



Equality Analysis

Health Visiting Programme

DH INFORMATION READER BOX

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

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Introduction

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general equality duty does not specify how public authorities should analyse the effect of their existing and new policies and practices on equality, but doing so is an important part of complying with the general equality duty. It is up to each organisation to choose the most effective approach for them. This standard template is designed to help Department of Health staff members to comply with the general duty.

Please complete the template by following the instructions in each box. Should you have any queries or suggestions on this template, please contact the Equality and Inclusion Team on 020 7972 5936 or aie@dh.gsi.gov.uk

Equality analysis

Title: Service vision for health visiting and the Health Visitor Implementation Plan

Relevant line in [DH Business Plan 2011-2015](#): see pages 21 and 22 of DH Business Plan 2011-15 for full sections on health visiting.

What are the intended outcomes of this work?

The Government has made a commitment to deliver an extra 4,200 health visitors by 2015.

The service vision for health visiting in England and the Health Visitor Implementation Plan (Feb 2011) set out a vision and programme of action to expand and transform health visiting services to maximise the potential of their role to support children and families and to build and use the resources of local people and communities to improve health and wellbeing.

In April 2012, the first implementation year of the new service vision was completed having been undertaken by 26 Early Implementer Sites located across England. A second wave of sites were announced in May 2012 in order to further progress roll-out. The Health Visitor Programme has explored different aspects of equality in relation to the health visitor workforce and the receivers of services – children, families and communities - over the course of 2011/12 in line with legislative requirements and with the benefit of a growing evidence base from Early Implementers and Programme stakeholders.

Who will be affected?

The health visiting workforce, children, parents and families - particularly women and socio-economically disadvantaged children.

Evidence

What evidence have you considered?

In evaluating the potential impact of the service vision for health visiting in England and the Health Visitor Implementation Plan on those with protected characteristics we have made reference to the following sources of evidence:

- The Impact Assessment and Equality Impact Assessments for the Public Health White Paper, 'Healthy Lives, Healthy People'. Published by The Department of Health, November 2010. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122242.pdf
- the Equality Impact Assessment for Getting it Right for Children & Families Maximising the Contribution of the Health Visiting Team through Ambition, Action & Achievement (published by DH October 2009 – **insert weblink**)
- Pudney, S and Shields M A (2000) Gender and Racial Discrimination in Pay and Promotion for NHS Nurses, *Oxford Bulletin of Economics and Statistics*, 61 Special Issue, Blackwell Publishers Ltd., Oxford.
- Barlow, J., Schrader McMillan, A., Kirkpatrick, S., Ghante, K., Smith Thomas, M., Barnes, J., (2008) *Health-led Parenting Interventions in Pregnancy and Early Years*, DCFS, London

- Beishon, S., Berthoud, R., and Hagell, A. (1995) *Nursing in Multi-Ethnic NHS*, Policy Studies Institute, London
- Finlayson, L. and Nazroo, J. (1997) *Gender Inequalities in Nursing Careers*, Policy Studies Institute, London
- Smith, A., Allan, H., Henry, L.W., Larsen, J.A., and Mackintosh, M. (2005) *Valuing and Recognising the Talents of A Diverse Healthcare Workforce*, European Union, Royal College of Nursing, University of Surrey, The Open University, London
- Watson, R., Manthorpe, J., and Andrews, J. (2003) *Nurses over 50: options, decisions and outcomes*, The Policy Press, London
- National Survey of NHS Staff, Department of Health 2006
- Healthcare Commission (2007a), *Primary Care Trust Staff Survey*
http://www.healthcarecommission.org.uk/db/documents/Staff_survey_2006_PCTs_key_findings_tagged.pdf access March 2008
- Healthcare Commission (2007b) *Mental Health & Learning Disability 2006 Survey*
<http://www.healthcarecommission.org.uk/healthcareproviders/nationalfindings/surveys/healthcareproviders/surveysofnhstaff/2006.cfm> accessed March 2008
- Healthcare Commission (2007c) *Acute Trusts Staff Survey*
http://www.healthcarecommission.org.uk/db/documents/Staff_survey_2006_Acute_trusts_key_findings_tagged.pdf accessed March 2008
- Healthcare Commission (2006a), *National Survey of NHS Staff 2005: Summary of Key Findings*, Commission for Healthcare Audit and Inspection, London. Healthcare Commission (2006b) *National Survey of Staff 2006*, Healthcare Commission, www.healthcarecommission.org.uk
- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074258
- National Statistics. Children looked after in England 31 March (2007) DCSF, London
- Care Matters, Transforming the Lives of Children and Young People in Care. (2007) DCSF, London

