

Tower Hamlets - Health Visiting Stakeholder Engagement Report

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Introduction	4
Local Context.....	4
Section 1.....	6
Stakeholder Engagement Process.....	6
Phase 1 and 2: Stakeholder Engagement Findings.....	8
Needs	9
Competency, skills and capabilities	10
Access to services.....	15
Communication between services.....	19
Partnership.....	22
Health promotion.....	26
Early intervention	27
Information and guidance	27
Training	29
Information technology	29
Resource.....	30
Management.....	30
Safeguarding	31
The 4 tiers of service	33
Conclusion.....	36
Section 2.....	38
Phase 3: Summary Report.....	38
Introduction	38
Engagement Process.....	38
How do we strengthen the role of the Health Visitor in community engagement and development?	38
What do we need to do to fully implement the antenatal contact?.....	40
How do we strengthen the integration of the Health Visitor Service with Primary Care and Children’s Centres?	41
How do we improve the capabilities, competencies and capacity of the Health Visiting service?	42
What do we need to do to offer a more intensive service for high needs families that do not meet the threshold for statutory services?	43

Health visiting services in the London Borough of Tower Hamlets

Introduction

The health and wellbeing of children and young people matters and health visitors are key professionals in supporting families, babies, infants and young children in the developing years 0-5 to have the best possible health and development outcomes. Health visitors are specialist community public health nurses who provide expert advice, support and interventions to families with babies and young children. They help empower parents to make decisions that affect their family's future health and wellbeing. Health visitors are supported by a skill mix team. From 1st October 2015 Local Authorities will be responsible for commissioning early years (0-5 years) public health services, including the health visiting service.

In January 2015 Prederi were commissioned by the London Borough of Tower Hamlets (LBTH) Public Health Department to develop and deliver a stakeholder engagement project to inform the future commissioning of health visiting services.

The project was carried out in 3 phases. Phases 1 and 2 were discovery phases to explore stakeholder views on LBTH health visiting services, in particular to find out what was valued about the service and what was not working well and could be improved upon, including ideas for future services. Stakeholders included members of the health visiting service, parents and carers and a range of professionals from health, early years, social care and third sector services.

The purpose of Phase 3 was to reflect findings from the previous 2 phases back to engagement participants. Information on national recommendations for service developments and innovative practice occurring in other areas was also presented. Participants were asked to make suggestions for how local services could be developed.

This report consists of 2 sections. Section 1 is the full report on Phases 1 and 2 describing the stakeholder engagement findings. Section 2 is a summary from the Phase 3 discussions regarding future service developments.

Local Context

The transfer of 0-5 public health commissioning to the local authority, along with the significant expansion of the health visitor workforce, provides an important opportunity to strengthen health visiting services in the London Borough of Tower Hamlets (LBTH). This includes strengthening the public health role of health visitors in prevention and early detection, improving integration with other local authority children's services and improving continuity for children and their families. It is important to do this whilst maintaining and strengthening links with primary care and other NHS and voluntary sector services.

Public health commissioners in LBTH recognise that when commissioning future services the health visiting service specification should include requirements mandated in the national health visitor service specification¹ but also be tailored to reflect local circumstances.

Prederi were commissioned by LBTH to manage and run a stakeholder engagement process to enable the Public Health Department in LBTH ensure the best possible provision of the health visiting service through identifying current strengths, challenges and priorities, and the changes required locally to ensure a high quality, innovative service that is responsive to local needs and priorities.

¹ http://www.england.nhs.uk/wp-content/uploads/2014/03/health_visitor_serv_spec.pdf.

Section 1

Stakeholder Engagement Process

Phase 1 was designed to hear and collect the views and suggestions of health visitors and parents and carers of children who are currently 5 and under. We engaged with members of the health visiting service in a single workshop. Participants included established health visitors, newly qualified health visitors, clinical leads, wider members of the health visitor skill mix team² and student health visitors. The views of parents and carers were sought in 8 focus groups (FGs) held at Children's Centres and through an online survey.

In Phase 2 we engaged with general practitioners (GPs), early years professionals (EYPs)³, children's social care (SC) professionals, commissioners of services for children and child health professionals, including speech and language professionals (SALT), midwives, family nurse practitioners (FNPs) and mental health professionals.

Engagement took place in three parallel workshops:

1. Early Years Professionals (EYP) workshop
2. Key Professionals (KP) workshop
3. Social Care Professionals (SC) workshop

The views of GPs were gained through an online survey. An additional focus group was held with representatives from the third sector and a member of the project team also attend a LBTH Safeguarding Meeting and fed back issues relevant to this project.

(Phase 3 focussed on drawing out themes from Phases 1 and 2 and discussing these with all stakeholders. It is documented in Section 2 of this report.)

All the workshop engagement consisted of a set of open questions which were along the lines of "Tell us:

- *about health visitor in LBTH*
- *what is going well*
- *what needs to be developed or improved*
- *and how?"*

All information was anonymous and this approach created open discussions giving participants the opportunity to tell us what they thought of the current service (positive and negative) and discuss their ideas about what to change or improve and how.

The online surveys asked far more detailed questions supplying more specific data. They also gave the project a far wider reach and enabled us to access those who could not attend a workshop. Surveys included both closed and open-ended questions (free text responses).

Details of the engagement sessions are given below.

² These include several roles such as community nursery nurses and community nurses and in this document are referred to as support workers.

³ These included Children's Centre workers and members of the wider early years workforce.

Table 1: Stakeholder Engagement Session – locations and number of attendees.
Phase 1- Parents and Carers and Health visitors
8 parent and carer focus groups at Children’s Centres: <ul style="list-style-type: none"> • Ocean • Isle of Dogs • Overland • Meath Gardens • APCC (Poplar) • Crisp St • Marner • Wapping In total 44 parents and carers attended.
Parent and carer on-line survey: <ul style="list-style-type: none"> • 82 parent/carer survey respondents
1 Health visitor workshop: <ul style="list-style-type: none"> • 56 members of the health visiting service attended
Phase 2 - Practitioners, Professionals and Clinical staff
The following workshops were held: <ul style="list-style-type: none"> • Early Years Professionals workshop - 23 attendees • Key Professionals workshop – 23 attendees • Social Care Professionals – 13 attendees • 1 third sector focus group – 3 organisations
GP on-line survey <ul style="list-style-type: none"> • 36 respondents

Below are the Objectives, which were discussed within each workshop.

Table 2: Workshop Objectives
Phase 1: Health visiting service (HV) workshop
<ol style="list-style-type: none"> 1. To gain an understanding of the needs of parents/carers and their young children from the perspective of HEALTH VISITOR service practitioners 2. To gain an understanding of how current practice meets these needs, including what is valued most about the health visitor service that shouldn’t be changed and anything that could be done differently 3. To elicit and explore new and innovative ways of working that can be realistically achieved and will further meet the needs of parents/carers and their families.
Phase 2: Early Years Professionals workshop
<ol style="list-style-type: none"> 1 a) What is your understanding of what the Health visitor Service currently does? 1 b) What do you most value about the Health visitor Service and what would you want to improve and how?

2 a) What impact could an improved Health visitor Service have on you and your job and are there opportunities to better work together?

2 b) And what would your proposed changes mean for babies/children parents and carers in Tower Hamlets?

Phase 2: Key Professionals workshop

1. What do you value about the health visitor service?

2. What would you improve about the health visitor service?

3. What are the Opportunities for Joint Working, Barriers and Enablers?

Phase 2: Social Care Professionals workshop

1. What do you value about the health visitor service?

2. What would you improve about the health visitor service?

3. What are the Opportunities for Joint Working, Barriers and Enablers?

Notes were taken by an observer during focus groups. Workshop attendees were asked to record all their comments on paper. These were subsequently collated into master transcripts for each workshop.

Phase 1 and 2: Stakeholder Engagement Findings

A thematic analysis was carried out on all focus group notes and workshop transcripts and survey free text responses. The following themes were identified:

- Needs
- Competency, skills and capabilities
- Access to services
- Partnership
- Health promotion
- Early intervention
- Information and guidance
- Training
- Information technology
- Resource
- Management
- Safeguarding

The majority of themes were cross cutting across all stakeholder groups, including parents and carers. Training, information technology, resource and management are less visible to service users and these issues were largely confined to members of the health visitor service and other professional groups.

Participants valued many aspects of the current health visiting service and these are described first for many of the themes identified, followed by perceived limitations and ideas for service improvements.

Needs

This was explored in all stakeholder events. In some events participants were asked directly about needs, in others these were explored through other objectives.

Participants in the HV workshop were asked to describe what they believed the needs of parents/carers and their babies/young children to be. Their answers are shown in the Table 3 below.

Table 3. Needs in LBTH as told by members of the health visiting service	
<p>Needs of Parents/Carers:</p> <ul style="list-style-type: none"> Preparation for parenthood Emotional support/wellbeing Mental health issues Postnatal depression Anxiety Attachment/bonding Breastfeeding Couple counselling Domestic abuse 	<p>Support for Vulnerable Groups:</p> <ul style="list-style-type: none"> Homeless Asylum seekers Refugees Travellers Hard to reach families Young carers
<p>Needs of Babies/Young Children:</p> <p><i>Prevention needs:</i></p> <ul style="list-style-type: none"> Home safety Cot death prevention Immunization Screening Audiology assessment <p><i>General needs</i></p> <ul style="list-style-type: none"> Oral health Behavior management Sleep management Toilet training Weaning Infant feeding Obesity Minor ailments Diagnosis and onward referral Skin conditions Infant Mental Health issues Learning Needs Autism Speech and language delays 	<p>Specialist support for Babies/Young Children:</p> <ul style="list-style-type: none"> Support to babies in special care baby units Disabled children Physical, emotional, sexual abuse/neglect

Whilst discussing this objective, health visiting service participants frequently highlighted the role of needs assessment and onward referral in both identifying and addressing need.

