THE UNIVERSAL HEALTH VISITING SERVICE

Unite/CPHVA Occasional paper produced for the Action on Health Visiting Programme 2009

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This paper was produced to inform the 'Action on Health Visiting Programme' announced by the then Secretary of State, Rt. Hon. Alan Johnson, M.P. in March 2009

INTRODUCTION

'Continuously assessing the health needs, and delivering and organising family focused health services to every family with pre-school children'

There are three major issues to be resolved in deciding how this recommendation should be taken forward.

First, a decision is needed about what is meant by a 'universal' family focused health service, provided to 'every family with pre-school children.'

Second, forms of practice and service organisation vary widely across the country, sometimes in response to different needs, but also according to local preferences and historical patterns of service delivery.

Third, whilst it has been accepted that health visitors should lead this service, the questions of who else should be involved in delivering it, and how, remain a question of debate.

UNIVERSAL SERVICE

Opinions about the intensity of service that every family should receive vary widely and influence commissioning patterns. A universal service for all families with pre-school children is required because of:

- increasingly strong evidence that early child development is a key period for influencing health inequalities *(1)*, and

- recommendations that actions to tackle the social determinants of health must focus on the whole spectrum of the population *(2)*

Health inequalities all follow a gradient *(3)*, which means that health needs, also, follow a gradient. Although they will be concentrated in deprived areas and specific population groups, needs and risks are widely spread through the population, leading to the so-called 'population paradox,' in which the highest number of needs are found among the more numerous, but lower risk, populations *(4)*.

This means there should not be a sharp cut-off, with some families receiving a large amount of support and others either very little, or sporadic, input. Health visiting is recognised as the universal service for pre-school children, with education as the universal service for school age children. A health visiting service that is provided in a 'universal but not uniform' way requires good assessment decisions, which in turn requires high level professional skills to identify which families to target from within a universal service. Principles to underpin the funding of universal health visiting services have been identified as follows *(5) (6)*:

- Services need to be based on principles of ‘progressive universalism,’ making provision for all families and more for those who need more

- Services should be developed according to an assessment of need at two levels:
    - o at an area/population level, to ensure that more health visitors, as well as enhanced children’s services overall, are provided in areas of greatest need;

    - o at an individual/family level, to ensure all those with health needs are identified, then to determine and personalise the particular provision required, according to a specialised ‘health visitor needs assessment,’

- health visitor assessments require professional judgement *(7)* based in a high level of knowledge and skill, and implemented in partnership with clients (families, children and parents) *(8)*

- the opportunity to identify and support children and families whose needs would not be picked up by population-level assessments explain why a universal service is required *(9) (10)*.

- Services should be based on current evidence about implementing home visiting programmes designed to promote family wellness and prevent child maltreatment *(11) (12)*.

- o Whilst not conclusive, there is extensive evidence suggesting that 6-12 visits over a year, within a multi-faceted programme, are likely to be effective in achieving a range of positive outcomes, including those specified in The Healthy Child Programme (THCP) *(13) (14)*

- o Survey evidence *(15)* and professional experience *(5) (6)* suggest that a gradient of provision might include 12 contacts, combining fewer visits with more centre-based activities for stable families, whilst more intensive, evidence-based programmes *(16)* of visits are needed for very vulnerable families.
- o By preventing or meeting most of the health needs as they arise, more comprehensive universal services reduce the need for provision of additional services *(15)* (indicated prevention).

- o There is some evidence that unmet needs surface inappropriately, elsewhere (e.g., in general practice, accident and emergency), when health visiting services are restricted *(17) (18) (19)*.

- Services need to operate through partnership working and strengths-based practice, which leads to the best outcomes *(10)*.

- Anticipated outcomes can be specified; starting with PSA targets, around 30 ‘markers of success’ suitable for auditing have been identified *(6)*.

