



Community Practitioners' and Health Visitors' Association response to



**Facing the Future –
A review of the role of health
visitors
October 2007**

Foreword

The English Department of Health Review of Health Visiting '*Facing the Future*' published in June 2007 presented an ideal opportunity for Unite/CPHVA to consult with its members and do an in-depth examination of where health visiting sits currently within the NHS and make recommendations on how it should move forward into the 21st century and beyond.

This interim paper provides a response to that consultation and the Review recommendations. A fuller document will be published on the Unite/CPHVA website (www.unitetheunion.org/cphva) in November. Although the review specifically targeted the role of the health visitor, the CPHVA response will also consider the different aspects of health visiting service delivery.

This consultation:

- was a comprehensive exploration of the current status of health visiting
- provided an insight into the barriers to effective service delivery that practitioners within the profession are experiencing
- provided an in-depth exploration of the recommendations made in the review
- outlined the interventions that practitioners within the profession felt were needed to provide a robust health visiting service which is 'fit for purpose' and able to deliver the required public health outcomes for the NHS of the future against the public service agreement (PSA) targets.

We have deliberately tried to include all the main themes coming out of the many meetings we held with our members.

It is only when someone spends time with a health visitor that they realise the complexity and skill required to deliver his or her role. I would like to suggest that if you are reading this response as someone who has not had this experience, but who is making decisions which affect the profession and the services it delivers, you should arrange to spend time with a local health visitor. Only then can you fully comprehend the challenging issues they grapple with

Consultation method

On publication, '*Facing the Future*', the review of health visiting was circulated to the Unite/CPHVA membership via its many dissemination channels, the website, the local and regional forums, the local accredited representatives and its newsletters and journal. Direct feedback was invited. Fifteen regional meetings were held with the membership around England to obtain direct verbal feedback; the relevant Unite/CPHVA committees were consulted within their meetings; discussions were held with senior members; the Unite/CPHVA professional team and members of the CPHVA national professional forum. Approximately 350 members and others attended the regional meetings and it is

estimated another 150 have contributed comments to the review via the other channels available. The majority of responses came from practising health visitors; but managers, educationists and specialist health visitors also inputted significantly.

The process of consultation was a very open one requesting overall feedback, feedback on the recommendations and views on the difficult areas such as who should employ health visitors, where they should be based and so on.

**Dr Cheryll Adams, Acting Lead Professional Officer, Unite/CPHVA
Unite/CPHVA
October, 2007**

Unite is the UK's largest trade union with 2 million members across the private and public sectors. The union's members work in a range of industries including manufacturing, financial services, print, media, construction, transport and local government, education, health and not for profit sectors. The Community Practitioners and Health Visitors' Association is one of the seven professional groups and associations in Unite Health Sector which is the third largest health union for nurses.

Unite/Community Practitioners' and Health Visitors' Association response to *Facing the Future*, a review of health visiting

Unite/CPHVA would wish to state unequivocally our support for the need to renew the role of the health visitor as called for in 'Facing the Future' (DOH, 2007).

No one can deny that health visiting has reached a crossroads and that there is a need for a catalyst to breathe new life into the profession if it is to go forward to serve the needs of families into the 21st century and beyond.

Unite/CPHVA firmly believe that our members, who are in daily contact with clients, are aware of what is needed and have the solutions to move the service forward. However they need to be given the opportunity to have their voices heard. To facilitate this Unite/CPHVA has formulated this response following its large scale consultation exercise comprising meetings with health visitors and their managers throughout England (June-September 2007).

In exploring the premise of a 'renewed role' as outlined in the executive summary of the review of health visiting '*Facing the Future*' Unite/CPHVA would like to make the following observations on the issues raised in relation to a renewed role:

Objectives of review

The review was tasked with describing a renewed role for health visitors that incorporated the following seven factors. The renewed role must be one which:-

- *Delivers measurable outcomes for individuals and communities and provides a rewarding and enjoyable job for nurses*

Unite/CPHVA agree; however it is important to acknowledge that many outcomes for children and families delivered by health visitors can be long-term (e.g. in relation to obesity and mental health). These outcomes are also dependent on collective/public health as well as individual approaches to care delivery. It is essential that robust data collection systems are in place to record health visitor inputs and outcomes.

A recent Unite/CPHVA survey of health visitors has demonstrated that morale amongst health visitors' is at an all time low (CPHVA, Omnibus survey of health visitor members, 2007). This must be acknowledged quickly by employers and commissioners; and the workforce numbers and training opportunities for health visitors must be subsequently increased. Then becoming a health visitor can be a rewarding and enjoyable job which must bring benefit to the clients they service

- *Has the support of families and communities*

The existing health visitor role continues to command tremendous support from families. This is illustrated in the findings from the recent Family and Parenting Institute survey (2007). This survey indicated that more than three

quarters of parents wanted parenting support and advice about their child's health and development from a well informed health visitor because they considered this professional to have the required skills and expertise (Family and Parenting Institute Survey, April 2007). A survey by Netmums also indicated that mothers valued the role of health visitors in providing support and advice on a broad range of health and parenting issues (Netmums online Survey, 2006).