The following needs were articulated by other stakeholder groups:

Parents/Carers called for more support for:

- Emotional wellbeing
- Postnatal depression
- Identification of concerns in the home
- Breastfeeding
- Sleep issues
- Help on how to cope immediately after birth
- Support for mothers following Caesarian sections
- Support for babies/infants with minor illnesses
- Weaning advice
- Healthy eating advice
- Support for minor illnesses when *“it is silly to go to the doctors”*.
- Speech and language delay

Key professionals called for more support for:

- New mums on postnatal wards
- Parental mental health
- Infant/child mental health

Social care workshop participants identified the following as local support needs:

- Domestic abuse
- Postnatal depression

Early years professionals highlighted the following:

- Speech and language concerns
- Developmental delay

General Practitioners

Survey respondents were asked what they considered the top 5 extra support needs of parents/carers were that LBTH health visiting service could help with. Twenty-eight GPs responded to this question. Support with parenting, family support and support with domestic violence were rated the most frequently as the top support needs. Support with postnatal depression was also ranked by many although as a lower priority, as was support for other issues, which are commonly, addressed by health visitor services e.g. advice on immunisations.

First most important extra support needs

Breastfeeding	Weaning/infant feeding support	Managing minor illnesses	Post-natal depression support	Family support	Support with parenting issues	Support with domestic violence
2	3	1	1	5	12	4

Competency, skills and capabilities

All stakeholders highlighted aspects of practice which related to the underlying competency, skills and capabilities of practitioners. This included a subjective assessment of practitioner knowledge and skills as well as views regarding their approach to care giving.

Table 4 below gives a description of the health visitor role as described by members of the health visiting service within the HV workshop. A summary description was given by one participant as:

To provide professional support, advice and guidance on child care issues, maternal health and social issues (HV workshop)

Table 4. Description of Practice		
Scope	Knowledge & skills	Approach
Babies Young Children Pregnant mothers Families Prevention to treatment/referral Universal Contextual to home environment	Physical Health Child development Mental health Emotional wellbeing Parenting Attachment Needs assessment Health navigator Advocacy	Holistic Relationship building Trusted Non-judgemental* Caring* Reassurance* Objective* Patience* Tolerance* <i>“Service with a smile”*</i> Consistent Pro-active Peer support to colleagues Timely and responsive

* Frequently raised by the HV support workers.

From a Service Users perspective

Parents/carers were asked what they valued about the current health visiting service. With respect to competency, skills and capabilities, health visitors were valued for:

- providing reassurance (this was a frequent theme)
“If your mum is not there, the health visitor plays a crucial part in reassuring, supporting, and informing you” (Parents FG)
- advice on small problems
- providing written and verbal information
- support with specific issues e.g. breastfeeding

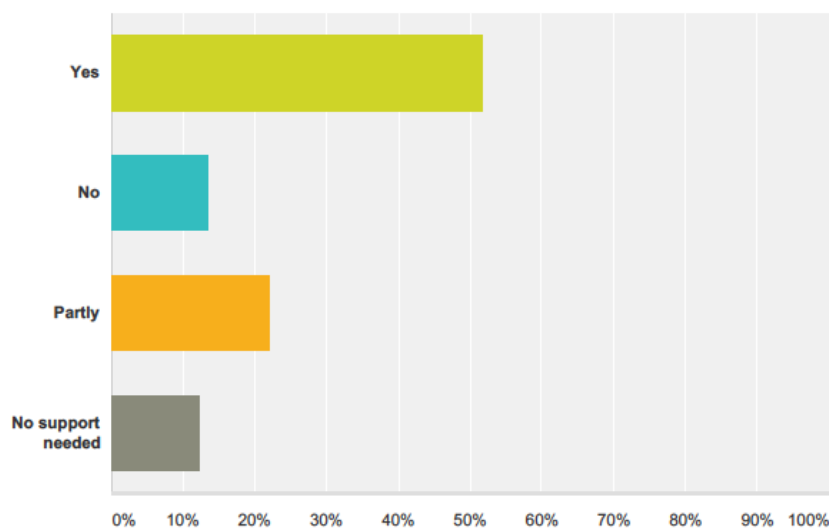
Survey respondents were asked if they had received support for specific concerns from the health visiting service and if so, to rate it. Table 5 shows the percentage of respondents who rated that support as ‘Very Good or Good’.

Table 5: Parent and Carer survey – quality of support received.			
	Total number who received support	Number rating support: Very Good/ Good	Percentage rating support: Very Good/ Good
Breastfeeding	42	25	60
Weaning/infant feeding support	22	14	64
Sleep management	16	8	50
Infant crying	13	7	54
Advice on toilet training	11	6	55
Advice on immunisations	23	17	74
Managing minor illnesses	15	10	67
Child accident prevention advice	8	7	88
Support with development concerns	7	5	71
Speech and language concerns	9	7	78
Postnatal depression support	9	5	56
Contraceptive advice	8	7	88
Family support	6	4	67
Support with parenting issues	6	5	83

Respondents were also asked if they had received all the support they needed. The results are shown in the graph below. Just over 50% of parents had received all the support they needed.

Q11 Thinking about your answers to the questions above, do you feel you had all the support you needed?

Answered: 81 Skipped: 1



Survey respondents were also asked to say what was ‘good’ about the LBTH health visiting service. With respect to competency, skills and capabilities many reported that they were pleased with the advice they had been given which they found up-to-date and reliable. Health visitors were seen as knowledgeable practitioners who provided a wealth of advice to families when needed.

“They’d give advice, even when I didn’t ask. They knew what I needed”

“Advice and reassurance from very knowledgeable Health visitors”

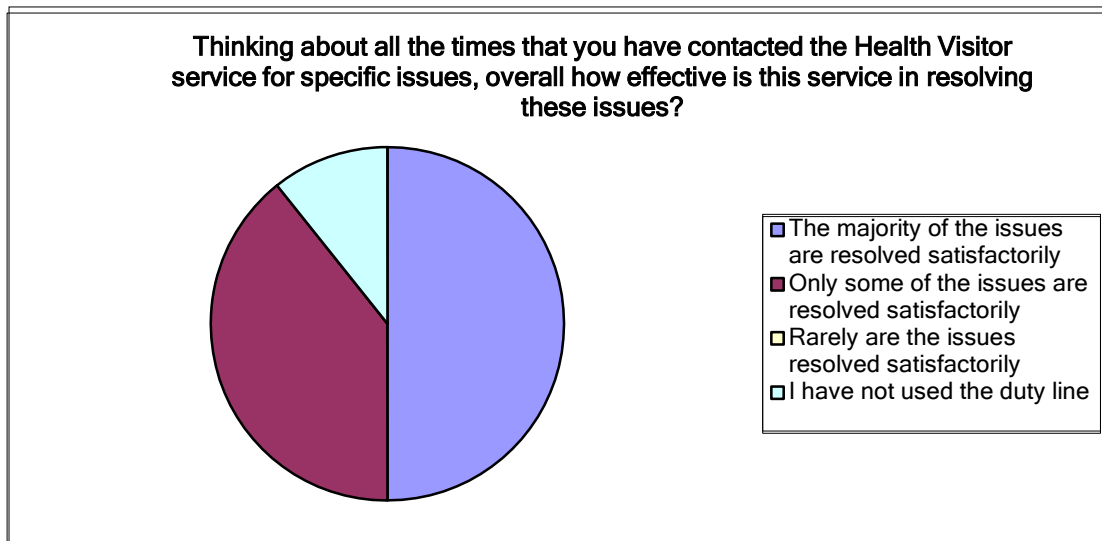
Overall there were 15 respondents that commented positively on the amount of and quality of advice/information they received from the health visiting service and 12 respondents commented on how helpful and supportive members of the health visitor team were.

From a professional perspective

Other professionals also valued health visiting service practitioners for:

- the reassurance given to parents
- as trusted professionals
- relationship building with families
- their public health role
- good support to vulnerable mums
- family focussed care
- health expertise
- acting in a lead professional role
- acting as an independent practitioner
- their local expertise
- *“the longer in practice the more experienced plus better knowledge of local area”* (KP workshop)
- skills in managing postnatal depression and providing emotional support

GP survey respondents were asked about the extent to which the health visiting service was able to resolve issues that they referred to them. Fifty percent said that the majority of issues were resolved satisfactorily.



Survey respondents were also asked to rate how well parents and carers extra support needs were being met by the health visiting service. Fifty percent of all responses indicated that needs were being met to a HIGH standard, although this support was not necessarily viewed as being available to all.

Limitations

Free text comments were made in the parent/carer survey which related to the competency, skills and capabilities of health visitor practitioners. Some respondents felt they did not receive enough or appropriate support for the following:

- toilet training (2 respondents)
- postnatal depression (3 respondents)
- infant colic (1 respondent)
- sleep management (1 respondent)
- breastfeeding (1 respondent)

Some parents/carers highlighted inconsistency in practice between health visitors. One talked about how the quality of care varied according to which health visitor was seen, describing it as a “hit and miss” experience. Newly qualified health visitors within the HV workshop also highlighted that consistency of advice and information was needed by parents/carers. This theme was also raised amongst EYP workshop attendees.

A few parents/carers were also critical of the advice they received, describing it as standardised and not tailored to individual needs.

“From personal experiences the group felt most of the health services were to ‘tick boxes’They are not computers the job is to be human beings” (Parents FG)

In a few focus groups parents and carers highlighted that they felt that too much emphasis was put on weighing their babies at the expense of discussing other issues that were of concern.

