



The Distinctive Contribution of Health Visiting to Public Health and Wellbeing: A Guide for Commissioners

**Addressing public health priorities
using the Principles of Health Visiting**

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Introduction

This publication came about through the recognition that despite health visiting's long history, many working in the health service and in local authorities fail to recognise the distinctive contribution of health visitors to promoting the public health of the population. In particular, those now commissioning children's services may have come to their post with little insight into the potential contribution of health visitors to promoting children's wellbeing and the public health of families. Recent cuts in the health visiting workforce have confirmed this to Unite/CPHVA. The unique contribution of this 'public health army' has apparently either not been successfully articulated or well understood, and that is why it is not being invested in.

This publication is intended to be used by many, but its primary aim is to help children's commissioners understand how proper investment in health visitors and health visiting teams will deliver their objectives in line with the government Public Service Agreement (PSA) targets for public health and Local Delivery Plans (LDPs).

Whilst a great deal of detail is provided in many of the examples we do not consider these to comprehensively cover health visitor interventions in each area, rather to make clear the distinctive leadership contribution of the health visitor in each case. The material can be used in different ways, the first page provides an introduction to health visiting theory and practice, the subsequent pages can stand alone or will provide in-depth information regarding the considerable range of interventions which provide the largely unique toolkit of the health visitor.

A number of different authors have contributed to this publication, mainly from the Unite/CPHVA Health Visitors' Forum but supported by the Unite/CPHVA professional team and others in practice. As a result, there are small variations in style in the different examples for which we make no apology. I would particularly like to thank Maggie Fisher who has done the difficult job of pulling all these contributions together into this final format.

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The Distinctive Contribution of Health Visiting to Public Health and Wellbeing

This document will help commissioners of services and members of the public understand the distinctive contribution that health visitors make in general to the health and wellbeing of a community.

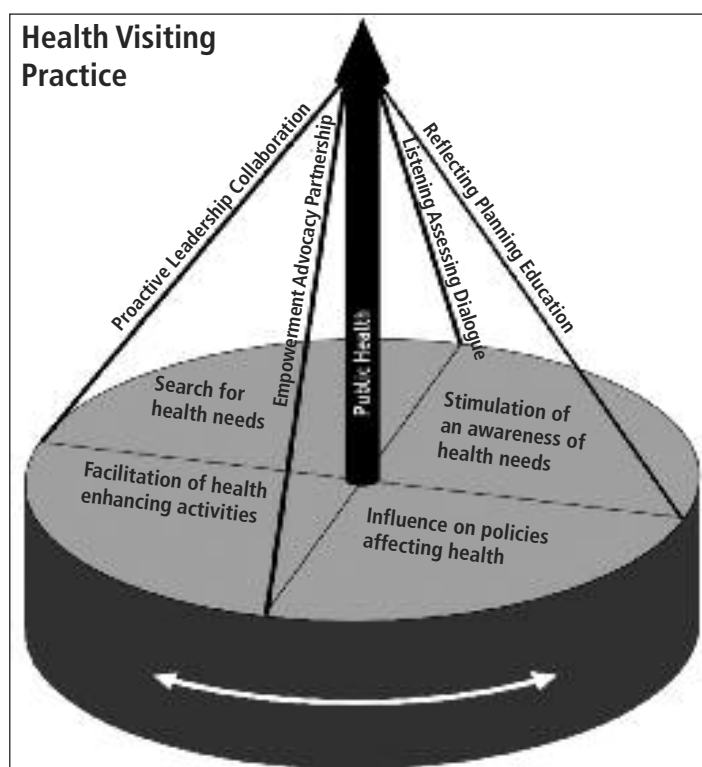
Health and health care is a dynamic process that is subject to internal and external factors. Health visitors practice through a set of clearly defined principles, first identified by the Council for the Education and Training of Health Visitors (CETHV), and represented in the diagram overleaf. These principles overlap and are inter-related, placing health visitors at the forefront of the public health agenda in promoting health and reducing health inequalities. There is interplay between health visiting activities along a continuum working with individuals, in families and groups, and with the wider community, through implementation of the principles. These are not simply skills to be learnt or tasks to be completed, but encompass a philosophy and way of working that makes health visiting a distinctive profession in the following ways:

- Health visiting activity is directed at the individual and public health needs of children, families and communities.
- Health visiting is unusual among health professions in that it focuses on health and wellbeing rather than disease or illness.
- Health visitors identify recognised and unrecognised health needs; often people with the greatest health needs are unaware of these needs.
- Health visitors provide a universal home visiting service to all families with infants and children, which is non-stigmatising and has high levels of acceptability to the public.
- Health visitors see health as a process not a state of being to be obtained, and they consider health in its overall socio-cultural context.
- Health visitors have particular skills in their ability to see beyond the task; they understand the interplay of complex contextual issues that affect the health of individuals, families and groups and the community as a whole.
- Health visitors are the one professional group who are likely to have contact with, and provide an accessible, personalised service to, those who may not contact support services. The use of a partnership approach and an empowerment model of service delivery ensure acceptability to them.

- Health visitors draw on a social model of health that focuses on promoting resilience and building on strengths.
- All health visitor interventions operate on a partnership and empowerment model of delivery which ensures acceptability of the service.

The diagram below explains the four principles of health visiting in practice. They are:

- Searching for health needs.
- Stimulating an awareness of health needs.
- Influencing policies affecting health.
- Facilitating health enhancing activities.



Using these principles, the following tables provide examples of how the health visitor role may influence public health issues in practice and help Primary Care Trusts/Employing Authorities to meet PSA targets and implement the LDPs.

The Promotion and Support of Positive Parenting by Health Visitors

Health visitors should be making a distinctive contribution to ensuring positive parenting practices in families. *The Children's Plan*¹ and *The Child Health Promotion Programme*² place a major emphasis on parenting support to include:

- Encouraging strong couple relationships and stable positive relationships within families.
- Supporting mothers and fathers to attuned parenting in particular during the first months of life.
- Ensuring contact with the family routinely involves and empowers fathers, including non-resident fathers and supporting the transition to parenthood for first time mothers and fathers.

It is widely recognised that parenting has a significant impact on outcomes for children in terms of educational achievement, physical and mental health, and the reduction of offending as the following quote illustrates.

'Parenting is probably the most important public health issue facing our society. It is the single largest variable implicated in childhood illness and accidents, teenage pregnancy and substance misuse, truancy, school disruption and under achievement, child abuse, unemployment, juvenile crime and mental illness. These are serious in themselves but are even more serious as precursors of problems in adulthood and the next generation'. Hoghugi, (1998)³

Parenting is a key component of the public health work that health visitors do with families and the above quote emphasizes the importance of parenting on child health. Health visitors play a pivotal role in promoting both positive parenting and the *Every Child Matters: Change for Children*⁴ Agenda, where they work as part of a multi-agency team. By providing a universal health visiting service to all families, health visitors play a core role in identifying the continuum of need that exists in the population and in differentiating between children in need and children in need of protection.

Table 1: Promotion and Support of Positive Parenting by Health Visitors

Principle of Health Visiting	Action
Search for health needs	<ul style="list-style-type: none"> • As per <i>The Child Health Promotion Programme</i>². • Antenatal home visit exploring parents perceptions of pregnancy, baby and likely postnatal support, particularly from own parents and partner, housing and financial needs. Assessment of need and risk should be comprehensive and continuous both at individual and population level. This holistic assessment by skilled practitioners helps to identify both expressed and unexpressed needs (PSAs 10-15, 18-19 & 21). • Postnatal home visit to explore with parent, impact of birth on parental relationship, parent-infant interaction, exploration of parental feelings, housing and financial needs (PSAs 18-19). • Discussion re parents' experiences of being parented. • Maternal mood assessment as per <i>The Child Health Promotion Programme</i>² and NICE Clinical Guideline for <i>Antenatal and Postnatal Mental Health</i>⁵ (PSAs 10, 12-14, 18-19). • Six to twelve month assessments of baby's physical, social and emotional development (PSAs 10, 12-13 & 18). • Two to two-and-a-half year review of children's physical, social and emotional development as per <i>Child Health Promotion Programme</i>² (PSAs 10, 12-14, 18-19). • Awareness of frequency of requests from parents for advice regarding behavioural difficulties (PSAs 10, 13 & 18). • Monitoring of PSA targets against the LDP to audit services and identify areas for improvement.
Stimulating awareness of health needs	<ul style="list-style-type: none"> • Bring to the attention of the community and commissioners of service the results of the above. • Bring to the attention of commissioners the role of parenting in achieving PSAs 10-14 & 18. • Provide information for parents regarding babies' and children's emotional development and the impact of different parenting styles. • Support parents to understand their role as their child's first educators (PSA 10). • Involve parents in meetings to discuss ways in which they might like their parenting to be supported within the community (PSAs 19 & 21). • Involve Children's Centre staff, early years' education and voluntary sector in discussions around the need to support parents, parent-child interaction and appropriate referral pathways (PSA 10). • Work through local and national professional organisations and forums to raise issues around parenting and the need for parental support (PSA 19). • Provide commissioners with evidence of how the health visiting service is contributing to the LDPs and meeting of PSA targets.