- *Primary Care Trusts (PCT's) and Practice based commissioners will commission*

This is predicated on the knowledge and understanding that commissioners have that a properly resourced health visiting service can make to reducing health inequalities and improving the health and wellbeing of all families and communities. If the future health visiting service is to be able to achieve this objective then it is imperative that information for commissioners is developed through existing government policy, for example, Every Child Matters, (DfES, 2003) the National Service Framework for children, young people and families (DOH, 2006) and guidance from the National Institute for Health and Clinical Excellence (NICE). However it must also be predicated on an understanding of the health needs of socially excluded groups, some of which are very large for example, ethnically diverse groups who have English as a second language.

Health needs assessment is both a cornerstone of effective commissioning and a cornerstone of health visiting practice. Health visitors therefore also have an important role to play in demonstrating their skills in this field thereby helping commissioners to commission effective services.

- *Delivers government policies for children and families, improving health and reducing inequalities and social exclusion*

This is central to the philosophy of health visiting. However, in recent times the role of the health visitor has been eroded by a financially driven medical model. This has resulted in the development of teams with inappropriately skilled members, reduced access to education and training and a negative image being portrayed to policy makers of the role of the health of the health visitor.

- *Fits the new system of providing choice and contestability through new providers that promote self-care, service integration, improved productivity and local decision making.*

There is no objection to providing choice for families provided that those who are delivering services are well trained and professionally regulated so that the interest of the public is protected. This is not easily done in a service which seeks to provide a holistic health visiting service to vulnerable families who may not necessarily have conspicuous needs. Again this type of policy approach which is a better fit within a medical model, is less suited to a psycho-social model of service provision. Improved productivity, in terms of health outcomes is not possible under the current provision as many of our members observe current services are being run on a shoe string with little attention being paid to quality or long term health outcomes by those who

commission them. According to Sure Start Children's Centres Practice Guidance issued by the DfES in November 2006, 75% of parents and carers, regardless of their background, feel there are times in their lives or the lives of their children when they need access to additional information and support.

- *Can adapt and respond to changing needs and aspirations*
Again this is central to the philosophy of health visiting and can be clearly seen within the *Principles of Health Visiting*. However, in order to achieve this objective the future role of the health visitor must be supported by a clear strategic vision, research evidence and robust professional leadership which is free from the constraints of inadequately informed service providers and commissioners dictating the level of service provision.
- *Attracts a new generation to the profession*
There is a pressing need to attract the next generation into the profession. As it stands currently, health visiting is no longer viewed by nurses as a viable career progression and this is hardly surprising when one considers the stress and demoralised state of the workforce as evident from the CPHVA Omnibus, 2007. The combination of larger caseloads and inappropriate skill mix with ever increasing demands for more complex interventions in areas of need including; domestic abuse, maternal mental health, safeguarding and working with marginalised families, juxtaposed by an ever-dwindling skilled workforce has contributed to this position.

Recommendations of the review

Details of the responses received from members in relation to the 9 review recommendations are presented in Appendix 1. It is important to note that the majority of the recommendations received a large measure of support. However there was universal disagreement with recommendations 6 and 7 which suggest four possible roles for the next generation of health visitors:

1. *Leading and delivering the Child Health Promotion Programme using a family focused public health approach*
2. *Delivering intensive programmes for the most vulnerable children and families*
3. *Wider public health packages*
4. *Primary care nursing service for children and families*

It was felt that the first 3 roles could not be separated from one another and the ability to deliver these should be core to every health visitor's education and practice even if a decision was taken locally for health visitors to specialise in one of the three areas. It was felt that failure to adopt this integrated role would lead to an unworkable service with enormous discrepancies in the standard of service available to families and consequentially a detrimental effect on the health and wellbeing of children and families. There was ambivalence with regard to the fourth role as it was felt that this role could be predicated on a medical role of nursing and not on health promotion but as such this could be counterproductive if a holistic approach was not taken.

Conspicuous gaps identified in the Review

- The Review alludes to the need for ‘clarity and direction about the current and future role of health visitors for commissioners, health visitors and other professions, leaders and the public’ but fails to take the opportunity to provide it. Rather it leaves the reader to interpret the recommendations. Unfortunately as with so much other government policy appertaining to the health visiting service we have evidence that already the recommendations are being used to reduce health visitor input for families still further.
- There was a lack of evidence for some of the recommendations made by the Review.
- Although the Review is considering the role of the health visitor; within the document, reference is consistently made to ‘nurse’ which respondents felt undermined the level of expertise that is required to practise effectively as a health visitor. It was felt that referring to health visitors as nurses gives the impression that any type of nurse could do the same level of skilled work as a health visitor.
- The failure to include the ‘Principles of Health Visiting’ as one respondent said:

‘Why when the rest of the world envies the principles of health visiting practice are they not supported by our own Department of Health?’