Access to services

This was a theme that came through strongly from all stakeholder groups.

Access to health visiting services was discussed both in terms of service user accessibility and also communication between professionals. Each is discussed in turn.

Service User Accessibility

From a service user perspective

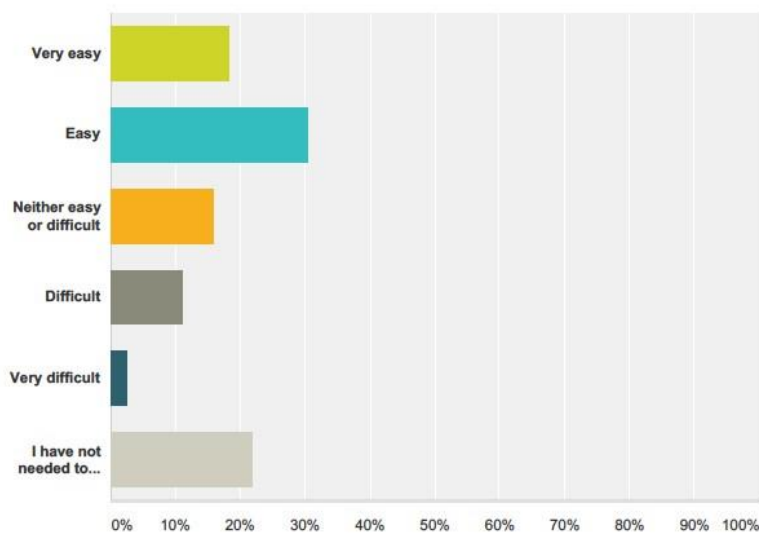
Parents and carers expressed both satisfaction and dissatisfaction with their access to the health visiting service.

What went well:

- Eighty two percent (67 out of 82) of parent/carer survey respondents stated that they knew how to contact the health visiting service.
- Respondents were also asked how easy it was to contact the health visitor service when they needed support. Approximately one half replied very easy or easy.

Q8 How easy has it been to contact the Health Visiting service when you have needed support?

Answered: 82 Skipped: 0



- The majority of survey respondents thought the service was very flexible
- Parents and carers liked the new birth visit at home and expressed anxiety about it being replaced by a clinic visit as they claimed is the practice in a neighbouring borough
- There was a general feeling that experience of the health visiting service was positive if parents and carers saw the same health visitor at all appointments and they had the time to talk to them

- Parents and carers who were interviewed at Children’s Centres stated that they liked going there because it gave them the opportunity to meet other parents and their children could play in play sessions whilst they were waiting to see the health visitor.
- Some parents and carers expressed satisfaction with how the developmental reviews were run.

Limitations

- Parent/carer survey respondents were asked what could be done to make the service better. There were 48 free text replies and many of these were concerned with better access including a desire for more locations for the health visitor to operate from, more ways to contact the service and more flexible appointment times and service hours.
- Thirteen percent of parent/carer survey respondents stated that they found it difficult/very difficult to contact the service when needed. A number of Focus Group parents and carers also stated they did not know how to contact the health visiting service, although others stated that they did.

“The number is in the Red Book but this wasn’t explained and no one explains the Red Book.” (Parent FG)

- Many parents and carers highlighted long clinic waiting times which were often coupled with short appointment times. The quote below reflects the experience of many parents and carers that attended the focus groups.

“In the clinic there were long waits 2 hours, then about 5 minutes with the health visitor, not much time, I did ask for something extra, for them to measure the height of my baby, and I was told that there we people waiting outside, but I had waited 2 hours.” (Parent FG)

- There was a common perception amongst parents and carers that health visitors were *“rushed off their feet”*.
- Long queues for drop-in clinics were cited as being problematic for working parents.
- A few parents and carers believed that the service was not available to older children (after babyhood and infancy) and they had commented that they had not seen a health visitor after their child was two.

“At two years the health visitor finishes. The health visitor needs to be longer.” (Parent FG)

Crossover between services

Parents/carers described the crossover in use between different services:

“A lot of parents said that when GP appointments were not available, they relied on HEALTH VISITORS to offer advice” (Parents FG)

“Parents get more help from children centres than health visitors” (Parents FG)

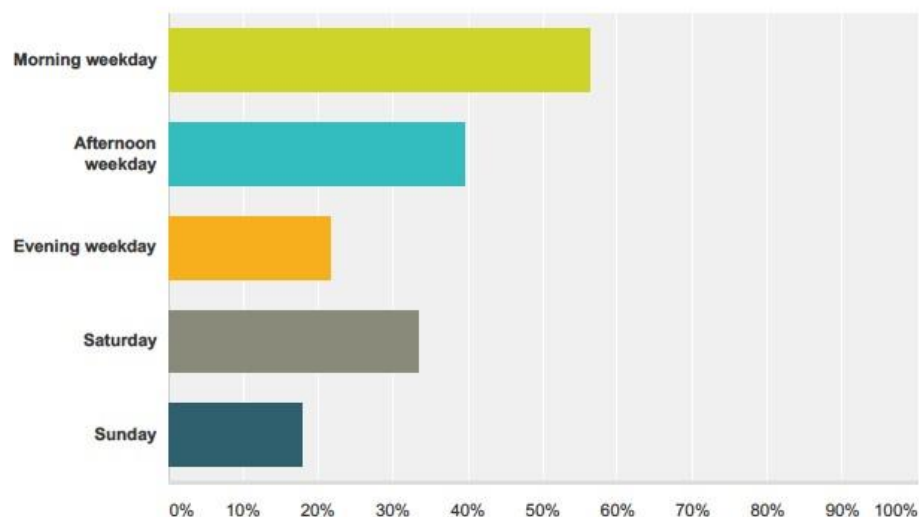
Suggestions for improving accessibility:

Parents and carers made the following suggestions for improving accessibility to health visiting services:

- More open access clinics at Children’s Centres
- More clinics to be held in community settings such as libraries, schools and play groups
- More home visits
- Instigate an appointment based system as well as having drop-in clinics
- Instigate evening and weekend provision - although 19% (15 out of 78) of parent/carer survey respondents found the service to be very flexible with respect to the time of day they could access the service and a further 56% (44 out of 78) found this to be ok, both focus group participants and survey respondents asked for more flexible provision. The chart below shows the survey responses to the question ‘At what time of day would you prefer to use the health visiting service?’

Q16 At what time of day would you prefer to use the Health Visiting Service? Please tick all that apply.

Answered: 78 Skipped: 4



- Consider setting up a telephone help line. As one survey respondent put it: *“I wish there was a way I could telephone health visitors for advice. The clinic set up means that you have to call on the day and it is pot luck whether you will get an appointment. It cannot be booked in advance and is not a drop in but rather last minute appointments. Does not suit me as a working mother as I cannot risk a day off and not get an appointment. It is too rigid. A phone service would be helpful and follow up booked appointment if necessary”.* (Parent/carer survey respondent)

From a professional perspective

Accessibility to services can be sub-classified into the following themes⁴:

- Acceptability – this refers to the characteristics of the service which the user perceives as desirable and which facilitate use
- Accommodation – this is the relationship between the manner in which resources are organised to accept users and the users ability to accommodate them
- Availability – this is the relationship of the volume and type of existing services and resources to person’s volume and type of need. It refers to the adequacy of the supply of health care providers and facilities
- Accessibility – this is the relationship between the location of supply and the location of the potential user, taking account of transportation resources.

The table below describes how professionals currently view health visiting services in terms of their accessibility to service users alongside suggestions for service improvements using the above framework. Viewpoints arising from the HV workshop are shown in bold.

Currently Valued	Ideas for Service Improvements
Acceptability	
Continuity of care Consistency in care Approachable staff Baby friendly setting with toys in Children’s Centres Tailored to family needs Translation services Culturally appropriate	More translation services Written material in many languages More Bangladeshi health visitors and support workers One stop shop for all health and social care needs Named Health visitor per family for antenatal care until 1 year (this was also a strong theme amongst EYP, SC and KP workshops) More baby friendly settings Improve organizational knowledge regarding cultural beliefs of families
Accommodation	
Flexibility of appointments/ability to see at short notice Drop-in clinics Home visitor Phone advice	Increase methods of contact – telephone, text, social media Online information in many languages Flexible working – evening and weekend clinics to accommodate working mothers and fathers Out of Hours service Single point of contact for all parents/carers More home visitor
Availability	
Universal services (appreciated by all stakeholders) Targeted according to need Regular clinics both in location and timing	Increase numbers of skill mix staff and extend their role Mobile working More Health visitors (EYP) Limit caseload size to 250 max (KP)

⁴ PENCHANSKY R, THOMAS JW. The concept of access. *Medical Care* 1981;**XIX**(2):127-40

<p>Full time service Responsive service</p>	<p><i>“Health visitors in Tower Hamlets have too many clients, and can only tackle the clients on the enhanced service, but those that are borderline get missed. Then you don't get seen until two years. The eight month check is a bit hit and miss.” (EYP workshop)</i></p>
<p>Accessibility</p>	
<p>Home visits Convenience of GP and CC clinics</p>	<p>Locality focused Health visitors in community settings e.g. schools, PVI settings (EYP) More clinics in Children’s Centres (EYP)</p>

Results from GP survey

Twenty-five out of 28 GP respondents thought that the workload of the health visiting service had increased and 18 out of 25 (72%) cited a reduced workforce as a reason for this. Additionally 23 out of 28 (82%) of respondents thought that lack of capacity to cover workload was the most significant challenge facing the health visitor workforce.

