# Celebrating Early Implementer Achievements – One Year On

150 years of Health Visiting Services (1862–2012)

## DH INFORMATION READER BOX

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| **Policy** | Clinical | Estates |
| HR / Workforce | Commissioner Development | IM & T |
| Management | Provider Development | Finance |
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| **Description** | The 26 Early Implementer Sites (EISs) established in March 2011, have been aiming to deliver the full health visitor service vision and lead a step-change in the way these services are provided. This document captures their early successes, activities and learning and will inform future service development. |
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| **For Recipient's Use** | |

# Foreword From Viv Bennett, Director of Nursing and Government's Principal Advisor on Public Health Nursing and Nick Adkin, SRO for The Health Visitor Programme

**The health visitor early implementer site programme is the bridge to the future.**

Our sites are developing and providing the new services that we want to see for children, families and communities that support parents to give children the best start in life. We would like to thank the practitioners, leaders and managers in these sites for their huge commitment and to congratulate them on all the early successes set out in this booklet. We would also like to thank the DH teams that have been supporting the delivery of this programme.

**Viv Bennett** **Nick Adkin**

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# Your community

# Universal services

# Universal plus

# Universal partnership plus

# Executive Summary

Twenty-six Early Implementer Sites (EISs) were established in March last year with the aim of delivering the full health visiting service vision and helping lead a step-change in the way these services are provided across the country. Each EIS has teams with strong clinical leaders, local partnerships and health visitors who are passionate about delivering the best for local families and communities. A number of sites have worked in conjunction with children's centres in delivering significant achievement and learning over the past year.

This 'one year on' report provides more detail about the outcomes of the early implementers' activities and is a 'one stop' access point to the main elements of learning that stem from the initial group of EISs. This will inform a second wave of service vision roll-out, due to commence shortly – enabling them to further improve and develop local services. Details of the new sites will appear on this website.

EISs' achievements and learning over the past year include: ensuring universal clinical delivery of the Healthy Child Programme (HCP); and improving antenatal services, breastfeeding and immunisation rates, parental confidence and information sharing among practitioners and parents. Specifically, ALL sites have:

- Delivered at least one project over the past year linked to antenatal visits or the 2–2.5-year review.
- Plans to embed health visiting service specifications for 2012/13.
- Aligned their services to the 'four tier' offer.
- Developed at least one of their improvements into a poster.
- A named health visitor on the board of the local Sure Start Children's Centre.
- Developed evidence-based care packages aligned to the HCP.
- Put in place measures and metrics to support service delivery and their portfolio of success.
- Plans that all their health visitors, including students, are trained in safeguarding every 12 months.
- Developed their implementation journals.
- Increased staff morale through being part of this programme.
- Worked with Sure Start Children's Centres and local authorities in order to deliver the health visitor commitment.

- The belief that all the tools are available to help them deliver the health visitor commitment.
- Delivered significant changes with little or no workforce growth.

It is acknowledged that the sites have been 'ambassadors' of a new service model at a time prior to the impact of the increase in health visitor numbers – where the commitment is to increase health visitors by 4,200 (from a May 2010 baseline), over the course of this Parliament. Workforce expansion is being driven by the Department's four-year transformational programme of recruitment and retention, professional development and improved commissioning linked to public health improvement. This will secure a future health visiting service that is universal, energised and fit for long-term growth.

# Index of Sites

# Brighton and Hove Children and Families Services

## Case studies and Practice examples

- Health visitor-led children centre model
- The Early Permanence Team
- Antenatal pilot for all first time parents

## Innovation Illustration

Pilot new style antenatal visit for all first time parents to identify family support needs and offer early parenting support and development interventions.

Transformational workforce development plan to enhance health visitor's skills – in motivational interviewing, solution-focused approaches, protective behaviours and risk management tools.

Menu of evidence-based interventions available for health visitors to inform universal plus and universal partnership plus offer.

The Early Permanence Team (EPT) is a new initiative which aims to improve outcomes for babies who are born to vulnerable parents and are at high risk of becoming a Looked After Child. Health visitors lead on assessing and supporting development of parenting skills and abilities.

Successful breastfeeding peer support service – breastfeeding prevalence well above national average, even in areas of deprivation.

A menu of evidence-based interventions has been developed and there has been a general shift to ensure that all plans for families are explicit in their outcomes and regular reviews developed to monitor effectiveness of the interventions.

## Outcome of the work

The impact on children and families has been more meaningful face-to-face time with health visitors, a clearer plan of action where required, access to integrated community resources and providing a more focused evidence-based interaction with children and parents

The breastfeeding work is already very successful, in Brighton and Hove our drop off rate between initiation and six weeks in the third quarter of 2011 was the lowest in England. Our breasteeding prevalence was 79.7 per cent in quarter three and even in our most disadvantaged area the rate is 62.7 per cent.

The content of an antenatal contact has been developed. The antenatal project has allowed us to re-examine our Healthy Child Programme (HCP) delivery and, through regular workshops, all health visitors have been involved and made contributions. Communication pathways with key partners, including midwives, have been developed and the effectiveness of these will form part of the process of evaluation for the project.

A transformational workforce development programme is running alongside this which will allow all health visitors to undertake training in key areas such as solution-focused interviewing and signs of safety. An innovative aspect of the workforce development programme is that it will be fully integrated with colleagues in children and families teams such as social care.

The Early Permanence Team is supporting families and has already had some success in speeding up timescales.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Service Specification for 2011–12 in place (under review for 2012–13) |
| | Local health outcomes have been defined and are being measured | Outcomes framework – HCP measures being set in place for 1.4.12 Other health outcomes being measured: Breast Feeding quarterly, Obesity annually, Smoking Quarterly, Hospital admissions annually |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Parent satisfaction survey 2011<br>Parents survey completed 2011<br>4783 questionnaires sent out<br>990 returned (23.6 per cent return rate)<br>Parent volunteers 60<br>Parents sit on Advisory Group |
| | Building and strengthening partnerships between GPs and children centres | Additional briefings for CCG and GP Lead HV team link being reviewed, team approach being considered |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Children Centres leaflets. Health visitor led children centre model |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | Data collection being reviewed and strengthened. Unable to report on this yet. Data reported from 1.4.12 on Outcomes Framework |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | BHCF Menu of interventions |
| | Pilot Project – New approach to antenatal visits for all primips | Antenatal pilot for all first time parents |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | BHCF Menu of interventions. The Early Permanence Team |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal Partnership Plus & Safeguarding** | Staff receive training on safeguarding | BHCF SCT Annual report. Level 3 Safeguarding competence data collected throughout the year and reported annually |
| | HV contributions to multi agency working where there are CP concerns | Reports to start 1.4.12 Some difficulty getting hard data but reports from RIO show that where a HV is invited to attend 100 per cent attend or a HV manager attends as a replacement |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | Practice Educators B7 oversee Practice Teachers B6 and mentors who are not yet able to sign off student HVs |
| | Staff are regularly listened to and their voice helps transform service delivery | Evaluations from staff workshops |
| | Dissemination of learning from EIS work and projects | HV workshop attendance |

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# Buckinghamshire Healthcare NHS Trust

## Case studies and Practice examples

- Improve breastfeeding rate
- Parenting concerns
- Genograms – looking at family relationships
- Infant emotional wellbeing
- Sleep problems

## Innovation Illustrations

**Targeted antenatal contact** (Universal Partnership plus) – to work with parents on relationships, attachment and support with behaviour change along with promotion of breastfeeding. Women are identified using the predictors of vulnerability for midwives and health visitors for assessment of clients in the antenatal period (Department of Health 2008). They are offered two antenatal contacts (28 and 32 weeks respectively) providing assessment, specific information and advice and continue to provide support and information for the family, using a planned approach if required.

The rationale for this is that within Buckinghamshire we did not routinely offer a targeted antenatal contact. It varied from team to team and it was down to the individual health visitor as to whether they carried out an antenatal contact. It is a national and local directive to deliver antenatal contacts as mentioned in the HCP. Evidence shows that education in the antenatal period improves outcomes and the mother's experience of birth and parenthood. In particular, evidence has shown that antenatal education helps manage and reduce maternal anxiety and depression during pregnancy and early childhood.

Neuroscience research also shows the links between early brain development and outcomes in later life. Early and effective intervention and prevention can improve a child's immediate future well being and outcomes which include social disadvantage, emotional development, educational achievement and life chances.

## Outcome of the work

The targeted antenatal contact enables early health visitor intervention to those parents identified as vulnerable at an earlier stage.

- There will be early identification of those in need of further support in the postnatal period.
- Early recognition of mental health problems in either parent.
- Increase of parental involvement with early years services.
- Increase rate of initiation and continuation of breastfeeding.

A pathway and package of care has been developed. The audit team will assist in the evaluation of the pilot. We will be auditing two teams. These are the pilot sites and a team who are not yet using the pathway. Learning from the pilot will be shared across all eight teams and partner agencies including children centres and GPs.

There is a plan in place to roll out the targeted antenatal contact across all eight teams by the beginning of December 2012. Plans are in place to start working on a universal antenatal contact.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Service specification being reviewed ready for 2012–13 |
| | Local health outcomes have been defined and are being measured | Outcomes within 2011/12 Service Spec:<br>• Percentage of new baby reviews by 21 days with mother and father, face to face by HV – Annually<br>• Post natal depression assessment offered at 6–8 weeks post natal – Annually<br>• VSB11 Prevalence of breastfeeding at 6–8 weeks – Quarterly<br>Outcomes framework – HCP measures being set in place for 1.4.12 other health outcomes being measured |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Children's Centre Survey (a joint initiative with Children's Centres and other EIS) – September 2011. Parents survey completed 2011<br>4783 questionnaires sent out<br>990 returned (23.6 per cent return rate)<br>Parent volunteers 60<br>Parents sit on Advisory Group |
| | Work closely with Sure Start Centres and other local partners | List of Children's Centres and named HVs List for early years settings and HVs will be attached when available |
| | There is engagement with a range of commissioning stakeholders (GPs, Public Health, PCT, LA) in order to ensure a seamless early years service | HV project board and Steering Group and all Working Groups have partner membership |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Named health visitor list |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | Data collection being reviewed and strengthened<br>Data reported from 1.4.12 on outcomes framework |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | Bucks Healthy Child Programme Pack – January 2012 |
| | Work with midwives is in place and demonstrates strong relationships in pregnancy and early weeks | HCP Pathways |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | Buckinghamshire Specialist Community Public Health Nurse, Healthy Child Programme, Care Packages |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | Currently all Practice Teachers are signed up to the new service vision and family offer |
| | Staff are regularly listened to and their voice helps transform service delivery | Presentations and write up from Staff workshops – October 2011 |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Workforce (Improved professional support development, education and morale)** | Staff have access to and undertake the Building Community Capacity Programme, Leadership training and HCP e-learning as part of their CPD offer | Beds University will be providing a Clinical Supervision Course in 2012/13 to ensure staff have the skills necessary to develop and implement a robust clinical supervision strategy which underpins good quality practice as part of delivery of the HCP<br>Re. Leadership Training – Discussions are underway with the Trusts' Training Department re. provision of a Leading and Managing Teams Coarse for HVs (this is already provided to Band 7 staff across the Trust)<br>Re. e-learning for the HCP – This is currently available to all staff; staff have been directed to undertake all modules. Negotiations are underway with the Trusts' training department re. monitoring of staff uptake of the modules. A robust system should be in place during 2012/13<br>Re. Building Community Capacity – The Trust is supportive of the Building Community Capacity Programme and all staff are aware. It has been raised at the Project Board Meeting and input from Public Health Requested<br>All existing staff will have undertaken the necessary training by the end of 2012/13/New staff will be required to complete training within their first year of employment. Monthly targets will be added for 2012/13 |

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# NHS County Durham and Darlington

## Case studies and Practice examples

'Team around the Nursery' enabling agencies to come together to support early intervention and prevention

The impact of implementation of the electronic clinical record 'SystmOne', and application of the early warning assessment tool to this system

## Innovation Illustration

### Service Health Directory

Work has commenced with the two local authorities (LA) across County Durham and Darlington (CDD) to develop their statutory Family Information Service (FIS) websites to include appropriate and accessible health information. It was agreed at the CDD implementation meeting that this was a suitable approach to take, rather than developing a heath specific service directory, as the health staff in County Durham and Darlington are working in integrated teams with LA in a single line management arrangement. More importantly, it simplifies the process for families by having all the necessary information in one site.

Both LA have agreed to work together to have consistent information on their FIS, to include all existing information as well as the developing health information. This is a positive development, as joint working has not happened in the past. Information

governance approval from the foundation trust has been sought with regard to uploading of health information onto the LA website.

## Suggested health information/links to be included:

Updates from One point and Early intervention team in Darlington. Link to County Durham and Darlington Foundation Trust website requested, awaiting approval from the trust Family Nurse Partnership. Information about Out of Hours provision (Urgent Care Centre, walk in centres, new 111 telephone number) Children's Allied Health Professional information i.e. speech and language therapy, children's occupational therapy, children's physiotherapy Midwifery information. Each FIS to have a link to:

- Department of Health Pregnancy and Birth to 5 book.
- Healthy Eating guidelines 0–5.
- Link to DH children, families and maternity bulletin.
- Link with poorly child pathway to be explored once completed.
- Web links to Local Safeguarding Children's Board (currently available in Darlington but not Durham)
- Web link to Health Protection Agency website.

## Consultation

Each LA has agreed to consult with parents about what they would like to be included on the family information site. Health visitor champions will also be consulted for their views on additions from a professional perspective.

## Rationale behind the work

Work has commenced to ensure we can fulfil the requirements of being an Early Implementer Site, to ensure the communities have a range of services that health visitors work to develop and make sure families know about them.

## Outcome of the work

Work is on going and feels very positive, particularly with regard to bringing together the two LA and production of a standardised approach for parents across County Durham and Darlington. LA staff have welcomed the input as they were struggling with health contacts and knowing the appropriate health information to include. It has been agreed that links to health information/websites would be beneficial as any information produced specifically for the website would need significant resource to keep updated to ensure it always contained current evidence-based information. Each LA has an agreed quality control process for systematic review of information held on their websites, currently annually. It has been suggested this should be six monthly.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Final draft completed,consultation complete. For incremental implementation over the next six months |
| | Local health outcomes have been defined and are being measured | Health outcome measures in draft format. Consultation completed Final version to be released |
| | There is engagement with a range of commissioning stakeholders (GPs, Public Health, PCT, LA) in order to ensure a seamless early years service | Minutes of implementation group meetings. Terms of reference |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Web-based Service Health Directory |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Names of Children centres in County Durham and Darlington and their named HVs on the advisory boards. Advisory boards are in the process of being re-established following implementation of an integrated service service delivery model |
| | Number of staff undertaking the Building Community Capacity course | Identify HVs enrolled to undertake the course. More staff were keen to undertake the Building Community Capacity course but have been unable due to capacity issues |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | Health Visitors may have performed the 2–2.5-year review using generic care plans rather than specific care plans on SystmOne, therefore data sumitted does not reflect a true position |
| | The new health visiting service is developed under the four offers and include safeguarding | Review of HCP to include the new service offer. Local HCP in progress of being reviewed to include new service model |
| | A directory of services is developed to underpin each element of the service vision and family offer and is regularly being quality assured | Link to websites:Darlington http://darlington.fsd.org.uk/. www.countydurhamfamilies.info The two local authorities who work alongside the foundation trust have been engaged in revising the existing Family Information Service directory to include health links/information. Work ongoing |
| | Work with midwives is in place and demonstrates strong relationships in pregnancy and early weeks | Review of the Communication protocol in collaboration with Head of Midwifery. Review of the communication protocol in progress |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adultment | Electronic clinical record 'SystmOne', and application of the early warning assessment tool to this system. Team around the Nursery' enabling agencies to come together to support early intervention and prevention |

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# Derbyshire Community Health Services

## Case studies and Practice examples

Breastfeeding: Peer supporters across the county who visit on postnatal day three, undertook a social marketing exercise to determine what would work best with parents

Working with service improvement methods to improve delivery of the HCP Improving delivery of the 2–2.5-year review: using Ages and Stages approach to improve parent partnership

Developing an antenatal review within the second trimester

Working with The Centre for Parent and Child support to use promotional interviewing techniques

## Innovation Illustration

The service has worked with local parents to improve the range of support we provide to help families to breastfeed their babies. It began with a breastfeeding research project and social marketing campaign within the two areas where breastfeeding rates were low. Talking to parents and staff about the service, what had worked for them and what they thought would help them further.