Input from Health Visitor Programme Delivery Partnership Group (which consists of members from the NHS, social care, the independent sector, other Government Departments and Sure Start Children's Centres) at their meeting on 11 January 2012. Group work covered how to achieve a universal service while identifying and supporting vulnerable and hard to reach families. It explored current local practice and appropriate and effective national levers for change.

Disability

Workforce

There is currently limited data available on the number of disabled qualified nursing, midwifery and health visitor staff. We are therefore not able to make meaningful comparisons between health visiting and other parts of the nursing workforce in relation to disability. As of May 2011, approximately 2% of all health visitors in England disclosed that they suffer from a disability. The same figure was reported across all Strategic Health Authorities.

As part of Programme evaluation (which we are committed to do as part of our overarching Impact Assessment as well as the Health Visitor Implementation Plan) we will monitor the profile of the health visitor workforce and – working with relevant partners and equality leaders – adapt our approach as appropriate should inequalities begin to emerge.

Service Provision

As well as setting out the universal Healthy Child Programme, the Service Vision for health visiting defines additional services, including services for families with a disabled child. Health visitors will have a key role to play in identifying needs and providing additional care programmes and ongoing

support.

Health visitors should routinely advise on mental health issues in respect of children and parents. They will also routinely signpost and/or refer to more specialist services where appropriate. Increased numbers of health visitors and an empowered, focussed service will result in those families in greatest need of this advice receiving it.

Failure to meet the health needs of children and young people can lead to problems or difficulties in the future and have a profound impact on their adult health. The principle of 'early help' is crucial to identifying need and establishing appropriate support to avoid crisis, health visiting services are crucial to delivering the 'early help' offer (<https://www.education.gov.uk/publications/standard/Childrenandfamilies/Page1/CM%208062>). Early help is part of the core offer in the 'service offer' and the model encourages local services to adopt this fundamental approach to ensure delivery needs of the most vulnerable young people are met. This approach will encourage joint working with key partners including social care.

Sex

Workforce

The health visitor workforce is predominately female. As of September 2010, in England there were 9,995 female health visitors compared to only 101 male health visitors. Thus, approximately 99% of health visitors are female. This ratio of male to female health visitors is seen across all Strategic Health Authorities. Only registered midwives have a lower ratio of male to female staff with 99.6% of the workforce female in September 2010.

It is worth noting that to qualify as a health visitor, one must first be a qualified nurse or midwife, so the health visitor workforce is significantly influenced by the demographic make-up of those professions.

There is evidence of women experiencing gender discrimination in the wider nursing profession, for example:

- Male nurses are more likely to be found in higher grades than female nurses and this pattern has persisted over time (Finlayson and Nazroo, 1997)
- Some studies suggest that difference in working patterns may put female nurses at a disadvantage in comparison to their male counterparts (Care Matters, 2007). However, others suggest that taking into account working patterns, male nurses still do better than their female counterparts (National Statistics, 2007)
- Discrimination in terms of gender and age may be amplified over time, for example male nurses achieve promotion at a younger age than their female counterparts, and therefore are likely to have earned significantly more at retirement age (Pudney and Shields, 2000).
- Equal pay for equal value continues to be an issue with female nurses likely to earn less over their life course as a nurse than their male counterparts (Care Matters 2007)
- While some data sources identify little difference in access to and take-up of training courses (National Survey of NHS Staff, Department of Health 2006)
- other sources suggest difficulties in accessing opportunities such as getting time off, getting fees paid, being told about courses (Care Matters, 2007) and (Barlow et al, 2008).