“They are doing the best they can, capably, going beyond the call of duty, extra unpaid hours. Problem is lack of capacity and also consequent lack of continuity with families and with fellow professionals.” (GP survey)

“would have rated excellent in my network as the team work very hard and are great in communicating etc. but focus tends to be on the high risk patients and less time on universal needs due to capacity/ work needs” (GP survey)

Communication between services

From a Service User perspective

Parents and carers discussed how communication could be improved between services.

“There is a communications issue between the midwives, health visitors and GP. The problems between the midwives and health visitors should really be worked on.” (Parents FG)

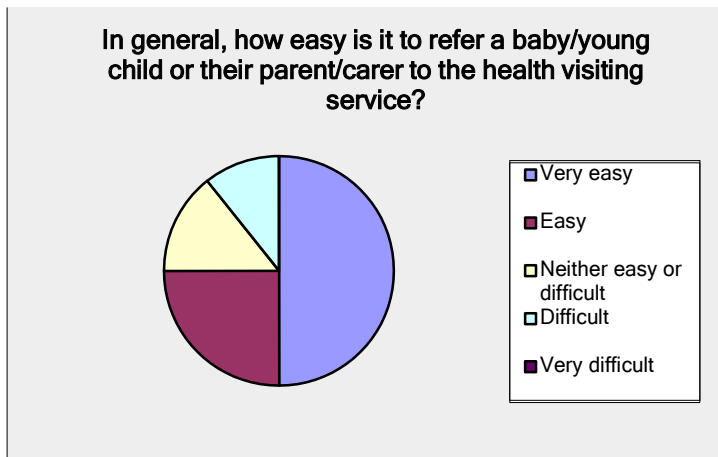
Other service users also raised the issue of poor communication between midwifery and health visitor:

One parent asked if there is a relationship with health visitor and midwives? Is it a blaming relationship, Do they feel united and can support each other? The parent discussed how this is not apparent and the two services could be more united to allow parents to feel more supported. (Parents FG)

From a professional perspective

Many stakeholders raised communication between services as an issue. In general informal communication between health visitors and other professionals occurred when services were co-located and this was viewed positively.

When asked how easy it was to refer into the service 75% of GP survey respondents replied very easy or easy and 22 out of 28 (79%) of respondents said they were very likely or likely to get a timely response if they contacted the service for families with URGENT support needs.



Limitations

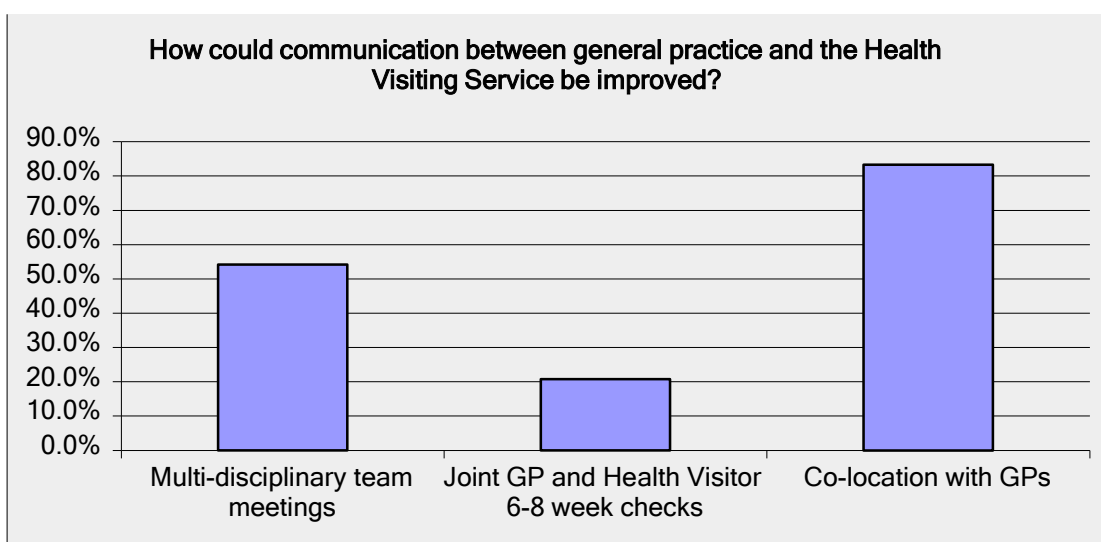
Many professionals described difficulties in contacting the health visiting service, explaining that this could be very time consuming.

Missed opportunity when health visitor telephones and social workers away from desk, as a lot of work will have gone into trying to talk (SC workshop)

Email is the most effective way to get hold of the Health visitor, they are hard to access i.e. you have to call between 8 and 8.30 in the morning. (NGO FG)

Suggestions for improving communication between professionals

GPs survey respondents were asked how communication between general practice and the health visitor service could be improved. The results are shown in the figure below.



Further suggestions came from other professionals:

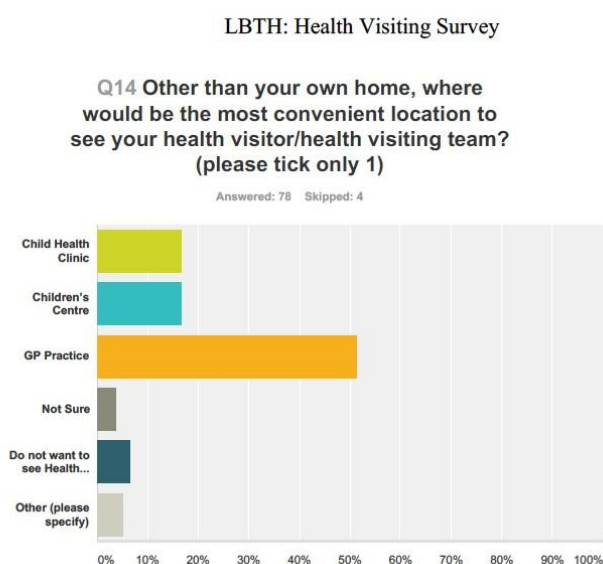
- Identify a named health visitor as a contact
- Centralised contact number
- Establish secure email between health visiting and non-health services.

Location of services

A range of views were expressed about where Health visitor services should be located.

From a service user perspective

All the parents and carers focus groups took place in Children’s Centres and when asked where they would like to see their health visitor many respondents chose Children’s Centres. However, 50% of parent/carer survey respondents replied that their GP practice would be the most convenient place to see their health visitor.



Participants in the focus groups cited the following as reasons for preferring to see their health visitor in a Children’s Centre:

- They meet other families
- Children can attend play sessions whilst they wait
- They are child friendly locations

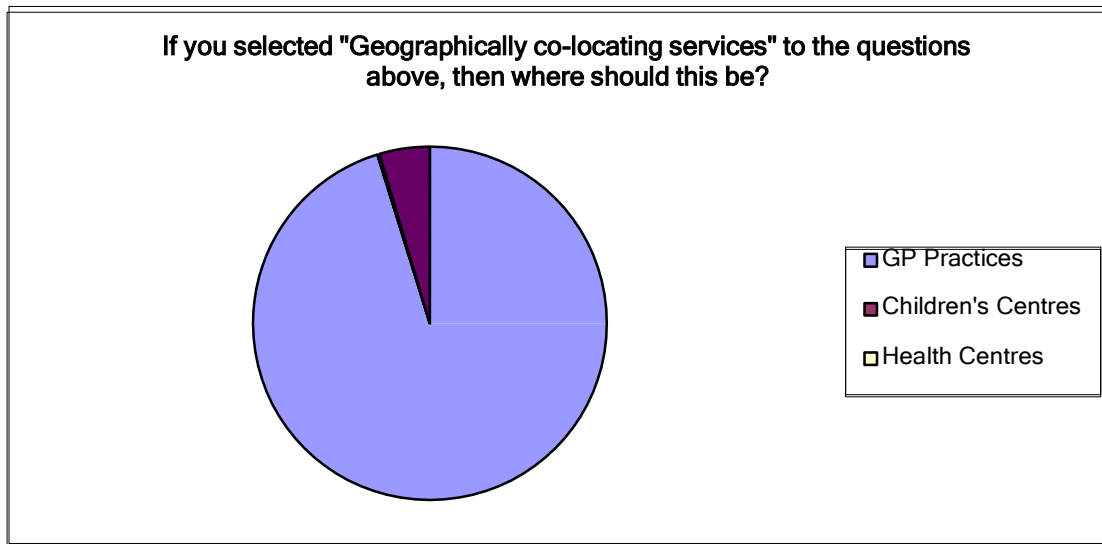
However it was also acknowledged that it was convenient to attend GP surgeries and that it was useful to be able to see a GP at the same time if necessary.

From the perspective of the Health visiting service

Established and newly qualified health visitors and support workers valued practicing from GP surgeries and their links with GPs were highly regarded. Practitioners did not want to lose this close working. Clinical leads wanted more locality working including more alignment with Children’s Centres. They recognised the challenges of doing so within the current service configuration.

From the perspective of GPs

The GP survey asked GPs where they would like health visiting services to be co-located. Twenty-one responded and of these 20 (95%) stated GP practices. One respondent wanted services to be co-located in Children’s Centres.



From the perspective of other professionals

Participants in the EYP workshop really valued a health visitor presence in Children’s Centres:

“Love 2 year reviews in Children’s Centre buildings!” (EYP workshop)

There was a call for health visitors to work in other settings:

“We would like a health visitor monthly or two weekly, to hold surgery at our school” (EYP workshop)

Participants in the EYP and SC workshops thought co-location of their services with health visiting services would improve communication and SC professionals spoke of how it would reduce the time spent *“trying to get hold of”* health visitors.

Partnership

From a professional perspective

It was an aim of all workshops and the NGO focus group to explore how well services currently work together and to generate ideas for more joined up working. Many issues arose and there was much commonality between stakeholder groups as well as some differences. Findings have been tabulated to show the provenance of topics as well as the frequency with which they arose.