Key levers for change were:

- We successfully tendered to provide paid breastfeeding peer support and integrated the roles within the service, blurring the transition between midwifery and health visiting to provide a seamless service.
- Worked towards achieving Unicef baby-friendly status and improving clinical practice through a training package for all staff.
- Developed a distributed leadership model with a local health visiting champion role within each locality (one day a week).
- Development of a family poster campaign working with women who were breastfeeding, highlighting the role of friends, partners and grandparents.
- Launching the new breastfeeding web site in March 2012.

### Rationale behind the work

- Improving leadership within the service at a community level for both practitioners and mothers.
- Reaching out to the communities with the lowest breastfeeding rates, aiming to improve antenatal education and support; matching resource to need, to address health inequalities.
- Improving clinical skills for practitioners within health visiting and children's centres.
- Providing earlier support for families closer to delivery and before the traditional day ten visit from the health visitor.
- Developing locally accessible services through a partnership approach.
- Working with parents to develop a range of materials that meet their needs.
- Using good quality data to assess performance at a locality and team level.
- Improving breastfeeding retention rates from ten days to six weeks.

## Outcome of work

The leadership for this work was provided through a locality manager role as part of her leadership portfolio. A steering group that included specialist roles and locality representatives guided the development of breastfeeding services.

### The achievements are:

Audit of statistics in the two localities with lowest breastfeeding rates compared ten days in February 2011 and February 2012 and demonstrated a 10.4 per cent increase in locality one and a 4.1 per cent increase in locality two in mothers' still breastfeeding.

An audit with mothers following staff training showed strengthened clinical skills and provided insight into areas where we could improve further.

Putting mothers at the centre of our paid peer support service. The service offers an integrated seamless approach, providing support from the ante-natal to post-natal period involving peer supporters being based in the heart of the health visiting teams and in the communities they live in. These mothers are recruited from their own communities and offer 1:1 and small group support in the antenatal period.

Launch of the new website http://www.breastfeedingderbys.co.uk/

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | New service specification in place reflecting HVIP |
| | Local health outcomes have been defined and are being measured | HCP: new birth, 3 month, 12 month, 2–2.5-year including development of antenatal visit, BMI at 2–2.5-year and breastfeeding sustainment rate<br>Outcomes framework – HCP measures being set in place for 1.4.12 other health outcomes being measured |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Parents survey completed 2011 (a joint initiative with Children's Centres and other EIS)<br>4783 questionnaires sent out<br>990 returned (23.6 per cent return rate)<br>Parent volunteers 60<br>Parents sit on Advisory Group |
| | There are effective links with GPs-Primary care teams | Annual report, guidelines for monthly meetings (have an audit from last year and new draft protocol for practices)<br>Children's Centre Surveys – including health input – have been completed annually most recently September 2011. These have supported plans for future user involvement in HV service development<br>Going forward surveys are likely to be completed in partnership between Health visiting and Children's Centres |
| | Families and communities are engaged in the family offer | Evaluation report with strengths and areas for improvement with a plan. To test out in pilot before end of march and roll out across DCHS in two cohorts at the beginning of year and end of year<br>Involvement of all key stakeholder groups in Workgroups and Project Steering Board |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Audit will take place March 2012. SLA in place with key responsibilities for a named HV for each centre and place on board |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | Data collection being reviewed and strengthened<br>Data reported from 1.4.12 on outcomes framework |
| | Learning is taking place and adapted from FNP | Monthly data report from March 2012. Currently every Children's Centres has a named Health Visitor. Early Years settings do not yet have a named HV but this is being implemented and should be in place by end of April 2012 |
| **Workforce (Improved professional support development, education and morale)** | Workforce growth numbers (including training commissions) are known and agreed between provider and commissioner | Pilot started 1 January – figures will be available for March return<br>Monthly data returns using ESR and non ESR data verified by SHA |
| | Staff have access to and undertake the Promotional interviewing | Measure from January–December, then sub measure for utilising promotional interviewing within antenatal contact |

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# East Coast Community Healthcare CIC

## Case studies and Practice examples

Specialist health visitor for Primary Infant Mental Health Specialist (PIMHS) involvement in the delivery of Mellow Parenting Programme

Developing work with the migrant population around cultural challenges with regard to domestic violence in partnership with third sector partner

Safeguarding workshops

Postnatal group – Bambinos

Children's Centre delivering HCP 2–2.5-year reviews for children attending their nursery

Practice Teachers supporting mentors to deliver health visitor training to large number of students

## Innovation Illustration

This project focuses on the quality antenatal contact offered to all women using the antenatal promotional guides and Preparation for Birth and Beyond.

Facilitating managers and staff to develop the skills to enable them to have ownership of the pilot to deliver Preparation for Birth and Beyond in two pilot sites prior to going to scale.

The demographics of the population we deliver service to show the largest per centage of safeguarding referrals and registrations for neglect. There is historic evidence of low aspirations, and instances where up to four generations within a family have not experienced paid employment. We felt we needed to focus on an early intervention project that supports parents to achieve the best outcomes for their children. Evidence shows that there is a 'window' of opportunity in the antenatal/early postnatal period to support parents to achieve these improved outcomes using a strengths-based approach to the intervention.

## Area of the Service Vision and Family Offer this work meets

The work covers three areas of the service offer:

- Universal – all families will receive an antenatal contact from staff trained in the use of the Antenatal Promotional Guides.
- Universal plus – first time parents will be invited to Preparation for Birth and Beyond programmes.
- Universal Partnership Plus – these families will be offered early intervention visits using the Antenatal Promotional Guides information linked with Preparation for Birth and Beyond in a one-to-one home environment working in partnership with midwifery, Children's Centre and where appropriate Children's Services.

## Rationale behind the work:

This work has been the focus of our EIS development as we are aware that we need to be working in partnership with parents to support them to improve their children's health outcomes. East Coast Community Healthcare covers some very deprived communities within the East of Norfolk and North of Suffolk.

There is a history of intergenerational lack of aspiration and some families where four generations will have lived in workless households. Our largest registration for children with a Child Protection plan is neglect.

The project leads felt that we should be focusing health visitor intervention in the antenatal period as Robin Balbernie's states 'Babies cannot wait'. We know from research and evidence from Family Nurse Partnership that there is a 'window of opportunity' within the antenatal period when positive interventions can help parents improve outcomes for their babies and themselves. This is why we chose to focus our service improvement on this area of intervention. We are also aware, from research by Dartington, that money spent in this early phase of childhood gives better health outcomes than later interventions.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | Local health outcomes have been defined and are being measured | Outcomes framework – HCP measures being set in place for 1.4.12 other health outcomes being measured |
| | There is evidence of building capacity and using that capacity to improve health outcomes | Percentage of women who receive an antenatal contact |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Parents survey completed 2011 (a joint initiative with Children's Centres and other EIS)<br>4783 questionnaires sent out<br>990 returned (23.6 per cent return rate)<br>Parent volunteers 60<br>Parents sit on Advisory Group<br>We have just developed a feedback post card which is being used for groups, clinics and contacts. We have also produced an insert for the CHR which explains the new service offer |
| | A directory of services is developed to underpin each element of the service vision and family offer and is regularly being quality assured | Directory of Services available on intranet and then though new organisational website |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | We have just won a joint tender to deliver services to 4 Children's Centres. Children's Centre Staff delivering HCP 2–2.5-year reviews for children attending their nursery |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | Data collection being reviewed and strengthened<br>Data reported from 1.4.12 on outcomes framework |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | We are currently offering four evidence based programmes in the Universal Plus aspect of the HCP and with the introduction of Preparation for Birth and Beyond this has increased to five. Data on coverage for these is currently in development |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal & Universal Plus** | Increase coverage of the Antenatal Promotional Interview offered to all pregnant women. Increase number of notifications of pregnant women to the HV service. Systems are being developed to improve communication between three midwifery units and health vis | Pilot to deliver Preparation for Birth and Beyond in two sites in preparation to widening coverage |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | Developing work with the migrant population around cultural challenges with regard to domestic violence in partnership with third sector partner. Specialist Health Visitor for PIMHS involvement in the delivery of Mellow Parenting Programme |
| | Staff receive training on safeguarding | Workshops on safeguarding are delivered to Health visitors |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | Practice Teachers supporting mentors to deliver HV training to large number of students |
| | Plans are in place for dissemination of learning from EIS. Organisation just starting to develop training programme – to run from January 2012–March 2012 in first instance | Although training has commenced as it is delivered over two days a month apart they have not all completed the course |

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# East Sussex Healthcare NHS Trust

## Case studies and Practice examples

The HCP 0–5 service in East Sussex for 2011/12 will be commissioned jointly under a Section 75 pooled budget agreement. In 2011–12, health visiting and Children's Centre services will collaborate in a pilot programme to develop and implement a new model for the delivery of the universal Healthy Child programme

As part of the HCP 0–5 delivery plan a pilot is going to be developed in partnership with children's centres to deliver an integrated frontline service including community midwifery, family outreach service (children's centres) and health visiting

Workshops on Good Start delivered for all staff (working in HCP 0–5 services) in East Sussex

Plan to offer all Solihull Approach both 1–1 and group delivery (as appropriate) to all staff across county

Successful expansion of Family Nurse Partnership (FNP)

## Innovation Illustration

The Good Start Team (Bexhill pilot) ensures that the four domains of health visiting – Community, Universal, Universal Plus and Universal Partnership Plus are clearly formulated within the service vision and that the appropriate services are in place where there are safeguarding and child protection concerns.

Focuses on early intervention and prevention thus increasing contact for all parents (both first-time parents and second time parents) during the antenatal period.

All parents will have access to a clear service specification (in the pilot) with the Good Start team of midwives children's centre family Outreach Workers and health visitors during their pregnancy with clear signposting to other support services as necessary.

The Good Start Service ensures that children receive appropriate referral-to-specialist services and that each family receives support that is appropriate for their needs – with the most vulnerable families receiving intensive interventions and co-ordinated support packages.

It ensures that it has partnership working with parents and carers as a central theme with a firm commitment to involve families at all levels of the development process.

## Outcome of Work

The service delivery focusing on early intervention was designed by a working group of locally-based practitioners from many services who have designed a service that offers additional support to all pregnant mothers both antenatally and postnatally.

This service is in addition to the local HCP 0–5 and the Community Midwifery Core service and offers:

- A Duty Service daily from 9am–12pm run by the Good Start Team.
- A weekly Team around the Family Meeting supported by Social Care (monthly).

**Antenatally**

- Two Antenatal contacts to all pregnant women – at 21 weeks and 31 weeks.
- An earlybird antenatal session that supports general health and well being in pregnancy including antenatal screening, smoking cessation obesity etc.

- Antenatal education – Pregnancy Birth and Beyond in two groups of three sessions – one at 24–27 weeks and then at 32–36 weeks. Delivered jointly by the Good Start Team and the National Childbirth Trust.
- Antenatal Promotional Interviewing Training to health visitors across East Sussex – not only with the Good Start Team.

## Postnatally

- A breastfeeding contact by the Good Start Team (all Unicef trained) at 48 hours following discharge to give additional breastfeeding support and signposting to the Breastfeeding Peer Support programme and Children's Centre Support Groups.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Good Start Programme and agreed specifications for both HV and FNP will go to S75 joint commissioning board for final sign off 12 March |
| | Local health outcomes have been defined and are being measured | Breastfeeding initiation rates and prevalence at six weeks and actual feeding status at six weeks. Smoking status at new birth visit and at six weeks. To be agreed |
| | There is current understanding within the provider and commissioner of training places being filled and trajectory split by returnees and new trainees | East Sussex has not achieved this for 2011–12 but is confident of achievement for 2012–13 |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | HV client satisfaction survey 2010, reported on in 2011 with implementation of recommendations including development of local website, piloting three-year contact and universal provision for all families, as well as HV duty provision. Parent focus group as part of the developing Good Start programme |
| | Learning is taking place and practice adopted from FNP | Percentage staff trained to use the ASQs<br>Percentage staff using the ASQs |
| | There is evidence that health visiting services form part of the high intensity multi agency services for families where there are safeguarding and child protection concerns | Number of families being held within the universal plus service |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Well baby clinics. post natal groups. Co facilitate parenting groups. Breastfeeding support run by HV team in some Children's Centres |
| | Families and communities are engaged in design of services | Good Start Pilot has a thriving and engaged parents focus group who are supporting the service re-design |
| **Universal Partnership Plus & Safeguarding** | Staff receive training on safeguarding | Within East Sussex community staff have a two-day foundation CP training at appointment. Three yearly one-day updates are also mandatory. From 2011 the one day update is an integrated training alongside children's social care staff |

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# Hillingdon Community Health (Central and North West London NHS Foundation Trust)

## Case studies and Practice examples

Maternal mental health – specialist Health Visitor role in developing Cognitive Behavioural Therapy (CBT) group for mothers identified as having postnatal depression – group work with own child focuses upon building attachment, coping strategies and problem solving

Breastfeeding – antenatal classes provided by children's centres, all community staff attended two-day breastfeeding management course, in-house volunteer programme, volunteers represent local communities in ethnicity, language and age, based in both children's centres and in hospital

RIO information used to geographically map breastfeeding rates, trends and hot spots; Geographical 'hot spot' pilot underway

Domestic Violence – Specialist Health Visitor role in the development of traffic light system, joint training, awareness and templates for documentation

Documentation – Development of templates to ensure high levels of consistency, detail and analysis in patient records

Team around the child – Pilot

Mini Mend

Geographical breastfeeding pilot

In order to attract experienced health visitors, specialist band seven posts were developed for substance misuse, domestic violence, maternal and infant mental health, and parenting

## Innovation Illustration

Hillingdon is focusing on the 2–2.5-year health review. We were aware that even though we had reintroduced the 2–2.5-year health review in a new format (group and one to one depending on identified need) it was not achieving the required outcomes. A review of the content and process of the health review was completed.

At the start of the project, uptake of the service was 23–27 per cent. The invitation letter was previously sent with a stated date and time and venue and our Did Not Attend (DNA) rates were running at 50 per cent in some sites. An 'opt in' invitation letter was sent to parents so they could contact us to arrange an appointment. It is now recognised that a combination of both approaches is required.

Although it was universally offered, the uptake of the service was an area that needed to be addressed. The content needed to be revised and updated, taking into account the latest evidence-base and revisions of the HCP in 2011 and staff training was organised.

## Outcome of the work

The longitudinal aims of the project are:

- A reduction in Accident and Emergency attendances for children under five years for accidents.
- A reduction in dental cavities in the under-five population.
- An increase in referrals to parenting classes for parents with children under the age of five years.
- An increase in children being identified and referred to agencies such as speech and language, audiology and child development centre.
- Early identification of children at risk of obesity and referred to Mini Mend project and other health eating projects.
- Identification of maternal mental health issues and referral for treatment.