SERVICE LOCATION, ACTIVITIES AND WAYS OF WORKING

Location

Health visiting developed in the voluntary sector in the 19th century, becoming a statutory service under local government in 1929, before moving to the NHS in 1974. Services were initially organized in geographical areas, but attachment to primary care/general practice became the norm with integration into the NHS. This situation appears to be reversing, with roughly equal proportions of health visitors based in GP surgeries and community bases *(20)*.

Types of activity

Health visiting activities are very broad in scope and diversity, but they can be roughly divided into one-to-one client contacts (in order of frequency: home visits, telephone consultations, child health clinics, consultations at centre/base, developmental checks) and community outreach/group activities (liaison/collaboration, support groups, parenting education, antenatal education) *(15)*. Decisions about the relative proportion of each type of activity need to be made locally, since issues such as facilities, travelling times, consumer culture and preference etc., all affect differential uptake and acceptability.

There is far more evidence about the acceptability and effectiveness of home visiting than about the other activities, about which there is less research. A recent trial in Camden, for example, compared community group support (CGS) with monthly home visits by a support health visitor (SHV). Uptake of the CGS intervention was low: 19%, compared with 94% for SHV. SHV women had different patterns of health service use, with fewer taking their children to the GP, less anxious experiences of motherhood than the control group and high user satisfaction with SHV *(21)*. These results accord with consumer surveys showing parents want advice and support from health visitors *(22) (23)*, preferring to receive it at home

(23); and local experiences of the impact on other services when health visiting services are cut back *(17-20)*.

Ways of working

The principles of health visiting were first identified in the 1970s *(24)* and have been refined and expanded through focused discussion, research and education *(25)*. 'The principles' has become a shorthand term used to describe the underpinning ethos, values and processes that underpin the work, which is about promoting health, using a partnership, strengths-based approach, engaging clients on their own terms. Unite-CPHVA have produced a description of the 'distinctive contribution of health visitors,' organized around a principles framework, for example *(26)*. Health visiting is most effective when carried out through this form of practice, which is goal-focused, but achieved through partnership working and relationships *(27) (28) (29)*. These skills underpin the specific 'health visitor assessment process,' which has been widely researched and has been shown to be applied relatively consistently *(30) (31)*. It requires specific, in-depth knowledge about children and families, potential risks and sources of support and strength; as well as knowing when to introduce validated instruments to assess specific concerns about health or development. This assessment process is required to ensure all families who need the service receive it.

Traditionally, health visitors held sole responsibility for a specific number of families ('a caseload') derived from the general practice or geographical area in which they worked. This has changed quite rapidly, with an increase in different forms of team and corporate working to ensure coverage in the face of many part-time workers, sickness and vacancies. There is little research about the impact of these different approaches, and whilst some forms of team can be extremely successful, there have been concerns about the extent to which they have been implemented to cover staff shortages, without adequate attention to key issues *(20)*. In particular, consumers dislike the lack of continuity, there is a risk of serious concerns and safeguarding issues being missed and lines of accountability can easily become confused.

SKILL MIX AND TEAM WORKING

Health visiting services have been described as those delivered and led by qualified health visitors, but provided in collaboration with colleagues, like children's centre staff and primary care teams *(6)*. They include team members who are less highly qualified, such as community nursery nurses, administrative support workers and (registered) staff nurses, to whom specific activities may be delegated. Distinctions between delegation, referral and collaboration are not always clear, in the kind of multi-component service offered in most areas *(32)*.

Collaboration and referral

Health visitors are often engaged in complex liaison arrangements, for example with Local Sure Start Programmes (LSSPs), which are most effective where health visitors are actively engaged *(33)*. This form of liaison is likely to increase with attachment to Children's Centres *(14)*, but it will be important to retain the elements responsible for this success in the original LSSPs; local links and knowledge of all pre-school children, derived from the universal service, were considered particularly important *(34)*.