- There is no mention in the Review of the health visitor’s role in supporting families who have children with special needs’, they are often one of a large number of socially excluded families which includes those excluded due to disability, mental ill health and poverty. The health visitor is often the only professional who can identify and help ameliorate family characteristics which may predispose to exclusion.
- The special requirements and challenges of working with families from a multitude of ethnic backgrounds, for example, in Portsmouth it has been reported that there have been 10 new languages spoken in the last year. This is particularly pertinent since the expansion of the EU and the rapid influx of large numbers of new migrants and their young families.
- Clarity on how the wider determinants of public health will now be addressed by a service which, it is suggested, might increasingly support individual approaches.
- The Review does not identify a clear career pathway for future health visitors.
- The Review fails to outline an appropriate pay structure for health visitors under Agenda for Change, which recognises the challenging nature of the work they do. This is a very sensitive issue for the profession with many banding disputes already being taken forward.
- The Review fails to outline the basis on which skill mix decisions are to be made.
- Valuing existing staff who have massive professional skill with so many, over 20% able to retire now (CPHVA, 2007) in the twilight of their careers. These skills have been taken for granted but will soon be lost if not utilised in the next 5 years to train the next generation of health visitors.

Unite/CPHVA vision for the future of the health visitor

The following is a summarised version of the vision our members have for a renewed role of the health visitor which is fit for the future:

- A **universal service** which makes decisions about the provision and delivery of care based on the findings of a holistic assessment of need, the development of a therapeutic relationship, prevention through health promotion and the delivery of early and effective interventions targeted to support the health and wellbeing of all families as and when required.
- A service predicated on the *'The Principles of Health Visiting'* (Cowley, Frost; CPHVA 2006) in which prevention, early intervention and health promotion are paramount in influencing the long term public health outcomes for the population.
- A service whose workforce has up-to-date **education and skills** to enable them to respond effectively to the health needs of all families with pre-school children.
- A service which is **evidence based**, has clear objectives and systems in place to measure outcomes.
- A service which can utilise an evidence-based **'toolkit'** of interventions to support the health and wellbeing of children and their families.
- A **universal** service that offers basic information and support to everyone; that recognises the importance of relationships based on trust; that appreciates the dynamic nature of health and need and the importance of strengths-based assessment and has the capacity to provide more intensive tailored support to families as and when they need it.
- A service which is able to effectively meet the needs of the **most vulnerable** families but which is also able to respond to the health needs of all families as they arise.
- A service which is able to provide **home visits** when they may be the most appropriate mode of contact.
- A service which is able to provide the **same standard** of service for families wherever they may live abolishing the current postcode lottery.
- A service which commissioners can correctly identify the **unique contribution** that health visitors make to the health and wellbeing of children and their families.
- A service which works in **partnership** with families in order to help them build on their intrinsic strengths.

Unite/CPHVA recommendations for the provision of a robust health visitor workforce

Having consulted widely with their membership and professional experts Unite/CPHVA would like to make the following proposals for developing health visitors fit for purpose in the 21st century:

1. **Human resources**:- There is an urgent need to increase health visitor numbers, both to replace those staff lost over the past few years of financial deficits in health care organisations and to allow provision of health visitors to work in the family-nurse partnership model for vulnerable members. We

calculate an additional 4000 whole time equivalent health visitors would be required to allow effective dissemination of the family-nurse partnership pilot for all estimated 120,000 families who may require that model of intensive support, if a decision is taken to nationalise at the end of the pilot.

2. **Education:-** Health visitors require a new standardised education programme which can make them fit for purpose in line with the current evidence base for promoting health and wellbeing in children and families.
3. **Principles of Health Visiting:-** Health visiting practice must continue to be underpinned with the tried and tested ‘The Principles of Health Visiting’ (Cowley, Frost; CPHVA 2006).
4. **Entry Requirements:-** Health visitors work within a psycho/social model of health, promoting social and emotional wellbeing in families and communities recognising that *happy children are successful children*. However, having their roots in nursing allows health visitors to also address physical health issues for children and families. It could be very beneficial to develop new shortened entry routes into health visiting, through nursing, for graduates from complementary disciplines such as psychology and child care
5. **Workload:-** There must be a policy requirement for a *maximum* full time caseload size of 300 families so the health visitor is able to establish a relationship with every family allowing her to then support each family in determining any health needs and to either manage these needs or refer to the wider services available.
6. **Research and development:-** National research funding must be made available to determine the most effective models of service delivery by health visitor teams and any new proposals for health visiting should be piloted prior to implementation.
7. **Leadership:-** Professional leadership must be resourced and valued within health visiting.
8. **An attractive career option:** - There is a need to rebuild the current professions’ confidence so that health visiting becomes an attractive option as a career once more.
9. **Five year plan supported by the Department of Health:** - There should be a government led 5 year plan for reinvigorating and regenerating health visiting, implementing these recommendations from the profession. The outcome would then coincide with the 150 year anniversary of the profession.