The Service Vision and the Implementation Plan propose initiatives to increase numbers of health visitors regardless of gender. We need to ensure that recruitment to the profession targets all eligible individuals, regardless of sex. As part of a national recruitment drive to attract nurses to the profession, we are working with marketing colleagues to mitigate the low proportion of males in the workforce, including use of materials that include case studies from existing male health visitors.

As part of Programme evaluation (which we are committed to do as part of our overarching Impact Assessment as well as the Health Visitor Implementation Plan) we will monitor the profile of the health visitor workforce and – working with relevant partners and equality leaders – adapt our approach as appropriate.

Service Provision

The key issue emerging in service provision on gender equality focuses on parental engagement with health visitors and, in particular, fathers.

The universal Healthy Child Programme, which will be delivered by health visiting teams, identifies the need to ensure that all children and families are supported. This support will be provided to mothers and fathers alike. Health visitors will work with and in Sure Start Children's Centres, which often offer support to encourage fathers to get involved in child play and development.

The policy intention is to improve health outcomes by ensuring continuation of universal health visiting provision, offering family health services with more extended contracts to support new families and a range of interventions for those with greater needs, championing wider health and wellbeing, prevention and public health and building family and community capacity. This is likely to have a particular impact on women (and pregnant woman) and socio-economically disadvantaged children.

In addition, health visitors are identified as key professionals delivering the Mental Health Strategy, which emphasises the importance of early help for children and parents experiencing mental health difficulties.

We have a gender mix on our task groups and partnership groups, additionally our Stakeholder Forum has representation from the Father's Institute and 4Children. As we progress towards full implementation of the service offer to families, we will ensure publicity materials are tested and developed with male and female audiences to ensure their appropriateness.

Race

Workforce

Nationally, approximately 85% of health visitors (of whom the ethnic group is known) are white. The next most common ethnic groups are Black (7%) and Asian (2%). All qualified nursing, midwifery and health visiting staff in 2010 were more likely to be white than from any other ethnic group. However, compared to other nursing and midwifery professions, health Visitors have proportionately higher numbers of staff from ethnic groups other than white. This is seen across all Strategic Health Authorities with the exception of London, which has a significantly higher proportion of health visitors who are Black or Black British compared to what is seen nationally and across all other Strategic Health Authorities. In London, 34% of the health visiting workforce (of whom the ethnic group is disclosed) are Black or Black British and 52% are white.

Through our ongoing work with Strategic Health Authorities, we are aware that some areas are addressing racial workforce balance locally in partnerships with universities. Our marketing and publicity materials illustrate health visiting as a profession for all racial backgrounds and our Service Vision case studies describe services from all parts of the country, serving varied and mixed communities across England.

As part of a national recruitment drive to attract nurses to the profession, we are working with marketing colleagues to encourage nurses from mixed ethnic backgrounds to join the health visitor workforce. We have also produced a central comms toolkit for SHAs and PCTs to adapt and use,

meaning changes can be made to best reflect local communities and their needs.

As part of Programme evaluation (which we are committed to do as part of our overarching Impact Assessment as well as the Health Visitor Implementation Plan) we will monitor the profile of the health visitor workforce and – working with relevant partners and equality leaders – adapt our approach as appropriate should inequalities begin to emerge.

Service Provision

Evidence suggests that some BME groups are disproportionately represented in socially disadvantaged groups and will experience the impact of broader health inequalities. For example, 26% of 'looked after children,' are from a BME group and tend to have a broader range and higher level of need than their peers, yet 1 in 5 do not receive annual health checks (Care Matters, 2007).

A key aspect of the Health Visitor Implementation Plan, is emphasis on delivery of services in a range of settings to maximise reach into communities, for example, in the home, in children's centres, in community and general practice. Via the new Building Community Capacity training module, health visiting teams have been given resources to understand their local population and communities, including their racial make-up and lifestyle patterns, such as travelling communities. Using local tools such as the Joint Strategic Needs Assessment, health visiting teams are encouraged to adapt services so that a universal offer is available to all parts of the community they serve with an understanding of cultural attitudes to family health. This may involve working with local community groups and providing services in appropriate venues or locales.