- Early identification of poor parent/child attachment and bonding and referral for support.
- Longitudinal aim (five years or more) there will be an demonstrable increase in the score of children at the Early Years Foundation Stage assessment. Demonstrating more 'school readiness'.
- Although only four months into this project uptake has increased to 50 per cent and we have commenced Saturday morning health reviews and a health visitor clinic, which are very well attended.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Forthcoming service spec yet to be finalised with commissioners |
| | Local health outcomes have been defined and are being measured | HCH are currently collecting measures for the following: completion of HCP e-learning modules; increase uptake of 2–2.5-year reviews on a Saturday morning; measure uptake of Saturday morning child health clinics; increase referrals via RIO into HCH Children's and families services; increase uptake of 8–12 month review; decrease dental caries; increase breastfeeding uptake and longevity; increase referrals of families requiring universal plus services; Increase identification of children who are overweight and refer for further support; maintain uptake of routine EPNDS; Increase in referrals to parenting courses; Increase of uptake of training for substance misuse awareness; increase and maintain immunisation uptake<br>Plan for 2012/13 to take over the 13 measures – review when the service spec is agreed above |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | 240 families were surveyed in November 2011 – a second survey will be launched for the month of May evaluating the Health visitor service (audit formulated). By the end of 2013 it is hoped that 5 per cent population feedback is achieved (this will be an annual number of approx. 1100 families) |
| | Promote ease of referrals into the HV service for families, GPs and outside/partner agencies | Team leaders to keep a tally of number of referrals received via e-mail into the health visiting team from parents/outside agencies and internal services – this will be reported to the health visitor development group from March 2012. Monitoring commences as of April 2012 – teams will report to the chair of the HV development group |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | HE Clinics, Health reviews, Parenting Classes, Baby massage classes, Self esteem classes, Maternal depression support group, Postnatal groups, Health promotion groups |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | 2012/13 target has been set using total average performance for 2011/12 and increasing by 25 per cent – annual performance will be taken into account at the end of each financial year in forthcoming target planning |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | Can be seen in the care pathways launched December 2012. Version 2 of the care pathways to be released in May 2012 – further content added |
| | Completion of HCP e-learning module | Monthly monitoring is currently underway and from March 2012 will be monitored via staff appraisals and monthly monitoring of team performance will be overseen by the health visitor development group. Launched in November 2011 Completion of the e-learning package includes all 12 sections and subsections. Workforce training underway – forthcoming trajectory yet to be agreed – there has been a 100 per cent increase in child protection cases since December 2011 |
| | Increase uptake of 2.5 health reviews by offering Saturday morning service for local families | Pilot commenced February 2012 in the North of the borough (two Saturday's monthly) – Pilot Commencing in the south of the borough every Saturday Saturday morning working commenced February 2012 |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal & Universal Plus** | Increase access to the health visitor service by Implementing a Saturday morning service for local families for health and wellbeing | Pilot commenced February 2012 in the North of the borough (two Saturday's monthly) – Pilot Commencing in the south of the borough every Saturday Saturday morning working commenced February 2012 |
| | Increase uptake of the 8–12 month health review | The RIO reporting system (informatics team) can accurately map attendance rates and DNAs<br>Plan is based on 25 per cent increase on annual performance and will be reviewed each year |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adultment | Can be seen in the care pathways launched December 2012. Version 2 of the care pathways to be released in May 2012 – further content added (care pathways) |
| | Staff receive training on safeguarding | Monthly mapping and monitoring of a training register |
| **Workforce (Improved professional support development, education and morale)** | Staff are regularly listened to and their voice helps transform service delivery | Awaiting staff survey report to be broken down into disciplines of CNWL workforce (report not yet available) |

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# NHS Blackpool

## Case studies and Practice examples

- Universal Antenatal Pathway
- Perinatal pathway
- Job descriptors for Specialist Health Visitors, Children Centre Links, GP link HVs
- Implementation of Brazleton training
- Linking children's service directory across services via Family Information Services as a central repository
- Arm's-length mentoring of students
- Clinical supervision
- Antenatal exchange of information electronically
- Infant feeding and SATOD tools in the antenatal contact

## Innovation Illustration

### Hello Baby!

'Hello Baby!' is an intensive five-week parent/infant interaction and attachment course aimed at mums with very young babies from birth to four months old who, were identified antenatally with perinatal depression (PND), have developed PND after birth or have identified attachment and bonding difficulties.

The focus of the course is to provide the mother with individualised information about their infant's behaviour so they can appreciate their baby's unique competencies and vulnerabilities, begin to recognise baby's cues and thereby understand and respond to their baby in a way that meets his/her developmental needs.

## Rationale behind the work

Hello Baby! is intended to be an intensive programme that impacts as early as possible on the infant-carer relationship. This early intervention aims to help mums to develop a harmonious and responsive relationship with their babies. Parents will learn to understand the needs and cues of their babies, increase attachment and bonding, enhance the parent-child connection thereby reducing the long-term impact of unresponsive parenting and improve outcomes for children. For these reasons, identified participants will be referred to the group which will be accessed via the Universal Plus or Universal Partnership Plus levels of the service offer.

## Outcome of the work

So far, one group has been run with mums and their babies. The group was deliberately small so that mums who are perhaps lacking confidence feel less intimidated in a smaller more welcoming and personalised environment.

The mums were asked to complete a pre-course questionnaire at the start of the first session. This was so these answers could be compared with the answers on the post-course questionnaires, at the end of the course. The questionnaires were designed to see if there would be any improvements or changes in the way the mums felt about themselves and their babies.

Babies' ages ranged from four weeks to 16 weeks old. All babies were male and all were first babies.

It was interesting to note that all mums felt they had a 'difficult or traumatic birth experience'. 67 percent of the mums had depression during their pregnancy, 33 percent did not, but all six were diagnosed with postnatal depression.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Signed off service specification for Health Visiting reflecting the four family offers, and FNP Specification agreed |
| | Local health outcomes have been defined and are being measured | Both antenatal and 2–2.5-year checks are measured however there are some system issues that will be resolved in 2012/13 |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Real time Patient Experience Questionnaire and HV Vision Patient Questionnaire. Issues in relation to recording all evaluation/audit activity found. This is being reviewed during 2012/13 |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Named link Health Visitor for each Children's Centre, with a defined role of their involvement |
| | Health Visitors lead the Healthy Child Programme for their population | Record of Antenatal visits, primary visit, Link Role descriptions for GPs, Children's Centres, Specialist HV roles, CHIS data for individual children, Red Book, contribution to wider KPIs, CC Registrations. Data requests need to be formalised from CHIS and baseline required in 2012/13 |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | 60 per cent of children aged 2–2.5-years have a development check |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | There are eight evidence based packages including Hello Baby and Positive parenting |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal & Universal Plus** | The new health visiting service is developed under the four offers and include safeguarding | Information in red books, communication to public and partners, agenda and/or minutes from meetings where offer discussed, face to face communication with wider population and HVs to families<br>Implementation of full HCP starting with Antenatal contact is being rolled out with a staged approach. The plan for 2012/13 will reflect a per cent increase each month as a proportion of baseline |
| | The Health Visitor provides, delegates or refers to additional services, intervening early to prevent problems developing or worsening | Caseload audit of referrals to additional services or response for advice, Red Book, client feedback. Robust collection of this data is being explored in year and baselines established during 2012/13 |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | Elements led by Specialist HVs<br>• Homeless<br>• FNP<br>• Perinatal and Infant Mental Health<br>• Two Surestart Hubs<br>• Development Centre (Partnership) |
| | Staff receive training on safeguarding | Figures for 2010/11<br>This is a manual audit of training numbers at year end, more robust way of monitoring to be finalised in 2012/13 |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | Just for Practice Teacher (not including HV mentors for pre-reg which is almost all staff). The per centage of practice teachers and mentors signed up to the new HV vision is 100 per cent. New mentors coming on line in 2012/13 will be added to the figure as they come on line |
| | Staff are regularly listened to and their voice helps transform service delivery | Minutes and attendance lists from team meetings, workshops and away days to discuss HV. Clinical supervision sessions and audit, HV involvement in task and finish groups, HVs attendance at national/regional HV events<br>Currently collating data from the areas of evidence |
| | Staff have access to and undertake the Building Community Capacity Programme, Leadership training and HCP e-learning as part of their CPD offer | Numbers enrolled and completed the Building Community Capacity, Leadership, e-learning packages. This is part of our training strategy that states all HVs must complete the e-learning modules and awaiting for confirmation of sponsorship for Building Community Capacity. A robust system for monitoring staff training in key areas being developed in year |
| | There is a strategy and mechanism to capture good practice and disseminate as appropriate | Pebblepad; Sharepoint; Staff Workshops; Audit: Clincal Supervision; Case Studies; Use of staff newsletters; Staff Survey<br>Robust collection of this data is being explored in year and expectation to build to 90 per cent clinical supervision sessions attended by individual HVs |

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# Hertfordshire Community NHS Trust

## Case studies and Practice examples

2–2.5-year review – improving the quality, consistency and coverage

Involvement in 'Targeted Advice Service' (multi agency 'triage' of referrals in to social care)

Collaboration with supermarket to deliver services from their site

Video interactive guidance

Two-year funded childcare places

Collaboration with supermarket to deliver services from their site

HCP programme for students health visitors out in practice ('Academy approach')

Potential project to 'buddy' student health visitors with newly-qualified SWs

eCAF project – using on line Common Assessment Framework (CAF) process

Linking health visitor teams with Tier 2 social care teams

## Innovation Illustration

The aim of the pilot project is to empower health visitors by establishing, evaluating and disseminating a virtual *Community of Practice of Health Visitors (CoP-HV)*. Funding has been provided by the Burdett Nursing Trust for two years. The project will consist of an extensive partnership including Hertfordshire NHS Trust, Barts and The London NHS Trust, The Health Visiting Task Group of the Royal Society of Public Health, The Open University, The University of Hertfordshire and Netmums. (Researchers – S Kendall, C Adams, R Bryar, S Cowley.)

The project encompasses all four levels of the 'Family Offer' and meets the service vision in enabling learning, development of the evidence base, spread and adoption of good practice across the health visiting service and enabling this to occur not only on a local level but regionally and nationally.

Communities of Practice (CoP) are formed by 'groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis' (Wenger, 1998, p.4).[1]

Health visitors are ideally placed to benefit from a CoP as they form a coherent professional group and can be isolated professionally and geographically from their peers. The CoP will enable the sharing of ways to provide evidence for addressing recurring problems in health visiting practice.

This will enable enhanced practice in new and innovative ways, where use of existing knowledge will improve practice and make a real contribution to child and family public health outcomes.

Evidence for health visiting practice is frequently not available in a format that health visitors can readily access or use. Therefore to produce and/or facilitate the use of evidence and practice digests via the CoP will develop and disseminate best evidence and practice digests for key areas of health visiting. The digests will be short briefings relevant to practitioners, educationalists and managers. They will be prepared by experts in evidence-based practice, drawing on work undertaken by the National Institute for Health and Clinical Excellence (NICE) and others and undertake original reviews of evidence, ensuring incorporation and contribution from practising health visitors.

Etienne Wenger, 1998, Communities of Practice: Learning, Meaning, and Identity, Cambridge University Press

1 Etienne Wenger, 1998, **Communities of Practice: Learning, Meaning, and Identity, Cambridge University Press**

The anticipated outcomes for this project are:

- A more skilled, confident and empowered health visiting community providing more efficient, uniform, comprehensive and evidence-based services.
- A one-stop-shop for knowledge and learning about health visiting practice.
- Promotion of leadership in health visiting through discursive practice-based forums and shared learning.
- In the longer term, an improved experience of the health visiting service by parents and better outcomes for children and families.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Service specification |
| | Local health outcomes have been defined and are being measured | Service specification |
| | Commissioned posts are identified and recruited to, delivering the annual workforce growth trajectory needed to deliver the ambition | Workforce data |
| **Communications & Partnership working** | Wide ranging media and or channels are being utilised for promotion and communication (including regional communication campaigns around raising the profile, raising motivation, attracting people to the profession | Communications strategy and hits on the website<br>Collaboration with supermarket to deliver services from their site<br>Linking HV teams with Tier 2 social care teams<br>Linking HV teams with Tier 2 social care teams |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | 2–2.5-year review – improving the quality, consistency and coverage |
| | The new health visiting service contacts all mothers in the ante natal period | Activity reporting |
| | The new health Visiting service offers face to face visits to all families moving into the area with a baby under one year old | Activity recording |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | eCAF project – using on line Common Assessment Framework (CAF) process. Involvement in 'Targeted Advice Service' (multi agency 'triage' of referrals in to social care) |
| **Workforce (Improved professional support development, education and morale)** | There is a medium to long term workforce strategy for the new Health Visitor workforce to deliver the new service vision and family offer which includes a training development plan for the current and future workforce | Training data and establishment. HCP programme for students HVs out in practice. Potential project to 'buddy' student HVs with newly qualified SWs |

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# NHS Portsmouth working in partnership with Solent NHS Trust (Portsmouth)

## Case studies and Practice examples

Plans are in place to offer all elements of the HCP 0–5 through the pre-birth to five years commissioning strategy

Universal, universal plus and partnership plus offered to all families dependent on needs to improve outcomes for children and working to be service of choice for client group

Plans to increase all contacts to face to face with a particular emphasis on increased coverage to first time parents and assessment of child development at 2–2.5-years

Preparing for birth and beyond (PBB) pilot

Early Years Payment by Results pilot focused on increased breastfeeding rates and information sharing

Increased coverage and quality to be a focus on 2–2.5-year contact and ASQ PREview tool to be considered for use in Portsmouth

Joint Action Team to be established January to reduce inappropriate referrals to social care and increase Common Assessment Framework (CAF) activity

## Innovation Illustration

Early Implementer Pilot of 2–2.5-year Health Review to improve coverage and quality of service delivered as universal family offer. Use of ASQ-3 developmental assessment tool as part of the health review, sent in advance of appointment with client was overall deemed a success. Appointing, the process used to invite parents to bring their children to the 2–2.5-year health review, needs further refinement but coverage is up from 42 per cent to 61 per cent, which is encouraging. Quality of the assessment is to be audited and will be improved due to revised use of the HCP 0–5.

In addition, exploring use of Department of Health published Becoming a Parent interactive resource, delivering it in sets of groups of six spanning early pregnancy (16 weeks) to postnatal group, with delivery undertaken by a midwife and health visitor in a children's centre on a Saturday morning. Five pregnant women and their partners are signed up to attend. They will also receive their clinical care at this time. Training being organised for ante-natal and post-natal promotional interviewing for health visitors plus interest in Restorative Supervision. In addition, Portsmouth is close to delivering on PREview, which is an exciting partnership collaboration between midwifery, health visiting, the local authority and public health.

### Benefits

Through focus on delivery of the evidence-based HCP as a high quality initiative health visitors will improve the health outcomes for the children and families in their care.

Focus on the 2–2.5-year review as a pilot will be taken to scale across the organisation plus the learning can be transferred to the other health reviews. The evidence to improve early antenatal contact is compelling so we are delighted to be able to implement a pilot using this new resource Pregnancy Birth and Beyond (PBB) modelling partnership working with midwifery and children's centres. Additionally the National Childbirth Trust has trained the staff to pilot the course.

Training staff in the use of antenatal and postnatal promotional interviewing along with the PBB resource will further develop our relationship building with parents and is a strengths-based approach to complement the learning from the FNP.

Support for staff in the form of Restorative Supervision is vital as the health visiting service progresses and transforms to ensure that staff are well supported and contained to enable them to undertake their work and PREview offers us the information to commission and target resources most efficiently.

## Outcome of the initiative

As a result of the pilot, this method needs further development and refinement to include:

- A trial of sending an appointment and asking them to ring if it is not convenient.
- To offer a text reminder if we have their mobile phone number (prompt/reminder).
- To follow up sooner with the subsequent phone calls if they do not respond (in the pilot we left it a month before we began to follow up).

Other initiatives are still in the development phase but also exciting with activities across all four service offer levels being developed. Interest in undertaking the Building Community Capacity is growing with capacity being the issue to release staff in advance of health visiting whole time equivalent growth and maintaining service delivery at current activity levels.

It is important not to underestimate power of the Pre-birth to five Strategy in Portsmouth that gives grounded context to delivering this agenda. PREview supports the shared vision offering to give in-depth information within Portsmouth to gain further improvement of commissioning and provision of targeted services.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | New Service Spec in draft, being consulted on and in negotiation to April 2012. Finalised Q1 2012/13 and in place with annual refresh of KPIs |
| | Local health outcomes have been defined and are being measured | Children's Trust Plan 2011–14, 2011–12 Quarter 3 Performance Report<br>Pre-Birth to 5 Strategy top 3 multi agency outcomes: Reducing Obesity, Improving Speech and language and Reducing inappropriate referrals to Social Care |
| | Commissioned posts are identified and recruited to delivering the annual workforce growth trajectory needed to deliver the ambition | Planned investment against monthly report of actual |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Health Visiting Postcard survey and HV handheld survey are examples of local responses to understanding the offer as baseline. Developing tools and partnership working to increase coverage to the eligible population on an incremental basis |
| | Learning is taking place and practice adopted from FNP | Pilot report and recommendations with scaling to cover population |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Well Baby Clinics, Developmental assessments, baby massage, 1st time parents groups, preparing for Birth and beyond groups (February 2012 onwards) There are 16 children's centres in Portsmouth with a named HV for every centre and involvement in every Children's Centre Board. Plan to audit this once a year |
| | Joint Strategic Needs Assessment, informs the needs of local communities | Preview tool for Portsmouth City |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | Request report from RIO to establish baseline over last six months since RIO was implemented and then on a quarterly basis working towards an agreed target |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | Written evidence based care packages in use (written evidence based protocols already exist) |
| | The new health visiting service is developed under the four offers and include safeguarding | Service specification and directory |
| | Work with midwives is in place and demonstrates strong relationships in pregnancy and early weeks | Evaluation from parents who have completed the programme |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | Children with Complex disabilities under 5 years old, Family Nurse Partnership, seconded NV to Joint Access Team based in Social care Portsmouth by end Q4 2011/12 and Portsmouth Perinatal Pathway |
| | Staff receive training on safeguarding | Service Specific and Mandatory for HV staff |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | Baseline Audit of PT and Mentors to measure commitment and evidence to support competencies relating to the new service vision and family offer. This will be based on recent DH survey monkey questionnaire |
| | Staff are regularly listened to and their voice helps transform service delivery | Format for staff team meetings, Professional Forum, Staff Survey, Evidence on staff consultation and input to fourth way development (local action on GP alignment and Children's Centres working), discipline specific events, service planning, multi-agency forums and workshops to influence strategy development and service delivery for all children and families 0–19 across Portsmouth<br>Workforce skills audit to take place in Q1 of 2012 and report in Q2 of 2012 |

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# Rotherham, Doncaster and South Humber NHS Foundation Trust

## Case studies and Practice examples

The Edlington Health Visiting team have looked to offer 100 per cent of all expectant parents a one-to-one home visit undertaken by the SCPHN as guided by Doncaster's HCP 0–5. This visit is offered after 28 weeks and before 36 weeks

## Innovation Illustration

### Edlington Antenatal Event – a quality intervention, inspired by experienced professionals, influenced by parents, families and communities alike

Exploring the HOW to deliver the HCP 0–5, the Edlington health visiting team have worked hard to offer 100 per cent of expectant parents a one-to-one home visit during pregnancy. Guided by Doncaster's HCP 0–5 this visit, undertaken by a health visitor is offered between 28 and 36 weeks gestation. Implementing this is seen to be a challenge, with many visits either being none effective or being cancelled due to ongoing work commitments. Along with reduced opportunities to involve fathers within working hours, the team spent time exploring ways to improve engagement with our expectant parents.