Table 6. Valued aspects of partnership working	
Topic	Provenance (Frequency)
Links with other services A large number of stakeholders stated they valued the links that	

<p>the health visiting service has with other services. In these instances the nature of the link was not elaborated on although services were cited as:</p> <ul style="list-style-type: none"> Gateway midwives Children’s Centres Voluntary sector Other services Social care: <i>“We rely on health visitors an awful lot despite knowing there are only a few and they see many families”</i> (SC workshop) 25/28 (63%) of GP survey respondents valued the liaison between health visiting services and social services 	<p>KP (1) HV (3) EYP (5) KP (2) HV (2) KP (1) KP (1) SC (1) GP survey</p>
<p>Signposting and referral to other services This was a very common topic and health visitors were highly regarded with respect to it. Many professionals highlighted this as a top priority when asked what they valued about the health visiting service. Health visitors were explicitly valued for the referrals they made to speech and language therapy (SALT), audiology, breastfeeding and Children’s Centre services such as playgroups. Health visitors and support staff recognised the good liaison they had between services.</p>	<p>HV (1) EYP (5) KP (3) SC (2)</p>
<p>Information sharing with and support from other health services Health visitors and other health professionals valued the support between Health visiting service and the following:</p> <ul style="list-style-type: none"> GPs SALT Psychological services/CAMHS <p>Data sharing with health was also acknowledged as a service strength</p>	<p>HV (4) KP (2) HV (2) HV (1) HV (3) KP (1)</p>
<p>Informal data sharing This was valued by EYPs when health visitor teams operate out of Children’s Centres.</p>	<p>EYP (1)</p>
<p>Interpersonal relationships between professionals This was acknowledged in the safeguarding meeting as an important enabler of joint working which should continue to receive support. Children’s Centre staff also liked forming relationships with health visitors who worked from Children’s Centres.</p>	<p>SG (1) EYP (2)</p>
<p>Joint working with the CAF Social care professionals highlighted the importance of health visitor involvement in the CAF and stated they were key members of the Team around the Child/core group.</p>	<p>SC (3) EYP (1)</p>
<p>Health visitors as expert advisors Early years professionals appreciate health related advice given by health visitors to other services.</p>	<p>EYP (1)</p>
<p>Joint home visits</p>	

Participants described how health visitors carried out joint home visits with EYPs and social care professionals and these were both useful and highly thought of.	EYP (2) KP (1)
Registration at Children’s Centres	EYP (2)
Transition from Health visitor to School Nursing	HV (3)

Areas for improvement

The following emerged as areas where joined up working could be strengthened.

Table 7. Partnership working – areas for improvement.	
Topic	Provenance (Frequency)
<p>Handover between midwifery and health visitor services Participants called for this to be improved (with the exception of handover from gateway services)</p>	HV (4) SG (1)
<p>Better links (unspecified) between health visitor and other services Although many professionals valued the links between services, others called for them to be improved:</p> <ul style="list-style-type: none"> Midwifery Social care Children’s Centres Community paediatrics PVI settings Housing (one health visitor commented on how they were unable to influence housing decisions even though there was local need was great) Third sector 	<p>HV (2) KP (3) HV (3) HV (3) KP (1) EYP (1) HV (1) KP (1) NGO (1)</p>
<p>Better data sharing with non-health services This included sharing more data AND Sharing better quality data consistently including information on sub-threshold families with additional needs. Health visitors highlighted that this also applies to information shared from other services into the health visiting service.</p>	<p>EYP (4) HV (3) SC (1) EYP (4) SC (1) NGO (1)</p>
<p>More joined up working for families with additional needs Including:</p> <ul style="list-style-type: none"> Health visitors to attend more multi-disciplinary team meetings Health visitors to initiate and complete more CAFs Health visitors to take on the lead professional role more frequently 	<p>SC (1) SC (1) EYP (2) EYP (1)</p>

Suggestions for service improvements

These came from all professional groups as indicated.

Organizational level

- Health visiting and Early Years services should share a service vision including shared outcome targets (EYP, KP). Participants in the KP workshop called for service managers to be given the time and resources to be able to do this.

Integration between health visiting and early years services

- Many EYP participants called for joint assessments to be carried out by EYPs and health visiting team members, in particular highlighting the opportunity of an integrated 2 year review. Health visitors wanted a “multiagency approach to the 2 year review” (HV workshop).
- There was a call to link Health visitor caseloads to Children’s Centres to “lighten the load” (EYP workshop)

Co-delivery between services

The following were identified across professional groups as facilitating co-delivery:

- Shared language between health, early years and social care professionals
- “harmonise assessment tools” (EYP workshop)
- One stop health and early years shop
- Shared training sessions across professional groups (EYP, KP) and upskill EYPs in health
- Joint clinics held between midwives and health visitors (HV workshop) and health visiting and SALT and occupational therapy (KP)
- More joint home visits

More joined up services

The following was suggested as promoting more seamless services:

- Joint care pathways for midwives, health visitors and EYP and condition specific pathways between health visiting and other health services (KP)
- Midwifery services operating from Children’s Centre (HV workshop)
- Each social care team to have a named health visitor (SC workshop)
- When asked what would help create a seamless service for families 100% responded ‘having a named health visitor’ (GP survey).

New services

- Practical parenting support delivered by health visiting team skill mix (HV workshop)

Greater understanding between services

- New health visitors to attend Children’s Centre groups as part of their induction programme (EYP workshop)
- Health visitors in other settings e.g. nurseries and ideas stores (EYP workshop)

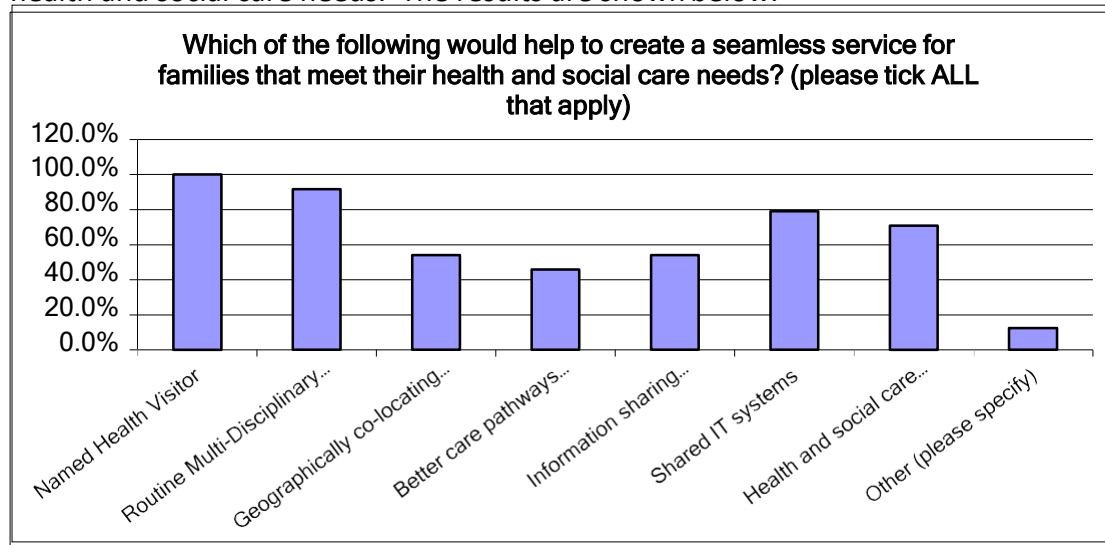
Improved data and information sharing

- Refresh LBTH data sharing agreement and promote widely to all professionals (HV workshop)

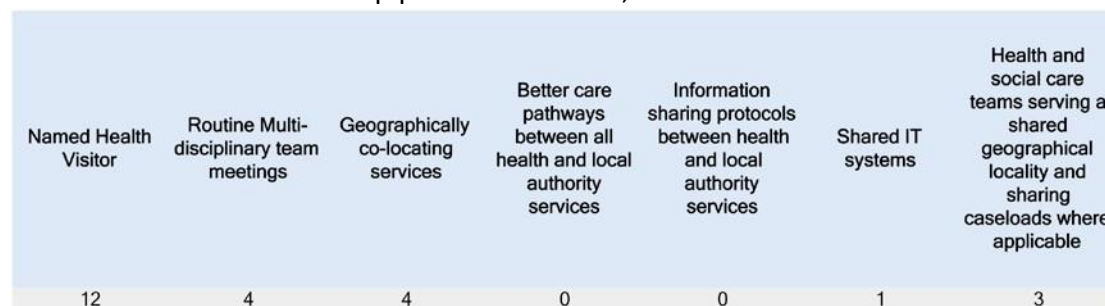
More joined up working for families with additional needs

- Simplify CAF (HV, SC workshops - top priority)
- Multidisciplinary CAF panels (HV and EYP workshops)
- Promote awareness amongst GPs of guidelines regarding what to do with families who ‘do not attend’
- Senior health visitors to attend MDT meetings (SC).

GPs were asked what would help to create a seamless survey for families that met all their health and social care needs. The results are shown below.



When asked what is their top pick of the above, the results are shown below.



Health promotion (primary prevention)

This was a theme that arose in all engagement events with the exception of the Social Care workshop and Safeguarding meeting. It arose fairly frequently and participants in the Health visitor, Early Years Professionals and Key Professionals workshops identified health promotion/education as an important issue. Both health visitors and EYPs highlighted it as a top priority. Health visitors and support workers described what they were already doing:

Health promotion and advice e.g. dental care and immunisations

Healthy advice: Educating and information: housing issue, good hygiene, weaning, Home safety and parents to have facilities for their children's development

Participants in the key professionals workshop wanted health visitors to do more Health Promotion/Health Education and this was also listed as a top priority amongst HV workshop participants, with ring-fenced funding for Health Promotion also being identified as a top priority.