The Child and Maternal Health Intelligence Unit (ChiMat) is to undertake work to identify and draw together all health and well-being data sources on ethnicity of children and young people. These measures will help to inform those planning or commissioning services locally to focus on local priorities and needs as well as informing future policy development.

Age Workforce

- The age profile of health visitors shows that the majority are between 45-54 years old. This age profile makes careful workforce planning particularly important.
- There is some evidence that the needs of older nurses are not taken on board by employers, for example in the design of return-to-practice initiatives (Watson et al, 2003)
- Some older nurses, like other healthcare workers, do report being discriminated against on grounds of their age (Healthcare Commission, 2007)

We do not believe that the changes proposed by the Service Vision and Health Visitor implementation Plan would prove discriminatory in relation to age of the health visiting workforce, on the contrary, there will be new opportunities to advance equality of opportunity. These opportunities include flexible entry routes into practice and commissioners encouraging return to practice offers and retention incentives that serve to encourage older health visitors to remain in the profession and not to take early retirement. There will be increased training and professional development opportunities for health visitors, a revitalised public health role and an improved career structure and pathway including improved continued professional development, support and clinical supervision

Having identified that a number of health visitor professionals are concerned and unclear about:

- Their rights around entitlements when returning to work after early retirement;
- Flexible working; and
- Part-time working,

we commissioned work to identify the issues surrounding these areas in order to make sure that employees and employers know about the flexibilities offered by the current NHS pension scheme. We also liaised with Strategic Health Authority colleagues to assess whether a more proactive response was required to identify issues, possible solutions and best practice.

As a result, the Department worked in partnership with NHS Employers to produce 'myth buster' guidance for health visitors and commissioners, which outlines facts options around pensions, pay flexibilities and other initiatives to help with recruitment and retention. This has been supported by active communications that serve to educate and reassure both commissioners and health visitors on these issues.

Service Provision

The Implementation Plan considers the health and development needs of families with children from pregnancy to 5 years.

We have developed professional pathways for midwives, health visitors and school nurses to ensure effective join-up of services for children, young people and families from pregnancy to 19 years.

Gender reassignment (including transgender)

Most research suggests that until puberty (when sexual awareness is developed), it is impossible to tell for certain what a child's sexuality will be. This is confirmed by the findings of the Outproud/Oasis survey of 1,960 young lesbian, gay, bisexual and transgender people between the ages of 10 and 25. Its results showed that at the age of 10, only 21% were aware of their sexuality, only 2% had accepted the fact, yet by the age of 16, 93% were aware of their sexuality, and 54% had accepted it (Hellen, Mark, 2009). Pupil information regarding trans-gender is not collected centrally.

There is insufficient data to quantify the likely impact on transgender people in health visiting both from a workforce and service provision perspective. We believe this will form part of the resulting equality impact assessment devised locally when implementing this programme and will feed-into the programme checks to ensure that NHS staff, and service users are not disadvantaged.

In December 2011, the Government Equalities Office, in collaboration with others, committed to updating and disseminating advice to employers in recruiting and employing transgender employees and how to support employees undergoing gender reassignment with their transition. (Working for Lesbian, Gay, Bisexual and Transgender Equality: Moving Forward, published by HM Government March 2011).

The Department of Health also committed in this document to work 'to better understand the nature and size of the transgender population and how to support public bodies to deliver public services to the transgender community. Further, the Department will 'work with the NHS to increase awareness of LGBT health issues and how medical staff can work more sensitively with their LGBT patients.' (See below).

Sexual orientation

Workforce

As of September 2010, of those NHS staff who were willing to disclose information about their sexual orientation, the vast majority of 4150 health visitors were heterosexual and a minority were gay (5),

lesbian (10) and bisexual (10). Several Strategic Health Authorities had no health visitors employed who described themselves as gay, lesbian or bisexual.

As part of programme evaluation (which we are committed to do as part of our overarching Impact Assessment as well as the Health Visitor Implementation Plan) we will monitor the profile of the health visitor workforce and – working with relevant partners and equality leaders – adapt our approach as appropriate should inequalities begin to emerge.