Understanding the community in which we work, the team was able to acknowledge the close family networks and the significant influences of surrounding family members. We considered that any intervention should look to engage expectant parents, siblings and extended family members. Looking to involve the whole family, we explored the value of working outside the standard working week.

Hoping to develop an idea that looked to offer early intervention by way of an informal gathering within the local health centre, we did not wish to replace the one to one antenatal home contact, but to complement it as part of a move towards building community capacity. Looking to involve both expectant parents early in pregnancy, this event now takes place on a Saturday morning, as a once a month event. Ensuring we meet the needs and expectations of our community, the initial content of the event was determined by the guidance of the HCP 0–5, Pregnancy Birth and Beyond, Early Intervention (Allen and Smith 2008), and other influential local and national documents, along with a in depth client/professional consultation.

Early intervention talks of forming a culture of change, improving outcomes for future generations. We are looking to utilise up to the minute evidence-based recourses that are seen to empower and inspire parents to foster secure attachments. We have looked to promote positive parenting education that celebrates the strengths of individuals, families and communities alike.

In order to address our community challenges, it was vital to consult with those living within the Community. Understanding the why, what and how to deliver our project would be fundamental to its success.

We launched our first event on 21 January 2012, with two further events in February and March. We have planned further events over the summer months.

Criterion for invitation is simply notification by community midwife of pregnancy; each expectant mum receives a personal invitation to attend the event. So far of the 66 expectant mums invited over the three events already completed, 19 did attend, giving an attendance rate of 29 per cent of our target group. Along with this, many mums brought their supporters as encouraged. Partners, siblings, extended family and friends were all welcome. This has given a total footfall of 33 people.

Already three months into our project each event has been shaped by ongoing consideration and evaluation. While the local community midwives were fully consulted in terms of the content of our event, due to capacity they had been unable to attend the initial two events. While clients had not identified the midwives as missing, the health visiting team felt their attendance would be of significant

value. Indeed their attendance at the third event was very well received by parents, has a result midwives hope to increase their commitment.

With participation of the local children's centre, and success of partnership working, other professional groups have since been approached. The Dental Health Educator offered a board of information and will be looking to attend future events. The Sexual Health Nurse, hearing of the January event was present February at her own request, a multi-professional response that we would hope to see grow and progress.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | Local health outcomes have been defined and are being measured | Reported within Children Young People and Families Performance Report |
| | Learning is taking place and practice adopted from FNP | Training Plan for implementation of Ages and Stages Questionnaire<br>The FNP Partnership Board merged with the Health Visiting Implementation board in order to facilitate the sharing of FNP learning<br>Awaiting delivery of ASQ material Plan – Under development with proposed start date for first cohort of training June 2012. Monthly performance target to be agreed once training plan completed |
| | Health Visiting professionals in the local area are supported in community development work and have access to the Building Community Capacity Programme as part of the CPD programme | Case studies |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Quarterly patient satisfaction survey issued to 125 families each quarter Your opinion counts system in place to encourage engagement of families in to provide feedback re services received The portfolio of success has highlighted the need for a more specific HCP client survey as the current patient survey is very clinically focused and does not link well with portfolio outcomes. There is an action plan to address this issue |
| | Health Visitors are building and strengthening partnerships including with general Practice and Sure Start Children Centres | Benchmarking current compliance with monthly meetings between HV and GP practice in order to set target for improvement against this success Model of Practice has been developed in Portsmouth EIS site linking HV to GP Practices and Children's Centres |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Achieved in 20/21 sites, the remaining site has been identified and will be addressed. Work being undertaken to develop a job role for the lead HV for each Children's Centre |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | Coverage is currently at an acceptable level. Development of the use of ASQ's is in progress with a view to linking this to the EYFS in the Children's Centres to improve the quality and content of the assessment |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | Adjustments to be made to SystmOne recording templates and performance dashboard to align safeguarding threshold levels with HCP levels of intervention |
| | Case studies and practical examples are developed and shared | This qualitative data, will report on number of case studies shared, who they are shared with and examples of good practice adopted as a result of the sharing |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | Adjustments to be made to SystmOne recording templates and performance dashboard to align safeguarding threshold levels with HCP levels of intervention. Raised for discussion and development; needs to be worked up alongside the One Team Working Agenda. Would expect to be implemented in the next financial year 2012–13 |
| | Staff receive training on safeguarding | Number of staff completing Safeguarding training audited quarterly |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | Number HV CPEs – 10<br>Number Mentors – 104<br>Number of available mentors – 49<br>(Data from monthly DOH return)<br>Currently working with RDASH learning and development team and Hallum university to fast track the remaining staff to access the mentorship course |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Workforce (Improved professional support development, education and morale)** | Staff are regularly listened to and their voice helps transform service delivery | Introduction to EIS – June 2011 Nov Building Community Capacity workshops – 1 January HCP Practitioner Forum |
| | Staff have access to and undertake the building Community Capacity Programme, Leadership Programme and HCP e-learning as part of the CPD offer | To be added to the Children Young People and Families Performance Report |

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# Homerton University Hospital NHS Foundation Trust

## Case studies and Practice examples

Partnership working in children centres

Parenting: The Solihull Approach

Training roll-out for early years staff to undertake the 27-month review

Antenatal notification pathway for vulnerable women

Growing the health visiting workforce and the development of a quality learning environment Raising the profile of the health visiting service

Interventions offered as part of the HCP 0–5

## Innovation Illustration

### What we did:

Developed a systematic electronic process for demonstrating that all children aged 0–5 born in October 2009 had been offered all the age appropriate clinical interventions in the HCP 0–5.

### Outcomes

- Improvement in data completeness recorded on the electronic Child Health Information System i.e RIO.
- Improvement in the data and quality of the information put on RIO by staff in the health visiting teams.

- Identification of children who had no clinical interventions recorded or were no longer the responsibility of the health visiting service as they had left the area.
- Improvement in staff knowledge and skill of how to use RIO.
- Roll out of training for early years staff to undertake the 27-month review.

## What we did:

There was a need to strengthen partnership work between Health and Early Years to increase access to the HCP 0–5 and ensure that children had their 27-month review undertaken in a timely fashion.

A pilot was undertaken with health visitor and early years staff in one children's centre and the following steps were taken:

- Governance arrangements agreed between Health and Early Years.
- Link health visitor identified for each nursery (monthly contact).
- Training successfully delivered to early years staff by Homerton staff.
- Health reviews carried out by early years staff under the supervision of a health visitor.

## Outcome from the pilot was:

- Consistent increase in reviews.
- Reinforcement of integrated working and improved information sharing with early years settings and the health visiting team regarding all children receiving the HCP 0–5 and Immunisation Programme.

## Outcome:

A report was written and presented to the multi-agency Healthy Child Programme Group which has now approved the proposal/implementation plan to roll out the model to all the health visiting and early years teams in Hackney. Training to be delivered by Homerton staff for early years staff is scheduled to take place in May.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Following the commissioning and provider workshop on the 23 March 2012 the 2012/13 service specicfication should be ready for sign off by the end of May |
| | Local health outcomes have been defined and are being measured | These outcomes are being reviewed in light of the new Ofsted framework |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Information about Health Visiting Services is also available from the Local Authority Service Centre |
| | There are multi-professioal/agency steering and working groups in place to support the development of the HV service offer | There is a steering group jointly led by commissioners, HUH and an operational group, both have reps from the HV service |
| **Universal & Universal Plus** | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | In development |
| | Work with midwives is in place and demonstrates strong relationships in pregnancy and early weeks | Pilot completed and report being written |
| **Universal Partnership Plus & Safeguarding** | Staff receive training on safeguarding | There are high levels of HV and associated staff compliance with safeguarding training |
| | The Health Visitor provides, delegates or refers to additional services, intervening early to prevent problems developing or worsening | 72 per cent of HV staff had Common Assessment Framework (CAF) training in 2011/12 but this has not resulted in a significant increase in the number of CAFs undertaken or onward referral to the Children Centre MAT meetings |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | In development |
| | Staff are regularly listened to and their voice helps transform service delivery | SPTs and HV students have engaged in discussions about the new HV offer as part of the internal CPD programme, however sign off has not been achieved – this is being incorporated into the appraisal process |

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# Leeds Community Healthcare NHS Trust

## Case studies and Practice examples

Early Start Team (EST) Initial Family Health Assessment

Helping Hand Framework

PAUSE AT 2: Delivering the HCP 2–2.5-years Review

## Innovation Illustration

Early Start is an integrated service supporting all families and their children from pregnancy through to five years of age to have the best possible start in life. Working in partnership with early years services, GPs, midwives and other health services, Early Start will help families play a positive role in their children's development through reducing social isolation, promoting wellbeing, increasing parenting capacity and supporting access to training and employment.

## Vision

The service will:

- Ensure that families from pregnancy to five years are offered HCP 0–5 and the children's centre core offer including Foundation Years Curriculum.
- Identify children and families, where additional preventative programmes and interventions will reduce their risks and improve future health and well being.
- Promote and protect health, well being, learning and school readiness.
- Provide access into specialist services.

### Area of work

- A structured framework has been developed for health visitors to use at the antenatal contact as part of the HCP 0–5.
- An early intervention tool is being used to assesses family's needs and puts the health visitor as leader of those interventions.
- The principles of delivering this framework will run throughout the delivery of care of every contact a health visitor makes.

### Rationale

- Identifying the parent – child attachment at this early stage will enable appropriate and timely responses that result in the improved social and emotional well being of children and families.

### Outcome of the work

- An improved initial contact helps to initiate trust and understanding on both parts and is more likely to lead to better outcomes in the health and well-being of those involved.
- Increased job satisfaction for health visitors.
- Increased parent satisfaction rates in the support received for the parenting role.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Considerable work has been undertaken between commissioners and providers and partners in Early Years to develop an integrated service specification that is informed by the national implementation plan and health visiting model, local health needs and statutory, NICE, evidence base and OFSTED requirements. The specification will be included in contracts from April 2012. In addition a service specification has been produced for sustaining and expanding the local FNP service – this will also be included in the provider contract for April 2012 |
| | Local health outcomes have been defined and are being measured | Considerable work has been undertaken with commissioners, providers and partners to develop an Early Start Service quality and performance dashboard, which will be reported against quarterly. This includes evidence of delivery against the family offer (levels), safeguarding measures and public health outcomes (of which there are 8 distinct outcome measures such as breastfeeding, childhood obesity, readiness for learning)<br>Prior to this dashboard being agreed the HV service used the existing vital signs as outcome measures – Year R NCMP, Breastfeeding, and Immunisations |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Families have been involved in the journey from the start and played a funadmental part in the universal service review which recommended the approach being implemented in Leeds. Families are being kept informed of progress and are helping to further shape the service through consultation with the pilot sites.<br>An EST service leaflet has been produced to support this work |
| | Work closely with Sure Start Centres and other local partners | Terms of reference are being established as part of learning from the pilot sites and will be included when finalised |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Please refer to the EST service specification for integrated HV offer |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Community** | Health Visitors lead the Healthy Child Programme for their population | This is part of the EST service dashboard and included in the EST service specification. Systems and processes for collecting this information at organisation and team level are being developed and will be ready for April 2012 |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | This is included in the EST specification and dashboard. It will also be included in the EST Handbook which will be completed in year and added as evidence when available. As part of the 2 year review project systems and processes for collecting this information at organisation and team level are being developed and will be ready for April 2012 |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | Please see the EST service specification which indicates that these are being developed. The first five are in development and will be included as evidence when finalised |
| | The new health visiting service is developed under the four offers and include safeguarding | This is part of the EST service dashboard and included in the EST service specification. This will also be detailed in the Early Start Handbook to be in place September 2012<br>Systems and processes for collecting this information at organisation and team level are being developed and will be ready for April 2012 |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult ment | Please see the service model in the EST specification. Helping hands has been specifically designed to deliver this tier of service |
| | Staff receive training on safeguarding | The service are monitored against a number of safeguarding measures each month, these inlcude the level of supervision received and proporation of staff who have completed the appropriate safeguarding training |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | Measure is the number of Clinical Leads and Practice Teachers who have attended the specific leadership event around the new service model and are signed up to support its delivery. Restructuring of the Health Visting leadership team has included Practice Teachers having a defined clinical leadership role. The content of leadership support programme has been attached as evidence |
| | Workforce growth numbers (including training commissions) are known and agreed between provider and commissioner | There is a tracker system in place and monthly returns are made to Yorkshire and Humber SHA |
| | Flexible HR practices are utilised to retain the existing Health Visitor workforce, including acting proactively on staff surveys | The service are actively working to improve staff retention. Staff are given development opportunities, exit interviews are documented and reviewed as a service, HR policies e.g. Flexible Working have been tailored to the service, and the staff survey results in action plan with milestones |

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# Medway Community Healthcare CIC

## Case studies and Practice examples

- Children's Social Care has also been restructured and a new threshold criteria has been developed which fits well with the new health visiting model
- Full offer of the HCP 0–5 should be addressed once vacancies are filled. This needs be monitored and audited
- Public health role not fulfilled in relation to stop smoking and healthy weight and geographical areas to be targeted according to the joint strategic needs assessment
- Further work needs to be done to bridge the gap between health visitors, GPs and children's centres to improve communication/liaison between them
- Establishment of a parent's forum to foster user engagement with the development and evaluation of the new service
- In conjunction with Medway Council we are piloting a virtual domestic abuse team with a social worker, police officer and our nurse
- Antenatal Parenting Programme being piloted (Pregnancy, Birth and Beyond) to be rolled out in children centres
- Proposal for funding to undertake a needs assessment of children's services across key partner organisations

## Innovation Illustration

Medway Community Heath are developing health visitor care packages as part of our new service offer to families in Medway. We had the opportunity to work with NICE in developing new, evidence-based packages of care and prior to the set up of working groups. Steve Sparks, Associate Director for NICE in the South East, attended a staff engagement workshop to share some of the guidelines, tools and care pathways relevant to the HCP 0–5.

### Area of the Service Vision and Family Offer the work meets

**Community**

Engaging with local services and children's centre/community groups activities.

### Universal

Positive offer of contact with families at defined points in their child's life in line with the HCP 0–5.

### Universal plus

Additional support following assessment of need for a defined period of time followed by re-assessment and evaluation.

### Universal Partnership plus

Clear referral pathways and use of Common Assessment Framework (CAF) with step-up/step down to/from social care.

## Rationale behind the work

Health visitors in Medway have been working with packages of care for some years, but these have not been systematically reviewed to take into account new evidence, guidelines and models of service delivery.

## Outcome of the work

Health visitor packages of care have been reviewed and developed as above to incorporate latest guidelines and evidence. Some of the groups developed client information leaflets which can form the basis of contracts/agreements between the client and health visitor. Other partners were co-opted onto the groups to ensure the packages were linked to existing care pathways e.g. postnatal depression. These will be launched at a local conference in March.

Engagement of health visitors and team members in reviewing and developing the packages of care was clinically-led with management support, which motivated the staff involved. Staff used their local knowledge of families in Medway to develop the menu of packages.

## Next steps

The project gave us the opportunity to work closely with NICE and access resources such as NICE pathways and guidance.

Although we already had packages of care in place this project gave us the opportunity to review and update our service offer to reflect current needs of our population and an increasing focus on early intervention and local public health priorities.

