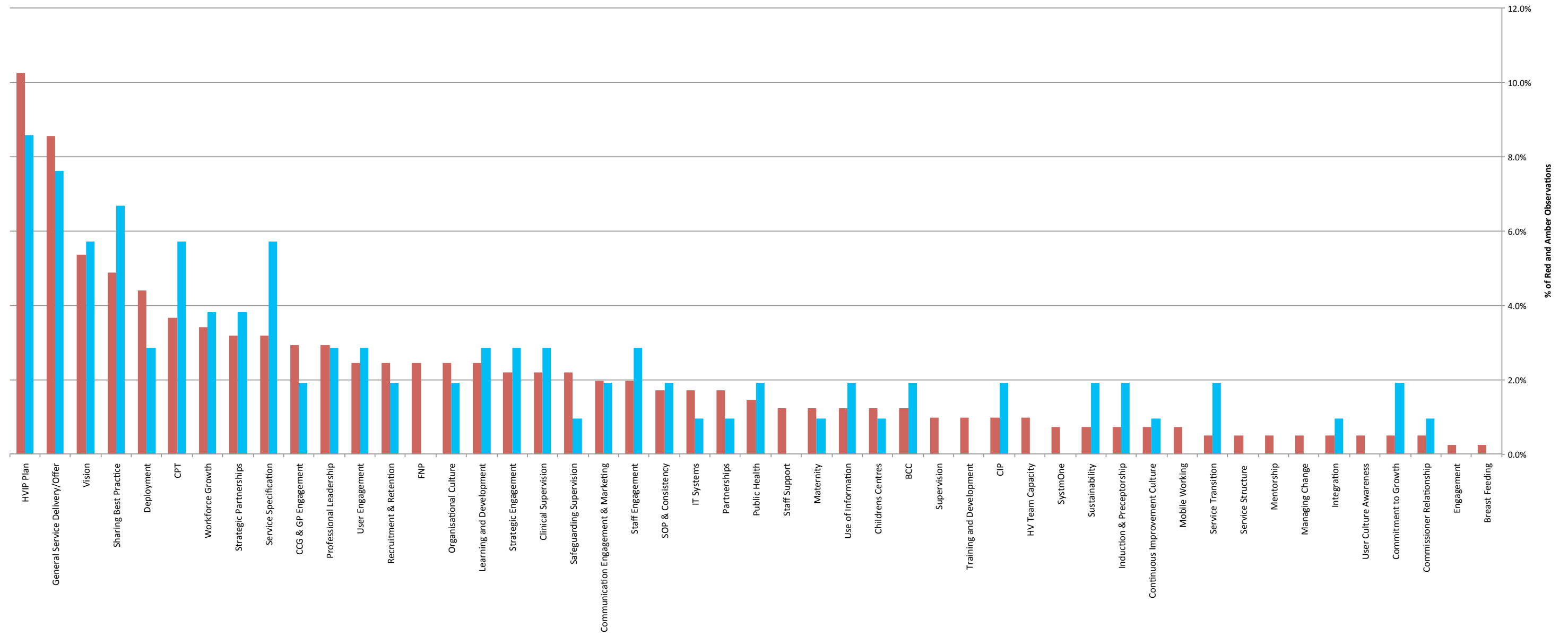
Comparative NHS Midlands and East and SHA Regions – Support Recommendations