Service provision

Restoring health visitor workforce numbers to a level that will ensure universal coverage of the Healthy Child Programme will mean that all families benefit without discrimination. The increase in numbers will also mean that families and children receive the level of help and support that they need, i.e. those requiring greater involvement from a health visitor will be able to receive it at the most appropriate time.

Religion or belief Workforce

At the national level, as of September 2010, for those health visitors who disclosed their religious belief, the breakdown was:

86% Christianity;

6% atheist;

<1% Islam, Judaism, Hinduism, Sikhism and Buddhism.

As part of programme evaluation (which we are committed to do as part of our overarching Impact Assessment as well as the Health Visitor Implementation Plan) we will monitor the profile of the health visitor workforce and – working with relevant partners and equality leaders – adapt our approach as appropriate should inequalities begin to emerge.

Service Provision

A key aspect of the Health Visitor Implementation Plan, is emphasis on delivery of services in a range of settings to maximise reach into communities, for example, in the home, in children's centres, in community and general practice. Via the new Building Community Capacity training module, health visiting teams have been given resources to understand their local population and communities, including their ethnicity and lifestyle patterns, such as religious communities. Health visiting teams are encouraged to adapt services so that a universal offer is available to all parts of the community they serve with an understanding of cultural attitudes to family health.

The Child and Maternal Health Intelligence Unit (ChiMat) is to undertake work to identify and draw together all health and well-being data sources on ethnicity of children and young people. These measures will help to inform those planning or commissioning services locally to focus on local priorities and needs as well as informing future policy development.

Pregnancy and maternity Workforce

See section above concerning work completed to identify and address issues, which may negatively impact on age and profile of the health visiting workforce, including flexible and part-time working.

Service

The Implementation Plan considers the health and development needs of families with children from pregnancy to 5 years.

We have developed professional pathways for midwives, health visitors and school nurses to ensure effective join-up of services for children, young people and families from pregnancy to 19 years.

Carers Workforce

See section above concerning work completed to identify and address issues, which may negatively impact on age and profile of the health visiting workforce, including flexible and part-time working.

Service

The Implementation Plan considers the health and development needs of families with children from pregnancy to 5 years. Health visitors will routinely assess, signpost and refer families when extra help and support is required, which may be the case if caring responsibilities are present.

The 2001, UK census showed that there are 175,000 young carers in the UK, 13,000 of whom care for more than 50 hours a week. Facts from Barnardo's state that the average age of a young carer is 12. More than half of young carers live in one-parent families and almost a third care for someone with mental health problems (Barnardo's).

We have identified young carers as a group where health outcomes can be affected by their caring responsibilities – there will be on-going work to develop a school nurse professional partnership pathway and raise the awareness of meeting the health and wellbeing needs of young carers.

Other identified groups

There is an opportunity for enhanced health visiting provision to have a greater benefit in the lower socio-economic groups. Health visitors initiate or help with a wide range of interventions with parents, for example increasing breast-feeding rates, which are known to be lowest in the lower socio-economic groups.

Socio-economic status has a significant impact on health inequalities amongst children. There is evidence that children born to lower socio-economic groups are more likely to be of low birth weight, die in the first year of life and to suffer significant episodes of mortality. (Public Health White Paper, Healthy Lives, Health People Impact Assessment.)

In 1995, 37.7 per cent of women in the lowest socioeconomic group were breastfeeding their babies at 6 months, compared with 53.1 per cent of women in the highest socioeconomic group. In 2004/05, the proportions in these two groups were 37.1 per cent and 66 per cent, respectively.

NHS Information Centre (2007) *Infant Feeding Survey 2005*

<http://www.ic.nhs.uk/webfiles/publications>

Across the United Kingdom, 88% of mothers in managerial and professional occupations breastfed initially, compared with 77% of mothers in intermediate occupations, and 65% of mothers in routine

and manual occupations. Breastfeeding rates among mothers who had never worked were the same as those found among mothers in routine and manual occupations (65%). This association between socio-economic classification and breastfeeding was evident in all countries.

In consultation with our stakeholders it emerged that health information regarding travellers, asylum seekers, homeless people and offenders may be disproportionately low as often these groups are not registered with local GPs consistently. However, Primary Care Trusts have specific responsibility for the health of offenders and their families.