Principle of Health Visiting	Action
Influencing policies affecting health	<ul style="list-style-type: none"> • Attend local parenting forum meetings. • Attend inter-agency meetings to ensure parenting support is on the agenda for statutory and voluntary organisations (PSAs 19 & 21). • Involvement in the formation of local authority parenting strategies and being involved in multi-agency steering groups that are responsible for setting the strategic agenda for parenting support locally (PSAs 19 & 21). • Be familiar with the local Children and Young People's Plan, Local Area Agreements (LAA) and LDPs to ensure all services are working together to meet the five outcomes of <i>Every Child Matters</i>⁴ (PSAs 12, 15, 18-19). • Identify and liaise with the local authority parenting commissioners and the strategic leads for children and families. Update them regularly on the local work being done and send them annual reports with evaluations, outcomes and progress against the LDPs and PSAs. • Work nationally through professional and national organisations to promote the importance of parent-child interaction and ensure quality of services to enhance this (PSAs 12 & 19). • Conduct regular audits of services provided and ensure they comply with the <i>National Service Framework for Children, Young People and Maternity Services Core Standards</i>⁶ and <i>The Child Health Promotion Programme</i>² (PSAs 15 & 19). • Ensure that the services provided by the health visiting service meet the recommendations in <i>Every Parent Matters</i>⁷ (PSAs 15 & 19).
Facilitating health enhancing activities	<ul style="list-style-type: none"> • In line with the <i>Children's Plan</i>¹ adopt a whole-child approach to address the link between health, behaviour and achievement to ensure that every child fulfils their potential (PSAs 18-19). • In one-to-one and group work promote parent-infant interaction and attachment (PSAs 10, 12-13). • Provide early identification and management of postnatal distress (PSAs 10, 12-13). • Promote and provide support for breastfeeding, healthy eating and management of feeding and sleeping difficulties (PSAs 12-13 & 18). • In collaboration with others, facilitate parenting programmes across the age range, starting with transition to parenthood. • Ensure that training is available to staff to facilitate evidence based parenting groups and one-to-one support to parents. • Work in partnership with others in Children's Centres, voluntary and statutory services to ensure parenting support is available at an universal level (Tier 1) and specialist levels (Tiers 2 and 3) (PSA 19). • Ensure that the parenting provision provided is evidence based. • Ensure that those practitioners working with parents are adequately trained and supervised and meet the <i>National Occupational Standards for Working with Parents</i>⁸. • Provide services that are actively inclusive of fathers and encourage their participation (PSA target 15 & 19). • Promote multi-agency and multi-disciplinary work with families and ensure that clear referral pathways are in place (PSA 19).

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Expected outcomes

- Reduced length of Child Adolescent Mental Health Service (CAMHS) waiting lists of children referred for conduct disorder/behavioural difficulties.
- Increased percentage of children demonstrating good personal, social and emotional development aged 5 years (PSAs 10, 12 & 18).
- Reduced numbers of children on safeguarding children register (PSAs 10, 13-14 & 18).
- Reduced numbers of children/young mothers attending accident and emergency as a result of self harm (PSA 13).
- Reduced Anti Social Behavioural Orders and juvenile offenders in the community (PSAs 10, 12-14).

References

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The Promotion of Antenatal and Postnatal Mental Health and Wellbeing by Health Visitors

Health visitors make a distinctive contribution to maternal mental health and wellbeing. They offer a universal preventative service at the same time as focusing on vulnerable babies, children and families to address some of the serious issues we face as a society. This model of progressive universalism with the additional support and services is outlined in the *The Child Health Promotion Programme*¹. A robust universal home visiting service is essential for safeguarding children and public protection. Early intervention and

working with newly identified needs as soon as possible is part of the safeguarding continuum and not a separate sphere of activity.

Health visitors work in partnership with families using a model based on strengths and empowerment. Health visitors understand the bio-medical model of health and its importance in disease aetiology (pathogenesis) but their practice is developed from their primary interest in what creates health (salutogenesis) (Cowley & Frost 2006)².

Table 2: Promotion of Antenatal and Postnatal Mental Health and Wellbeing by Health Visitors

Principles of Health Visiting	Action
Search for health needs	<ul style="list-style-type: none"> • Identification of vulnerable or depressed women antenatally through routine notification and informal contact. • Antenatal assessment to identify and promote resilience factors, and note previous mental or emotional issues, history of depression, anxiety, family history and lifestyle. This assessment includes the father where possible. The health visitor can provide information and support for him and respond to his individual concerns (PSAs 12-13). • Assessment of the mother's emotional health at all contacts. • In line with NICE guidance <i>Antenatal and Postnatal Mental Health</i>³ at 4-6 weeks and 3-4 months, health visitors should ask two questions to identify possible depression. If the woman answers 'yes' to either of the initial questions, the mother is asked if she needs or would like help or support with this. • As part of a subsequent assessment, or for routine monitoring of outcomes, self-report measures such as the Edinburgh Postnatal Depression Scale (EPDS), Hospital Anxiety and Depression Scale (HADS) or Patient Health Questionnaire (PHQ9) may be used (PSAs 12-14, 18-19). • Assessment of infant-parent attachment and sensitive attuned parenting. Promotion of skin-to-skin contact and use of baby carriers to encourage this. • Promotion and support of breastfeeding to facilitate bonding and promote closeness. This supports the LDPs PSA 12, Indicators 1 & 2. • Routine enquiry for domestic abuse. NICE guideline on <i>Postnatal Care</i>⁴ does not support routine enquiry as there is insufficient evidence to recommend for or against this, however health visitors usually carry this out, as it has important safeguarding implications. NICE guidance <i>Antenatal and Postnatal Mental Health</i>³ recommends that '<i>Healthcare professionals need to be alert to symptoms or signs of domestic violence and women should be given the opportunity to disclose domestic violence in an environment they feel secure</i>' (p186 3). Furthermore, the Confidential Enquiry into Maternal Deaths⁵ endorsed routine questioning about domestic violence in antenatal care but emphasised the need for supporting protocols and strategies (PSAs 12 &13, Indicators 3-4 & PSA 18).

Principles of Health Visiting	Action
Stimulating awareness of health needs	<ul style="list-style-type: none"> • Discussion of psychosocial health issues with the mother and partner and the strategies for avoiding and managing risk factors, such as loneliness and low self-esteem. This helps to promote awareness in parents of factors which affect their emotional health and well being, such as alcohol and substance use and dependence (PSAs 13, 18-19). • Promotion of an understanding of the infant's emotional needs and the importance of sensitive attuned parenting¹. • Promotion of physical activity for mental wellbeing and provision of support for family members to reduce/stop adult smoking (PSA 18, Indicators 2-3 to reduce adult smoking and contribute to the LDPs).
Influencing policies affecting health	<ul style="list-style-type: none"> • Lobbying local council to provide affordable and safe recreational facilities for families (PSAs 13, 19 21). • Lobbying for a perinatal mental health service accessible to all parents. • Making clear to health care management the potential mental health consequences for families of inappropriate service redesign (PSA 19, Indicators 1 & 6 and PSA 15, Indicator 5). • Providing commissioners with evidence of how the health visiting service is contributing to the LDPs and meeting the PSAs through relevant research and involvement of service users (PSA 19). • Campaigning for adequate professional training and support/supervision including cultural awareness and competence. (PSA 15, Indicator 5, PSA 18).
Facilitating health enhancing activities	<ul style="list-style-type: none"> • Promotion of parent-child attachment through provision of, and involvement in, baby massage classes. • Provision of access to preparation for parenthood, postnatal and parenting groups for health information and social support (PSAs 15, 18-19 & 21 to tackle the underlying determinants of ill-health and health inequalities). • Provision of support for couple relationships as recommended in <i>The Child Health Promotion Programme</i>¹. • Emotional and practical preparation for fatherhood particularly for first time fathers and young fathers (PSAs 15, 19 & 28). • Provision of specialist health visitors in infant mental health to reduce the risks to vulnerable children and children in need (PSAs 12-13 & 18). • Cognitive or solution-focused therapy for parenting difficulties and referral for early intervention and support. • Provision of non-directive listening visits as recommended in the NICE guidance <i>Antenatal and Postnatal Mental Health</i>³ (PSA 18). • Appropriate referral to other agencies and provision of access to support groups for those mothers with depression to reduce mortality rates from suicide and undetermined injury (PSAs 12-13, 15, 18-19). • Signposting to voluntary and other groups for social contact e.g. National Childbirth Trust, Netmums.

References

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- 5 Confidential Enquiry into Maternal Deaths. 2002, *Why Mothers Die 1997-1999: Midwifery Summary and Key Recommendations*. London: RCOG Press

The Prevention and Early Detection of Child Maltreatment to Safeguard Children by Health Visitors

Health visitors make a unique contribution to safeguarding children when able to provide a robust universal service. The health visiting services contribute to universal prevention through the delivery of *The Child Health Promotion Programme*¹ and early identification of children at risk of harm. The principles of health visiting can be used to develop child care services to prevent child maltreatment and ensure rapid and appropriate help for families. Health visitors lead, deliver or participate in care packages to support the most vulnerable children. Health visitors are also the primary professionals in the identification of domestic abuse in families with pre-school children and in supporting families to achieve safety.

'Children need to feel loved and valued, and supported by a network of reliable relationships to achieve these outcomes. Parents themselves need support and asking for and accepting help should be seen as a sign of responsibility rather than a parenting failure'. Working Together to Safeguard Children (2006, p.33)²

Following the death of Victoria Climbié in 2000, safeguarding children has become a key priority for public service organisations, including healthcare providers. Section 11 of the Children Act³ places a statutory duty on key professionals and agencies to safeguard children and promote their welfare. Health visitor work in this area supports many PSA targets but particularly PSAs 10, 12-15, and 18.