Within the appraisal commissioned we were asked to define areas of support that we felt where required where the skills, knowledge or capacity where not readily visible within the provider organisation or the system. One of the key expectations of this at the outset was that it would drive regional thinking and help inform areas where collective pieces of work and or support would be useful in delivering the programme. This output, which is broadly in line with the headline observations at the beginning of the report should be of benefit in assisting Area Teams and local commissioning and service teams in considering some of the areas which would benefit from a more cohesive approach. In the same style as the previous sections above the relevant support suggestions that were classified with the area noted (e.g. Vision for the Service) are expressed as a percentage of all support suggestions for that region. This is compared to the same measurement for the NHS Midlands and East overall.
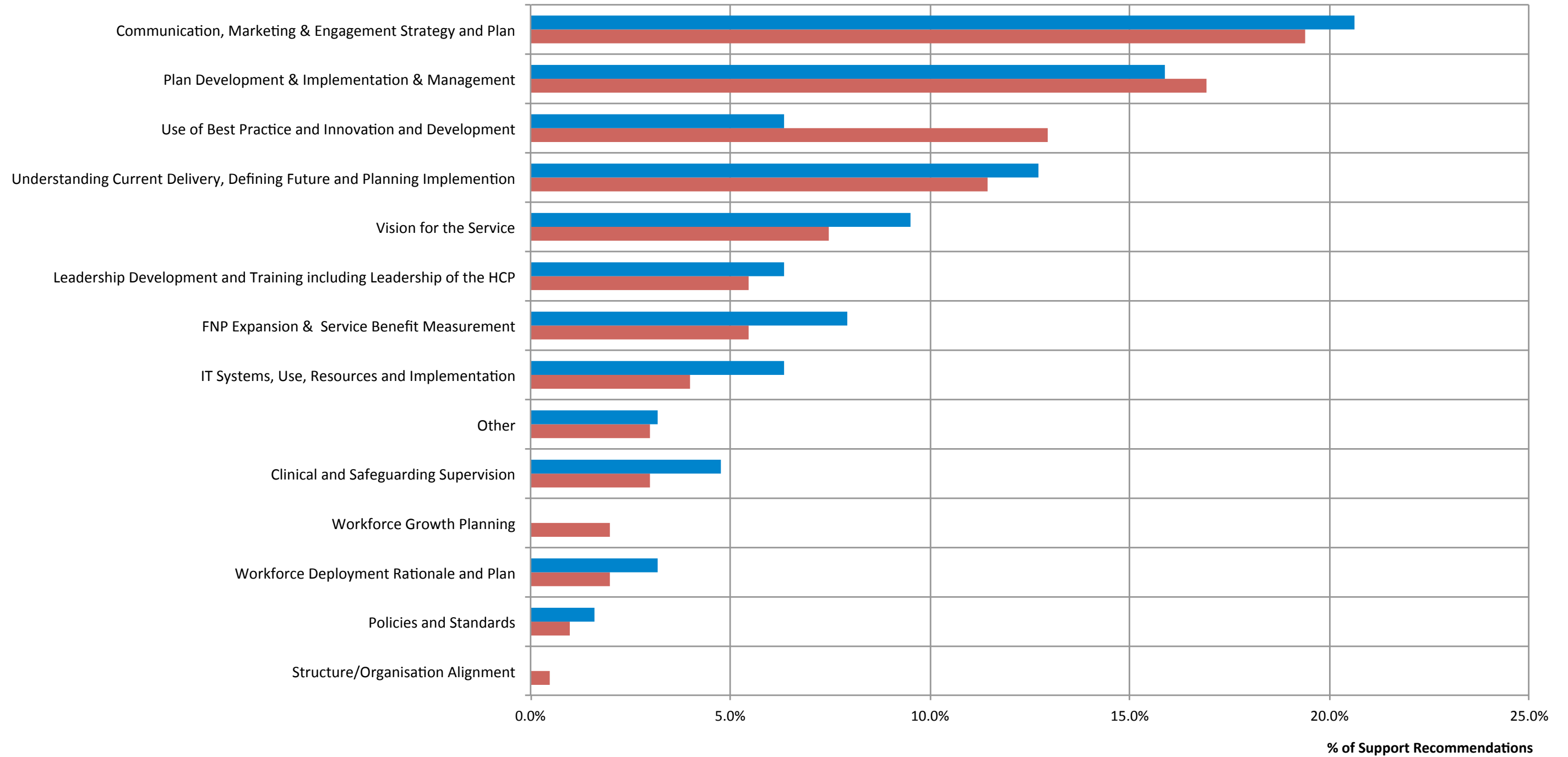
All Original SHAs – Support Recommendations

Legend:
- East of England
- West Midlands
- East Midlands

% of Support Recommendations

East of England – Support Recommendations

Legend:
- East of England (dark blue)
- All Midlands and East Regions (red)

Chart categories (top to bottom):
- Communication, Marketing & Engagement Strategy and Plan
- Plan Development & Implementation & Management
- Use of Best Practice and Innovation and Development
- Understanding Current Delivery, Defining Future and Planning Implemention
- Vision for the Service
- Leadership Development and Training including Leadership of the HCP
- FNP Expansion & Service Benefit Measurement
- IT Systems, Use, Resources and Implementation
- Other
- Clinical and Safeguarding Supervision
- Workforce Growth Planning
- Workforce Deployment Rationale and Plan
- Policies and Standards
- Structure/Organisation Alignment