Unite/CPHVA recommendations for providing an effective health visiting service for families

1. **Minimum Core Service:** - There should be a minimum core service ‘contract’ agreement offered to all families which shows them what they can expect to be offered as a minimum service, with all families having access to that information at first contact.
2. **Appropriate Skill Mix:** - Skill mix in health visitor teams should be utilised to enhance, not dilute health visitor services.
3. **Flexible Approaches:** The service must be flexible enough to work either one to one with families or utilising community development and group approaches when they may be most beneficial.
4. **Improving Links:** -Links with GPs and Family Centres should be strengthened.

5. **Positioned within Children's Centres:** -Health visitors should be based in children's centres where possible and should be considered for leadership roles in children's centres.
6. **Data collection:** ICT systems should be enhanced to allow the efficient and effective collection of information to demonstrate needs and outcomes from the service.
7. **Better informed Children's Commissioners:** - Children's commissioners require training to understand the contribution the health visiting service can make to the health and wellbeing of children.
8. **Reduction in paperwork:** - A conscious effort needs to be targeted at reducing the paperwork responsibilities of health visitors as they have been reported to erode up to 50% of clinical time- this can be helped by increasing clerical support and improving access to appropriately designed ICT software.

References

- CPHVA (2007) *The CPHVA Omnibus*. Durdle Davies (a confidential survey conducted on behalf of the CPHVA, headline results will be published in Community Practitioner, November, 2007)
- Family and Parenting Institute. (2007) *Health visitors - an endangered species*. FPI
- Healthcare Commission Staff Survey (2006)
- Cowley & Frost (2006) *The Principles of Health Visiting, opening the doors to public health practice in the 21st century* CPHVA

Appendix

CPHVA members' feedback on the review recommendations

Recommendation 1

The core elements of health visiting should be:

- *Public health and nursing*
 - *Working with the whole family*
 - *Early intervention and prevention*
 - *The value of knowing the community and 'being local'*
 - *Pro-active in promoting health and preventing ill health*
 - *Progressive universalism*
 - *Safeguarding children*
 - *The value of working across organisational boundaries*
 - *Team work and partnership*
 - *Readiness to provide health protection service*
 - *Home visiting.*
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- **Public health and nursing:** It was felt that this suggested a very medical model for health visiting and perhaps this was intended so that other workers could be employed within a health visiting team on lower grades. Such an intention would be counterproductive to achieving effective health visiting outcomes. There was strong agreement that health visitors need to be nurses first although it was felt that if the goal was to become a health visitor there should be an alternative shortened route through nursing encompassing the components most necessary to a health visitor. It was felt a retrograde step that in recent years the need to have an obstetric certificate as a minimum entry point had been dropped. Key elements from nursing were considered to be: medical, paediatric, psychiatric, obstetric, primary care and A&E. It was agreed that nursing offered many core skills of value to health visiting and that the nursing training was constantly of value, particularly due to its underpinning in health. However whilst employers understand practical hands on nursing skills they don't understand the different approach taken by health visiting. It was considered counterproductive to over emphasise the nursing roots of health visiting
 - As stated earlier there was real concern that neither in this list or elsewhere in the report was there any mention of *The Principles of Health Visiting* and specific health visiting skills rather the focus was on skills which other professionals have.
 - There were some members who felt strongly that there could be alternative routes into health visiting from the childcare professions.
 - **Working with the whole family:** It was felt there needed to be a definition of family as the current definition tends to be quite broad. Does this still stand?
 - **Early intervention and prevention:** Widely accepted
 - **The value of knowing the community and 'being local:** Widely accepted
 - **Pro-active in promoting health and preventing ill health:** Widely accepted
 - **Progressive universalism:** The term *progressive universalism* evoked a great deal of discussion and confusion as it was felt it described the existing health visiting practice model though using this term seemed to be suggesting something new and different. Instead of progressive universalism it was thought the current model

should increasingly be termed '*regressive*' universalism as not everyone will get an adequate standard of care. It was widely agreed people from all social classes need the service and many commented '*you need a service where people will have been visited enough by a skilled health visitor to determine need*'. If there isn't the opportunity for health visitors to build a relationship with all families it was felt impossible to provide a service based on progressive universalism. It was generally agreed progressive universalism should apply to the service delivered by health visitors, but some said already managers were interpreting this to mean that where there wasn't conspicuous need other workers could provide primary visits. The point was made again and again that most psycho/social need won't be conspicuous but it can have severe long term consequences for children and families. It was strongly felt there should be no change in the existing model of health visitor engagement without a strong research base to support an alternative.