Table 3: Prevention and Early Detection of Child Maltreatment to Safeguard Children by Health Visitors

Principle of Health Visiting	Action
Search for health needs	<ul style="list-style-type: none"> • Holistic health needs assessment conducted by the health visitor at each contact to identify risk and resilience factors in families. Assessment of need and risk should be comprehensive and continuous both at individual and population level. <i>The Framework for the Assessment of Children in Need and their Families</i>⁴ should form the basis for the assessment of children at each contact. Use of a holistic assessment based on an ecological framework enables skilled practitioner's to identify both expressed and unexpressed needs. • Routine enquiry for domestic violence and monitoring of the impact of this on children. Encouraging families to recognise the impact of domestic abuse on their children and how to minimise the effects and keep children safe. • To provide a safe environment in which victims of domestic abuse can discuss concerns and receive information about sources of support for domestic abuse. Referral to local specialist services as part of a multi-agency strategy. • Use of listening and observation skills to identify indicators of abuse. • Screening for maternal mental health and wellbeing. Use of appropriate and sensitive questions to identify depression or other significant mental health problems such as those recommended by the NICE guideline Antenatal and <i>Postnatal Mental Health</i>⁵. • Partnership working, both interagency and multi-agency, to identify vulnerable children and families. • Health visitors work in close collaboration with midwifery and GP colleagues and services to ensure good communication and sharing of information regarding families who may require extra support both antenatally and postnatally. • Use of demographic and practice profiles to identify safeguarding issues and trends, map local resources and identify gaps in provision. • Routine follow up of A & E referrals and close partnership working and liaison with the hospital liaison health visitor or specialist safeguarding nurse regarding children seen in casualty or admitted to hospital. • Training on safeguarding and domestic abuse for all staff who work in the health visiting team and primary care to raise awareness of the issue and the warning signs. • Evaluation of outcomes and markers of services for children and for populations of children. • Monitoring of PSA targets and Indicators against the LDP and the safeguarding agenda to audit services and identify areas for improvement.
Stimulating awareness health needs	<p>Discussion of psychosocial health issues with the family and mechanisms for avoiding, reducing or of managing risk factors such as:</p> <ul style="list-style-type: none"> • Promotion of an understanding of the infant's emotional needs and the importance of positive parenting (PSAs 12 & 18). • Promotion and support of breastfeeding to promote bonding (PSA 12). This also contributes to the sign off criteria for the LDP. • Promotion of healthy lifestyles to encourage mental wellbeing (PSAs 12 & 18).

Principle of Health Visiting	Action
Stimulating awareness health needs	<ul style="list-style-type: none"> • Working with statutory and voluntary agencies to raise public awareness that safeguarding children is everybody's business and responsibility. • Provision of child protection training by named nurses and specialist safeguarding health visitors to contribute to the training of hospital and community staff and early years' providers. • Support and consultation provided by named nurses, specialist safeguarding health visitors, school nurses and health visitors to nurseries, playgroups and schools. • Providing commissioners with evidence of how the health visiting service is contributing to the LDPs and the meeting of PSA targets.
Influencing policies affecting health	<ul style="list-style-type: none"> • Working with pressure groups and through professional bodies to raise awareness of safeguarding and supporting national and local campaigns e.g. Multi Agency Risk Assessment Conference (MARAC), and the Domestic Violence Intervention Programme (DVIP), and Respect⁶ a membership organisation supported by the government that aims to increase the safety of those experiencing domestic abuse. Respect also provides support and intervention for perpetrators. Respect states that there are four key elements towards greater safety for victims: <ol style="list-style-type: none"> 1. Challenge denial mechanisms and gender-based assumptions. 2. Support those affected by abuse. 3. Professionals must give the message that domestic abuse is unacceptable and hold perpetrators to account. 4. The community as a whole must develop an intolerance to abuse. • Lobbying government through professional organisations to fund research into what works well with the most vulnerable and at risk families. • Partnership working with other agencies to ensure robust systems are in place, to ensure that children are protected from harm. • Health visitors can work proactively to ensure the adequate supervision of children and to raise awareness of safety issues to prevent death or injury on the roads and in the home. • Campaigning for the provision of safe working environments for staff so they can practice effectively and be supported by experienced practitioners who have specialist expertise in providing regular quality child protection supervision to health visiting teams. • Provision of case based advice and supervision to skill mix staff which frequently results in further identification of safeguarding concerns. • Child protection supervision can increase effective prevention and early intervention to strengthen resilience factors and decrease risk factors in families. It can also help to reduce staff burn out and stress in the primary health care team (PHCT). • Identification of specialist nurses in each employing authority who have advanced expertise in child protection to support the strategic development of policy and practice at local and national level in the management of safeguarding. • Developing and maintaining good communication and partnership with the Local Safeguarding Children's Board (LSCB) to ensure co-ordination at all levels of service delivery, so that interventions are systematic and supported within and across all agencies with clear lines of accountability and responsibility for resources and tasks. • Campaigning for the provision of specialist safeguarding liaison health visitors who work within the hospital setting and liaise with health visitors and primary care staff over safeguarding concerns for children or parents who attend or are admitted to hospital. • Ensuring best practice on <i>Information Sharing Agreements and Protocols</i>⁷ is supported by regular multi-agency training to improve integrated working and ensure all staff are kept updated. Practitioners are advised to keep up to date with the latest <i>Information Sharing Guidance for Practitioners and Managers</i>⁸ The lack of an information sharing agreement between agencies should never be a reason for not sharing information that could help a child. • Influencing the development of clear integrated care pathways and protocols in situations where children may be at risk. • Ensuring that the markers of good practice in <i>Core Standard 5 of the National Service Framework (NSF) for Safeguarding and Promoting the Welfare of Children and Young People</i>⁹ are adhered to and that service provision is audited annually against this. • Ensuring that there is adequate provision of quality child care through child minders and nurseries to help compensate when parenting is neglectful.

Principle of Health Visiting	Action
Influencing policies affecting health	<ul style="list-style-type: none"> • Lobbying for adequate play and holiday activities to support vulnerable children and families and provide safe areas for children to play in (PSAs 13 & 18). • Advocating for adequate services that offer respite to support parents managing very challenging children or children with special needs. • Ensuring that there is adequate local provision to support vulnerable children through the use of family support workers, and schemes such as Homestart and Community Mothers. • Lobbying government to end child poverty and ensure adequate housing for children and families. • Influencing the development of clear integrated care pathways and protocols in situations where children may be at risk.
Facilitating health enhancing activities	<p>Promotion of parent-child attachment through the provision of:</p> <ul style="list-style-type: none"> • A universal health visiting service with more intensive support for those in need (progressive universalism) to ensure all children have the opportunity to fulfil their potential and outcomes aspired to in <i>Every Child Matters</i>¹⁰. • Good quality antenatal care and support and preparation for parenthood with early identification of risk factors (PSAs 12, 18 & 19). • Providing access to health visitor led postnatal parenting groups for health information and social support (PSAs 12-13, 18-19). • Promotion of parent-child attachment through the encouragement and support of breastfeeding (PSA 12 and contributes to sign off criteria for the LDP). • Assessment of parent-baby interaction using validated tools and referral to specialist attachment-orientated or parent-infant psychotherapy interventions for those who require it. • Access to health visitor led perinatal mental health services and support groups run in conjunction with other agencies for parents with postnatal depression (PSA 13). • Signposting and supporting access to community services such as, infant massage sessions, and family learning activities to enhance parent/child interaction (PSAs 12-13, 18-19). • Provision of brief health visitor led counselling for relationship difficulties and access to parenting groups which address parental conflict using specially designed training resources. • Cognitive or solution focused therapy for parenting difficulties. • Provision of teenage parent support groups run with health visitors, midwives and other agencies. (PSA 14). • Universal and targeted provision of group based parenting programmes to cater for different levels of need and intervention (PSAs 12, 14 & 19). • Rapid referral and access to Tiers 2 and 3 service provision such as Children's Services, CAMHS, drug and alcohol teams and adult mental health teams before families are in crisis (PSAs 12-14 & 19). • Signposting to community resources to reduce social isolation and enhance social cohesion and support for families (PSA 21). For example signposting to community support groups, family learning activities, parenting courses and smoke stop services as well as the one-to-one work that the health visiting teams do with adults who smoke. • Using evidence based interventions that are proven to be effective. • Involvement in family group conferences and case conferences to ensure children are protected and the family's parenting capacity and strengths are supported by the provision of appropriate services. • Health visitors contribute to the core assessment and are responsible for following up health concerns. • Health visitors are key members of the core group following child protection conferences and in the development, implementation and monitoring of the child protection plan for the under fives • Health visitors play a pivotal role in ensuring that the duty to co-operate and share information concerning suspicions of child maltreatment is complied with by other members of the PHCT and other organisations they have contact with. • Health visitors play a vital role in the early identification of children with additional need. They use the <i>Common Assessment Framework</i>¹¹ and form part of the 'virtual team' that works with the locality team to provide services for the 'team around the child'.

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The Promotion, Support and Protection of Breastfeeding by Health Visitors

Whilst many professionals and volunteers promote breastfeeding health visitors can provide a unique contribution. *The Child Health Promotion Programme*¹ emphasises the importance of making breastfeeding the 'norm' for parents and encourages health professionals to continue to promote it as a priority for improving

children's health alongside raising awareness that breast milk provides the best nourishment for babies up to 6 months. Hall & Elliman² relate to the growing evidence that both the initiation and maintenance of breastfeeding can be influenced by various interventions, despite a client's cultural or social background.

Table 4: Promotion, Support and Protection of Breastfeeding by Health Visitors

Principle of Health Visiting	Action
Search for health needs	<ul style="list-style-type: none"> • Collection of data and analysis of trends relating to initiation, duration and use of NICE Clinical Guidelines and Evidence Review for Post Natal Care³ to audit services (PSA 12, Indicator 1). • Evaluation of reasons for discontinuing breastfeeding. • Identification of client's needs of the service. • Use of community and practice profiles to identify local public health issues that influence women's decisions regarding initiation of breastfeeding. • Participation in research. • Focusing on 'disadvantaged families' (PSAs 12, 15, 18-19 & 21).
Stimulating awareness of health needs	<ul style="list-style-type: none"> • Discussion with individual families and groups about the short and long term benefits of breastfeeding for child, mother and environment (PSA 12, Indicators 1 and 3, PSA 18, Indicator 2). • Use of the experiences of women who breastfeed successfully in the local area to influence others (PSA 21). • Production of displays and written literature and participation in national and local campaigns promoting breastfeeding (PSA 12). • Promotion of environments in health care and public places which are conducive to breastfeeding (PSAs 15, 19 & 21). • Promotion of the normality of breastfeeding in the community, including use of local media (PSAs 12 & 21). • Active involvement of fathers in breastfeeding education supported by <i>The Child Health Promotion Programme</i>¹ (PSA 15). • Provision of information on lactation and positive reasons for breastfeeding to school children (PSA 12).