Ideas for Service Improvements:

- Public Health workshops delivered by health visitors in nurseries (EYP)
- More Health Promotion group based work; more community based HP work (NGOs)

- Once a month drop-in clinics giving advice on normal child development and parental health (parent focus group)

Early intervention (secondary prevention)

All professional stakeholder groups emphasized the importance of early intervention and it was listed as a top priority in all workshops and the NGO focus group. Many comments were written about this theme:

Health visitor workshop:

“Early intervention-Heads off problems-builds therapeutic relationships”

“nested within a universal service”

Social care workshop:

“risk identification.....an outcome of contact and relationship building with families”

NGO focus group

“The fact that they can see in the home and mums that are not “presenting” in another setting, this gives a valuable power for early intervention

Seeing in the home is critical.” (NGO focus group)

Early Years Professionals workshop

“Because they see everyone they might pick up on issues and they signpost.”

Key professionals workshop

“Frontline professionals with mother/baby at a critical time who can pick up problems before they escalate.”

All stakeholder groups valued health visitors with respect to early intervention, but there was recognition both within the service and from other professionals that more needed to be done. Home visits were seen as particularly important to this. Participants in the SC workshop wanted earlier intervention for cases of postnatal depression and domestic abuse.

Overall participants believed that an improved health visiting service would do more early intervention.

Ideas for service improvements

- Increase capacity and role of skill mix to allow them to focus more on early intervention (HV workshop)

Information and guidance

A call for more information about LBTH health visiting services was a consistent theme across all stakeholder groups.

Parents and Carers

Many parents and carers were unclear about the services on offer and there was a lack of clarity regarding the health visitor’s role:

“No one knows what a health visitor does” (Parent FG)

Parents and carers highlighted how they were often confused about the roles and remit of different professionals particularly between midwives and health visitors. One mother described how she was not sure whether it was a midwife or health visitor visit her. Other

parents and carers stated how they would like more support in knowing when to go to the health visitor and when to the GP. One parent suggested having a sheet to say when to go to the GP and when not to and possibly some guidance to stop going to the GP unnecessarily.

Very many parents and carers agreed that the service should be promoted to first time parents with clarity about what health visitors do and how and when to access them:

“A call from the HEALTH VISITOR would be helpful with an introduction of themselves, and advice of what will happen next” (Parent FG)

Professionals

Many participants within the workshops and focus groups called for a greater awareness of the health visiting service, both amongst themselves and also for parents and carers. As one stated:

“There are such a huge amount of early years professionals and we don’t know who they are and what they all do.” (KP workshop)

This was recognised by members of the health visitor service who wanted to see their profile raised and highlighted this as a priority for improving services. This included managing expectations by informing service users and other professionals of what the service *“can and cannot do”* (HV workshop).

Professionals wanted a greater understanding of the knowledge and skills of the health visitor workforce as this would support closer working and enhance the interface between services. Some participants in the EYP workshop did not know that there was a skill mix within the service. Professionals also recognised the need to manage expectations:

“Promote health visitor service more widely so parents learn what they can expect from it” (KP workshop)

Ideas for service improvements

From the health visiting service:

- Relaunch the health visiting service to increase profile and recognition e.g. Start for life, ad on TV, mention far more info etc.

From Parents and Carers

- Antenatal contact with a health visitor
- Awareness sessions for parents and carers about health visitor services
- Parents given a schedule of visits and what to expect from health visiting services. This could be included in the red book, which should be given to parents/carers before birth.

Training

Members of the health visitor service explicitly valued the training they received and this was also recognised by KP workshop participants who highlighted the support that newly qualified health visitors receive during their preceptorship period. However there was also a call for more training from all professional groups and for this to be up-to-date, varied and contextually relevant to local needs. In particular SG meeting participants recognised that newly qualified health visitors needed support in dealing with vulnerable families. Key professional workshop participants called for better training for health visitors on breastfeeding.

Ideas for service improvements

From the HEALTH VISITOR service

- More regular training sessions including an increase in access for support workers. Allow practitioners to access teaching sessions across the borough and in neighbouring boroughs where appropriate.
- Develop specialist roles and enable specialists to support and train generalist health visitors
- Standardise some aspects of practice e.g. new birth visit in order to achieve a quality threshold.
- Link in-house training with a local University to ensure that students are being taught consistent practice

From other professionals

- Co- training on data sharing between health visitors, early years professionals and social care (EYP workshop)
- Training in utilising multi agency setting (SC workshop)

Information technology

Information technology was viewed by professionals as both a barrier and an enabler of efficient and joined-up working. This theme came through most strongly from participants in the Health visitor workshop. It was also frequently cited as a service improvement in the Key Professionals workshop.

Members of the Health visitor service and other health professionals (KP workshop) valued sharing information amongst healthcare staff (particularly community midwives) using the EMIS system, which is also used by GPs. However it was noted that this system did not always work well and could be slow.

Limitations

From the perspective of the health visiting service:

Health visitors described how the current IT arrangements impacted on workflow and caused inefficiencies. One group described them as *“not fit for purpose”* (HV workshop). Health visitors do not have mobile phones or laptops and are not able to input or retrieve data remotely although the majority of their work is conducted away from their base. When asked about service improvements one comment was:

“appropriate tech to be able to do our jobs” (HV workshop)

From the perspective of other professionals

Other professionals recognised the limitations of the current IT system especially the lack of interoperability between systems used by different agencies. They highlighted that this:

- Adversely affected the number of common assessment frameworks (CAFs) that were either initiated or completed by members of health visitor teams. Participants in the EYP workshop thought that this was in part due to health visitors having to enter data into 2 systems which is very time consuming.
“Transfer of data is problematic and health visitor assessments in EMIS, which are CAF compliant, could, but are not currently able to be transferred electronically.”
 (Safeguarding meeting)
- Inhibited information sharing between agencies, although it was also recognised that professionals needed explicit guidance as to what data could and could not be shared and when.

Professionals also stated that it was difficult to share real time information with health visitors as they did not have access to the same secure email system.

Suggestions for service improvements

Nearly all groups within the HV workshop proposed IT solutions as ideas for service improvements with many earmarking them as top priorities. The following suggestions originate from the HV workshop unless otherwise indicated.

- Robust commissioning around IT and investment in the Child Health Information System and EMIS
- Laptops or tablets and mobile phones to support mobile working
- Interoperability between health and local authority IT systems
- IT to support routine transfer of CAF data between agencies (SG meeting)
- Secure email between health and other agencies (SC, EYP, KP)
- Access to EMIS support

Resource

Service funding was not frequently raised as an issue in itself, but many references were made both by parents/carers and all professionals about a lack of availability of and a need for more health visitors and support workers (see Accessibility section). Some participants highlighted that a lack of staff resulted in the service only having the capacity to deal with the most needy families leaving a gap at the universal plus tier (NGO FG). Members of the health visiting service also called for more resource to be put into estates, IT, facilities and administrative support.

Management

Participants from all workshops and the NGO focus group identified management issues.

Comments on current management practice:

These mainly came from health visiting service practitioners:

- Health visiting service practitioners valued their clinical supervision and the role of practice educators and mentors
- Frontline practitioners highlighted the following management issues:

- Staff feel disconnected from management and would like more transparency and communication between management and front-line staff. This includes more information about the service e.g. current establishment.
- Staff feel disempowered to lead and there is a suggestion that team leaders and band 7s were not given enough authority
- All professionals identified that there was a high turnover of staff
- When asked to comment on what could be done to make the Health visitor service better, 5 GP survey respondents highlighted that management appeared “distant” to front-line staff and there was a perception that they were not adequately supported.

Understaffed and staff poorly supported by their management so massive and demanding workload cannot be managed as well as they would like. (GP survey)

Service Improvements

The following were mainly identified within the HV workshop unless indicated otherwise:

- Clear vision and leadership (all)
- Health visitor roles and responsibilities including skill mix explicitly defined (all)
“not jack-of-all-trades” (HV participant)
- Shared vision and outcomes between services
 - Link with family wellbeing model (social care and safeguarding)
- Outcome based service (KP, EYP and HV)
 - Outcomes to be qualitative as well as quantitative
 - Evidence based
- Frontline staff represented at management level (HV workshop)
- Increased capacity at management level to support and implement change

Participants in the HV workshop identified the following as supporting delivery of care:

- Caseload management which adjusts caseload size according to underlying need and case complexity
- Skill mix – increase capacity and role of support workers
- Development of specialist roles
- Increase in workforce
- Better recruitment and retention of staff (also discussed in the KP workshop)
- Empower staff to be professionally autonomous (SC workshop)
- Increase time for training/mentorship and reduce caseload of specialist practice teachers and mentors

Safeguarding

Safeguarding was discussed within all the workshops and the NGO focus group. Additional information about this topic has also been gathered from a LBTH safeguarding meeting. The word safeguarding was a commonly used term amongst all stakeholders.

The role played by health visitors in safeguarding was valued highly by all professionals, in particular the benefit to safeguarding that home visitor brings.