- ***Safeguarding children:*** Widely accepted and felt essential this is proactive not reactive as is more commonly the case at the moment.
- ***The value of working across organisational boundaries:*** Widely accepted as essential health visiting practice
- ***Team work and partnership:*** It was frequently asked what was meant by team working/partnership as these were existing models of practice, was the document suggesting something different? Many concerns were expressed regarding grade mix teams when it was felt more health visitors could deliver much better outcomes due to the task orientation of other workers roles and their need for training and supervision. Often the presence of grade mix was felt to dilute rather than enhance the health visitors' role. Access to clerical staff was considered to enhance outcomes for health visitors and yet members identified that these staff were the ones least likely to be resourced.
- ***Readiness to provide a health protection service*** evoked enormous discussion as written like this there was real concern that GPs would expect that health visitors would be available to provide general immunisation clinics for all children and for yearly flu campaigns. A member identified a case study where the health visitors had been brought in by trust managers to cover a school immunisation campaign due to a lack of school nurses. Respondents did feel health visitors should provide an immunisation service in the case of an epidemic such as avian flu. Furthermore to be able to support the whole family in such a situation.
- ***Home visiting:*** There was considerable relief that the value of home visiting was acknowledged as it seemed to have been denigrated in recent years. However concern was raised that this was placed at the bottom of the list. This created discussion regarding all the lists in the document and whether they had been compiled in any specific order.

Generally it was felt that the health visiting service should be flexible, being designed to fit the demography of the community. Recent service redesign has led to a loss of relationships with families and knowledge of local communities in some places.

Recommendation 2

Focus

The focus of health visitors should be early intervention, prevention and health promotion for young children and families as this is where their nursing and public health skills and knowledge can have the greatest impact.

Whilst there was a majority view that health visitors should be working with children and families it was often said that in an ideal world there would be a similar service for the elderly. Other comments:

- Whilst this recommendation is the aspiration of current services it isn't being properly delivered due to workforce and training issues. It is a huge remit and the need for adequate funding must be recognised. There was concern that as the existing service is being eroded, how this would be delivered.
- Concern at the reference to nursing and public health skills rather than health visiting skills which are different. *'This suggests an illness rather than a health model.'*
- The issue of the age group the report referred to was raised time and again. Whilst Children's Centres were thought to be very important they were not thought to be able to deliver adequate services for 2-5 year olds without health visitor intervention. There is also the issue of child protection for this age group, who would be responsible? Also the issue of those children who go in and out of vulnerability.
- Transition was seen as really important, especially within the 0-19 agenda. There was some feeling that health visitors should continue to be responsible for vulnerable children beyond the age of 5. Also it was raised how there could be an adequate handover at the pre-school/school transition if children hadn't been seen by a health visitor since they were probably under one? Specific comments included:

'If there is a definite age range then this takes stress from health visitors and they don't have to justify locally if problems are missed.'

Norwich
Andover

'Need to include assessment and developing relationships'

Brings up other issues regarding training. South Central Strategic Health Authority is only going to train 40 students next year across HV/SN/DN/children's mental health nurses (an area that covers nearly 4 million people).

Hampshire

'The statements are fine but don't have any teeth. Early intervention is key, but you can't do that in 1 visit. Most health visitors are working in skill mix teams, so families and health visitors are complaining that they can't build up relationships as there is no continuity of care.'

Birmingham

'We are only seeing families once, the core offer is being used as a standard, not a minimum.'

Portsmouth

'Should say early identification, early intervention leads on from identification'

Esher

'Is the language used in the review, understandable by non-health visitors?'

London

Recommendation 3

Priorities

Priorities in which health visitors will need to play a lead role are:

- *Preventing social exclusion in children and families*
- *Reducing inequalities*
- *Tackling the key public health priorities in particular, obesity, smoking, alcohol, drugs and accident prevention*
- *Promoting infant, child and family mental health*
- *Supporting the capacity for better parenting i.e. improving pregnancy outcomes, child health and development, parents' economic self-sufficiency, safeguarding children, addressing domestic violence, supporting parental relationships and fathers in their parenting role.*

- There was a strong view that if the main attention of health visitors was the final bullet then the other issues would be addressed without special attention
- Many asked how outcomes would be measured.
- There was support for all these issues as being the most important ones for health visitors but future training needed to reflect this.
- It was felt that to deliver this agenda effectively required a massive resource for health visitors and their teams.

'All many health visitors are doing at present is child protection, with very high thresholds. Social care is working to levels 4+ so HV's are picking up the shortfall'.

Manchester

- The gap was felt colossal between local implementation and the national policy.
- There was a call by some for key objectives and monitoring of how health visitors can be effective in achieving them. Success must be publicised to support dissemination of effective interventions.
- One respondent said *'Maximising the potential of parents'* would be better terminology.

Other comments included:

'These are the areas health visitors should be leading on but it is impossible to do this effectively or even scratch the surface without addressing the workforce issues in the profession.' Esher

'If we concentrate on the 2% are we encouraging social exclusion, with some families having the common assessment framework (CAF) as a benchmark for when you will get more services "have we been CAF'd yet?" Esher

'It is important that commissioners are informed about what health visitors do'.