We were able to use the new national service model as a template to develop our packages across all tiers: Universal, Universal plus and Universal partnership plus. Further work is planned around the Community level as we roll out the Building Community Capacity module for our staff.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | A service specification has been drafted but further work need to agree KPIs and outcome measurements |
| | Local health outcomes have been defined and are being measured | A local outcomes framework has been drafted and further work needed to refine and agree these |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Patient Survey returns and data to be collated |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Proposal for funding to undertake a needs assessment of children's services across key partner organisations |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | Data to be collated from EPEX following data cleansing exercise |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal & Universal Plus** | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | The total number of different packages offered is 6. Ante-natal Parenting Programme being piloted (Pregnancy, Birth and Beyond) to be rolled out in children centres |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | A list of all the additional services offered will be embedded. In conjunction with Medway Council we are piloting a virtual domestic abuse team with a social worker, police officer and our nurse |
| | Staff receive training on safeguarding | This is an organisational KPI so is collated for all eligible staff. HV numbers to be extracted from here |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | Workforce Tracker will indicate numbers |

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# Shropshire County PCT and NHS Telford and Wrekin

## Case studies and Practice examples

- Workload allocation panels with children's centres
- Health visiting triage line

## Illustration of Innovation

The introduction of an Advice Line providing a faster, triaged, relevant and localised service to new mums and dads with the following benefits to local families and professionals:

- Advice and support to families from a qualified health visitor Monday to Friday 9am to 5pm – this means that often people get the advice they need straight away, rather than having to wait till the end of the day or even the next day for a health visitor to return their call, which was typical in the old way of working.
- Families getting access to quicker health visiting advice means that they do not have to make use of another NHS service – such as GP consultations or treatment and care from Emergency Departments as frequently. This helps reduce demand on other services.
- Through triaging of family concerns, those that need access to a face-to-face consultation with a health visitor can be booked into a clinic straight away, or,

if appropriate can be booked in for a home visit or provided with advice to access other NHS services as relevant.

- Through appointment-only clinics, families do not have long waiting times, unlike the old system of drop-in clinics.

## Area of the Service Vision and Family Offer this work meets

- Universal: Advice and signposting.
- Universal Plus: Access for additional support when required.
- Partnership Plus: Agencies working with families identify and consult on additional help and support from the service.

## Rationale behind the work

One of the technical problems with the centralisation of local health visitors meant that where previously each health visitor had access to a single, personal telephone with answer-phone facility, the provision of 24-plus individual direct dial phone lines into one office was both costly and impractical.

## Outcome of the work

- Since introducing the Advice Line, the team have received an increase in the volume of enquiries, they have also seen an increase in the actual range of topics being enquired about – it seems that clients often feel more comfortable asking someone on the phone about something, rather than face-to-face. Those families that need and want a face-to-face appointment are still able to get one – without the long waiting time.
- Other NHS services and GPs are starting to refer more and more to the Advice Line. It's quick and easy for them and their patients to get the help they need.
- Other partner agencies that visit hard-to-reach groups are also making use of the Advice Line whilst they are with the client – helping to show that it is easy to use and encouraging good behaviour change in these groups, who would normally not engage with the service.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | There are currently service specifications in place for 2011/12 which include coverage of the HCP. A separate service specification is in place for the FNP programme in Telford and Wrekin. New service specifications will be drafted to incorporate the cluster wide template by July 2012 |
| | Local health outcomes have been defined and are being measured | Health outcomes yet to be agreed, subject to revised service specification negotiation. Local Health Outcomes are currently being worked up based on Public Health Outcome Framework. However, 2011/12 CQUIN indicator included Health Visiting: HCP – core contacts – two per cent funding<br>Percentage of families offered a core visit<br>PND – options two per cent funding<br>Percentage of Post Natal Depression (PND) assessments completed<br>Breastfeeding two per cent funding<br>Percentage population recorded as breastfeeding at primary visit<br>Implementation Plan four per cent funding<br>Percentage progress to increase FTE Health visiting |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Picked up through communication strategy development. Label inserted into red book to advise of core contact times |
| | There is a stakeholder analysis and an effective communications and stakeholder engagement plan for the service, professionals, stakeholders and public | Health Visiting Communication Plan |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Workload allocation panels with Children's Centres |
| | Health Visitors lead the Healthy Child Programme for their population | Health Visiting triage line |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | 100 per cent offered from April 2012, proactive targeting of vulnerable families |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | Detailed within Health Visiting in Shropshire Practice Handbook |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | Young Parents Health Visiting Team (YPHVT) article |
| | Staff receive training on safeguarding | Three year rolling programme as per WT2010, annual target for health visitors currently 28 per annum based on current headcount. Training figures for 2011/12 total 49 health visitors have received training which exceeds the annual target |
| | Work with midwives is in place and demonstrates strong relationships in pregnancy and early weeks | Draft pathway written |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | Will be addressed through annual appraisals |
| | Staff are regularly listened to and their voice helps transform service delivery | Minutes of the Health Visitor meeting, dates planned to December 2012 |

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# Northamptonshire Healthcare NHS Foundation Trust

## Case studies and Practice examples

Healthy Child project with children's centres

Developing Outcome measures

The use of ASQs and improved coverage for 2–2.5-year review

Healthy Child pilot working with children's centres

Developing the integrated review in partnership with early years

Three health visitors undertaking Building Community Capacity pilot

## Innovation Illustration

### Improving the quality and coverage of the 2–2.5-year review in Northamptonshire

Following analysis of data collected from:

- County-wide team meetings.
- EIS staff readiness questionnaire.

The following aims were identified:

- Improve quality and coverage of 2–2.5-year review.
- Standardise the development review tool.
- Improve communication with all staff particularly skill mix.
- Skills audit for all staff.

**ASQ identified as developmental tool**

- Training plan devised with FNP to share best practice and support staff.
- Successful implementation of change model used to support staff during training implementation and evaluation.
- Joint training with children's centre staff to share understanding, knowledge and collaborative working practices.

**Communication plan**

- Call to Action to be agenda item at all staff meetings.
- e-mail brief to all staff following every Call to Action Steering Group.
- Motivational presentation at Staff Development Day by Service Lead.

**Discussion with partner agencies**

Development of Care Pathway.

- Podiatry, Speech and Language, Paediatricians, CAMHS.

**Completion of skills audit**

Identified training needs in following areas:

- Solihull Approach.
- Leadership.
- Clinical supervision.
- Preceptorship of newly qualified health visitors.
- Building Community Capacity.

## Benefits

Joint training with children's centres led to shared learning and understanding of the HCP 0–5. Improved communication has led to development of shared working practices and improved collaboration between the health visiting service and children's centres services leading to better outcomes for families.

Children's centres offering play workshops around ASQ activities or information displays for parents around ASQ activities.

Use of the Successful Implementation of Change Model has led to training that included time for staff to familiarise themselves with and practice the ASQ tool.

There was also time for children's centre teams and health visiting teams to plan collaborative ways of delivering the HCP 0–5 and the 2–2.5-year assessment in particular.

Following initial training, evaluation visits to all teams to listen to concerns and feedback has led to successful embedding of the new tool and sharing of 'top tips' between localities.

Although still to be evaluated the Care Pathway should lead to a clear and consistent approach across the county when developmental delay is identified or there is a need for short term interventions. This should lead to improved outcomes for families and children.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Current commissioning requirements are that we achieve a high uptake in children with additional needs. For 2011–12 the overall per centage uptake in this group has been 82.1 per cent. Service specification developed |
| | Local health outcomes have been defined and are being measured | Developing Outcome measures |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Patient experience questionnaires are quarterly across all localities in Northamptonshire |
| | There are effective links with GPs | This was taken through the Local Medical Committee and all practices have signed up to the process |
| | Case studies and practice examples are developed and shared | Examples of case studies and pilots throughout |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Communications & Partnership working** | There is a medium to long term workforce strategy for the new Health Visitor workforce to deliver the new service vision and family offer which includes a training development plan for the current and future workforce | Skills audit undertaken |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Three Health Visitors undertaking Building Community Capacity Pilot |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | Healthy Child project with children's centres. The service has been training all staff to use ASQs for developmental assessments at two years |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | These are completed short term family interventions by month as agreed with commissioners for 2011/12 |
| | MMH – The Health Visitor provides, delegates or refers to additional services, intervening early to prevent problems developing or worsening | These are new internal outcome measures being collected by staff only introduced in February 2012 therefore data needs validation. These will continue for 2012/13 |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adultment | These are families assessed as requiring universal plus serrvices and categorise as level 3/4 on family assessment tool |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | Mentors increasing by 12 to 22 and PE continuing at 7 for 2012/13 |
| | Staff are regularly listened to and their voice helps transform service delivery | Development days and early implmentation meetings have been held regularly during the year |
| | Workforce growth numbers (including training commissions) are known and agreed between provider and commissioner | Agreement in principle Total of 5wte additional capacity for HVs across 2011/12 10 Training commissions for 2011/12 and 22 plannned for 2012/13 |

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# NHS South of Tyne and Wear and South Tyneside NHS Foundation Trust

## Case studies and Practice examples

- We are currently working with three local nursery/primary school heads to having a common consensus of what 'School Readiness' would look like and how we can work together to change a cultural perception of acceptable social, emotional and developmental attainment
- In the process of purchasing the ASQ-SE, developmental assessment tool to enhance the current development assessment offer. The training and roll out of the tool will be matched with health visitor capacity

As an Early Implementer Site the pilot that we decided would give the greatest benefit to our populations was the PB&B. The pilot was introduced into a deprived area of South Tyneside where a virtual multi agency team was being formed. The PB&B was delivered in a children centre over five weeks with support from a midwife and nursery nurse. From the pilot, a set of resources have been devised to support the roll out of the PB&B offer across all areas. Feedback from the pilot has been excellent from both the clients attending but also from staff who gained a great deal of job satisfaction from the group work

*'I have learnt about the importance of interaction with baby, baby is far more able and can do far more than you might think'* (participant)

## Innovation Illustration

In September 2010 and January 2011 the health visiting service across Gateshead, Sunderland and South Tyneside adopted the Virginia Mason methodology and held two Rapid Improvement Workshops (RPIW). The purpose of the workshops was to re-design the service to encompass the recently launched HCP 0–5. The workshops were attended by front line staff, supporting staff, admin and staff with management responsibility. The progress made at the RPIW was amazing and was the starting point for the change process that has continued ever since.

The aim of the organisation was to have a workforce and organisation ready and equipped to deliver the HCP 0–5 and therefore lay the foundations of good health and well being of children and their families in Gateshead, South Tyneside and Sunderland.

It was evident right from becoming an early implementer of the HCP 0–5 that to deliver the highest possible standard of care we would need to invest time for staff readiness. By that I mean staff needed to have dedicated time to upskill their current knowledge base. New research and resources are available within neurosciences, attachment and bonding that support the role of the health visitor to identify vulnerable families. As an organisation we have concentrated on making sure the foundations are right. This is a sample of the work we have undertaken to date:

- We have written a guidance document for student health visitors that supports the learning they should expect to receive during their practical placement, all newly qualified health visitors have an extensive preceptorship including the acquisition of an essential skills set through a planned training programme.
- We have devised a tool that will allow us to review the caseload and workload of each health visitor with the outcome that all caseloads are fair, equal and visible to all.
- We have identified the training needs of our staff and have written a business case to support the request for training in line with the requirements of the HCP 0–5 and service specification for health visiting.
- We have developed a child development training course and purchased the ASQ-SE to be introduced at 2–2.5 years.
- We are rolling out the Pregnancy Birth and Beyond.

## Outcomes

- Our staff are ready to embrace the HCP 0–5 and feel included in the developments to date.
- Staff have the most up to date knowledge base from which to make highly complex assessments.
- Staff have the skills to deliver effective interventions.
- Staff feel valued with a good sense of job satisfaction and are proud to deliver a good service.
- A recent survey with users of the service with children under the age of one year have reported to have noticed a difference in the health visiting service offered and this was better than before.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Draft service Specification developed and currently being shared for consultation with key stakeholders including local authorities and GPs. Specification has been developed as part of a North east development is to be agreed with North East PCTs |
| | Local health outcomes have been defined and are being measured | Draft outcome measures developed with further work required to finalise a standard approach across the North East |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Patient stories initiated by PPI service. Draft report available indicating a good response to the new delivery of the HCP including how to contact the service, attending baby days/ clinics/breast feeding support, baby massage are all included in services delivered in children centres |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Baby clinics, baby massage, PB&B, multiple birthsgroup, stay and play, family nurturing, breast feeding support, bosom buddies, tasty treats education sessions. To offer local authorities the provision of a health visitor on each board. Where a non health visitor local manager sits on the board we will include a health visitor to join with that manager |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | All children offered 2–2.5-year assessment, Order put through to purchase ASandQ SE questionnaire |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | All universal plus services offered are evidence based, attached are 2 documents used as a standard and to assure a level of competence. 100 per cent of packages offered are evidence based and delivered to the 11 per cent of children identified as requiring universal plus support |
| | Early intervention | Electronic birth book |
| | Demonstrate universal access to the HCP 0–5 | Electronic birth book |
| | Demonstrate access and uptake to universal plus interventions | Electronic birth book |
| | Optimal maternal emotional and mental health wellbeing | Electronic birth book |
| | Reduced smoking and smoke free homes | Electronic birth book Annual review of measures based 2012 outcome |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult ment | Services delivered by the health visiting team for those identified as partnership plus vary across the three different PCTs however, there are dedicated health visitors who deliver services for teenage pregnancy, FNP, Schedule of growing skills offered across the three areas for children identified as having special needs and nurturing groups are also offered. All parenting packages offereed in the home are based on the solihull approach. Recently introduced is the PB&B and to be introduced following training in May ASQ-SE |
| | Staff receive training on safeguarding | All staff need to have attended level 3 safeguarding training, the exception to this would be those on maternity leave or long term sick currently |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Workforce (Improved professional support development, education and morale)** | Staff are regularly listened to and their voice helps transform service delivery | HV group: The purpose of the group is for two-way communication and agreeing the way forward and changes in practice and the role of the members is to feed up and down the discussions at the group and to influence practice. Each PCT area has a locality health visitor group which has open access to all. Again this is for two-way communication. Future measure will be total attendance at all four meetings |

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# NHS Stoke on Trent in Partnership with Staffordshire & Stoke

## Case studies and Practice examples

- Ages & Stages Questionnaires (ASQ) introduced for all developmental reviews and delivered in partnership with parents & children centres
- Service improvement through service user engagement (utilising ele-lites)
- New evidenced based antenatal contact piloted in partnership with the midwives and in the process of roll out for universal antenatal contacts
- 2 year developmental review uptake increased by 7% to 95% utilising the ASQ
- Commissioning specification and outcomes framework
- Integrated mental health & teenage pregnancy pathway in development

## Innovation Illustration

Our journey to implement the Ages & Stages Questionnaires (ASQ) was based on learning from the Family Nurse Partnership (FNP). We needed a quality, evidence based and objective tool to support delivery of the Healthy Child Programme (HCP) for families in Stoke-on-Trent.

We trained all Health Visitors to apply the ASQ at all reviews, as this supports effective developmental and social-emotional screening for children (0-5) years).

The ASQ enables the Health Visitor to identify potential delays as early as possible and determine which children need further assessment or ongoing monitoring. The ASQ is parent- friendly, it is strength based and educates parents to understand developmental milestones. The added value of the tool is that it incorporates parents' expert knowledge about their children. Parent-report tools are accurate, time and cost effective method of developmental screening.

The lead commissioner (Programme Lead for the EIS) developed a CQUIN to advance this work due to the added value in line with the QIPP programme.

The ASQ tool and its implementation were shared with colleagues from the Department for Education and DH at a local Children Centre to share learning from the EIS and the partnership work with the Local Authority.

Children Centres continue to work with Health Visitors to develop a systematic approach to tracking the Early Years Foundation Stage and ASQs to inform a child's development from 0-3 years; previously information was predominantly limited to children aged 3-5 years. The Call to Action programme and the importance of the 2 year HCP review to inform early education and early intervention, has raised the profile of the Health Visiting role and the opportunity to further advance partnerships to meeting shared outcomes.

Other key partnerships to achieve outcomes included a pilot project of joint working with Midwives to improve information sharing during pregnancy to facilitate the Health Visitor ante -natal assessment.

Essential information was collated at booking by the Midwife and shared with Health Visitors. A criteria for eligibility was agreed and all maternities in the pilot area were offered a contact with the Health Visitor; as a priority, those women with agreed risk factors were contacted.