Comments on the existing service and areas that were valued were as follows:

- Health visitors have a key role in safeguarding as they are recognised as being non-threatening to families, which facilitates access to the home environment.
If a statutory authority needs to come into the home, parents can be defensive and on their guard; and they can disguise themselves.
- This was reiterated by members of the health visiting service:
Safeguarding is non-threatening and more likely to disclose to health visitors. Open and honest relationships in safeguarding, health visitors are consistent after family crisis times, clients value health visitors in these times. (HV workshop)
- Health visitors were recognised for their *contribution* towards child protection plans, working closely with social workers
- The role of health visitors in early identification of problems through comprehensive needs assessment was discussed in several workshops. The impact this has on safeguarding was widely recognised both through helping to address problems before they escalate and also by ensuring the timely involvement of multi-agency services.
- There was a desire to keep the Child Protection hotline

Limitations

- There is a strong pull from Social Services for further Child Protection involvement, wanting a ‘stronger’ role for health visitors in Child Protection and health visitor home visits being recognised as ‘formal’ Child Protection visits. Participants in the Social Care workshop wanted health visitors to carry out the role of the core group. They also called for health visitors to feel more confident in holding ‘high risk’ cases.
- The Safeguarding meeting discussed risk assessment tools in some depth, CAF and Signs of Safety (SOS). The level of need required may not reflect a safeguarding issue. There is interest in using SOS and it is in the early stages of being rolled out in GP practices. It is unclear, however, if this is being used systematically or ad-hoc. If this system were to be used then there would be a need to think about other details needed, and when to use a CAF. However it was suggested that until SOS was used by the local authority as a local intervention model, it would be difficult to progress further. It was indicated that this was about levels of need and identifying risk; in any new system it would need to be clear when it was more appropriate to do mapping and SOS, and when to use the CAF.
- Some members of the HV workshop found the CAF time consuming to complete. There was a general call to make safeguarding less “*time consuming*” overall.
- Participants in the Social Care workshop called for health visitors to be given more safeguarding training, in particular for physical abuse and also more support for newly qualified health visitors in their preceptorship period.
- It was suggested that although health visitors are notified of emergency department attendances there is not a structured process for risk assessment from these notifications.
- There was a suggestion that safeguarding could be improved by sharing data in nursery schools.

The 4 tiers of service

Information gathered during the stakeholder engagement exercise built a picture of current services, which are described in Table 8. This is not an objective evaluation of service provision, rather a high level description of each service tier based on stakeholder findings. It highlights issues that commissioners may want to consider when commissioning future health visiting services.

Service Tier	Stakeholder findings on current services	Considerations for future commissioning
<p>Community Offer</p> <ul style="list-style-type: none"> i. Building community capacity with local partners to support families support the health and wellbeing of their children aged 0-5. ii. Champion health promotion and support reduction in health inequalities 	<ul style="list-style-type: none"> • Stakeholders reported that the community offer is currently limited within LBTH • Health visitors have built good links with GPs and CCs 	<ul style="list-style-type: none"> • There was recognition that more could be done to champion health promotion at the community level and in general health visitor practitioners welcomed this • Findings suggested that the HV service could build more links with community services
<p>Universal</p> <ul style="list-style-type: none"> iii. Health and development reviews iv. Advising on best practice in health promotion in the early years of childhood v. Screening vi. Immunisation (advice) vii. Promotion of social and emotional development viii. Support for parenting ix. Reducing hospital attendance and admission x. UNICEF community Baby Friendly accreditation 	<ul style="list-style-type: none"> • New birth visit, 6-8 week check, 1 and 2.5 year development reviews offered and delivered. The service is considering how to implement a universal antenatal contact. • Health promotion delivered as part of routine contact with families. • Screening and immunisation advice identified as a service delivery by members of the HV service. • Members of the HV service highlighted the work they do in promoting social and emotional development and providing parenting support. This was valued by parents/carers and professionals. • UNICEF Baby Friendly status achieved 	<ul style="list-style-type: none"> • Parent and carer participants highlighted that clinics can have long waiting times and be very busy. Other stakeholders highlighted heavy health visitor workloads. • Better links with midwifery are needed to support the implementation of the antenatal contact and avoid duplication • All stakeholder groups identified the importance of health promotion and called for more. Suggestions were made for standalone health promotion sessions. • Greater integration of health visiting and early years services may support the delivery of developmental reviews.
<p>Universal Plus</p> <ul style="list-style-type: none"> xi. Responsive care at time of need xii. Early identification of developmental and health needs 	<ul style="list-style-type: none"> • Stakeholder findings suggest that provision at the universal plus tier is lacking due to capacity shortage and a need to concentrate resources on 	<ul style="list-style-type: none"> • A lack of continuity of care was considered to be detrimental to clients with additional needs • Stakeholders called for a different use of

<p>and signposting/onward referral if indicated</p> <p>xiii. Parenting support</p>	<p>families with the highest needs.</p> <ul style="list-style-type: none"> • All stakeholders recognised the contribution of health visitors in early identification and referral. • Health visitors and support workers offer parenting support on an individual client basis. Parenting/family support was identified as a local need by stakeholders as was emotional health and postnatal depression. These could be supported at the Universal plus level. 	<p>skill mix within the service to free up health visitors time for families with additional needs.</p> <ul style="list-style-type: none"> • Better links between services, including better data sharing, is likely to further support Universal Plus families • Development of specialist roles was welcomed by the Health Visitor service and could support UP needs.
<p>Universal Partnership Plus</p> <p>xiv. Identifying vulnerable and complex children</p> <p>xv. Establishing appropriate safeguards and interventions to decrease risk to the child and improve future health and wellbeing</p> <p>xvi. Working with other Agencies for children/families requiring intensive support</p> <p>xvii. Comply with statutory duty to share information and communicate with other agencies and health professionals when there are safeguarding concerns.</p>	<ul style="list-style-type: none"> • Established links with gateway midwifery services to identify and support vulnerable pregnant women • Health visitors work as members of multi-agency teams for families who reach safeguarding thresholds • Home visiting was recognised as particularly valuable to safeguarding 	<ul style="list-style-type: none"> • Although the role health visitors play in safeguarding is highly valued there is a call for them to do more • Newly qualified health visitors need additional support with safeguarding issues • There is a need to streamline safeguarding including use of risk assessment tools

Conclusion

Phases 1 and 2 of this stakeholder engagement project have generated great insight into health visitor services in LBTH. Health visitors and members of the wider skill mix team are highly valued and recognised for the unique and vital role they play in supporting families with young children in the borough. The health visiting service is regarded by stakeholders as essential to supporting the physical, emotional, developmental and wellbeing needs of children aged 0-5 and is at the centre of health, local authority and voluntary sector services that serve the early years population.

This project was commissioned to inform the future commissioning of LBTH health visiting services. The findings from Phases 1 and 2 have identified several priority areas for future service development.

Capacity

The findings suggested there is a need to increase frontline and managerial capacity to support delivery across all 4 tiers of service. Areas to consider include⁵:

- A change in skill mix to include an increase in support workers
- Extending the role of support workers
- Resourcing and implementing technologies to support mobile working
- Improving current IT infrastructure
- Increasing administrative support

Access

In general there was a call for health visiting services to be more accessible to service users and other professionals. Suggested initiatives to improve access could include:

- Flexible opening hours including evenings and weekends
- Increasing the number and type of locations for services without losing current links with general practice.
- Availability of drop-in and booked appointments
- Telephone advice line
- Named or single point of contact for service users and professionals
- Online services
- More use of translation services

Continuity of care

There was agreement amongst many stakeholders that service users would benefit from continuity of care, ideally seeing the same health visitor each time at least for the first year of life.

Links with other health and early years services

Findings suggested that links between services could be strengthened. Suggestions for improvements include:

- Developing a shared vision between health visitor and early years services

⁵ The expansion of the health visitor workforce under *A Call to Action* trajectories is not considered here as this is not within the scope of this project.

- Locality working
- Co-delivery/integration of health and early years services
- Joint working between different services such as midwifery and health visitor
- Improved data sharing between services supported by interoperable IT systems

Support for quality and consistency of care

Participants told us that areas to consider include:

- Building on current training, preceptorship support and clinical supervision opportunities
- Development of specialist roles
- Agreement on and use of clinical standards

Promote understanding of Health visitor services

This will benefit service users who told us that they did not know enough about the health visitor service and help support the appropriate and timely use of services.

The above issues impact across all 4 tiers of service provision. Findings also identified tier-specific issues that are of relevance to future commissioning.

Community

This appears to be lean with not much current activity

Universal

High caseloads and a lack of capacity are resulting in busy clinics with long waiting times. The service is looking to implement a universal antenatal contact.

Universal Plus

There is a suggestion that families with additional needs would benefit from more input from the health visitor service.

Universal Partnership Plus

Stakeholders highlighted a need to strengthen the role of Health visitors in safeguarding and streamline processes.

Stakeholder findings from Phases 1 and 2 were used to identify priority areas for discussion in Phase 3. A summary of these discussions is given in the next section.

Section 2

Phase 3: Summary Report

Introduction

The purpose of Phase 3 was to feedback Phase 1 and 2 findings to stakeholders who took part in any of the engagement events and other key stakeholders who were unable to attend these initial events. After discussion with LBTH Public Health commissioners it was also decided to use Phase 3 as an opportunity to progress ideas for service developments generated from the discovery phase findings.

Engagement Process

All attendees of Phases 1 and 2, and some key stakeholders who had been invited but were unable to attend, were invited to the Phase 3 workshops. Overall 55 people attended one of 2 workshops. The workshops comprised of:

- A presentation on the new National Health visitor Service Specification
- A high level report back of Phase 1 and 2 stakeholder engagement findings
- A presentation on future service design and configuration including models of innovative practice occurring elsewhere e.g. the Brighton commissioning model.

Attendees were asked a series of set questions on topics that were identified as priority areas by public health commissioners based on stakeholder findings.

1. How do we strengthen the role of the health visitor in community engagement and development?
2. What do we need to do to fully implement the antenatal contact?
3. How do we strengthen the integration of the health visiting service with primary care and children's centres?
4. How do we improve the capabilities, capacity and competencies of the health visiting service?
5. What do we need to do to offer a more intensive service for high needs families?