Principle of Health Visiting	Action
Influencing policies affecting health	<ul style="list-style-type: none"> • Lobbying for implementation of the WHO Marketing Code and strengthening of the UK Infant Formula advertising law. • Campaigning for breastfeeding-friendly environments in shops, cafés and workplaces (PSAs 12, 15, 19 & 21). • Recommending best practice standards in nursing education, especially on specialist community public health nursing courses. • Campaigning nationally and locally for media images and stories/features that portray a positive image of breastfeeding. • Providing commissioners with evidence on the health gains of breastfeeding and the potential savings in health costs and the results of audit and evaluation. • Providing commissioners with evidence of how the health visiting service is contributing to LDPs and the meeting of PSA targets. • Identification of a specialist in each PCT with advanced expertise in breastfeeding to support mothers and health visitors with the management of breastfeeding.
Facilitating health enhancing activities	<ul style="list-style-type: none"> • Provision of skilled support to pregnant women and breastfeeding mothers by the delivery of a service that is visible and easily accessible (PSAs 15 & 19). • Development of a network of peer support programmes. <i>The Child Health Promotion Programme</i>¹ recommends an evidenced-based programme to promote this e.g. <i>The Baby Friendly Initiative</i>⁴. • Participation in breastfeeding support groups and working in partnership with voluntary agencies (PSAs 12, 15, 19 & 21). • Giving information and support to families and friends of breastfeeding mothers. • Providing support and information for breastfeeding mothers returning to work (PSAs 12, 15 & 19). • The facilitation of training for those involved with supporting and encouraging breastfeeding.

Compiled by Judith Moore and other members of the Health Visitors' Forum

References

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- ⁴ The Unicef UK Baby Friendly Initiative. <http://www.babyfriendly.org.uk/> (Date accessed October 28th 2008)

The Contribution by Health Visitors to Support Active Fatherhood

Health visitors have a unique contribution to make in involving fathers actively in parenthood. The following examples demonstrate how the principles of health visiting may be used to support and develop a father's involvement with his children.

Statutory obligations about the equal treatment of men and women in all public service provision are enshrined in the Gender Equality Duty (2007)¹ which requires all public authorities to have 'due regard' to the need to promote equality of opportunity between men and women. It applies to England, Scotland and Wales.

Research has shown that father-child relationships have a profound and wide-ranging impact on children that lasts a lifetime. The relationships between father and child, can be positive, negative or absent. Occurring at any or every stage in a child's life, they are a crucial factor in the lives of children and this is true across all ethnic and cultural communities. Supporting both men and women in caring for children is relevant to gender equality and as the research proves is essential to children's wellbeing.

Table 5: Contribution by Health Visitors to Support Active Fatherhood

Principle of Health Visiting	Action
Search for health needs	<ul style="list-style-type: none"> • Expectant and new fathers’ health-risk behaviours are high, and research is identifying the perinatal period as a likely ‘teachable moment’ for men in this area. Health visitors can capitalise on this to give emotional support; encourage healthy behaviours during pregnancy and support joint decision making. Research indicates this yields the greatest net impact on family health². • Health needs assessments conducted by the health visitor at each contact to identify risk and resilience factors in families. It is particularly important that if the father is not present or non-resident that attempts are made to find out about him and to engage with him. If the father is not problematic, then failing to work with him fails the infant/child by not drawing on a potential strength and support. The most vulnerable children stand to gain the most from a strong father-child relationship and suffer the most when this is lacking (PSAs 12-13, 18 -19). • Establishing the contact patterns of non-resident fathers and the emotional, legal and financial involvement of non-residential fathers and father figures in the infant/child’s life (PSA 13). • Positively engaging with fathers and inviting them to be present if possible at future contacts. Health visitors ask but do not assume what roles the father/s and father-figures play in the family. • Health visitors involve fathers in discussions about their infant/child’s welfare and in any therapeutic work (whilst ensuring the safety of the infant/child and mother). • Both sexes tend to hear parent as ‘mother’. Information and invitations should be given to both parents or should specify that fathers are included. • Routine enquiry for domestic violence and the monitoring of the impact of this on children. Respect³ the UK charity which works to develop perpetrator programmes, suggests that screening for domestic abuse and then failing to engage with the abuser and his behaviour, amounts to collusion with the abuse. Such a failure may also put mothers and children at greater risk. • Encouraging families to recognise the impact of domestic abuse on their children and how to minimise the effects and keep children safe. Referral to local specialist services as part of a multi-agency strategy. • The obstetric literature indicates that psychosocial stress during pregnancy is associated with low birth weight and pre-term birth. Maternal psychopathology in the ante-partum period may be linked to psychopathology in some infants⁴. Assessing and addressing a range of attitudes and behaviours by expectant fathers/new fathers is key – not only domestic abuse, but also mental health, substance use, hostility, infidelity, rejection of the pregnancy (PSAs 12-13, 18-19). • Multi-agency and partnership working is crucial to identify vulnerable fathers and advocate for services to support them. • Monitoring of PSA targets and Indicators against the LDP to audit services for fathers and identify areas for improvement.
Stimulating awareness of health needs	<ul style="list-style-type: none"> • Promoting of an understanding of the infant’s emotional needs and the importance of the the father’s involvement for their infant’s/child’s optimum development. Ensure fathers are aware of the vital supportive role they play in the family (PSAs 12-13 &18). • Ensuring expectant and new fathers are aware of support organisations and the resources that are available to support fathers such as the Fatherhood Institute, the UK’s Fatherhood think-tank (www.fatherhoodinstitute.org) • Promoting and support of breastfeeding to promote bonding and the critical role fathers have in initiating and sustaining their partner’s decision/motivation to breastfeed. Ensure fathers are involved in breastfeeding education/support programmes (PSAs 12-13, 18-19). • Promoting healthy lifestyles to encourage mental wellbeing. Again addressing the specific needs of fathers and the pivotal role they play in supporting family life (PSAs 12 & 18). • Providing commissioners with evidence of how the health visiting service is contributing to planned outcomes and specifically implemented for fathers in line with the Gender Equality Duty (2007)¹ and the latest government policies. This in turn contributes to the PSA targets and LDPs.
Influencing policies affecting health	<ul style="list-style-type: none"> • Advocacy for father work within the organisation to create a support pathway for a father-supportive organisation up to employing authority board level. Without a documented mission to be inclusive of fathers at the highest level, organisational change is unlikely to occur. • Campaigning to ensure all staff receive training on the issue of working with men in general, and fathers in particular.

Principle of Health Visiting	Action
	<ul style="list-style-type: none"> • Using toolkits⁵ to audit the employing authority to ensure father-inclusive practice. • Lobbying for training/supervision to ensure staff have the opportunity to think through their feelings about their own fathers, their children's fathers, and men in general, to identify when personal issues may be colouring their approach. • Ensuring that health centres, clinics and other places of contact are father friendly and welcoming for both parents and have pictures and leaflets that promote a positive image of fatherhood. Rethinking content and style of programmes and information, remembering that fathers often respond well to factual information. Ensuring that there are specific leaflets designed for fathers (PSA 19). • Advocating flexible working times and clinics so it is possible to engage with fathers and mothers who work during the day (PSA 19). • Lobbying government through professional organisations to fund research into what works well with the most vulnerable and at risk fathers and establishing links with organisations at both national and local level. • Partnership working and advocacy work with other agencies to ensure the requisite services are in place to support fathers and the needs of fathers are understood (PSA 19). • Developing a strong image of good practice in engaging fathers and ensuring other organisations are aware of the precise service offered to fathers as well as mothers. • Ensuring that staff and employing authorities are aware that all fathers are different and will have different needs/issues to older/younger fathers as will fathers/step-fathers, resident/non-resident fathers, lone/co-resident fathers, employed/unemployed fathers and fathers from different cultural groups. One size will not fit all and there needs to be a variety of provision as there should be for mothers (PSA 19).
Facilitating Health enhancing activities	<p>Promotion of parent-child attachment through the provision of:</p> <ul style="list-style-type: none"> • A universal health visiting service with more intensive support for those in need (progressive universalism). Low income fathers spend more time caring for their children than middle class fathers; supporting and engaging with fathers is vital. Teenage parenthood continues to be a marker for social disadvantage; it is therefore important to ascertain the teenage father's needs as a basis for offering support and developing services (PSAs 12-14, 18-19). • Good quality antenatal care and support and preparation for fatherhood with early identification of risk and resilience factors. The attitude of the health visitor/health professional towards the father is of key importance; staff need to exude the belief that fathers are valuable and capable of succeeding (PSAs 12-14, 18-19). • Accessing health visitor led postnatal parenting groups for health information and social support, ensuring father friendly and supportive environments that recognise men's experiences, interests, attitudes and expectations are often different (PSAs 12, 18 -19). • Promoting parent-child attachment through the encouragement and support of breastfeeding that is inclusive of fathers and recognises and supports the crucial role they play in this (PSAs 12-14, 18-19). • Accessing health visitor led perinatal mental health services and support groups run in conjunction with other agencies for parents with PND both (male and female). Extra support needs to be available for men coping with a partner who has PND and the recognition of the negative effect this can have on the father's own mental health (PSAs 12-14, 18-19). • Signposting and supporting access to community services such as infant massage sessions and family learning activities to enhance parent/child interaction; ensuring that such services are father inclusive and available to fathers who work in the daytime so they can access them. • Providing brief health visitor led counselling for relationship difficulties. Supporting the couple relationship is of critical importance. Research by <i>Fathers Direct</i>⁶ has indicated that the best predictor of each parent's adjustment to parenthood is the quality of the relationship between them (PSAs 12-13, 18-19). • Cognitive or solution focused therapy for parenting difficulties. • Providing teenage parent support groups run with health visitors, midwives and other agencies. Father and baby groups and support groups just for teenage dads (PSAa 12-14 & 19). • Universal and targeted provision of group-based parenting programmes to cater for different levels of need and intervention that are father inclusive. • Rapid referral and access to Tier 2 and 3 service provision such as children's services, CAMHS, drug and alcohol teams and adult mental health teams before families are in crisis (PSAs 12-14 & 19).