Esher

Reducing inequalities: It was thought it would be helpful to have an agreed definition of health inequalities as these should go beyond social inequalities. For example

military families tend to have greater emotional health needs than the main population.

Preventing social exclusion in children and families: It was felt there needed to be an agreed definition of social exclusion? Health visitors were unsure if it was thought to include vulnerable populations such as asylum seekers, travellers, prisoners as well as families with children with special needs?

Promoting infant, child and family mental health: These were considered priorities but health visitors had training needs to tackle them effectively.

Supporting the capacity for better parenting i.e. improving pregnancy outcomes, child health and development, parents' economic self-sufficiency, safeguarding children, addressing domestic violence, supporting parental relationships and fathers in their parenting role: It was felt there needed to be clarity in the different roles of health visiting, social services and police in relation to domestic violence.

Recommendation 4

Commissioning

Commissioners should commission early intervention, preventive and health promotion services for all young children and families.

Many agreed with this statement with the following additional comments made:

- That the word 'infant' should be included.
- 'Assessment' should be included as it is the critical factor in determining the shape of the subsequent service delivered.
- 'What is the timescale for this?'
- Very clear guidance is needed.
- Outcomes should be in line with the PSA targets
- That there must be recognition that education has taken over the under 5s without understanding what health is already or should be doing for this cohort of children.
- There need to be children's leads in all Strategic Health Authorities (SHA) so that local commissioners are clear about what children and families need. Currently SHA's are focusing on activity and not outcomes.
- It can be hard for health visitors to access children's commissioners. It would be helpful if they had a much closer relationship with clinicians.
- That there is no mention of health visiting in this recommendation and it may be the most important one.
- It was wondered what 'all young children' means? Presumably it alluded to the universal service?
- It was felt that the statement should be stronger to entice commissioners to understand the benefit of commissioning these services.
- Also to understand that commissioners should widen their scope and invest in research and development to build the evidence base, to support innovation based on empirical evidence.
- Some felt commissioning would be led by local authorities in the future so it was interesting that it was in the review.

A possibly very important point was:

'What qualifications do commissioners have? It seems they want to work with the cheapest option, instead of commissioning for the needs of children and families.'

London

Recommendation 5

Level of practice

Health visitors are public health nurses working with young children and families. As highly trained professionals they should be responsible for the 'difficult things' i.e.:

- *Managing risk/decision making in conditions of uncertainty, including safeguarding children*
- *Building therapeutic relationships and addressing difficult issues in families with complex needs*
- *Leading multi-skilled teams*
- *Working across sectors and putting health into multi-agency work*
- *Delivering population level outcomes*
- *Assessment and identification of existing and future vulnerability*
- *Engaging hard to reach groups and individuals*
- *Translating evidence into practice.*

This was quite controversial eliciting a range of responses:

- Respondents were pleased that building therapeutic relationships was included
- There was concern that the statement implied that health visitors would have a management role and wouldn't be using their practitioner skills for the benefit of families. This suggested that the outcomes aspired to would not be delivered.
- There were real concerns re accountability and stress when managing an inappropriate band mixed teams.
- It was queried what shape the teams were expected to be? Did this suggest a diluted health visitor service? Also concern that the recommendation was implying inappropriate band mix. One health visitor said '*It is a very skilled job to 'search for health needs' in a universal population where they are not conspicuous.*'
- This recommendation suggests considerable training implications.
- There was discussion of the general practitioner versus the health visitor role. The role of the general practitioner was felt to be of high value to the Department of Health, with the role of health visitor receiving less value, but with a high expectation to deal and manage very difficult issues.
- It was queried whether the Department of Health recognised that health visitors can only access their clients by invitation through delivery of the universal service, this model suggests the clients may not have a choice.
- Many wondered what doing the 'difficult thing' really meant. There was concern that the report had not grasped the true nature of the challenges of health visiting as it seemed to imply that much client contact was very straight forward and didn't require a health visitor.
- There was a clear view that the make up of a client population should determine the mix of the team.

- There was also clarity that it was necessary to see all families to know what needs they have

In West Kent, the midwives (MW) do an assessment on families, then rate them as low, medium or high risk. The low rated families get a Community Nursery Nurse contact, a medium rated family gets a staff nurse contact and the high rated families, a health visitor. It was commented by a midwife with 20 years experience (now a recently qualified health visitor) that she didn't know how much she didn't know about health visiting before she trained as a health visitor, and that MW's do not have the competencies required to carry out that assessment.

Esher, meeting

Other relevant comments included:

'Implies management not a practitioner role, what happens to the practitioner role?'

Norwich

'How can complex family issues be addressed by someone leading a team? They often need lots of skilled health visiting time to resolve them'

Norwich

'Engaging excluded groups is something that we do, which most of Sure Start has failed to do.'

Huddersfield

'Only responsible for the difficult things will cause high stress and burn out'

Newbury

'Will this be accompanied by a pay rise?'