A summary of the discussions generated on each topic is presented below.

How do we strengthen the role of the Health Visitor in community engagement and development?

Currently there is only limited community engagement carried out by the HV service within LBTH. The majority of Phase 3 participants welcomed the idea of doing more although a few voices called for a greater understanding of why this was necessary.

Participants discussed the form that future community engagement and development could take and many ideas were generated that ranged from a strategic approach:

“It’s not about being in the community but working with community agencies.”

to a more service delivery orientated approach such as health visiting teams carrying out health events.

How to do community engagement and development emerged as an iterative process:

Embedding

Many participants believed that geographical (locality) working would strengthen links with other early years and community services. This would support HV practitioners to develop local community networks. There were suggestions that HVs should work in joint teams with other services e.g. Children’s Centre teams to strengthen their presence in the community. However, participants were also clear that clarification was needed around the roles and agendas of the health visiting service and other services to support dovetailing and avoid duplication.

Community profiling

“Health visitors need to get back to being out on the ground – profile the community to identify local public health issues to address”

Many participants highlighted the role of health visitors in helping to build a picture of local needs that could be used to help strategically plan services and support the development of community assets.

Emerging community role

There were many suggestions about how the Health Visiting service could ‘do’ community engagement and development.

Settings – there was a call for health visitors to provide services in community settings such as ideas stores, nursery schools and supermarkets to increase their community presence. Several local markets were cited as community assets where health visitors could practice from if suitable facilities were available e.g. within a healthcare setting in Crisp Street Market.

Participating in local community events – several participants thought health visiting teams could attend local community events to promote their services and deliver public health messages to the community.

Partnership working – suggestions were made for health visitors to co-deliver services with community groups e.g. HVs to attend community play sessions to offer ad hoc support to parents.

Advocacy – health visitors should advocate for families with wider needs e.g. housing and help harness community assets to meet these needs.

Enablers

It was widely recognised that enablers were needed to support health visitors fulfill a community role:

Capacity – there was recognition that practitioners would need time to carry out community engagement. This could be challenging within current service capacity.

Shared vision – between services to promote community working.

Widespread dissemination of information – to families to tell them what services are available to meet different support needs and help them navigate through services.

What do we need to do to fully implement the antenatal contact?

Participants discussed the format the contact should take, what should happen within this contact, access, links with midwifery and the logistics of delivering an additional universal contact.

Format

Many suggestions were made as to what format the antenatal contact should take and no single preferred option emerged. Some participants preferred face-to-face contacts whilst others suggested telephone consultations. Another suggested method was a virtual contact (Skype). When discussing face-to-face contacts, many participants thought this should be a home visit as it presented an opportunity for risk assessment and early intervention if appropriate. A home visit could be confined to first time mothers only and other forms of contact used in subsequent pregnancies. It was noted that HVs currently see women antenatally if they are deemed vulnerable, but a universal antenatal contact will help identify 'borderline' mothers.

When asked when the antenatal contact should take place, participants suggested it should be later on in pregnancy (26 to 32 weeks).

Content

Discussions were focused around what should take place in the antenatal contact. Ideas for content included:

- Information about health visiting services; although many participants thought this could be given out in leaflets or online
- Public health messages
- Advice on bonding and attachment

It was also acknowledged that some families might need more intensive support and referral onto other services.

Participants also discussed the usefulness of standardized tools and guidelines in the antenatal visit.

Access

Discussion took place regarding how to make the antenatal contact as accessible as possible, including to fathers. Apart from home visits participants thought face-to-face contacts could take place in antenatal clinics and parenting classes. There was wide

agreement that a different approach would be needed for hard to reach families who do not present in routine settings but this was not elaborated on.

There was acknowledgement that the service had to be flexible to support working mothers and fathers (evening and weekend availability). There was also a wish for there to be continuity of health visitor from this initial contact onwards.

Links with midwifery

These need to be strengthened to include better data sharing, more joined-up working/co-delivery between midwifery and health visiting and for a greater mutual understanding to be developed between these services. Participants were clear that there is a risk of duplication and were keen for this not to happen.

Logistics

Questions raised included:

- How to alert the HV service about pregnant mums?
- How to increase capacity in the HV service to deliver the antenatal contact?
- Who will have overall responsibility for joint midwife/HV working?

No clear answers emerged to these questions.

How do we strengthen the integration of the Health Visitor Service with Primary Care and Children's Centres?

The discussion is often about the most appropriate setting i.e. immunisations in a surgery and two year reviewing children's centres and different settings have pros and cons.

The clear definition of the health visitor role within the various setting maximises the best use of their skills and even more so alongside fellow colleagues. Clear pathways also benefit the HV role.

Location issues can be overcome by linking a health visitor to a location and with joint GP/HV meetings and models of working such as Team Around the Child and Multidisciplinary Team meetings, bring professionals together and promote integration into both GP surgeries and Children's Centres.

2 -year checks at children's centres are good practice to build on and further joint clinics can work in community settings or children's centres. However it is more challenging to integrate with a children's centre than a GP surgery.

There are examples of successful health visiting in children's centres and this can be copied elsewhere. Bromley-by-Bow was cited as a model of good practice where all relevant services are in one location. However GP premises can also be a barrier to co-location.

There needs to be strong leadership, a shared vision and borough-wide planning to address fragmentation.

The new service specification and commissioning could include the combined use of facilities.

As ever the effective sharing of information and IT are critical to success.

How do we improve the capabilities, competencies and capacity of the Health Visiting service?

Capabilities and competencies

Three areas to focus on came through strongly – leadership, increasing knowledge and skills, and supporting high quality practice.

Leadership

- There was a call for health visitor representation at senior levels of management to ensure that the service remains visible to senior decision makers
- Desirable for health visitor service leaders to retain a clinical role as they will be more aware of ‘on the ground’ competency issues and be able to detect gaps in competencies in frontline workers
- Service leaders to be further supported in their management training needs
- Support leaders to act as role models
- Establish a new leadership post dedicated to training

Increasing knowledge and skills

- Conduct skills and learning needs audit in order to focus training on learning needs
- Soft skills e.g. communication skills need to be developed as well as increasing knowledge
- Regular training to be accessible to all
- Protect time for learning
- Specialists to teach generalists
- Regular appraisal and practitioners to have professional development plans
- Build on current supervision and mentoring
- Develop HV specific learning and competency frameworks that practitioners can work to
- Practitioners asked to demonstrate achievement/competency following training events

Supporting high quality practice

- Consider developing minimum standards and standardize some clinical processes
- Support innovation to happen from the ‘bottom-up’ and allow time for change to bed in. Support a no blame culture to allow practitioners to take risks
- Minimize practicing in isolation through bolstering team working. This will help practitioners learn from others and also help build reliance.

Capacity

Participants discussed how the service capacity could increase by changing the profile of health visiting teams. There was general agreement that more support workers (community nurses and nursery nurses) were needed as well as more qualified Health Visitors.

Suggestions were made to increase administrative support to managers and frontline practitioners, as this will free up their time. There was a call to increase the number of

service leads to at least 4 locality leads. Streamlining services with other early years services may reduce duplication and free up capacity.

Recruitment

There was an acknowledgement that the service needed to recruit more staff by headhunting early in Universities for newly qualified Health Visitors and by developing support workers to become Health Visitors.

Retention

Many participants cited this an issue. However they also recognised the unique appeal of LBTH and many suggestions were made as to how these could be capitalized on to both recruit and retain staff. In particular reference was made to the appeal of LBTH as a diverse community which was well served by services and hence offered opportunities for interesting and innovative working. There was recognition of a need for more structured career progression. The chance to develop specialisms and undertake secondments in other workplaces were highlighted as attractive propositions which were thought would promote staff retention.

Heavy workload and lower pay in comparison to other boroughs were given as reasons as to why staff left the service in LBTH.

What do we need to do to offer a more intensive service for high needs families that do not meet the threshold for statutory services?

An over-riding summary of what to offer could be

“A more robust universal service from antenatal and focused on the first year = better engagement for vulnerable families. Offer standard review appointments at children’s centre play sessions. “

Initially the service must identify needs. The service should find a better way of identifying ‘high need’ or ‘borderline’ families and to be clear about who the vulnerable groups are and the social care thresholds. The service should also include mental health competencies, it could also benefit from specialist knowledge around attachment and Speech and Language. This argument could extend to specialist roles.

There are common tools and methods to support these families, which should be further exploited: TAC/lead professional, SOS, CAF, MDT, Family Wellbeing Model and the Meach Parenting Programme. As well as structured methods there should be joint appointments, stronger networks of professionals and core locality based teams. And a stronger relationship with social care.

Regarding working near the social care threshold there should be clear guidance from statutory services regarding further concerns and the health visitor should have the competence, experience, confidence and rigour to question, challenge and confirm. There are unrealistic recommendations from social care for some families who do not meet thresholds for statutory services. And therefore all professionals need to have a very clear understanding of thresholds and who is responsible for what. For higher need families,

responsibilities should be clearly defined with an explicit framework about who is doing what? And who is the key person?

There are risks within the workforce that the majority of current health visiting recruits have limited experience and therefore in the short term there are too few experienced health visitors to deliver more intensive programmes of support for higher needs families. There should be more training for junior health visitors.

The role of the health visitor

- The health visitor should understand the context in which the child/mother live- within family relationships, within community e.g. couple issues. And be able to recognise isolated mothers
- The health visitor is the lead, who pulls together all 'views' of child/family and identifies concerns and makes referrals and is identifiable to all of 'us'

It was stressed that the service must have two more Clinical Leads, giving LBTH four in total, one to cover each locality.