Children's Centres are supposed to establish a 'hub' of provision so that collaboration can be improved across agencies and services, leading to a seamless service for consumers *(34)*. So far, Children and Young People's Plans include little mention of pre-school children or their needs, and very limited descriptions of preventive health services *(35)*. In 2008, a Unite/CPHVA survey showed fewer than 10% of health visitors were based in children's centres *(20)*, often with inadequate facilities, and there are increasing reports of health visitors being moved out of surgery/primary care bases. With such variability, the new requirement for Children's Centres to each have a named health visitor *(14)* may be a challenge.

Health visitors are key gatekeepers *(36)*, using an established referral process *(37)* to enable families to reach services they need. A survey of 984 health visitors in 2005 showed they referred to social workers (94%), speech and language therapists (89%), audiologists (85%), orthoptists (77%), community paediatricians (74%), child and adolescent mental health services (70%), community dieticians (68%), counsellors (61%), clinical psychologists (40%) and educational psychologists (36%) *(15)*. Anecdotal reports suggest referrals from health visitors have fallen in line with the reduction in health visiting numbers. No formal audits or surveys have been found that would shed light on this, and the Health Select Committee on Inequalities said the government should commission research into the effect of health visiting staff shortages on children and families *(38)*.

Delegation

Research from Ireland *(39) (40)* , England *(41) (42)* and Scotland *(43)* suggests that, in programmes developed with (for example) the skills of community mothers, community workers or family support workers in mind, they can be both effective in their own right and of great benefit to the health visiting team and local community. However, considerable health visiting time is required to meet staff training, supervision and support needs.

Survey research shows that good administrative support helps health visitors to carry out more home visits *(15)*. There are a wider variety of centre-based activities, like post-natal support groups or sleep and behaviour clinics where community nursery nurses (CNNs) are in teams, but no difference if staff nurses are included *(15)*. Health visitors often report finding CNNs well able to support their work, since they are trained to support normal child development and behaviour; unlike

registered nurses whose skills are mainly focused on care and support of ill people.

Health visiting services are delivered to an undifferentiated caseload; which is to say clients have not been previously assessed and referred by doctors, as is the case for many nursing and allied health services. This is important in terms of deciding which work can be delegated, and explains the importance attached to health visitors carrying out assessments on all families on their caseload.
Skill mix staff can carry out home visiting if they can be sufficiently well briefed about what to expect and what to do in the event of a variation from an anticipated path.

This can happen if:
- the skills of the worker are known
- the client's situation and needs have been assessed and a plan formulated
- delivery of the package of care is expected to follow a fairly predictable path

If a client has not been seen by a health visitor at all, or for a long period of time (e.g. one year or more), then the situation is not predictable, and an assessment needs to be carried out by the health visitor who is accountable for the delegated care.

Substitution

In one of the few studies of substitution, Olds showed that delivery of intensive home visiting programmes by 'paraprofessionals,' who had no formal qualifications but in-service training only, led to outcomes that were far less effective than those delivered by the highly qualified nurses who were also trained to deliver the programme *(44)*.

Noting the lack of evidence, the Health Select Committee called for research about whether some of the elements of the health promotion roles carried out by health visitors could be done effectively by other staff, to ease pressure on the service *(38)*.

However, direct substitution of differently qualified staff into functions previously regarded as requiring a health visitor is happening already, where there are acute staff shortages. There are concerns about the quality of service provision in such situations, particularly bearing in mind strictures in the Laming Review about the need for sufficient, appropriately qualified staff *(45)*.
Lines of accountability are blurred where substitution is decided through organisational protocols, rather than individual delegation.

Health visitors may be formally accountable for care provided to a client they have never met and know nothing about, being delivered by a junior team member whose skills are not known to suit the situation and where no specific programme of care has been prescribed.

Such situations are reported with increasing frequency, causing great concern about the quality and safety of the service.

CONCLUSION

A universal family focused health service, provided to every family with pre-school children, needs to follow key principles set out above. Forms of practice and service organisation need to vary systematically, in response to different needs and cultures, not because of resource constraints in other services. Health visitors need to lead this service, using their professional skills to delegate and liaise with other services, to maintain safe, high quality services.

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