X-axis: 0.0% 5.0% 10.0% 15.0% 20.0% 25.0%

% of Support Recommendations

West Midlands – Support Recommendations

Legend:
- West Midlands
- All Midlands and East Regions

Chart categories (top to bottom):
- Communication, Marketing & Engagement Strategy and Plan
- Plan Development & Implementation & Management
- Use of Best Practice and Innovation and Development
- Understanding Current Delivery, Defining Future and Planning Implemention
- Vision for the Service
- Leadership Development and Training including Leadership of the HCP
- FNP Expansion & Service Benefit Measurement
- IT Systems, Use, Resources and Implementation
- Other
- Clinical and Safeguarding Supervision
- Workforce Growth Planning
- Workforce Deployment Rationale and Plan
- Policies and Standards
- Structure/Organisation Alignment

X-axis: 0.0%, 5.0%, 10.0%, 15.0%, 20.0%, 25.0%

% of Support Recommendations

East Midlands – Support Recommendations

Legend:
- East Midlands
- All Midlands and East Regions

% of Support Recommendations

Categories (top to bottom):
- Communication, Marketing & Engagement Strategy and Plan
- Plan Development & Implementation & Management
- Use of Best Practice and Innovation and Development
- Understanding Current Delivery, Defining Future and Planning Implemention
- Vision for the Service
- Leadership Development and Training including Leadership of the HCP
- FNP Expansion & Service Benefit Measurement
- IT Systems, Use, Resources and Implementation
- Other
- Clinical and Safeguarding Supervision
- Workforce Growth Planning
- Workforce Deployment Rationale and Plan
- Policies and Standards
- Structure/Organisation Alignment

X-axis: 0.0%, 5.0%, 10.0%, 15.0%, 20.0%, 25.0%

Timeline

April 2012	Set-up	

	Original Commissioner	Provider
May 2012	Great Yarmouth & Waveney	East Coast Community Health and Care
	Cambridgeshire	Cambridgeshire Community Services NHS Trust
June 2012	Bedfordshire	Bedfordshire Community Services - (SEPT)
	Luton	Cambridge Community Services NHS Trust
July 2012	Derbyshire	Derbyshire Community Health Services NHS Trust
	Derby City	Derbyshire Healthcare NHS Foundation Trust
	Black Country	Black Country Partnership NHS Trust
August 2012	Sandwell	Sandwell & West Birmingham Hospitals NHS Trust
	Peterborough	Cambridgeshire & Peterborough NHS Foundation Trust
	Norfolk	Norfolk Community Health and Care NHS Trust
	Walsall	Walsall Healthcare NHS Trust
September 2012	Wolverhampton	The Royal Wolverhampton Hospitals NHS Trust
	Northants	Northamptonshire Healthcare NHS Foundation Trust
	Milton Keynes	Milton Keynes Community Health Services
October 2012	Hertfordshire	Hertfordshire Community NHS Trust
	Suffolk	Suffolk County Council
	Staffordshire	Staffordshire & Stoke-on-Trent Partnership NHS Trust
	Nottingham City	Nottingham City Care Partnership
November 2012	Nottinghamshire	Nottinghamshire Healthcare NHS Trust: County Health Partnership
	Coventry	Coventry & Warwickshire Partnership NHS Trust
	Warwickshire	South Warwickshire NHS Foundation Trust
	Lincolnshire	Lincolnshire Community Health Services NHS Trust
December 2012	North Essex	Anglia Community Enterprise
January 2013	Mid Essex	Central Essex Community Services
	West Essex	West Essex Community Services - (SEPT)
	Leicestershire	Leicestershire Partnership NHS Trust
	Birmingham	Birmingham Community Healthcare NHS Trust
February 2013	Heart of Birmingham	Heart of England NHS Foundation Trust
	South East Essex	South East Essex Community Services - (SEPT)
	South West Essex	South West Essex Community Services - (NELFT)
	Worcestershire	Worcestershire Health and Care NHS Trust
March 2013	Shropshire	Shropshire Community Health NHS Trust
	Wye Valley	Wye Valley NHS Trust

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Health Visiting Rapid Appraisal
Summary Report