Engagement and involvement

Was this work subject to the requirements of the cross-government [Code of Practice on Consultation](#)? n/k

How have you engaged stakeholders in gathering evidence or testing the evidence available?

Yes (see below)

How have you engaged stakeholders in testing the policy or programme proposals?

We have worked with the Department for Education to develop the vision and model. We have a set of governance arrangements which has facilitated extensive engagement and 'testing' with all key partners and stakeholders including; professional organisations (RCN, Unite and the NMC), representatives from the health visiting profession, social care, commissioners and providers.

We have reviewed emerging good practice and examples of what works from local areas and service delivery.

The Health Visitor Stakeholder Forum was established to provide assurance that the Programme is rooted in the real world of service commissioning, service provision, working on the frontline and in the experience of service users. This group includes representatives from a wide range of partners from the professional, foundation years and independent sector.

We have tested equality issues and national assumptions with the Health Visitor Delivery Partnership Group (which consists of members from the NHS, social care, the independent sector, other Government Departments and Sure Start Children's Centres).

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

In September 2011, the Health Visitor Programme provided the Equality and Diversity Council with a summary overview of equality issues affecting both health visitor service users and the workforce itself. It also committed to work with colleagues from the Equality and Inclusion Team to ensure the Programme identified areas where action could be taken to address any apparent inequalities. Since then, the team has:

- Conducted a Workshop (supported by the Equality and Inclusion Team), with representation from policy, service implementation and workforce aspects of the Programme, to bottom-out what existing and emerging equality issues might be in terms of the health visitor workforce and the new health visitor service model as described in the Health Visitor Implementation Plan (Feb 2011). Building on analysis contained in the Public Health White Paper EqIA, the team familiarised itself with legal requirements set out in the Equality Act 2010 and discussed the need for equality assurance going forward.

- Splitting the Workshop into two, with one group focussing on workforce issues and the other on the service offer, the team worked through protected characteristics (as defined by the public sector Equality Duty), considering each and identifying any gaps in evidence and understanding of the category. In particular, careful thought was given to the implications for:
 - Health visitor service users (did the new service offer - which was designed to provide universal services to all families with children under 5 and targeted help to those families who need it across England - serve to reduce physical and mental health inequalities? Was there evidence that the new service offer might affect people who share protected characteristics differently?)
 - The health visitor workforce (did the protected categories and evidence highlight areas where the Programme could actively seek to redress workforce inequalities, e.g. flexi working and part time working, the low number of male health visitors, the relatively high age of health visitors as a nursing profession.)

We have tested equality issues and national assumptions with the Health Visitor Delivery Partnership Group (which consists of members from the NHS, social care, the independent sector, other Government Departments and Sure Start Children's Centres) at their meeting on 11 January 2012. The Group looked at how we can achieve a universal service while identifying and supporting vulnerable and hard to reach families. It explored current local practice and appropriate and effective national levers for change.

Agreed actions/activities going forward

- We will work with marketing colleagues charged with increasing health visitor recruitment to mitigate the current low proportion of the male workforce (1%).
- We will endorse a letter to all newly qualified nurses (to be issued by NHS Careers), which will draw to younger nurses attention the nature and importance of the health visitor role.
- We will share case studies emerging from Early Implementer Sites, which demonstrate good practice in terms of access to all groups in local communities.
- We will continue to roll-out the Programme's training module for health visitors, Building Community Capacity, and to work closely with the Department for Education to ensure maximum reach into families and communities to ensure a universal service.
- Should gaps in knowledge or indications of inequalities emerge, we will seek input and advice from the DH Strategic Partners Group, Chaired by Howard Chapman, which meets monthly and allows focussed engagement with relevant partners.

Summary of Analysis *Workforce*

There is no evidence to suggest that increasing the numbers of health visitors will have a detrimental impact on the workforce with regard to the protected characteristics.

Service Provision

Increasing the number of health visitors will drive-up health outcomes and reduce inequalities, working with all family members.