Principle of Health Visiting	Action
	<ul style="list-style-type: none"> • Signposting to community resources to reduce social isolation and enhance social cohesion and support for families (PSA 21). • Using evidence based interventions that are proven to be effective in engaging and working with fathers. • Following up notifications of Children and Young People at risk and Domestic Incident Reports in accordance with local protocols (PSA 13).

Compiled by Maggie Fisher, Professional Officer Unite/CPHVA

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The Promotion of the Childhood Immunisation Programme by Health Visitors

Health visitors have a unique contribution to make to the promotion of childhood immunisation programmes. Health visitors have contact with all pre-school children and their families. At each health visitor contact there is the opportunity to discuss the pre-school immunisation programme. This may include providing written and verbal information with regard to the serious diseases that children can be protected against, the availability of immunisations clinics within the community or at GP practices and detailed information about why immunisations are scheduled in the way that they are. *The Child Health Promotion Programme*¹

recommends contact at key stages when immunisations may be given, within 1 week, 6 weeks to 6 months, one to two years and over three years.

Many employing authorities and Health Boards have agreed Patient Group Directives to enable appropriately competent members of the health visiting team to give pre-school immunisations. Advice on consent which is specific to Wales, Scotland and Northern Ireland is available in Immunisation against Infectious Disease 'The Green Book'² downloadable from the DH Website.

Table 6: The Promotion of the Childhood Immunisation Programme by Health Visitors	
Principle of Health Visiting	Action
Search for health needs	<ul style="list-style-type: none"> • At the initial assessment contact with the parent/s, health visitors establish their perspective and attitude towards pre-school immunisations and offer information and evidence as appropriate. • At each subsequent contact information is obtained on the current immunisation status of the child/ren. This may be checked by use of the central recording system as necessary (Child Health Department). • Identification of children who may require additional immunisations i.e. BCG, Hepatitis B, Influenza and referrals made as necessary. • Informing the Child Health Department of the immunisation status of any child who has received immunisations overseas, and scheduling attendance for any immunisations that are part of the UK schedule that they may not have been offered. • It is a key role to ensure that looked after children, who may have been subjected to a difficult or chaotic early life, have their immunisation status established when they go into care so that they can complete any outstanding immunisations whilst in the care of the local authority.

Principle of Health Visiting	Action
Stimulating awareness of health needs	<ul style="list-style-type: none"> • Where child health promotion groups are held, immunisation may be a specific discussion topic i.e. Teenage Parent Groups, Postnatal Support Groups or more general groups and sessions held at Children's Centres. • Respond to local epidemiological evidence by prioritising contacts with parent/s when it is known that their children have not received the relevant immunisations (i.e. children who need one or two doses of MMR when there is a measles outbreak). • Routine provision to all parent/s with pre-school children, of sources of evidence-based information on immunisation i.e. Department of Health Immunisation Booklet, the Birth to Five Book3, and appropriate websites. • Health visitors are ideally placed to give parents and carers the most up-to-date information on changes to the schedule and the introduction of new or booster immunisations at their universal contacts.
Influencing policies affecting health	<ul style="list-style-type: none"> • Working closely with the locality immunisation coordinator and GP practices to identify and highlight issues regarding poor uptake within local areas and possible causes and solutions. • Increasing the accessibility and flexibility of immunisation clinics by encouraging GP practices and local clinics to: immunise opportunistically, offer 'Drop In' weekend and early evening appointments as well as scheduled week day appointments.
Facilitating health enhancing activities	<ul style="list-style-type: none"> • Health visitors obtain consent for immunisations at their primary visit following the birth of a baby. This ensures that the parents receive invitations to attend for immunisations at the appropriate times. • General advice about the few absolute contraindications to immunisations is given. • Advice on management of common side effects following immunisation and when to seek medical advice. As nurse prescribers health visitors can prescribe as necessary for such side effects. • Health visitors discuss what is meant by informed consent and parental responsibility prior to the immunisation appointment so that the child is appropriately accompanied to the clinic. There is no legal requirement for consent for immunisation to be in writing². • Health visitors identify when children are overdue immunisations for whatever reason to enable them to discuss this at their next contact. This may include children who have moved into the UK from overseas and have been on a different schedule. • Where there is no uptake or significant delay in the uptake of the immunisation programme, the health visitor can explore why this is with the parents. Additional information or alternative access opportunities can be offered, such as an appointment within a practice nurse clinic, a community clinic and in some situations a member of the health visitor team may be able to immunise at home.

Complied by Sally Hamer and Jackie Wrench, Health Visitors' Forum

Sources of information and evidence include the following

- The Department of Health Immunisation website http://www.immunisation.nhs.uk/Professional_Information (Date accessed November 3rd 2008)
- World Health Organization Website for information on different countries schedules and coverage rates <http://www.who.int/immunization/en/> Go to the country and then Immunisation Profile link. (Date accessed November 3rd 2008)

References

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- ² Department of Health (2006). *Immunisation against Infectious Disease 'The Green Book'*. . London: The Stationary Office http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079917 (Date accessed November 3rd 2008)
- ³ Department of Health (2007). *Birth to Five*. London: DH http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074924 (Date accessed November 5th 2008)⁴ The Unicef UK Baby Friendly Initiative. <http://www.babyfriendly.org.uk/> (Date accessed October 28th 2008)

The Contribution Health Visitors make to Preventing Obesity and Increasing Exercise in Children and their Families

Health visitors have a unique role in the prevention of obesity which many feel has been overlooked by commissioners. Some consider it significant that a rise in childhood obesity has followed a reduction in health visitors and in the nutritional content of their training since the mid 1990s.

Throughout the UK there is increasing concern regarding the current and future problems that obesity and lack of exercise presents to individuals, families, communities, the economy and the health service in particular. If the expected devastating increase in health problems that are attributable to excess weight and insufficient exercise including heart disease and Type 2 diabetes are to be halted, education and action which meets the needs of the population generally and those most at risk in particular, must be a priority. The provision of nutritional advice through a universal service has been a traditional role for the health visitor due to their universal access to families.

Health visitors therefore have a key role in the reduction in obesity and increasing exercise within families and populations. By visiting all families with young children they are widely held to be a reliable and accessible source of relevant health advice and local information. They have the skills to assess families antenatally, at the birth of a new baby and throughout the early years of a child's life.

Health visitors have the potential to enthuse their clients by supporting them to define and come up with solutions to their own problems. By building on the knowledge and skills that a family may already have, health visitors can promote health eating and ways to improve their lifestyle. Families can be signposted to existing local services and groups that support healthy eating and leisure activities. Health visitors can work with others within the local community and national pressure groups to highlight the gaps in provision and the issues families face.

Table 7: The Contribution Health Visitors make to Preventing Obesity and Increasing Exercise in Children and their Families

Principle of Health Visiting	Action
Search for health needs	<ul style="list-style-type: none"> • Audit health visiting caseloads, to highlight children who have potential vulnerability to obesity, being mindful of the research evidence that a child is more likely to become obese if one or both parents are obese¹ • Skilful and competent growth measurement and interpretation of results for parents/carers at an early stage in the child's life. • Assessment of the child and family particularly when the infant or child is gaining weight at an excessive rate. • Use of demographic and practice profiles to identify issues and trends around excessive weight gain and identify gaps in local provision. • Evaluation of the outcomes for children and for populations of children using best practice guidance on the management of obesity and implementation of NICE¹ recommendations. • Evaluation of the LDPs against PSA targets for obesity and breastfeeding.
Stimulating awareness of health needs	<ul style="list-style-type: none"> • Advice to parents regarding the value of breastfeeding and supporting the establishment and maintenance of breastfeeding as the first steps towards a sustainable, appropriate and healthy diet for the infant and parents (PSA 12). • Identify barriers to healthy eating and increased exercise. Work with families/communities to find ways of making 'the healthier choices the easier choices'. • Work with communities/populations to reduce stigma and anxiety so that families with members who are overweight /obese are not afraid to accept support and advice for fear of being negatively judged or referred to children's services (PSAs 12-13, 18 & 21). • Identify and acknowledge the fact that those most 'in need' are often those who will not engage easily and may be reluctant to accept help. • For parents with limited knowledge/experience of cooking or nutrition, provide advice and practical support about shopping on a budget and different ways of cooking to maximise nutrition. • Respond individually and locally to specific difficult situations that some families find themselves in e.g. those with limited cooking facilities, lack of easy access to good quality, cheaper foods, restricted finances, limited storage space for food within the home. • Encourage a healthy lifestyle and fun activities for all the family that promote physical and emotional wellbeing (PSAs 12 & 18). • Advice to parents regarding the appropriate time and way to wean their infant on to a nutritious family diet, utilising widely available sources of nutritional information e.g. <i>Birth to Five</i>² and DH weaning leaflets. • Promote the uptake of the Healthy Start scheme. • Opportunistically offer healthy lifestyle advice at each contact.