An evidence based tool, based on Preparing for Pregnancy, Birth & Beyond, was developed for one to one contacts and all practitioners were trained in promotional interviewing to improve the effectiveness of the visit. The evaluation has reported positives benefits for both Health Visitors and their clients, in terms of gaining new skills, confidence, information sharing and early assessment to inform care planning.

## Outcomes

The implementation of the ASQ has achieved the following outcomes:

- Professional mobilisation and enhanced confidence and competence in the assessment of children.

- Promotes engagement of parents/carers in their child's development, as an effective method of assessment.
- Application of a reliable evidence-based tool to complement the HCP 0–5 which covers communication, gross motor skills, fine motor skills, problem solving, personal-social skills, and overall development across time.
- A systematic approach to electronically tracking development progress to inform health and early years services i.e. early access to education (preschool) and intervention, school readiness and to inform overall child health and social wellbeing.

The antenatal pilot has shown the following outcomes:

- Improved HV skills and knowledge
- An increase in antenatal contacts
- Early identification of need and appropriate support offered
- Parents report an early awareness of HV offer and services
- More effective and efficient partnerships developed with Midwives.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Service specification FNP and HV Provider Business Plan and Specification submitted February 2012 |
| | Local health outcomes have been defined and are being measured | Subject to outcome framework agreement |
| | Commissioned posts are identified and recruited to, delivering the annual workforce growth trajectory needed to deliver the ambition | Health Visitor budget report ESR and SHA return<br>Now unable to obtain Stoke data due to ESR merger (TCS).Projected Target for 2015: increase of 8.2 WTE HV as at February 2011 |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Elelites<br>FNP Advisory Board<br>Children's Centre Parents Representatives FIS and directory<br>Building Community Capacity parental engagement<br>PHCR various media<br>Focus Groups/Unicef assessments |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Within Stoke on Trent there are three advisory boards which govern the 11 children's centres |
| **Universal & Universal Plus** | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | Evidence in Operational Service Portfolio currently being revised |
| | Antenatal Pilot project in place and aims to improve communication and joint working with Midwifery during pregnancy and early weeks | Information sheets received from Midwives in the pilot area. Eligibility criteria: women with an estimated date of delivery between 13.2.12 and 24.5.12 under the care of two midwives and living in a specified geographical area<br>The intention of this pilot is to inform the health visiting antenatal offer to families from April 2012 futher detail in HCP project plan<br>Progress made to improve booking information to inform total per cent eligible for Antenatal contact |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adultment | Integrated mental health and teenage pregnancy pathway in development. Evidence in Operational Service Portfolio currently being revised |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal Partnership Plus & Safeguarding** | Staff receive training on safeguarding | Training data from OLM system<br>Workforce competences in this area ensures consistent, safe and quality practice. This performance managed through appraisal and supervisory processes |
| | There is evidence that health visiting services form part of the high intensity multi agency services for families where there are safeguarding and child protection concerns | Minutes from the local safeguarding practitioner subgroup (LSPS)<br>Children Partnership Minutes: Priority Two – Risk and Resilience tool pilot<br>In addition to the Common Assessment Framework (CAF) process there is also a newly established Multi Agency support Team (MAST), Multi Agency Referal Group for Domestic Violence (MARAC). Additional value – OFSTED/CQC and multi agency planning and service improvement |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way. | Locally the PT Trainees are classified as Mentors for this assignment<br>Regular appraisal<br>Director of Nursing sign up and workforce strategy drafted<br>Involved in Professional Mobilisation programme<br>Model agreed<br>Ratio proportionate to students<br>Expansion of PT trainees<br>Workforce Trajectory on track |
| | Learning is taking place and practice is adopted from FNP | Training data<br>Practice adopted<br>MoU with Children centres re data input and tracking |

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# Norfolk Community Health and Care NHS Trust

## Case studies and Practice examples

Implementation of the 'roving' Practice Teacher role to support the large increase in numbers of students from September 2011

Increase in quality and quantity of health visitor home antenatal contacts to support the improvement of health outcomes through good attachment between babies and their parents

Use of The Solihull Foundation Approach in health visiting, with the Infant Mental Health Team and in children's centres

Integrated approach to delivering HCP 0–5 in children's centres. In health run centres Programme Manager line manages health visiting team

Project to develop HCP 0–5 Leads in teams to lead delivery of HCP 0–5 across children's centres, GP practices and health visiting teams

One of five national pilot sites for integrated 2–2.5-year review

## Innovation Illustration: Babies can't wait

This project undertaken by Norfolk Community Health and Care NHS Trust has focused on improving the uptake and quality of health visitor antenatal home visits. The scope of the project included all health visiting teams within the organisation and all health visitor students undertaking their practice placements within the health visitor teams.

Our vision for the project was that parents would feel better prepared for parenthood, with improved assessment by health visitors supporting earlier intervention if indicated, and improved outcomes for children and families.

A multi-disciplinary project group oversees the work which has included a whole day seminar delivered to all health visitor students, 48 in total, around baby brain development and attachment theory. This was facilitated by a psychologist from the PIMHS team and the FNP supervisor. A series of training days was also organised for health visitors in March and April that all were required to attend. In addition, a clinical psychologist was commissioned to deliver a two-day training session to 20 health visitors on the antenatal promotional interviewing and further sessions will be delivered over the coming year. Work is also in progress to improve the liaison pathways between health visitors and midwives.

## Rationale behind the work

This project is part of a whole system change towards achieving the ambition of early assessment and intervention for families in Norfolk. By building on the foundations already present, such as the Solihull approach, a Parent Infant Mental Health Team and FNP, we have been able to consider this ambitious project.

The perceived benefits of this project are:

- Parents will feel better prepared for parenthood.
- Parents and health visitors will understand the importance of baby brain development and its impact on outcomes for children.
- There will be improved assessment by health visitors in the antenatal period to support earlier identification of need. If indicated this will support earlier intervention and access to services as needed including safeguarding.
- Where additional need is not indicated there will be improved signposting to universal services e.g. children's centres.
- Improved liaison between midwifery and health visiting services.
- Improved longer term health and social outcomes for children.
- Meeting Key Performance Indicators of HCP 0–5 delivery.

## Outcome of the work

Increases in numbers of health visitor antenatal home visits are being monitored on a monthly basis and are expected to increase significantly over the coming months.

In order to ensure parents' views are central to the programme a baseline questionnaire has been delivered to over 130 women receiving an antenatal contact from a health visitor. The outcome from this will be used to shape the delivery of antenatal contacts going forward.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | Local health outcomes have been defined and are being measured | Breastfeeding uptake, smoking cessation in pregnancy, year R height and weight |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Survey of families opinions of child health clinics, baseline questionnaire to antenatal families to commence January 2012. Taking part in Kings College research into families views of HV service |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | NCH&C have just completed a retendering process for children's centres and have been successful to provide majority of children's centres from July 2012. Sensitivities are high and it is likely that there will be no increase possible until after July 2012. There is a link HV for each children's centre |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | In the process of redefining data collection to fit with parameters suggested by DH. Aim to be ready for March data collection<br>Update 17.4.12. Cleansed data now available. Trajectory for 12/13 to be set with commissioners as HV capacity increases<br>Project to develop Healthy Child Programme Leads in teams to lead delivery of HCP across children's centres, GP practices and HV teams<br>One of five national pilot sites for integrated 2–2.5-year review |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | Solihull Foundation training for all health visiting staff, PAFT, Care Index, Neonatal Behavioural Observation, Antenatal Promotional Guides Training<br>Have embedded Postnatal Promotional Topic Guide from South London and Maudsley |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | FNP (annual report imminent), Gateway Resettlement Project for refugees from Congo. The Solihull Foundation Approach in health visiting, with the Infant Mental Health Team and in Children's Centres |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | Sign up sheet for mentors and PTs re HCP learning. Spreadsheet showing latest position in development 'roving' Practice Teacher role to support the large increase in numbers of students from September 2011 |
| | Staff are regularly listened to and their voice helps transform service delivery | Staff Engagement Events, monthly briefings, team meetings, Implementation plan group, antenatal group |

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# South Warwickshire NHS Foundation Trust

## Case studies and Practice examples

- Producing an Early Years Health Directory
- Evaluation and research study of promotional interviewing by Warwick University
- Use of Ages and Stages pathway development
- Education model for Practice Teachers
- Antenatal group sessions run by children's centres and health visitors at 30 weeks plus
- Ages and Stages pilot completed. A further pilot for the Social and Emotional component of the Ages and Stages for the nine month review to be able to demonstrate level of need for early intervention
- A 2–2.5 review combining the Ages and Stages, Welcome tool and the Early Years Foundation Stage at the same contact

# Illustration of Innovation

## Early Years Health Directory

**Rationale for developing the Early Years Health Directory:**

The Warwickshire Schools Health Directory developed back in the early part of 2000 and updated in 2009, proved to be a very useful document to both schools and professionals in Warwickshire. At the time there had always been a desire to develop a similar directory for the early years. Being an Early Implementer Site gave us the impetus we needed to get this new Directory off the ground.

The ***Early Years Health Directory*** will enable professionals working in early years settings and parents who access the settings to know what is available to them; to have up to date information about such things as immunisation and infectious diseases; to know how to contact the various health professionals outlined in the Directory and also to feel confident in looking after a child with additional needs. The Directory will have web links to other services, for example, the Family Information Service and children's centres.

Collating the Directory was a huge task as there was so much material that required checking and rechecking. The draft document was then sent out for everyone for a final consultation. A colleague in the Family Information Service went through the document adding web links before uploading the document to the County Council website: www.warwickshirecountycouncil.gov.uk/EarlyYearsHealthDirectory

**Outcomes expected from having an Early Years Health Directory include:**

- Staff and parents of children in early year's settings will feel confident about where to get information regarding the care of pre-school children and how to make contact with the relevant health professionals.
- The settings will be able to provide up to date information to parents about a range of issues such as immunisation, infectious diseases, diet, and care of children with additional needs.
- Children with additional needs will be supported with the right level of care so that parents will be confident that the care they receive in the settings is consistent and evidence based.

We will review the Directory in a year's time and evaluate the usage. It is too early to demonstrate its effectiveness at this stage.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | Local health outcomes have been defined and are being measured | Data for: breast feeding initiation, breastfeeding duration at new baby review, six week check. Data for primary immunisations, MMR uptake, smoking in pregancy, and check that blood spot has been taken |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | All families receiving an evaluation questionnaire about ages and stages. Antenatal group sessions run by Children Centres and HVs at 30 weeks plus |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Producing an Early Years Health Directory. Baby clinics, breastfeeding support groups, post natal groups, baby massage, the two to two and a half review, nine month review, introduction to solid food sessions<br>Health Visitors lead on health related topics. Health Visitors attend family matter meetings to discuss families who may be in need of Universal Plus and/or Universal Partnership Plus at least fortnightly. Consent gained at new baby review visit to share new birth data with Sure Start Children's Centre. Health Visitors provide supervision to breastfeeding peer supporters |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | A 2–2.5-review combining the Ages and Stages, Welcome tool and the Early Years Foundation Stage at the same contact. Use of Ages and Stages pathway development |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | Evaluation and research study of promotional interviewing by Warwick University |
| | Increase coverage of the Antenatal Promotional Interview offered to all pregnant women. Increase number of notifications of pregnant women to the HV service. Systems are being developed to improve communication between three midwifery units and health visiting | Monthly audit started from October 2011 for Health Visitors |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | Ages and Stages pilot completed. A further pilot for the Social and Emotional component of the Ages and Stages for the nine month review to be able to demonstrate level of need for early intervention |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | Education model for Practice Teachers. Involvement in the new 'Warwickshire Model' of group teaching using the new HV Service Model. Supportive documentation available |
| | Staff are regularly listened to and their voice helps transform service delivery | Staff trained in Ages and Stages tool in Summer 2011. Attendance lists and evaluation forms. Discussions at meetings. Introduction of paperwork. Three pilot sites in October. Universal Offer from November 2011. All parents are asked for feedback via evaluation forms |

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# Whittington Health NHS Trust

## Case studies and Practice examples

Training programme for newly qualified Health Visitors, Practice Teacher and mentors

Antenatal to school pathways in collaboration with maternity services

Integrated 2–2.5-year review

Proactive telephone support for breastfeeding peer supporters

## Innovation Illustration

To deliver the new model of health visiting practice our starting point in Whittington health was to provide a good, well-resourced health visiting service. Our intention is to not only grow the workforce but to build on what we do best across Haringey and Islington, and strengthen health visitors parenting work in pregnancy, and the transition to parenthood and beyond. The growth and preparation of the workforce are crucial to improve service delivery to clients as the HCP 0–5 including PBB and the 2-year review require the application of a newly available and emerging body of theory, knowledge and skills. We want to create solid foundations by taking an innovative approach to growing, supporting and developing our health visiting workforce.

We are creating alternate pathways and flexible systems to attract new people into health visiting such as:

- Two-year part-time SPHCN course for RN's 'on the job'.
- Fast-track RN or health visitor training for graduates.

- Doubling student health visitor numbers year on year.
- Testing new opportunities for mobile working: tablet technology.

We want to provide a learning environment for health visitors and their teams that enhances and develops their skills to embrace new ways of working. To do this we are:

1. Providing a bespoke educational and support programme for our four newly qualified health visitors.
2. Working with mentors and practice educators to enable them to support newly qualified health visitors and students with the new model of health visitors practice.
3. Taking a creative approach to growing, supporting and developing the workforce and bringing new people in.
4. Planning, for the delivery and evaluation of a sustainable learning programme of theory, knowledge and skills practice for all health visitors and their teams focusing on:
    - The importance of the antenatal period (PBB) and first two years.
    - Evidence-based interventions and tools e.g. Motivational Interviewing.
    - Skills practice.
    - Model of supervision and cycle of improvement.

## Outcome of the work

We are engaging and mobilising the local health visiting workforce to improve outcomes for maternal and child health. Although early days, the containing and reflective nature of learning sets, mentorship, supervision and line management should have a parallel process effect on how our practitioners relate to families.

Retention of staff will be evident as will career and personal development. Mentors will hopefully feel valued by the organisation as they try out new tools and ways of working in practice and this, in turn, will enhance the experience and practice of their students enabling us to try out a model that we can replicate with a larger number of students in September 2012.

We are mobilising and valuing our current health visiting workforce and we have organised a whole service Health Visiting study day that will be delivered in April 2012.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Service specifications for 2012/13 provided in partnership with Haringey and Islington commissioners (documentary evidence to be provided once formally agreed with commissioners). Service specification for Islington provided for 2011/12<br>Islington: service specification 2011/12 includes delivery of HCP but not expansion plans for FNP. Haringey: service specification for 2011/12 does not include delivery of a universal HCP; FNP is in first 3-year contract so no current plans for mainstreaming |
| | Local health outcomes have been defined and are being measured | 1. New Birth Visits: An initial assessment is completed within 10–14 days<br>2. Quarterly increase in Breastfeeding Prevalence at 6–8 weeks<br>3. 2–2.5-year review coverage<br>4. Quarterly per cent increase in childhood immunisation uptake as agreed with NHSL<br>Islington: 4 health outcomes agreed with commissioner for 2011/12. Haringey: outcome measured for NBV at 28 days and CP dashboard the only HCP outcomes measured 2011/12.(Number of outcomes will increase for 2012/13 for both Haringey and Islington but yet to be confirmed) |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Planning in progress to provide appropriate level of evidence for this marker in 2012/13<br>Islington and Haringey HV services are in transition currently and commissioning for each service in negotiation; service users to be involved in planning/HV workforce development from 2012/13 |
| | There are narratives developed for each of the main stakeholders and these are being used throughout the patch | 1. Prepared presentations/narratives relevant for: GPs, SSCCs, midwives, HV practitioners, potential HV students, commissioners and Trust Board<br>2. Evaluations from presentations<br>3. List of groups/conferences etc presented at |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | 1. Child Health Clinics held in 4/6 clusters in Islington<br>2. Immunisations held in 3/6 clusters in Islington<br>3. 2–2.5-year health review |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Community** | | 4. Mini-MEND led by HV team in one SSCC<br>5. Health Promotion training for SSCC staff<br>6. Parent support groups eg first time parents/ toddler groups in 15 SSCCs across Islington<br>7. Baby massage. (not all above in every SSCC)<br>Islington: HV locality managers sit on 6 cluster Advisory Boards; named HVs sit on Area Strategic Team (AST) management groups. Haringey: named HVs on Advisory Boards although number of advisory boards/children's centres currently being re-configured |
| | Health Visitors lead the Healthy Child Programme for their population | Named HV attendance at six weekly meetings with GPs: GP/HV liaison database for Haringey and Islington services |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | RIO coverage data for Islington (Haringey do not offer universal review currently); Islington is one of 5 EIS sites participating in the Integrated 2–2.5-year review project DH/DfE<br>Islington: 2–2.5-year review largely carried out by nursery nurses (except universal partner plus caseload). Uptake approx. 55 per cent but variable – high 80 per cent one team to lowest team 20 per cent. Haringey: very targeted. Measure plan to take into account per cent not given the two year review across both boroughs |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | 1. Breastfeeding peer support programme and UNICEF baby Friendly; Islington has achieved step 1 towards accreditation and Haringey has certificate of commitment<br>2. Early identification of maternal mental health issues using Woolley questions |
| | There is evidence that health visiting services form part of the high intensity multi agency services for families where there are safeguarding and child protection concerns | Social Care CP conference audit |
| | Pathways from midwifery to health visiting and health visiting to school nursing have been developed and are understood by HV, midwifery and school nursing practitioners | 1. Care pathways from midwifery to health visiting and health visiting to school nursing QIPP programme<br>2. Number of incident forms/completed action plans (Audit in progress March 2012)<br>3. Referrals to health visiting from midwifery |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | 1. Both Haringey and Islington have FNP programme<br>2. All Islington HV and SSCC teams have been trained in the Solihull approach<br>3. HV services work with LA Early Years to ensure families can access appropriate parenting programmes<br>4. HVs in Islington attend multi-agency meetings with SSCCs following family support CAF/TAC process; HV service sits on fortnightly CAF panel in Haringey<br>5. Identification of maternal mental health issues supported by HV listening visits and onward referral if necessary |
| | Staff receive training on safeguarding | All HV clinical staff are trained at levels 1 and 2 and at level 3 where appropriate |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | 1. Appraisal information to be collected for 2012/13<br>2. Percentage attendance of PTs/mentors support group<br>3. PT survey May 2012 To be reviewed with PTs and mentors at 2012/13 appraisal (April–June 2012) |
| | Staff are regularly listened to and their voice helps transform service delivery | 1. Visible leadership; management team attendance at locality/team meetings<br>2. HV development group<br>3. HV study day 18 April 2012 – see presentation attached |
| | There is a medium to long term workforce strategy for the new Health Visitor workforce to deliver the new service vision and family offer which includes a training development plan for the current and future workforce | 1. Workforce Strategy<br>2. Training plan<br>3. Attendance of newly qualified Health Visitors at training programme |