Portsmouth

'Lewisham is trying to get 11 staff nurse posts, but staff prefers community nursery nurse posts, the job description puts the staff nurse working for hospital avoidance in a nursing model, whereas the community nursery nurses work with children and families. But teams can't just work with families, they need to work across communities so they must have sufficient numbers of health visitors'

Lewisham

'People do not understand the importance of time to develop a relationship with our clients'

Plymouth

'Vulnerable families are being expected to attend children centres and then don't.'

Portsmouth

'Assessing vulnerability on limited resources is near impossible.'

Birmingham

'A mother brought her 2 year old to one of my clinics because he was being described by friends and family as "weak". This is a term often applied to children in my Pakistani community who are not obese but often extremely healthy. This little boy was not particularly thin because he had a diet consisting almost exclusively of fresh

milk. However, he was extremely pale and obviously anaemic. His Mother was not concerned about his pallor and I had a job to persuade her to go for a blood test - his haemoglobin reading was 4.5! Again, this would not have arisen had I seen him at regular intervals, because diet would have been discussed thoroughly.'

Manchester

'On the one hand health visitors are responsible for community nursery nurses and have got to get them to do more and more, but then the health visitor is responsible when it all goes wrong.'

Rochester

Recommendation 6

The primary role of the health visitor should be either:

- Leading and delivering the Child Health Promotion Programme using a family focused public health approach, or*
- Delivering intensive programmes for the most vulnerable children and families.*

There was very considerable concern that the review was suggesting health visitors taking on only one role and that that should be so defined, when the actual nature of community and public health is complexity and the need for flexibility in service delivery. Points made were:

- Feeling that health visitors couldn't do one without the other.
- There were huge implications for training.
- Unworkable in London and other major cities.
- There was a risk of stigmatisation to the families involved.
- It was wondered if the families identified themselves as vulnerable or the service would be imposed on them?
- There were concerns regarding the potential for high stress levels for health visitors.
- Vulnerability was felt to be fluid.
- The Child Health Promotion Programme seems to represent a tiny percentage of what health visitors currently do. One Trust had audited this and found it accounted for only 15% of the health visitors' time.
- There were felt to be massive staffing implications.
- How to define 'most vulnerable' for those who need it?
- It was felt this suggested a disinvestment in public health which goes against current policy (E.g. Wanless, D. Five year report, 2007)
- Seen as a two tier system which will have a negative effect on existing poor morale
- Inspirational leadership was felt to be required to make this work, staff are currently very vulnerable and suffering a lack of leadership
- Most health visitors are already just working with high risk families but this is not helpful to enhancing general health
- That it felt like a medical rather than a social approach to public health. Reflections of *Health for All Children 4th Ed*, 2002 (Hall IV) where managers ignored the psycho/social content as they could more easily grasp the medical aspects. It was felt it wouldn't improve the health and wellbeing of children

and families if the majority of the service is delivered by task orientated non health visitors.

- Managers were already interpreting this recommendation as saying that inexperienced health visitors and the skill mix team will carry out the child health promotion programme work with more experienced health visitors completing the intensive home visiting work.
- If this meant two career pathways, it would ultimately lead to a loss of skills and flexibility?
- It was queried where families who move in and out of vulnerability would fit. It was felt they be missed by these models?

'Missing 98% of population is unacceptable. There is a need to look a lot more at integration, joined up thinking, with greater resources. When working with commissioners, it will be all done on numbers, so the service will end up with robbing Peter to pay Paul, finger in the dyke method leaving most families getting an inadequate service.'

London

'If this recommendation reduced social exclusion it would be worth paying the price but this can't happen without a universal service which in fact supports social inclusion. The whole issue with Olds is that there has to be a relationship built up with families but this has always been true with any family. The suggestions that are being made will lead to a reduction in the health visitors' ability to build up that relationship with a huge majority of families and the outcome will be losses not gains'.

Esher

'Missing 98% of population is unacceptable. Need to look a lot more at integration, joined up thinking, with greater resources.'

Norwich

- It was queried how the most vulnerable families would be found without the input to identify that need. It was felt this could only be achieved thorough ongoing health needs assessment.
- The recommendations were felt to be too simplistic again querying how vulnerable families would be found? It lacked reliance on the *Principles of Health Visiting*. Families were considered to be dynamic with their needs changing.
- By focusing on just vulnerable families it was felt health visitors would lose their links with communities which could only be detrimental and against recommendation 1.
- It was also felt this recommendation put health visitors into silos with an elitist approach and went against Every Child Matters and integrated agendas.