Principle of Health Visiting	Action
Stimulating awareness of health needs	<ul style="list-style-type: none"> • Offer weight/height measurement to ascertain family member's BMIs and take waist measurements if appropriate, with advice and referral, if this is required. • Signpost to local services e.g. weaning groups, cook and eat groups, health walk groups, local leisure services (PSAs 12, 18 & 21). • Support parents in finding ways to include their children in the preparation and cooking of family meals and snacks. • Provide commissioners with evidence of how the local health visiting service is contributing to the LDPs and meeting the PSA targets.
Influencing policies affecting health	<ul style="list-style-type: none"> • Advertise places where mothers can breastfeed when out and about. Support the local infant feeding co-ordinator to increase the number of places that breastfeeding is welcomed. • Support for changing the law in England to be the same as that in Scotland, which has made it illegal to object to a mother breastfeeding in public (PSA 12). • Support local campaigns for improved school dinners, the Healthy Schools Initiative and the drive to have schools cooking food in their own kitchens, rather than the outsourcing and transportation of food from an external provider. • Work with school health services to influence school pricing policies to ensure healthy snack alternatives such as fruit is cheaper than the chocolate/crisp alternatives, if the latter are sold within schools. • Work with early years providers to support the provision of nutritious, tasty food within local nurseries and pre-school settings. • Make sure that all early years' providers have, and adhere to, an agreed food policy, covering food brought in by children, food offered as rewards, prizes, birthday gifts etc. • Work with the local Chambers of Commerce, family learning and voluntary groups to improve the availability of fresh fruit and vegetables. • Work with local allotment groups and activists to promote the number, quality and use of allotments by individual families or small groups (PSA 21). • Work with local dentists to educate children about the dangers of eating sugary foods and drinks between meals. • Become involved with local services and activists regarding access to and the safety of parks, local green open spaces and play areas (PSA 21). • Join campaigns to introduce traffic calming and management measures which support walking/ cycling to school initiatives. Campaign for exercise in schools i.e. the continuation of PE classes as core, rather than optional for all school age children. • Work with other professionals who have responsibility for children (early years' providers, schools, clubs etc) to raise their awareness of some of the issues children who are overweight may face such as bullying and poor self-esteem etc. Ensure that exercise and physical activity for such children is handled sensitively otherwise it may reinforce their low self-esteem and poor body image (PSAs 13 & 18). • Encourage understanding of the complexity of the needs of obese children and establishing care pathways that manage obesity in a holistic way, taking in to account the multi-disciplinary and collaborative approach that is needed to treat this multi-faceted disorder successfully. • Educate the public and other professionals on the difficulties obese children and families face and the psychological support and input that may be needed. • Promote positive pictures of overweight people rather than negative stereotypes. • Work with local leisure centres to make sure that there are affordable family activities (PSAs 12, 18 & 21).
Facilitating health enhancing activities	<ul style="list-style-type: none"> • Support the establishment of a food co-operative and community cook and eat projects (PSA 21). • Run training with local dieticians and family learning services and encourage attendance by those mothers and fathers who 'can't cook, won't cook'.

Principle of Health Visiting	Action
Facilitating health activities	<ul style="list-style-type: none"> • Where they exist, encourage parents to join school walking buses with their children. enhancing • Support the development of, and attendance at, community initiatives such as weight reduction/ healthy eating/exercise classes which are run in local venues by local people (PSAs 18 & 21). • Work with police and local councils to facilitate safe road crossing, safe lighting, bus stops etc. to make it easy for families to access recreational facilities (PSAs 13 & 21). • Support parents in attending local toddler swimming sessions. For some groups this may require single sex sessions and the availability of specifically designed swimming costumes (PSA 15). • Encourage the use of local parks, green open spaces, and leisure facilities. • Work with outreach colleagues to provide befriending and initial escort schemes for parents who lack confidence to use local recreational facilities alone.

Compiled by the Health Visitors' Forum and the Professional Team Unite/CPHVA

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How Health Visitors Support Young Parents Using the Principles of Health Visiting

Health visitors are well placed to make a distinctive contribution to supporting young parents. Although the birth of a child to young parents is not inevitably problematic, the future life chances of child and parent depend on the level of support available. There is considerable scope for health visiting practice to identify and reduce the concepts of risk, vulnerability and disadvantage that dominate the

literature concerned with teenage pregnancy and young parenthood¹.

Health visiting interventions will impact in delivery of PSAs 9-12 with significant contribution to: PSA Delivery Agreement 14, Increase the number of children and young people on the pathway to success. Indicators 1-5.

Principle of Health Visiting	Action
Search for health needs	<ul style="list-style-type: none"> • Use of demographic and community profiles to identify trends, map local resources and identify gaps in service provision. • Identify barriers to accessing services through consultation with families as outlined in <i>Reaching Out</i>². • Health needs assessment at each contact to identify risk and resilience factors in families using an ecological framework. • Assess parental emotional health and infant –parent attachment. • Routine enquiry regarding domestic abuse.
Stimulating awareness of health needs	<ul style="list-style-type: none"> • Discuss psychosocial health issues with the parent/family and identify strategies for avoiding or managing risk factors such as isolation or loneliness. • Promote an understanding of the infant's emotional needs and the importance of positive parenting. • Prioritise antenatal home visits to all young parents. • Discuss antenatally the short and long term benefits of breastfeeding for mother, child and the environment. • Actively encourage fathers to engage in the practical and emotional role of caring for their child.

Principle of Health Visiting	Action
Stimulating awareness of health needs	<ul style="list-style-type: none"> • Complete Healthy Start applications and encourage good nutrition especially during pregnancy, postnatally and in the early years of a child's life. • Empower and encourage young mothers to contribute to sex and relationship education in schools.
Influencing policies affecting health	<ul style="list-style-type: none"> • Lobby the local council to provide inexpensive and safe recreational facilities for families. • Lobby government to fund research into what works well with vulnerable families such as teenage parents. • Identify a named person at a senior level to lead on teenage pregnancy/parenthood. • Campaign nationally and locally for media portrayal of a positive image of breastfeeding for young mothers.
Facilitating health enhancing activities	<ul style="list-style-type: none"> • Participate in antenatal groups targeting pregnant young people and their partners. • Ensure a seamless transfer between midwifery and health visiting services. • Respond to the 'catalyst for change' that parenthood brings to address parental behaviour e.g. drug & alcohol use, antisocial behaviour. • Develop a network of peer support schemes, such as young parent breastfeeding support groups. • Encourage long term sustainability of groups, and encourage members to take ownership of them³

Compiled by Judith Moore Health Visitors' Forum and Lisa Willis (student health visitor)

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¹ Jewell, D. Tacchi, J & Donovan, J (2001). *Teenage Pregnancy: Who's Problem Is It?* *Family Practice* Vol 17: 522-528

² HM Government (2006). *Reaching Out: An Action Plan on Social Exclusion*. London: The Cabinet Office

³ Department of Health (2006). *Our Health, Our Care, Our Say*. London: DH

How Health Visitors use the Principles of Health Visiting to Promote Child Safety and Prevent Accidents

Health visitors can make a distinctive contribution to accident prevention. Indeed home visiting to improve parenting can reduce the risk of accidents to children in the home by up to 26%¹. Accidents in the home are the major cause of death in the under fives. *Choosing Health*² makes accident prevention a priority area.

Staying safe is one of the five outcomes from *Every Child Matters*³.

Staying safe is more than just about preventing accidents, it is concerned with keeping children safe from bullies, crime and anti-social behaviour and protecting children who are at risk of abuse and neglect. The quality of parenting is closely related to child safety. Health visitors support parents in identifying risks in the home and how these can be reduced as well as promoting sensitive, attuned parenting.

Table 9: How Health Visitors use the Principles of Health Visiting to Promote Child Safety and prevent Accidents

Principle of Health Visiting	Action
Search for health needs	<ul style="list-style-type: none"> • Use the following sources of information to seek out factual data to use to develop a systematic approach to prioritising safety issues: <ul style="list-style-type: none"> - Department of Trade and Industry/WHO - Child Accident Prevention Trust. - Annual Health reports from Trusts - Local hospital A & E statistics; liaison health visitor information - Local GP/Pharmacy - Sure Start, local playgroups, nurseries, play schemes for older children.

Principle of Health Visiting	Action
	<ul style="list-style-type: none"> - Neighbourhood-based outreach work and multi-agency projects - Requests for information and outcomes from group work, one-to-one contact with clients - Have systems in place for monitoring trends in own caseload/corporate team (PSAs 13 & 18).
Stimulating awareness of health needs	<ul style="list-style-type: none"> • Promote and use public information literature, advertising campaigns, posters and leaflets in all possible venues. • Use of media sources, such as examples from TV programmes as a basis for discussion with target groups re keeping safe, substance use, road safety, car seats, safety and preventing accidents at home. • Partnership working with a wide range of neighbourhood groups and outreach teams to raise awareness of safety issues with local people at neighbourhood meetings. • Discussion in local child health clinics/surgeries, either one- to-one or in group work. • Discussion of safety issues during all home visiting with regard to either preventing accidents or by following up after an event (PSAs 13 & 18). • Work closely with skill mix staff to raise awareness of home safety and accident prevention work opportunities arising during home visiting (PSAs 13 & 18).
Influencing policies affecting health	<ul style="list-style-type: none"> • Lobby local councils re meeting the aims of <i>Every Child Matters</i>³ in providing safe play areas for all age groups. • Contribute to and support professional organisation campaigns regarding accident and safety initiatives (PSAs 13 & 18). • Support local initiatives/groups re specific accident issues; road crossings, safety glass in windows, use of car seats, cycle helmets, smoke detectors, safe play areas and misuse of play areas (PSAs 13 & 18). • Use the liaison health visitor as an expert to represent health perspective at multi-agency meetings providing specialist knowledge of accidents and injuries in local areas.
Facilitating health enhancing activities	<ul style="list-style-type: none"> • At every encounter with clients the team member/s provides or signposts to current information and support to promote all aspects of safety for children and families (PSAs 13 & 18). • Careful planning to match appropriate health promotion events/stalls to the target public group, working with wider agencies and outreach groups as practical. • Ensure access to information and other services through the use of interpreters, community support workers and provision of translated leaflets/information. Signposting to English classes as appropriate (PSAs 13, 15 & 18). • Demonstrate correct use of equipment, examples of safety products on clinical sites or in the home. • Provide information on local services that may have loan or donation schemes for safety equipment. • Partnership working with other agencies, such as the Fire Service who may provide a home visiting service to vulnerable clients and installation of smoke detectors (PSAs 13, 15 & 18).

**Compiled by Anna East, Health Visitors' Forum in collaboration with
Bernadette Osbourne, Community Staff Nurse and Theresa Taylor, Senior Nursery Nurse**

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¹ National Children's Bureau (2004), Highlight Research Summaries, London

² Secretary of State for Health (2004) Choosing Health: *Making Healthier Choices Easier* London: The Stationary Office.

³ Department for Education and Skills (2004). *Every Child Matters: A Change for Children*. Nottingham: DfES Publications.

The Promotion of Sexual Health in Families by Health Visitors

Health visitors can make a distinctive contribution to the promotion of sexual health within families. At all health visitor contacts there is the potential to raise sexual health issues. It is usually discussed at the primary visit (10–28 days after a baby's birth) and information on the availability of contraceptive methods, cervical screening, breast and testicular awareness and self-examination may be included. Health visitors can give information and signpost to sexual health

services appropriate for all family members, including teenage children.

Local sexual health strategies are based on the national priorities for reducing the rate of under-18s conceptions and preventing sexually transmitted infections including HIV and Chlamydia. The interventions below help to address PSAs 12, 14-15, 18-19.

Table 10: The Promotion of Sexual Health in Families by Health Visitors	
Principle of Health Visiting	Action
Search for health needs	<ul style="list-style-type: none"> • At home visits and when appropriate other contacts, ascertain the members of household who may be sexually active. This includes the parent(s), older children, extended family. • Assessment of individual family member's knowledge regarding sexual health matters including contraception. Signposting to the availability of local NHS and young person's services and sexual health services. • Work with teenage pregnancy services and school health services to identify areas with high conception rates. • Identify women eligible for cervical and breast screening and give information on the screening and its availability. • Discuss testicular self-examination and breast awareness when appropriate. Support with written information and/or physical resources. • Identify clients who are, or may be sex workers and give appropriate information including safe sex, the availability of condoms and other health/support services.
Stimulating awareness of health needs	<ul style="list-style-type: none"> • Give information on different types of contraception available, particularly the long-term methods, to all clients. • Give information on availability of methods including times of community clinics. • Discuss the need for condom use to reduce the risk of infections as well as conceptions. • Give information on the availability of Chlamydia testing and GUM services.
Influencing policies affecting health	<ul style="list-style-type: none"> • Identify areas where community sexual health services have limited or no availability. • Work with sexual health services to highlight the demand and need for the full range of sexual health services to be easily available for all age groups and both sexes. • Encourage employing organisations to provide health visitors and school nurses with training in contraception and sexual health including regular updates which will enable these workers to offer brief interventions and accurate information on methods/services available. This would be expected to encourage attendance for and compliance with contraceptive and sexual health services. • Be an advocate for individuals who have received a less than satisfactory sexual health service.
Facilitating health enhancing activities	<ul style="list-style-type: none"> • Support parents to discuss sexuality and sexual health issues with their children. Giving sources of appropriate information and resources. • Encourage attendance for routine breast and cervical screening. • Encourage individuals to provide honest feedback and make their concerns known when they receive poor services. • Issue 'first condoms' at primary visits in areas with high unplanned pregnancy rates or 'difficult-to-reach' client groups. • Signpost to sexual health services including GP services, community and specialist services.

Working with Homeless Families to Promote their Health

Health visitors have an important and distinctive role to play in promoting the health of homeless families. The principles of health visiting provide the basis for developing services for homeless families that are:

- Appropriate
- Accessible
- Flexible
- Equitable
- Accountable
- Just
- Capacity-building
- Innovative.

Homeless families face health inequalities due to being homeless. They are marginalised by being homeless and face multiple health inequalities due to not having a permanent home. As a consequence they present with complex and multiple health problems (both mental and physical).

When the principles of health visiting are used to develop and provide services in line with the above principles, this leads to improvement in the health and wellbeing of homeless individuals, families and communities. Services must be client-centered and developed on an outreach basis. There must be a multi-agency and multi-disciplinary approach in order to meet multiple needs.

Table 11: Working with Homeless Families to Promote their Health

Principle of Health Visiting	Action
Search for health needs	<ul style="list-style-type: none"> • Identify numbers of homeless families through a notification system; though working with partnership agencies i.e. housing, health, education, police, social services and the voluntary sector. • Develop a profile of homeless families to identify need, risk factors and vulnerability i.e. single parents, teenage parents, asylum seekers, families in poverty. • Identify individual/local causes of homelessness as this will identify possible risk factors i.e. domestic violence. • Identify length of homelessness as this affects health (PSAs 12-13, 15 &18). • Identify numbers of moves as this has an impact on health. • Identify gaps in service provision through individual assessments and consultations. • Identify barriers to services through consultation with families i.e. through Patient Advice and Liaison Services (PALs) or through other Forums. • Identify physical and mental health problems of homeless families through assessments and the collation of information through a data base (PSAs 12-13, 18-19). • Promote and support the initiation and maintenance of breastfeeding in homeless families. This supports LDPs to monitor PSA 12 to increase prevalence of breastfeeding rates especially in women from disadvantaged groups and contributes to reducing childhood obesity. • Carry out evaluations to identify health impact and improvement.
Stimulating awareness of health needs	<ul style="list-style-type: none"> • Raise awareness of the needs of families through the local homelessness strategy and the Local Strategic Partnership (LSP). • Ensure that the needs of homeless families are incorporated into all local strategies, where appropriate i.e. local children's strategy, mental health strategy and LDPs. • Raise awareness locally of needs of homeless families and gaps in service provision through the local homelessness strategy. • Conduct a holistic initial health assessment with each family to: <ul style="list-style-type: none"> - identify needs - develop action plans - signpost/refer families to appropriate services - offer focused health advice so as to improve health (PSA 18). • Use of the Common Assessment Framework 1 (CAF) to identify needs. • Develop multi-disciplinary/multi-agency training for staff at all levels (planning and service providers) on how to meet the health needs of homeless families (PSAs 12-13, 15, 18-19). • Develop an outreach service with specialist health workers who can meet the multiple and complex health needs (PSA 15, Indicator 5). • Use local services to meet need i.e. libraries, Children's Centres. • Education through school liaison and youth groups.

Principle of Health Visiting	Action
	<ul style="list-style-type: none"> • Offer screening opportunities and hold health fair days to attract homeless people for health screening. This screening should be culturally sensitive to diverse groups with different needs; this work contributes to PSA 18 to reduce health inequalities and provide support for those needing help with smoking cessation and healthy eating. • Provide commissioners with evidence of how the health visiting service is contributing to the LDPs and meeting PSAs. • Use the media to dispel myths about the homeless and present its human face, 'someone like me'.
Influencing policies affecting health	<ul style="list-style-type: none"> • Develop a local homelessness strategy with partner agencies to develop a multi-agency/ multi-disciplinary approach with both statutory and voluntary sector agencies (PSA 20). • Develop a homelessness forum to plan services for homeless families (PSAs 19-20). • Identify national policies that would influence the development of local policies and ensure that the LDPs are mindful of the special needs of homeless families (PSAs 12, 18-19). • Develop local policies to meet the needs of families through the forum and ratify through the homelessness strategy and LSP. • Identify a named person at a senior level at the PCT/employing authority to take the lead on health and homelessness. • Identify the needs of homeless families in LAAs as priority families who are at risk due to their vulnerability (PSAs 12, 18- 20, Indicator 4). • Identify the needs of homeless families with the LSP. • Through the homelessness forum increase capacity by sharing resources (PSA 20). • Through the homelessness forum apply for funding to meet needs (PSA 20). • Through the homelessness forum and the LSP, tackle barriers to care (PSA 15, Indicator 5 & PSA 19). • Link into regional and national forums and agencies i.e. Shelter. • Ensure nurse, midwifery and health visitor education and training, and that all who work with families receive regular information on the needs of homeless people. • Audit of services and data collection to improve outcomes for the homeless, and ensure commissioners and ministers are aware of how the health visiting service is contributes to LDPs and PSAs. Lobby through professional body or union for standards and quality in relation to services.
Facilitating health enhancing activities	<ul style="list-style-type: none"> • Identify areas of need for homeless families. • Develop services through partnership working to meet both mental and physical needs of adults and children. • Develop fast track referral procedures for homeless families. • Targeted specialist health workers/services to meet the needs of homeless families, for example work with sexual health and Local Implementation Groups to reduce the under 18s conception rate and improve sexual health within the homeless community (PSA 14 Indicator 4, & PSA 19). • Increase capacity of services through sharing resources. • Make partnership applications for funding. • Identify training needs through Personal Development Plans (PDPs). • Provide training and appropriate supervision for staff working with homeless families. • Link staff into national forums to develop knowledge and best practice e.g. Homeless Nurses' Group UK. • Develop a buddy system especially for young people in light of the high suicide rate; this contributes to (PSAs 13 &18). • Develop health promotion information that is appropriate for homeless families in different languages and through different media (PSAs 12-15, 18-19) • Develop health-enhancing activities for families i.e. play, healthy walks, encouraging breastfeeding, smoking cessation and healthy eating (PSAs 12-14, 18-19 & 21). • Develop accessible services for homeless families i.e. GP registration, play facilities, holiday clubs, advice services, after school clubs, parenting groups, health promotion groups (PSAs 15, 19 & 21). Provide life skill training i.e. parenting, cookery classes, budgeting (PSAs 12-14, 18-19).