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# Wirral Community NHS Trust

## Case studies and Practice examples

- Healthy Child Clinic – Contact Jo Chwalko Tel 0151 604 7320
- Breast Feeding App – Contact clare.whitehead@wirral.nhs.uk

## Innovation Illustration

Wirral Healthy Child Clinic – Increasing choice and accessibility to the health visiting service for children and their families.

The Health Visiting Implementation plan encouraged us to rethink the way we deliver our service not necessarily what we do. We sought views from peers, agencies and families through verbal discussions during our universal and targeted services, open parent forums, multi-agency meetings and asking parents using the local children's centre. This information identified themes on improving choice and accessibility and identified the diversity amongst agencies and families in terms of what health visitors do.

The Healthy Child Clinic is a drop in service for families Monday – Friday 09.30–16.30. Families can access any aspect of the HCP 0–5 including unscheduled immunisations. The rationale is one of addressing the themes identified, and to work in partnership with families in making decisions about their child's health (family and child centred care).

The universal, universal plus and universal partnership plus framework underpins the clinic, but in our experience families frequently move in and out of each area and seldom sit neatly within each domain. It is therefore imperative that we open

up accessibility to the universal service so that we can identify more families that need additional support and, most importantly, identify them earlier.

## Rationale

Families, particularly those accessing universal partnership plus rarely seek support openly either because a fear of being labelled or judged by professionals. They are normally identified through their lack of engagement or when another agency has highlighted a problem. We wanted to change this by allowing families to choose when they see us, build relationships and access support when they feel empowered to do so. For example, drawing upon our experiences we know that women present to professionals on numerous occasions before disclosing domestic violence or mental health. If we only provide an opportunity during current standard universal contacts at birth and six weeks then we are reducing the opportunity for women to discuss their issues and often women are identified when they have reached crisis. We still provide those contacts but we are now accessible on a one-to-one basis for an additional 35 hours a week. This is without any additional cost to the trust.

We have also moved away from the traditional appointment system for developmental reviews. We offer choose and book or 'walk in' reviews where parents can discuss their child's development. If this issue is not resolved during the drop-in session we create care plans for families underpinned by the universal, universal plus and universal partnership domains to support the family. Families determine where and when the care plan is delivered, whether at home or in a clinic setting. For universal partnership we use the Common Assessment Framework (CAF) to ensure families receive a joined up service.

## Outcome

The attendance figures have increased two-fold since opening in March 2011. We now have up to 120 families accessing the clinic weekly. The strongest indicator for this success is word of mouth by our clients. Families from across Wirral access the clinic despite its promotion being limited to one area.

The number of mothers receiving support for postnatal depression has increased since the clinic started. This is evidenced by monthly commitment data sent to managers which highlights the number of families we work with.

Caseload supervision highlights that support now sits within universal plus rather than universal partnership plus and although there are women within universal

partnership plus this has reduced. All women have been seen on a one-to-one basis with families commenting that we have 'time' to listen.

Integrated working has improved significantly. Due to demand we have now opened up the clinic to accommodate midwives and the local children's centre. We have other agencies waiting including one-to-one midwives (independent provider) and women's services. GPs refer directly into the clinic. The interest is generated through network meetings, joint work with families and monthly meetings with GPs. The clinic is promoted in social care, education and the voluntary sectors through meetings and literature.

Health visiting leadership and assessment skills are enhanced. The unpredictability of attendance at clinic ensures enhanced communication, assessment and leadership skills. Evidence is drawn from supervision documentation and training booked for motivational and promotional interviewing. We have an increased number of health visitors coming forward to lead on specific clinic related topics e.g. Immunisations.

The completion of developmental reviews has increased from 30–40 per cent to 80–100 per cent (2010–2012). This is evidenced by auditing appointment bookings during 2010 and choose and book/drop in sessions during 2011–12 and comparing data. Average of five appointments offered daily throughout the duration.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Service specification completed and signed off by senior management and commissioner |
| | Local health outcomes have been defined and are being measured | Teenage pregnancy breast feeding and speech and language referrals |
| | Commissioned posts agreed with commissioner and delivering on trajectory | Workforce trajectory negotiated with Commissioner and workforce planning agreed |
| | IT development plans in place. Resources confirmed and CQUIN agreed | Learning dissemination Procurement of IT in progress agreement from senior management and commissioner |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Public Engagement Initiative. Breast feeding App. Developed |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Solihull Parenting and antenatal groups child health clinics developmental reviews breast feeding groups weaning groups first time parents group |
| | Health visitors are supported in community development – learning taken from Building Community Capacity project leaders | Three health visitors completing Building Community Capacity. We have met with HEI to plan role out of Building Community Capacity for all health visitors |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | A 'No appointment drop in' Healthy Child Initiative rolled out with data demonsrating increased access |
| **Universal Partnership Plus & Safeguarding** | Work with midwifery services in place and evidence of strong relationships with other agencies | Collaborative working with midwives in place although this needs to be strengthened and agreed. Independent midwifery provider also commissioned in Wirral |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | There are plans to ensure all health visitors are trained to level 6/7 mentorship. Currently all PT trained at level 7 |
| | Staff are regularly listened to and their voice helps transform service delivery | Issues were highlighted by client/staff and staff helped to find the solution |
| | Additional training for all staff on Attachment, supported by planned commissioning of MI training for new staff. PI training will be completed in April for all health visitors – supported by planned revising of attachment and MI support | Learning and development planning agreed. Training and development plan being developed with agreement from Commissioner |

## Further information

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# Wye Valley NHS Trust

## Case studies and Practice examples

- Community nursery nurse and family support worker Café World
- Formulation of community based health visitor-led clinics, following information obtained for client questionnaire
- Formulation of multi-agency (midwife, health visitor, health visitor Community Nursery nurses, and children's centre family support workers) group antenatal provision for all parents to be, across the county
- Development of service for additional breastfeeding support in the postnatal period. Community nurse from the health visiting service receiving referrals from midwifery, undertaking support within mother's home environment
- MARSIS pilot site

## Community

### A Countywide Approach to Multi-agency Antenatal Education and Preparation for Parenthood

A programme of multi-agency group antenatal care has been devised between midwifery, health visiting, and children's centre services. Three group sessions will be delivered to all parents across the county covering the following areas:

- Baby brain development, the role of the new parents – health visitor led.
- Practical issues, and support caring for your new baby – Community Nursery nurse (health visiting) and family support worker (Children's Centre) led.

- Labour and birth – midwifery led.

Breastfeeding will be discussed throughout all three sessions. Lesson plans have been devised to ensure continuity across the county, and staff training undertaken in February 2012. The initiative commenced March 2012.

## Universal

### A Journey to parenthood – Antenatal Health Visitor home contact

- A pilot has been undertaken offering an antenatal home contact at 28–34 weeks gestation to all primigravida antenatal mothers, and unknown multigravida mothers.
- Health visitors have been utilising Promotional Interviewing when undertaking the contact.
- Questionnaires are utilised with clients to monitor success and will facilitate continual development of the antenatal provision.
- Progress will be charted through numbers of antenatal parents receiving a home visit between 28–34 weeks gestation.

## Rationale behind the Work

### A County-wide Approach to Multi-agency Antenatal Education and Preparation for Parenthood

Historically over the past five years health visitors have had very little input into group antenatal provision. This has been led by Midwifery, with only Health Visitor input within one geographical area in the county.

### A Journey to Parenthood – Antenatal Health Visitor home contact

Prior to the pilot a home antenatal contact by a Health Visitor was sporadic, and inconsistent, depending on individual Health Visiting Practitioners, and the geographical area in which they worked. Also there was no defined method of delivery for an antenatal contact.

## Outcome

### A County-wide Approach to Multi-agency Antenatal Education and Preparation for Parenthood

- Evidence based lesson plans have been devised, and training undertaken for health visitors to deliver the antenatal education session.
- Evaluation forms devised for clients to provide feedback in relation to the antenatal provision.

### A Journey to Parenthood – Antenatal Health Visitor home contact

- Training needed to deliver the antenatal contact has been identified and in the most parts delivery of training is complete, including Promotional Interviewing.
- An initial template for the antenatal home contact has been devised, and as training is completed will be cascaded to all health visitors.
- Client satisfaction information has been gathered, reviewed and utilised to enhance the antenatal home contact.
- The pilot has highlighted the profile of the antenatal home contact, and has enabled health visitors to prioritise the contact within the service provision provided.
- Stakeholders, for example General Practitioners, Midwifes, and Children's Centre staff have a deeper understanding of the Health Visitor role in the antenatal period.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | A Service Specification has been developed by Childrens commissioning, incorporating the Health Visitors role within the Healthy Child Programme. Further development is now required for the Service Specification to incorporate the Health Visiting Implementation Plan |
| | Local health outcomes have been defined and are being measured | Data collated in relation to breastfeeding and childhood immunisations, submitted to children's commissioning services, public health department and local authority children's services. Data collated for a CQUIN target in relation to numbers of clients we see who smoke, and the numbers of smoking clients we have supplied with stop smoking information. Data in relation to numbers of children who have received developmental assessment undertaken by the Health Visiting Service at: 9 months, 2–2.5-years and 3¼ years. Data collated in relation to numbers of women who were referred by Midwives for breastfeeding support services by the Community Nursery Nurses within the Health Visiting Service. Data in the relation to the percentage of woman who are continuing to breastfeed at 6–8 weeks following this support service. Therefore we are currently collecting 7 sets of health data |
| | Reducing smoking | This is a CQUIN target within Wye Valley NHS Trust. Smoking status and smoking advice given on Community Parent Administration System |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | This information is based on the client feedback/evaluation for the Health Visitor element of the group antenatal provision that commenced March 2012 |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | There is a named health visitor for the 11 Children's Centres, and they are invited to the centres' Management Advisory Board meetings. Several of the centres have joint advisory boards |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | Wye Valley NHS Trust Health Visiting service has mapped it's current service provision along side the Healthy Child Programme. All clients in Herefordshire are offered the following routine appointments with the Health Visiting Service:<br>• At least two postnatal home visits<br>• 9-month development assessment<br>• 2–2.5-year development assessment<br>• 3¼ year vision screen<br>Many clients are also offered an antenatal home contact, although this has been sporadic across the county and a pilot was completed offering an antenatal home contact to all primagravida mothers, between 28 and 34 weeks of pregnancy<br>All staff have received training and are now utilising Schedule of Growing Skills for all children's 9-month and 2-year assessments |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | Within Herefordshire Solihull approach is the evidence based tool that is utilised by all staff when working with families with any behavioural management issues in relation to their children<br>Relevant NICE Guidelines are reviewed, and action plans developed where necessary<br>Woolley questions are used by Health Visitors for screening for depression. This is audited on a twice-yearly basis |
| | Work with midwives is in place and demonstrates strong relationships in pregnancy and early weeks | Health Visitors meet monthly with Midwife colleagues<br>Group antenatal provision Health Visitor Community Nursery Nurses Breastfeeding Support<br>Numbers of women referred for breastfeeding support are measured. The percentage of these women who are continuing to breastfeed at 6–8 is also recorded and measured from January 2012 |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal & Universal Plus** | Health Visitors are making a home antenatal contact to all primagravida mothers to be | Health Visitor attendance at Child Protection Case Conferences and Core Group Meetings is audited by the Named Nurse for Safeguarding periodically<br>Evaluation and recommendations from the pilot, have been made, and amendments to service provision as appropriate following user feedback the service has continued to provide ante natal home visit to primagravida mothers and unknown multigravida mothers throughout the County, including fathers within this process |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | Multiagency group meetings have been developed across the County. Individual Common Assessment Framework (CAF) are discussed. Community issues or concerns are also discussed and action plans formulated<br>Herefordshire provided a Traveller Health Service, a Health Visitor is a member of this team<br>Herefordshire has a 0.2 WTE Specialist Domestic Abuse Health Visitor. A Health Visitor works as part of the Youth Offending Service. Health Visiting Service provides health input into the Polish family group |
| | Staff receive training on safeguarding | All staff, including clerical staff, receive annual update Safeguarding Training at Level 1. All Health Visitors and Nursery Nurses receive Level 3 training. Several have undertaken Level 4 Safeguarding Training. Safeguarding Forums are delivered by Named and Specialist Nurses for Safeguarding, four times a year. Staff are requested to attend three out of four Forums |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | There are four qualified practice teachers within the Trust. An additional seven Health Visitors are currently undertaking their Community Practice Teacher Training |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Workforce (Improved professional support development, education and morale)** | Staff are regularly listened to and their voice helps transform service delivery | • Monthly Health Visitor meetings for staff are held to discuss Early Implementer developments and service provision<br>• World Café events have been organised to discuss antenatal provision and Health Visiting outcomes<br>• Each Health Visitor has access to a Team Leader to discuss any ideas or concerns that they may have<br>• Health Visitor Team Leaders and Practice Teachers are involved with the Early Implementer Operational Group |
| | There is a training plan devised for current health visitors. The aim being to ensure successful delivery of the New Health Visiting Programme | We currently employ four community practice teachers for health visiting. An additional seven are currently undertaking the practice teacher training. We have four student health visitors who commenced training in September 2011. An additional seven students commenced their training in January/February 2012<br>• Health Visitors have undertaken Schedule of Growing Skills Training – as previously stated<br>• All Health Visitors are currently undertaking promotional interview training, as advised within the Healthy Child Programme. This will be completed March 2012<br>• Some Health Visitors have undertaken one-to-one relationship training again, as advocated within the Healthy Child Programme<br>• Six Health Visitors have completed the Health Visiting/Safeguarding Leadership Course. An additional two health visitors are due to commence this training<br>• Two Health Visitors have commenced the Building Community Capacity Module |

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# Bath and North East Somerset (Sirona Care and Health CIC)


## Case Studies and Practice examples

Early Relationships infant mental health case study to explain Universal Partnership Plus level of working across HV and children's centres

Application of the learning portfolio to HV Service Vision

2-year review and joint work with early years colleagues

- Antenatal visiting enhanced with support from promotional interviewing training. two pilots where quality is being checked before replicating throughout the area
- Pregnancy Birth and Beyond in an area of poverty in partnership with children centres
- Scoping joint 2-year review with children's centre and use of ages and stages questionnaire (ASQ)
- Building Community Capacity on two sites looking at postnatal depression and parenting

# Innovation Illustration

## Brief description of work

Building Community Capacity (BCC) (Two projects in first wave)

1. As health visitors we notice isolated families who have little or no family or friendship support and who fear the behaviour, substance use and criminal activity they perceive in their neighbourhood. A high proportion of the parents have been in care themselves and educational attainments are below average. We wanted to improve the support and opportunities for growing young children in these families and influence the community they live in. There has been a community group developed in partnership with local voluntary agencies, but firmly held by the universality of health visitors. There is a community-led focus on healthy eating and a healthy community.