Recommendation 7

Additional areas of practice

There are two further packages of services that health visitors or other nurses can provide depending on local circumstances:

- *Wider public health packages*
- *Primary care nursing service for children and families.*

These caused confusion. Comments made included:

'Why should public health be separated out instead of integrated with the delivery of child health promotion?'
Manchester

'What does Primary care nursing refer to? Does it include post operation visits, running eczema clinics, running baby clinics. This need to be much clearer. Whilst some of these roles are relevant to health visitors there needs to be real care about using health visiting skills where a paediatric nurse would be more appropriate.'
Norwich

- There was considered every likelihood that both children's and practice-based commissioners would misinterpret these roles without much more detail.
- It was felt this recommendation went against the concept of a family focused public health approach.
- Primary care nursing seems to be interpreted as just that, predicated on the medical model and nursing not on health promotion so could be counter productive if a holistic approach is not taken
- It was queried whether these would be separate roles? If so it was not felt a very efficient way of ensuring effective services being too task driven.
- Wider public health packages required explanation and was felt should definitely not be seen as a different role. If there was a need for a specialist worker to, for example, address the needs of travellers then it was felt there should be opportunity for that to be decided locally.
- Whilst there is a definite role for community children's nurses as part of health visitor teams there don't tend to be enough of them.
- There were difficulties highlighted with GP practices not being co-terminus with geographical areas worked by health visitors. It was queried where GPs would fit? They were felt to be really important and their role in safeguarding children could not be over emphasised but they needed to have a relationship of trust to work effectively with health visitors.
- There was felt to be a danger of losing the benefit of a needs driven local services in favour of a very generic but superficial service.

'In our trust we have been told to stop offering a specialist service for families that have had a miscarriage. The service has been well evaluated, but it has been stopped as it is only offered in our area of the PCT. We were told we had to stop it as we couldn't give one set of clients more than another.'
London

'These recommendations will not tackle social exclusion. This is a very confusing document!'
London

Recommendation 8

Organisational options

Health visitors are a key part of an integrated children's service; whether they are located within children's centres or the primary health care team, should be determined locally.

This caused some confusion until it was explained that it recognised the need for flexibility. Comments made were:

- Rural areas work best as integrated primary health care teams.
- A general view of there being value to being based in Children's Centres, but that that was rarely possible, many are only virtual and most have insufficient space.
- Some concern that some GPs don't fully understand the health visitor's role but still value it.
- Raises concerns re training, pensions and protection of employment rights. Health visitors do not want to move from the NHS but are happy to be working alongside local authority colleagues.
- Children's centres should do more to link in with local areas instead of just being a service which people access.
- Often services are designed around resources not need which is counterproductive to health gain.
- Virtual teams are not very effective and this is the more usual model
- Real concerns expressed by understanding of managers as inappropriate decision making not unusual, failure to listen to health visitors cited as a problem.

'Local health visitors should be involved in any decision making regarding work base as they know what works best in terms of client and professional relationships, and can support clients to have a voice regarding the issues.' Norwich

'It's a relief this flexibility is being suggested. We are under management pressure to vacate a successful base to move into a failing children's centre.'

'The fantasy of working under one roof leads to the reality of trying to find a box big enough to put people in. There's no room at the inn.' Manchester

Recommendation 9

National policy

National policy should support the implementation of this review by:

- 1. Issuing national guidance that strengthens and updates the NSF standard on the Child Health Promotion Programme and goes beyond the minimum core to include a model of progressive universalism bringing together screening, early detection, health promotion, health protection and parenting support into one programme for all families*
- 2. Assembling the relevant research findings to support a 21st century child and family health promotion service*
- 3. Strengthening the commissioning of early intervention and prevention health services for children*

4. Leading the development of the workforce through Modernising Nursing Careers to support current and future health visitors to undertake the roles described in this review

5. Clarifying and promoting the contribution of health in the government's policy on parenting.

There was a common view that this was blue sky thinking when commissioners seemed more interested in quantity not quality of services and didn't understand the *Principles of Health Visiting*. Many respondents expressed the view that the thinking underpinning the recommendation was from a medical model and not a social model. Other comments made:

- Funding and legislation will also be important to success.
- Research underpinning of future developments should be a priority for the Department of Health, there is a real lack of evidence cited in the review even though the evidence is building to demonstrate the effectiveness of health visitors and their teams.
- Need to ensure a holistic approach.
- It was considered essential that **all** families receive an adequate service, this definitely isn't happening now.
- There is also a need to ensure effective clinical leadership.
- Guidance for commissioners is a key gap.
- The consensus was that there should be an 80/20 skill mix split with 80% of family contacts being carried out by health visitors.
- There was a need to link to PSA targets to attract funding from commissioners.
- Health visitors must be involved in local decision making as they understand how services can be delivered to maximise health gain.
- It was important not to make assumptions about the level of understanding of commissioners.
- It should be recognised, and health visitors need to be supported, in the fact that they may need to provide about 25 reports to cover key outcome area whereas other services may have only 10 areas to report on.
- The title of 'health visitor' requires legal protection to prevent it being adopted by non-registrants working in childcare.
- Fragmented models won't work, there is a need to put the child and family in the centre and design services to meet their needs.
- Home visiting and universal services should be a priority