Compiled by J.E. Cook, Co-Chair of Homeless Nurses' Group UK in association with Sue Watson and members of the Health Visitors' Forum

Reference

¹ Department of Health (2000) *Framework for the Assessment of Children in Need and their Families*. London: The Stationary Office

How Health Visitors can Support Disabled Children and their Families using the Principles of Health Visiting

Health visitors have a distinctive role in supporting children with special needs and their families. In *Aiming High for Disabled Children: Better Support for Families*¹ the Government pledged to take action in three priority areas to improve outcomes for disabled children. These areas are:

- Access and empowerment
- Responsive services and timely support

- Improving quality and capacity.

Health visitors are ideally placed to ensure that disabled children and their families receive the 'core offer' and that they benefit equally from the Government's *Every Child Matters*² and *Every Parent Matters*³ programme. Health visitors can fulfill their full advocacy role and use their skills to influence the policies affecting health.

Table 12: How Health Visitors can Support Disabled Children and their Families using the Principles of Health Visiting

Principle of Health Visiting	Action
Search for health needs	<ul style="list-style-type: none"> • Antenatal visit: Encourage family to set own agenda e.g. negotiate package of care. Include understanding of the health visitor role as a resource for the whole family. Mobilize early support services (PSA 12 Indicator 5). • Postnatal home visit to explore with parent birth, impact of birth on parental relationship, parent-infant interaction, exploration of parental feelings, housing and financial needs. This holistic assessment by skilled practitioners helps to identify both expressed and unexpressed needs (PSAs 12, 15, 18-19). • Make active use of relevant local and national information to promote family health and wellbeing e.g. breastfeeding, smoking cessation (PSAs 12 & 18). • Exploration of the family's social support networks. • Use specific information to improve the experience of parenting a child with additional needs⁴⁻¹⁰ (PSA 12, Indicator 5). • Discuss availability of resources to support disabled children and their family e.g. Children's Information Services and other local and national support services. • Seamless interagency and collaborative working to support the child and address parental concerns. There should be quick and appropriate referral to other agencies to improve children's safety if there are concerns (PSA 13). • Planning and on-going monitoring and review to holistically re-evaluate the child and family's wellbeing e.g. change in health status of any family member; compliance with medication, therapy and vulnerability (PSAs 12, 18-19). • Monitor PSAs against the LDP and the safeguarding agenda to audit services and identify areas for improvement.
Stimulating awareness of health needs	<ul style="list-style-type: none"> • Bring to the attention of relevant agencies and disciplines the needs of the child and family and adopt a multi-agency approach (PSA 12, Indicator 5). • Involve voluntary, private sector and parent support groups using all available media (PSAs 19, Indicators 1 & 6, PSA 14, Indicators 1-4). • Involve parents as central to the care and management of their child (PSA 12, Indicator 5, PSA 15, Indicator 2, PSA 19, Indicators 1 & 6). • Respond to child and family needs focusing on quality and timely interventions e.g. issues of 'loss of the well/healthy child' and the impact disability has on a family. The family need information on the services that may be available to support them such as respite care, help with sleeping difficulties, Portage services and genetic counselling (PSA 12, Indicator 5, PSA 19, Indicators 1 & 6). • Utilise knowledge to inform strategic direction of service development and need for interagency planning and collaboration to address gaps in services e.g. psychology and infant mental health services (PSA12, Indicator 4, & PSA 18, Indicator 5). <p>Provide commissioners with evidence of how the health visiting service is contributing to the LDPs and meeting PSAs.</p>
Influencing policies affecting health	<ul style="list-style-type: none"> • Be familiar with the recommendations from <i>NSF Standard 8</i>¹¹. • Engage in local partnerships and communities. • Access to key professionals to support the child and family e.g. highlight unmet need to influence the development of appropriate services e.g. respite, housing, bereavement services (PSA 12, Indicator 5). • Availability of resources in the locality.

Principle of Health Visiting	Action
	<ul style="list-style-type: none"> • Raise profile of client group to strengthen the family's functioning and to maximize the support available to them. Reflect multi-cultural needs of the community and ensure that services are actively inclusive of both fathers and others involved with the parenting role (PSA 12, Indicator 5, PSA 15, Indicator 5, & PSA 21, Indicators 1-4). • Establish of local integrated care pathways and protocols with the involvement of families and carers (PSA 12, Indicator 5). • Undertake clinical audit of the services provided for disabled children and their families e.g. Portage services, support for siblings such as Young Carers, postnatal distress services, respite provision, sleep support groups, local support groups and recreational facilities (PSA 12, Indicator 5, PSA, 15, Indicator 2, PSA 19, Indicators 1 & 6). Collate profile data relating to this client group for management purposes.
Facilitating health enhancing activities	<ul style="list-style-type: none"> • Supportive management of changing situations/transitions and circumstances e.g. sick child entering hospital, increasing or accessing respite, use of tertiary services. • Collaborate with other established groups or services both locally and nationally to support this client group (PSA 12, Indicator 5). • Ensure parenting support is available at both universal and specialist levels e.g. access to specific parent education programmes such as 'Early Bird' 12; Hanen Programme 13, maternal and infant mental health services and behavioural support services (PSA 12, Indicator 5 & PSA 15, Indicator 2). • Health visitors play a vital role in the early identification of children with additional need. They use the <i>Common Assessment Framework</i>¹⁴ and form part of the 'virtual team' that works with the locality team to provide services for the team around the child. • Ensure all practice and provision is evidence based. • Ensure practitioners are trained and supported and meet National <i>Occupational Standards for Working with Parents</i>¹⁵ and carers. • Take a lead role in the development of staff at all levels to ensure the necessary skills, knowledge and competencies to best support this client group whilst remaining alert to the limits of one's own professional practice (PSA 12, Indicator 5).

Compiled jointly by Breda Bradbeer, Specialist Health Visitor/Children with Special Needs and Rosie Robertson, Specialist Nurse for Pre School Children with Complex Special Needs. Additional input from Maggie Fisher, Professional Officer Unite/CPHVA

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Public Service Agreement (PSA) Targets identified as relevant to health visiting practice

PSA 9: Halve the Number of Children in Poverty by 2010-11; on the way to Eradicating Child Poverty by 2020

Indicator 1: The number of children in absolute low-income households

Indicator 2: The number of children in relative low income households

Indicator 3: The number of children in relative low-income households and in material deprivation.

PSA 10: Raise the Educational Achievement of all Children and Young People

Indicator 1: Early Years' Foundation Stage Achievement.

PSA 11: Narrow the Gap in Educational Achievement between Children from Low Income and Disadvantaged Backgrounds and their Peers

Indicator 1: Achievement gap at Early Years' Foundation Stage.

PSA 12: Improve the Health and Wellbeing of Children and Young People

The delivery of this target focuses on prevention and early intervention particularly the following indicators:

Indicator 1: Increase the prevalence of breastfeeding at 6-8 weeks

Indicator 3: Reduce levels of childhood obesity national targets by 2020

Indicator 4: Improve emotional health and wellbeing through the provision of comprehensive Child and Adolescent Mental Health Services (CAMHS)

Indicator 5: Parents' experiences of services for disabled children and the 'core offer'.

PSA 13: Improve Children and Young People's Safety

Indicator 1: Reducing the percentage of children who experience bullying

Indicator 3: Reducing hospital admissions caused by accidental and deliberate injuries

Indicator 4: Preventable child deaths as recorded through Child Death Review Panel processes.

PSA 14: Increase the Number of Children and Young People on the Path to Success

Indicator 1: Reduce the percentage of 16-18-year-olds not in education, employment or training

Indicator 2: More participation in positive activities

Indicator 3: Reduce the proportion of young people frequently using illicit drugs, alcohol or volatile substances

Indicator 4: Reduce the under-18s conception rate.

PSA 15: Address the Disadvantage that Individuals Experience because of their Gender, Race, Disability, Age, Sexual Orientation, Religion or Belief

Indicator 2: Level of choice, control and flexibility to enable independent living

Indicator 5: Fairness of treatment by services.

PSA 18: Promote Better Health and Wellbeing for All

Indicator 1: Improving the All Age All Cause Mortality (AAACM) rate

Indicator 2: Difference in AAACM between England and areas with the worst health and deprivation indicators. Indicator 2 will track progress in reducing inequalities in mortality rates

Indicator 3: Reduce smoking prevalence

Indicator 4: Proportion of people supported to live independently (all ages)

Indicator 5: Increase access to psychological therapies.

PSA 19: Ensure Better Care for All

Indicator 1: The self-reported experience of service users

Indicator 2: NHS reported referral-to-treatment times for admitted patients

Indicator 3: NHS reported referral-to-treatment times for non-admitted patients

Indicator 4: Number of women who have seen a midwife or maternity healthcare professional by 12 weeks of pregnancy

Indicator 5: Long-term conditions

Indicator 6: GP services, including primary care teams.

PSA 20: Increase Long-term Housing Supply and Affordability

Indicator 1: Number of net additional homes provided

Indicator 2: Trends in affordability. This will be measured using the ratio of lower quartile house prices to lower quartile earnings

Indicator 3: Number of affordable homes delivered (gross)

Indicator 4: Number of households in temporary accommodation.

PSA 21: Build more Cohesive, Empowered and Active Communities:

Indicator 1: The percentage of people who believe people from different backgrounds get on well together in their local area

Indicator 2: The percentage of people, who have meaningful interactions with people from different backgrounds

Indicator 3: The percentage of people, who feel they belong to their neighbourhood

Indicator 4: The percentage of people, who feel they can influence decisions in their locality.

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