2. Health visitors talked to young vulnerable mothers in their care about what would help their isolated situation and created a safe group for them to meet and connect close to their homes. Using evidence base of baby brain development young families became eager and engaged to know more about their vital role in getting the best for their child. Once the quality of their network is strong and the group's confidence increases we bring in children's centre's or local community groups as the next stage of support. Health visitors can be released to 'in reach' to the next wave of young families, but are still visible in the community.

# Service Vision

## Your Community

**Rationale** Health visitors are best placed to reach out to families with their public health knowledge and communication skills. In the interests of tackling social exclusion and health inequalities expected outcomes of our Building Community Capacity work are:

- Parents will make friendships that sustain outside the project.
- Parents will show increased sensitivity to their children's emotional and developmental needs (Shonkoff, 2011).
- Parents and community members will be involved in planning and running projects as they are able.
- Children will show progress in physical, emotional and social development particularly in areas causing concern.

## Outcome

- Health Visiting Teams are building up, enhancing and growing the skills of the community with creativity and leadership to improve health outcomes and lead the HCP 0–5 for their population.
- Families feel empowered to use and change services offered.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Monthly review of deviation and developments from original service spec quarterly reporting |
| | Local health outcomes have been defined and are being measured | KPI reporting Breastfeeding, Newborn screening, Immunisation Monthly collection quarterly reporting on scorecard |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Red book insert, leaflet and internet information under development Service user surveys feedback from focus groups |
| | The Health Visiting team locally are mobilised to deliver the new offer | Audit of records in an individual team on a monthly basis No of cases where service level identified |
| | Commissioned posts are identified and recruited to, delivering the annual workforce growth trajectory needed to deliver the ambition | Workforce plan |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | Names of health visitors on management boards. What's on with details of services provided by health visiting work towards assessment Work towards assessment of 'health outcomes' component of Children's Centres annual self assessment |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | Reporting of offer and take up of 2–2.5-year review monthly |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | Development of packages of care with supporting research and evidence. Work toward monitoring of parents reporting progress towards their families health goals |
| | All families are contacted at 28–30 weeks pregnancy and offered a home visit if first time parents | Health visitor training in promotional interviewing, antenatal assessment checklist adopted, data from monthly HV activity sheets |
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | Quarterly reporting from individual services i.e CBT delivery to individuals and groups, Early Support, teenage breastfeeding support |
| | Families with complex needs have coordinated multi-agency support | CAF and TAC activity |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | Annual PDP, evidence of recruitment, training, special events, supervision and support |
| | Staff are regularly listened to and their voice helps transform service delivery | Staff training needs audit,survey monkey, away day and clinical focus feedback, steering groups |
| | Provider EIS professional development (CPD) plans demonstrate that health visitors can access the ongoing specialist training they require | Tailored EIS Health visitor training programme ALPS training outlines Away day agenda Clinical focus agendas |

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# Cornwall Foundation Trust Health Visiting In Cornwall and the Isles of Scilly

## Case studies and Practice examples

Building Community Capacity

Band four plus development programme

## Innovation Illustration

As an Early Implementer Site Cornwall Partnership Foundation NHS Trust Health Visiting Services has focused on the development of the following areas:

**Community**

- Health Needs Assessment – Profiling the Health Visitor Caseload.
- Piloting the Building Community Capacity programme.

**Universal**

- Symmetrics: Matching Health Visiting staff to population health need.
- Commissioned Healthy Child Programme.
- Remodelling the Practice Teacher role.

**Universal Plus**

- Staff Development – evidence based delivery.
- Integrated working with other children's services and children centres.

**Universal Partnership Plus**

- Expansion of the Family Nurse Partnership.
- Investment in new roles to target those most in need.

### Stage one completed

Four specific areas of work were identified namely:

- Comprehensive Needs analysis.
- Mapping core offer of health visiting.
- Workforce profiling – capacity v demand.
- Develop new service specification and performance management regime.

The collected data was verified against other data sources including Early Years attainment scores which appeared to show similar themes regarding areas of higher need.

### Stage two completed

- Workforce remodelling – Practice Teacher job descriptions reviewed, mentor development.
- Skills Grid, team competencies and training programme devised.
- Restructuring of Children's Health Services into integrated teams.
- Investment Programme agreed with Commissioners – SCPHN workforce training plan.
- Expansion of the Family Nurse Partnership.
- Two health visitors pilot the Building Community Capacity Programme.

### Stage three ongoing

- Working with Commissioners to implement additional and new Health Visitor posts.
- Build on existing good work with Children Centres and plan for integrated commissioning.
- Commissioning of Preparation for Parenthood and Beyond.

## Rationale behind the work

#### Health Visiting prior to 2010

The local service had developed historically over many years without a substantial review of provision, capacity or demand. The picture in 2009 was one of 24 teams each providing a slightly different level and type of service to children under the age of five.

In achieving our responsibilities to deliver a high quality local service in line with best practice, best value and best outcomes there was a clear need for a comprehensive review.

## Outcomes of the work

1. The needs analysis identified substantial differences in levels of need by locality and is currently being repeated. A full atlas of need by locality for families with a child under the age of two years has been published on the PCT website.

2. On comparing areas of greatest need against health visitor capacity it was clear that the distribution of staff did not meet identified need. Without making any changes to staffing distribution, it was identified that the current service could achieve 91 per cent overall service delivery however, capacity in some localities enabled 100 per cent achievement whilst in others only 58 per cent. With slight movement of staff between localities, it was identified that the service had sufficient staffing to achieve 100 per cent in each locality and across the service as a whole. The current capacity enables an average ratio of 1:330 (Health Visitor: Child).

3. The Health Visiting offer As a result of the above work the table overleaf provides the schedule of core contacts that every family could expect to receive from the health visiting service in Cornwall and the Isles of Scilly. These are in line with the national Healthy Child Programme with an additional antenatal contact locally considered good practice. A similar table details the core offer plus a range of the targeted contacts.

4. Practice Teacher remodelling As a result of a restructure the opportunity to remodel the role of the Practice Teacher proved integral to the EIS development and investment in Health Visiting in regard to student investment and staff development. There is an agreed student development programme in place to meet the Health Visitor workforce investment.

5. The Family Nurse Team has doubled in size with eight nurses and one supervisor.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | Health Needs of population identified, staff in post according to local health needs | Health Needs Assessment and Symetrics model |
| | Workforce Plan in place for rolling programme of EIS students and staged delivery of new service plan | Business case, Student plan to 2015, Workshops with staff and Commissioning |
| **Universal Partnership Plus & Safeguarding** | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | Solihull approach. Training going live 2012, Learning from FNP |
| | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | Service Protocols-Pre Common Assessment Framework (CAF) assessment,Care Plans in place, Recorded as targeted intervention and in symetrics, FNP |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | Solihull approach. Training going live 2012, Learning from FNP |
| | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | Pre Common Assessment Framework (CAF) assessment, Care Plans in place, Recorded as targeted intervention and in symetrics, FNP |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | Engagement with Service Lead, Regional and Local Events |
| | Staff are regularly listened to and their voice helps transform service delivery | Workshops summer 2011 and November 2011 ongoing in 2012<br>Practice Teacher new role. Band four plus Development Programme |

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# Southern Health NHS Foundation Trust

## Case Studies and Practice examples

- Community Based Perinatal Mental Health Assessment
- Preventative working and Rapid Response to Parenting Concerns
- Children with complex health and development needs/Children with Long-term conditions

## Innovation Illustration

Raising the profile and duration of breastfeeding in Southern Health Foundation Trust.

Specific challenges that this project:

- The projects discussed are an integral part of our Baby Friendly Initiative (BFI) application which has enabled the author to identify localities where breastfeeding rates in Southern Health NHS Foundation Trust (SHFT) (at two weeks and six to eight weeks) are below the national and regional average.

Rationale behind the work:

- It is well recognised that breastfeeding is instrumental in providing key health benefits for both mother and baby including prevention of infections, obesity and it enables staff to deliver improved integrated key public health outcomes.

Global and national evidence is unequivocal that breastfeeding services are a cost effective intervention, contributing to NHS savings from GP attendances and hospital admissions.

Recognising and revisiting breastfeeding as a major public health priority SHFT supports our vision of improving the long term health and wellbeing of all the children of Hampshire and is a key building block to delivering our HCP 0–5.

## Outcome of the work

- Breastfeeding welcome scheme.
- Working with Eastleigh Borough Council to develop a community level scheme, to promote venues that adhere to a set criterion to offer a particular warm welcome for breastfeeding.
- Antenatal/postnatal electronic newsletter.
- Working with colleagues and partners in the Rushmoor area to develop an electronic resource that parents to be/new parents subscribe to receive regular information about breastfeeding relevant to their stage in pregnancy/age of baby. It is anticipated that this resource would complement the current universal services.

**Antenatal contact**

Health visitors in the Andover area are working towards re-framing the antenatal contact in terms of achieving this universal consultation between 28–32 weeks of pregnancy and maternal/baby emotional attachment with infant feeding choices.

**Breastfeeding training**

Provision of two-day breastfeeding management course for all Health Visiting team members with provision for Children Centre colleagues to uptake places.

E-learning package offered to all General Practitioners (GP) within SHFT area.

Breastfeeding Network (BfN) Helper Training – this 12-week course has been provided for mothers who have previously breastfed/are still breastfeeding and Children Centre colleagues to enable peer to peer breastfeeding support.

### The most important thing the project is achieving

Raising the profile of breastfeeding as the normal and expected way to feed a baby.

| Theme | Success Markers | Evidence |
|---|---|---|
| **Commissioning** | There are commissioning specifications for evidence based services for children and families that includes the new health visitor service and coverage of the healthy child programme (HCP) and where appropriate expansion of FNP | Service Specification 2012/13 agreed and signed off within contract with SHFT |
| **Communications & Partnership working** | Families understand the offer/know how to access the service and are actively involved in local development and, where appropriate, delivery, there is tracking at a local level of this measure of success | Communications Plan. Breast Feeding initiatives Smoking Cessation Parenting support packages |
| | IT development plans are in place which include the health visiting work force, ensuring all relevant data captured | Data provision for outcomes |
| | Families and communities are engaged in design of services | Feedback via a range of media |
| **Community** | There is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by Health Visitors through the centre | There is a HV at least on each cluster Children's Centres, if not more which is what I have reported. We are working with Children's Centre to establish HV on every PB but the Children's Centre do have to change their Governance to allow HV on the boards in most centres. We have a very good working relationship with Children's Centre in Hampshire. Also they are all out to tender so this may inhibit process |
| **Universal & Universal Plus** | The Health Visitors leads the Healthy Child Programme (ensures all elements are being delivered to an agreed level), e.g.: ensuring that all children receive their 2–2.5-year review, and preparing for pregnancy, birth and beyond | Within Southern Health we have agreed with five providers of acute and community Paediatrics to use the ASQ and ASQ SE for 1-year health review and 2–2.5-year health review. We have a working party with Paediatricians delivering child development training to all HIV with SALT ages and stages and tools to support practice |
| | There are evidence based care packages being offered as part of Universal plus, they are clearly defined | Care package details for Universal Plus |
| | The new health visiting service is developed under the four offers and include safeguarding. This includes MESCH Maternal Early Sustained Child Home visiting | Service spec and guidelines/audit |
| | Work with midwives is in place and demonstrates strong relationships in pregnancy and early weeks | Captured via data and in RIO |

| Theme | Success Markers | Evidence |
|---|---|---|
| **Universal Partnership Plus & Safeguarding** | There are additional services for vulnerable families requiring ongoing additional support. This support may be for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health | Detailed within care package details. Perinatal Mental health Andover Antenatal project |
| **Workforce (Improved professional support development, education and morale)** | Practice teachers and mentors are sufficient and signed up to ensure delivery of new service vision and family offer supporting the new workforce in a new way | All PT and mentors have corporate objective in PDR stating they are signed up to delivering new service offer and vision. Both have monthly action learning sets containing latest research and tools. All PT and Mentors have training booked in ASQ and promotional interviewing and we have purchased three DH EIS recommended texts to support learning |
| | Staff are regularly listened to and their voice helps transform service delivery | Held four professional mobilisation events in November/deck on new service offer and asking staff to develop care packages for their innovations |
| | There is a medium to long term workforce strategy for the new Health Visitor workforce to deliver the new service vision and family offer which includes a training development plan for the current and future workforce | Workforce plans |

## Further information:

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## EIS Year One Achievements

All EIS have:

- Delivered at least one project over the last year linked to antenatal visits or the 2–2.5-year review.
- Plans to embed health visiting service specifications for 2012/13.
- Aligned their services to the four tier offer.
- Developed at least one of their improvements into a poster.
- A named health visitor on the board for Sure Start Children's Centres.
- Developed evidenced based care packages aligned to the Healthy Child Programme.
- Measures and metrics in place to support service delivery and their portfolio of success.
- Plans that all their health visitors, including students are trained in safe guarding every twelve months.
- Developed their implementation journals.
- Increased staff morale through being part of this programme.
- Worked with Sure Start Children's Centres and Local Authorities in order to deliver the health visitor commitment.
- The belief that all the tools are available to help them deliver the health visitor commitment.
- Delivered significant changes with little or no workforce growth.

The majority of EIS have:

- Collected, or have plans to collect, local outcome measures.
- Listened to, or have plans to listen to, the voice of families, children and our health visitors.
- Identified local additional measures linked to our national success markers.
- Worked with GPs in order to deliver the health visitor commitment.
- Built a significant portfolio of evidence around their service delivery.

The previous pages are a collection of the innovative practice and achievements delivered over the last 12 months, summarised by the Early Implementer Sites.

# Glossary

| | |
|---|---|
| AN | Antenatal |
| ASQ/ASQ SE | Ages and Stages Questionnaire Social-Emotional |
| BCC | Building Community Capacity |
| BfN | Breastfeeding Network |
| BMI | Body Mass Index |
| CAF | Common Assessment Framework |
| CAMHS | Child and Adolescent Mental Health Service |
| CBT | Cognitive Behavioural Therapy |
| CC | Children's Centre(s) |
| CCG | Clinical Commissioning Group |
| CHIS | Complementary Healthcare Information Service |
| CPE | Clinical Practice Teacher |
| CPT | Clinical Practice Teacher<br>Community Practice Teacher |
| CQC | Care Quality Commission |
| CQUIN | Commissioning for Quality and Innovation |
| DfE | Department for Education |
| EIS | Early Implementer Site |
| ESR | Electronic Staff Record |
| EYFS | Early Years Foundation Stage |
| FIS | Family Information Service |
| FNP | Family Nurse Partnership |
| FTE | Full Time Equivalent |
| GP | General Practitioner |

| | |
|---|---|
| HCP | Healthy Child Programme |
| HEI | Higher Education Institution |
| HR | Human Resources |
| HV | Health Visitor/Health Visiting |
| HVIP | Health Visitor Implementation Plan |
| IT | Information Technology |
| KPI | Key Performance Indicator(s) |
| LA | Local Authority |
| MMR | Measles, Mumps and Rubella |
| NBV | New Birth Visit |
| NCMP | National Child Measurement Programme |
| NICE | National Institute for Clinical Excellence |
| NQHV | Newly Qualified Health Visitor |
| OFSTED | Office for Standards in Education, Children's Services and Skills |
| PBB/PBB&B | (Preparing for) Pregnancy, Birth and Beyond |
| PCT | Primary Care Trust |
| PHCR | Parent Health Child Record |
| PND | Postnatal depression<br>Perinatal depression |
| PT | Practice Teacher |
| RN | Registered Nurse |
| S75 | Section 75 Commissioning Agreement |
| SALT | Speech and Language Therapy |
| SATOD | Smoking at Time of Delivery |
| SCPHN | Social Care and Public Health Nurse |
| SLA | Service Level Agreement |

| | |
|---|---|
| SPT | Specialist Practice Teacher |
| SSCC | Sure Start Children's Centre(s) |
| SW | Social Worker |
| TAC | Team Around the Child |
| TCS | Transforming Community Services |
| WTE | Whole Time Equivalent |

With thanks to:

- Outward Facing Implementation Support
- Early Implementer Sites
- Strategic Health Authorities
- Family Nurse Partnership
- The wider Health Visitor Programme and its key partners

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