Eliminate discrimination, harassment and victimisation

Service Provision

Health Visitors are trained to recognise risk factors, triggers of concern and signs of abuse and neglect, as well as protective factors. Using this knowledge, they can concentrate their activities on the most vulnerable families. Through their preventative work, they are often the first to recognise the risk of harm to children and are best placed to initiate safeguarding procedures.

Health visitors maintain contact with families while formal safeguarding arrangements are in place, which is essential so that families receive an effective service during a crisis and ensures that families receive preventative health interventions.

Health visitors contribute to all stages of the child protection process, including serious case reviews and may be called upon to appear in court to explain the action they have taken. They support the work of the Local Safeguarding Children Board through the delivery of multi-agency training programmes and through their membership and task subgroups.

Advance equality of opportunity

Workforce

Recruitment and retention initiatives are designed to attract all potential health visitors to the profession, including students, nurses, and midwives.

Service provision

Restoring the workforce numbers to a level that will ensure universal coverage of the Healthy Child Programme will mean that all families benefit without discrimination. The increase in numbers will also mean that families and children receive the level of help and support that they need.

Promote good relations between groups

There is no evidence to suggest the programme will promote good relations between groups over and above the assumption that children, parents and families who are brought together in group and community activities to support health and development are more likely to establish and maintain good relations over time.

What is the overall impact?

Securing a future health visiting service that is universal, energised and fit for long-term growth demands immediate action and investment. More Health Visitors will drive-up health outcomes and reduce inequalities, working with all family members.

We anticipate a positive impact on disadvantaged groups. The policy intention is to improve outcomes by ensuring continuation of universal health visiting provision, offering family health services with more extended contracts to support new families and a range of interventions for those with greater needs, championing wider health and wellbeing, prevention and public health and building family and community capacity. This is likely to have a particular impact on women (and pregnant woman and socio-economically disadvantaged children.)

There are likely to be positive effects for children from earlier identification of development needs, but the main benefits are likely to be over the lifetime of the child. Health Visitors are skilled at identifying families with high risk and low protective factors, enabling these families to express their needs and deciding how they might best be met. Preventing and addressing problems in maternity and childhood lays the groundwork for a healthy and well life, and can help stop poor health being passed down generations, reduce inequalities and

improve infant, maternal and child health.

Health visitors are skilled at identifying families at risk or in need of extra support due to short or longer term issues and pressures families may experience, and can develop new ways of delivering services to families who find it difficult to connect with traditional service arrangements. They have a role in building a stronger local community and using that capacity to provide a wide range of services and choices to local people.

Health visitors provide direct services as well as supporting and encouraging other health professionals to help promote health. The skills of health visitors, working with individuals and communities should maximise health outcomes and reduce inequalities. The policies should therefore have a positive impact on health, mental health and wellbeing.

Addressing the impact on equalities

See below

Action planning for improvement

The Department has commissioned research through the National Nursing Research Unit at King's College London, to inform and help shape ongoing work on health visitor expansion. This will include:

- work on cost-effectiveness and outcomes
- outcome measurement
- work on skill-mix
- work on user experience.

- We will work with marketing colleagues charged with increasing health visitor recruitment to mitigate the current low proportion of the male workforce (1%). The brief placed health visiting firmly in the public health/prevention arena and noted the high number of female health visitors and a desire to explore broadening the current catchment of the health visitor recruitment pool.
- We will share case studies emerging from Early Implementer Sites, which demonstrate good practice in terms of access and service to all groups in local communities.
- We will continue to roll-out the Programme's training module for health visitors, Building Community Capacity, and to work closely with the Department for Education to ensure maximum reach into families and communities to ensure a universal service.
- We will continue to work closely with our Stakeholder Forum and Delivery Partnership Group to address equality issues over the course of the Programme.
- Should gaps in knowledge emerge or indications of inequalities, we will seek input and advice from the DH Strategic Partners Group, Chaired by Howard Chapman, which meets monthly and allows focussed engagement with relevant partners.

Please give an outline of your next steps based on the challenges and opportunities you have identified.

See agreed actions above.

For the record

Name of person who carried out this assessment:

Sarah Connelly

Date assessment completed:

6th July 2012

Name of responsible Director/Director General:

Viv Bennett

Date assessment was signed: