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Health Visitor Implementation Plan:

Quarterly Progress Report: October 2013 – March 2014

November 2014

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Health Visitor Implementation Plan:

Quarterly Progress Report: October 2013 – March 2014

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1. Introduction

Purpose of the report

The Health Visitor Implementation Plan: A Call to Action, published in February 2011, set out how, through expansion of the health visitor workforce, (securing an extra 4,200 health visitors) and by transforming the health visiting service across England by April 2015, it will help secure effective, sustainable services to support families to give all children the best start, and to promote health and wellbeing in local communities.

The service's expansion is intended to deliver a 4 tiered model of health visitor delivery of the Healthy Child Programme to all, support for all parents and early help when needed. It aims to:

- improve access to evidence-based interventions;
- improve the experience of children and families;
- improve health and wellbeing outcomes for under-fives;
- and ultimately reduce health inequalities.

The Implementation Plan also committed to publishing quarterly reports explaining the programme's progress.

This report summarises the progress of the Health Visitor Programme in the second half of 2013/14 i.e. from October to the end of the financial year at 31 March 2014. It has been developed by the Department of Health, NHS England, Health Education England (HEE) and Public Health England (PHE). Previous quarterly reports, can be found at: https://www.gov.uk/government/publications/health-visitor-plan-quarterly-reports-2013-to-2014

Changes to the health and social care landscape

Since April 2013, the programme has been delivered within the new health and social care system. Responsibilities for delivery of the programme's aims are now split across three key organisations: DH; NHS England; and Health Education England supported by PHE. This has meant re-arranging the governance and programme and project management arrangements to reflect 'Mandate' responsibilities and the complex relationships.

Organisational roles were outlined in the 2013/14 quarter 1 update as well as in the '*National Health Visitor Plan: progress to date and implementation 2013 onwards'* (published in June 2013 to mark the programme's half way point, and available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/208960/Implementing_the_Health_Visitor_Vision.pdf

2. Key achievements in the quarters 3 and four

Workforce Growth

At March 2014 the total number of health visitors in England stood at 10,383 full time equivalents (FTE). This meant that during the six months of the second half of 2013/14, the overall number of health visitors had grown by 833 – i.e. from 9,550 (FTE) at the end of September.

During the year 2013/14, the health visitor workforce grew by 1,250 FTE - i.e. to 10,383 from 9,133 at the end of March 2013.
By the end of 2013/14, the increase in the number of health visitors over the May 2010 baseline figure of 8,092 (FTE) stood at 2,291 (FTE), growth of 28%.

In 2013/14 2,046 health visitors completed their training qualification.
There were 2,743 new starters on health visitor training programmes during 2013/14.
In parallel with ensuring robustness of numbers into/emerging from the training pipeline, there has been action to maximise the retention of students and to support in tracking them into first employment.

Transforming service and revitalising the profession

The programme's activity has continued to focus on sustainable service transformation and has successfully provided specific funding to support local transformation projects. The focus has been on delivery of the four tiered progressive model of health visiting including the universal elements of the healthy child programme.

Professional leadership and mobilisation

A range of professional leadership initiatives have been undertaken to support transformation within the service, these include (see also page 20):

- integrated workshops between early years staff and health visitors to enhance joint working;
- interactive events with students to increase understanding of the expectations of new service model and facilitate the raising of queries/concerns;
- enhancement of the role of the practice teacher to improve the quality of clinical placements; and
- training programmes and support materials that enhance the skills and knowledge of all health visitors, including perinatal mental health and domestic violence and abuse training/e-learning materials.

Preparing for new commissioning arrangements (transition)

The Department of Health confirmed in January 2014 that the commissioning of 0-5 children's public health services will transfer to local authorities on 1 October 2015. This means that as the programme has moved into its key expansion and delivery phase, major focus has also been placed on preparing for a successful handover of commissioning these 0-5 services to local authorities.
This has instigated a period of close working between the NHS and local government, supported by PHE, that will ensure an effective transfer and that local government is well

prepared to receive these new responsibilities to add to existing early years and children's services.

3. Organisational responsibilities and programme governance

A summary of the changes to the health and care system that came into effect in April 2013 was set out in the earlier Q1 report (page 9), published at the time of changes and available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/265261/3_LOGOED_template_to_capture_final_agreed_version_pre_publication_final_v4.pdf

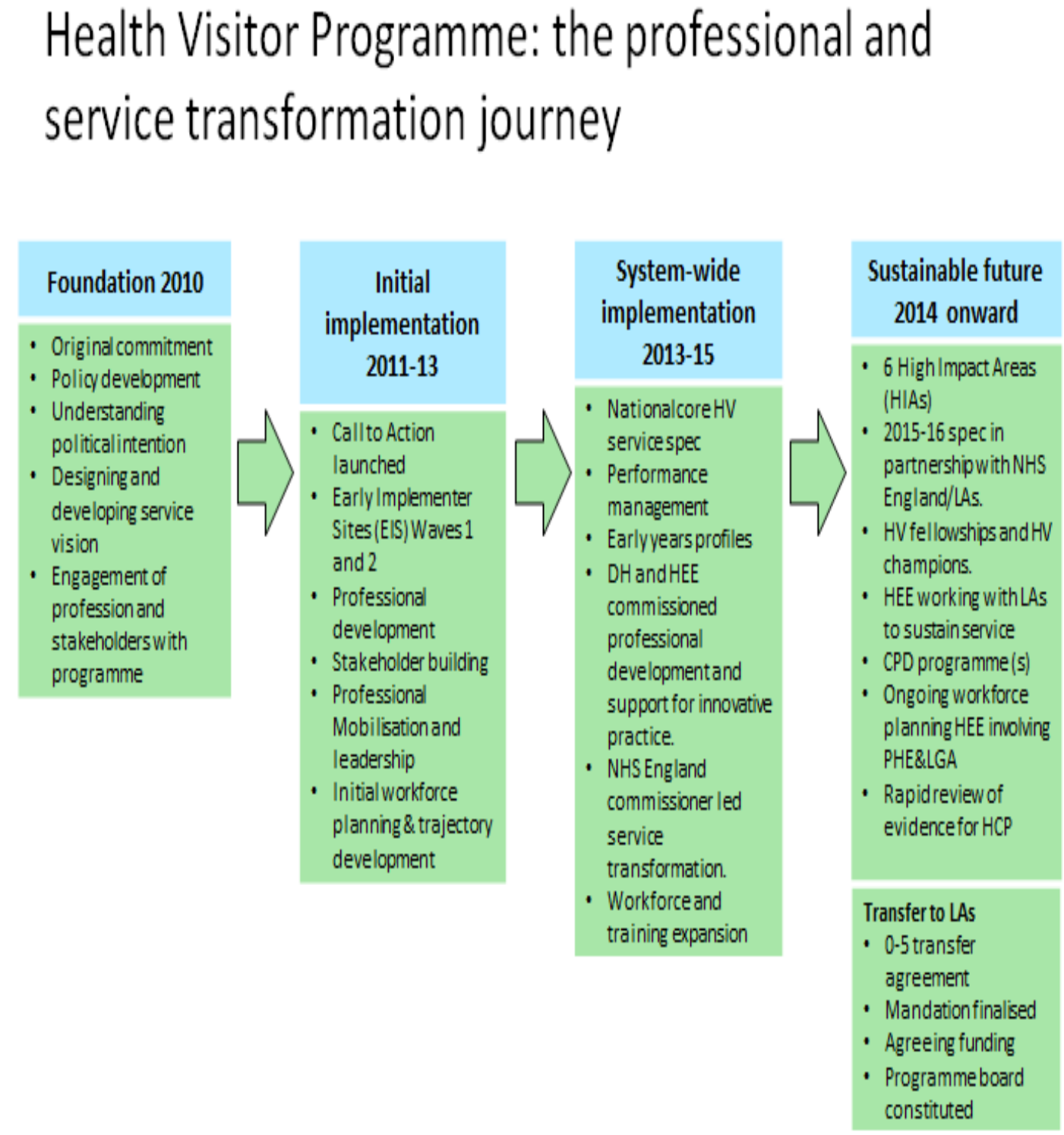
To reflect the need to deliver a safe and effective transfer of commissioning arrangements that see local authorities smoothly take over commissioning responsibility from NHS England for public health services (including health visiting) for children aged 0 – 5, a national level task and finish group was established to develop a comprehensive transfer plan.

The group under the leadership of Jon Rouse, Director General at DH, includes membership from NHS England, Public Health England, DCLG, LGA, SOLACE, ADPH and ADCS. It has five associated work-streams which aim to:

- support service stability;
- build on and supports continuing service transformation and integration; and
- ensure that local authorities have the funding, responsibility, capability and capacity to commission effectively.

In September this year, the group evolved to become the *0 to 5 Public Health Commissioning Transfer Programme Board*.

The diagram below illustrates the programme's development over time, capturing four key phases from its foundation, through to the current focus on ensuring sustainability.



4. Workforce expansion

Workforce trajectories

Workforce trajectories have continued to form the key basis for assessing and monitoring progress on delivering the programme's commitment to increase workforce capacity.

During the second half of the year (Q3 and Q4), programme partners worked very closely, including NHS England's regional offices/area teams, with HEE, local education and training boards (LETBs) and the Department to continue delivery of workforce plans.

Throughout the year, NHS England made use of the performance management framework, key lines of enquiry through Area Teams and the RAG rating of progress, to ensure robustness of delivery against trajectory*:

Discussions to agree the 2014/15 trajectories began in Q3 and continued throughout Q4. They were developed with regions, working closely with their area teams and providers and adopting a bottom up/top down approach to understand the detail which constitutes the make-up of plans to deliver each regions trajectory.

Throughout Q4 there has been robust challenge at all levels within NHS England to ensure transparent achievable trajectories are set. Health Education England oversaw and signed off the supply elements (from training) of the trajectories.

**The trajectory for 2013/14 was rebased to reflect actual FTE numbers in post as at March 2013*.

Workforce growth

At the end of Q3, (December 2013), there were 9,959 health visitors in post, whilst at the end of Q4 (March 2014) there were 10,383 health visitors. The end of Q4 figure represents a total growth in the health visitor workforce since May 2010 of 2,291 FTE (+28%).

At the end of Q4, the reported number of those starting training in 2013/14 to become a health visitor totalled 2,743 – 11 more than target, (recruited to three cohorts: September/October 2013; January 2014 and March 2014).

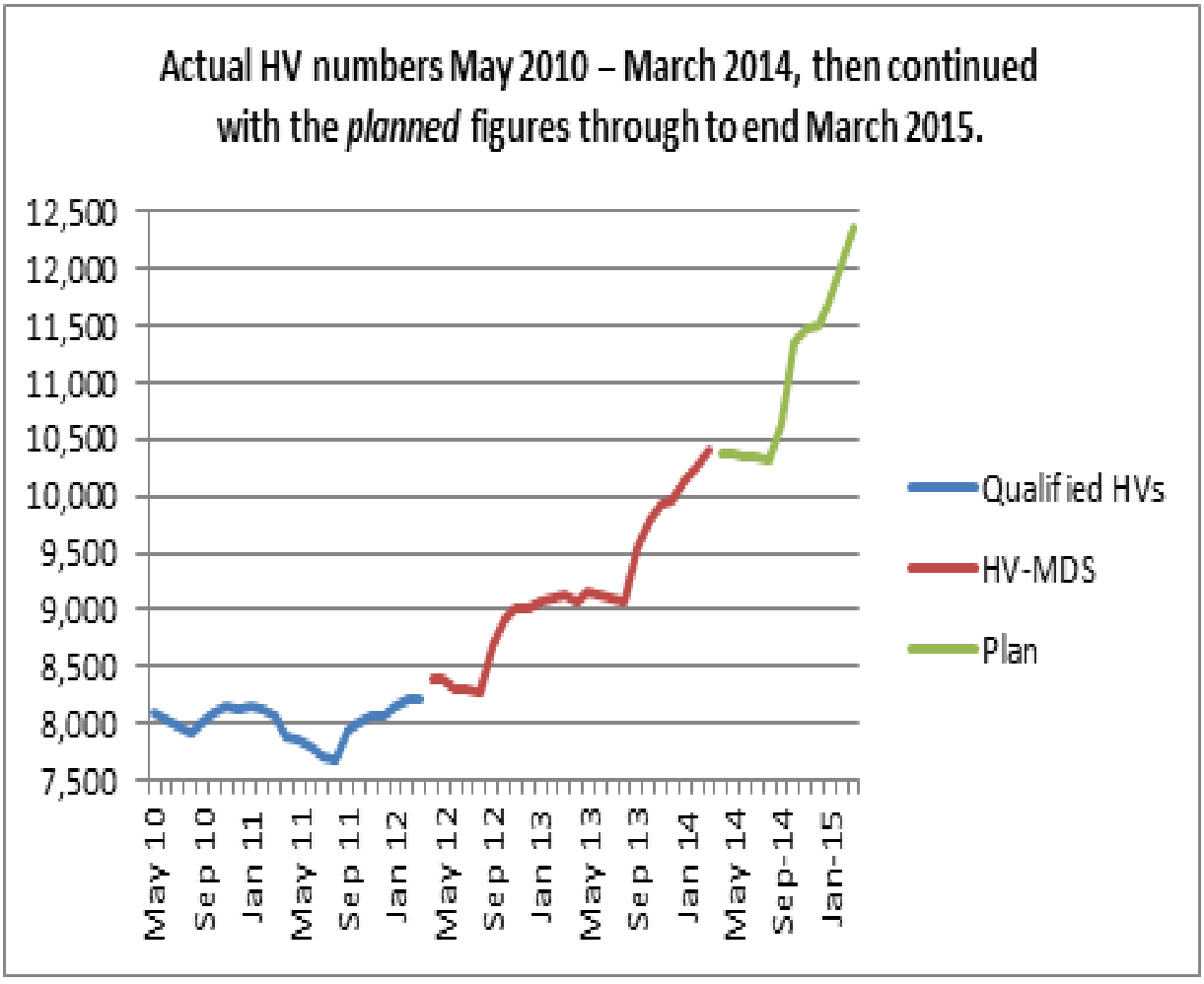
A total of 2,046 health visitors were reported to have completed training in 2013/14, an over performance of 155, (from two cohorts in September/October 2012 and January 2013).

Throughout Q3 and Q4, discussions at regional meetings, at which NHS England's national team participated, continued to focus on both the delivery of the additional health visitor numbers.

In Q4, regions, area teams, HEE LETB colleagues worked jointly to understand and address the challenges of students moving from training into the workforce, so as to ensure that the impact of the additional students is maximised. NHS England undertook to ensure this continues throughout 2014/15.

NHS England issued guidance regarding data cleansing. This supported an on-going focus with providers (via the regions), to ensure all health visitors are correctly coded and counted on the electronic staff record (ESR).

From Q4 onwards, both LETB and regional representatives have attended the NHS England and HEE *Health Visiting Joint Governance Group,* this has further strengthened the focus on delivery and ensure cross system working and effective sharing of good practice.



NOTES

1. The graph above shows growth of the health visitor workforce in England since the start of the programme up to the end of 2013/14, then (the 'plan' line), the trajectory for planned growth to the end of March 2015

2. Data related to the graph is available at Annex A, page 26.

3. The re-basing at April 2013 - when NHS England took up operational responsibility for delivering workforce growth, reflects joint adoption of a revised growth trajectory going forward to delivery in April 2015.

SOURCE: Data to end 2014 - Health and Social Care Information Centre, plan – NHS England.

Health Visitor training

Numbers starting health visitor training has grown more than five-fold, from under 500 in 2009/10 to 2,743 in 2013/14 – meaning these students will be able to join the health visitor workforce at some point in the twelve months from April 2014 onwards. The programme is ensuring that there are sufficient health visitor training places across the country, supporting workforce expansion by ensuring health visitor trainees are available in the right place at the right time. Through HEE, it has responsibility for:

- planning investment in health visitor training;
- commissioning health visitor training (university and clinical placements);
- supporting recruitment to those programmes;
- monitoring and, where appropriate, managing attrition from programmes; and
- supporting universities, employers and students to apply for and secure first posts in health visiting.

In the second half of the year, close joint working between HEE and NHS England ensured workforce requirements of the overall health visiting programme continued to be met, with a particular focus was on generating the appropriate pipeline of newly qualified health visitors. A focussed piece of work with LETBs was undertaken to provide an extra cohort of students that started programmes in March 2014. Following the delivery of the March 2014 cohort, focus turned to retention of students and tracking them to first employment.

In 2013/14 there were 2,046 health visitor completers, an over performance of 155, from two cohorts in September/October 2012 and January 2013.

In 2013/14 there were 2,743 new starters on programmes, 11 more than target, recruited to three cohorts: September/October 2013; January 2014; and March 2014.

Looking ahead, the target for qualified completers in 2014/15 is 2,542 (assuming an attrition rate of 8.7%), with 2,695 students still in training in July 2014 and due to complete studies in March 2015.

The LETBs are closely monitoring attrition across the three 2014/15 cohorts and providing support for students who are struggling through the universities. There are monthly data collections of leavers and monitoring of placement providers and programmes as part of the overall monitoring dashboard.

Reducing service turnover and improving retention: key activity 2013/14

NHS Employers was commissioned to undertake two elements of work:

(i) develop a **guide** to Recruitment and Retention Premia (RRP);
(ii) undertake a **recruitment and retention project**.

Recruitment and retention premia - development of the guide

The Guide's aim was to provide an overview of the some of the mechanisms that NHS organisations may wish to use in order to help recruit and retain health visitors, focusing on:

- recruitment and retention premia (RRP), to support providers of health visitor services on the use RRP to recruit and retain health visitors;
- how existing pension flexibilities can help to retain experienced health visitors within the workforce and how the new NHS Pension Scheme in 2015 might or might not affect the workforce.

While guidance is primarily aimed at the providers of health visiting services, it will also be useful to NHS England Area Teams and other organisations. It was subsequently launched in June 2014 on NHS Employers website: http://www.nhsemployers.org/

Health visitor recruitment and retention project with provider organisations

Work to support 30 providers in local retention activity – focusing on them implementing evidence-based strategies to retain their individual health visitor workforces. Two provider groups (London and outside London) were identified, with all being offered bespoke support suited to their own timetable.

A London cohort-based launched work in December 2013, with the second cohort (outside London), launching via webinar in February 2014.

From launch to the end of quarter four, the project team worked with individual organisations. All 30 providers received six days of allocated support including advice based on the individual needs of the organisation and relevant to the community it serves. They developed an action plan with support from NHS Employers, which if implemented effectively, could make a considerable difference to the overall satisfaction of the team and therefore the retention of individual skilled health visitors.

Each participating provider had the opportunity to share and learn from the work through their designated contact, a facilitated event and access to the existing NHS Employers share and learn network. Resources available on the NHS Employers website are also freely available for these providers and others to access.

As part of the project, NHS Employers launched the *Health Visitor Workforce hub* - which made available a range of health visitor recruitment and retention materials to employers at a single location. This is intended to develop over time to incorporate learning from the 30 organisations which took part in the project. The project went on to be completed in July 2014.

Liaison with NHS Employers and its networks

NHS Employers ran share and learn meetings, in the north (Leeds) and south (London) during both quarters. The meetings act as a network to discuss local issues, propose solutions and share learning. The key points were:

- attended by over 30 health visiting service and workforce managers with attendees' evaluation reporting excellent satisfaction;
- presentations included the topics; '*Building Community Capacity',* and the use of social media as a recruitment and retention tool;
- provided opportunity to promote NHS Employers' recruitment and retention resources to network members; and
- the Q4 meetings updated on the health visitor retention project.

Quarter 3 (October 2013-December 2013)

There was also ongoing communication of relevant news to employers via bulletins from its own website, with resources being reviewed to ensure they reflected the new NHS system, and a refreshed version of the '*Health Visiting: from Training to Practice'* guidance being published. In November 2013, a joint workshop on retention/reducing agency usage took place for both LETB and NHS England AT team leads.

Quarter 4 (January 2014- March 2014)

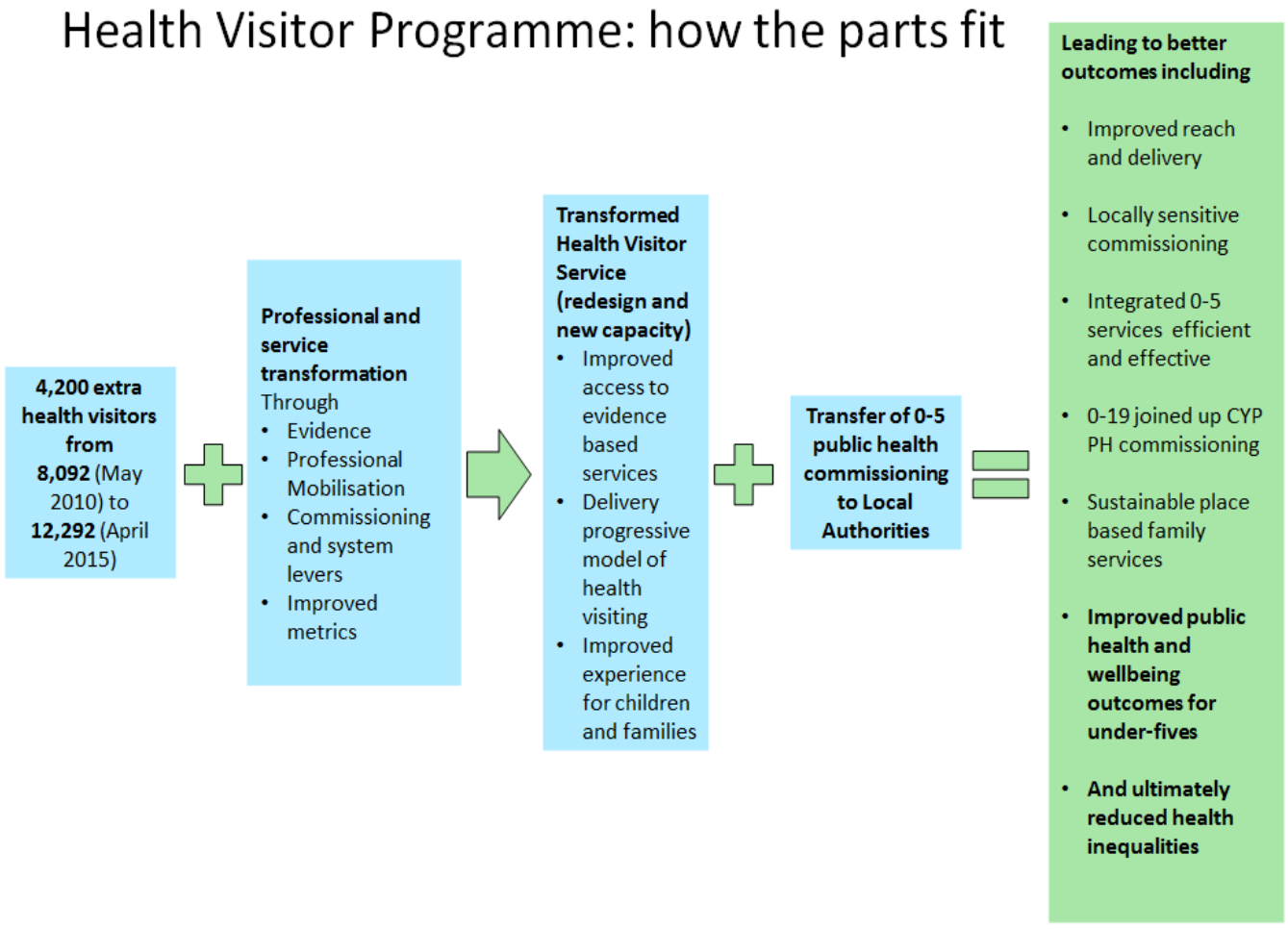
Relevant news continued to be communicated to employers via bulletins. Employers were able to freely access resources on recruitment and retention strategies (including using Total Reward and pension flexibilities in recruitment and retention). In January and February 2014 the average number of visits to the health visitor pages was 3,547 per month.

5. Transforming the service and revitalising the profession

Service transformation continues to be, alongside expansion of the health visitor workforce, the key aim of the programme. It is intrinsically linked with revitalising the profession and is being driven on three fronts:

- development of system and commissioning levers;
- service improvement programmes that are evidence-based and measurable; and,
- professional leadership and mobilisation.

DH, NHS England, LGA, HEE and PHE continued to work together to ensure that the success of the transformed service can be demonstrated, as well as enabling continuity and building sustainability. The partner organisations continue to build on an integrated approach to embedding health visitor service transformation, as shown in the diagram below - which identifies the system levers and how component parts fit together.



System levers: Commissioner-led activity/local level support

In autumn 2013, NHS England invited bids from Area Teams for funding to support systematic delivery of the new model of health visiting and demonstration of service transformation[1] in particular to support provider and commissioner development.

The amount available per Area Team related to their 0-5 years population. It was recognised that each geographical area had individual requirements to deliver transformation, therefore area teams consulted with Health and Wellbeing Boards, providers of health visiting services and key stakeholders to define the local need. Bids were assessed against their ability to deliver the four-tiered progressive model of health visiting comprehensively as well as progress on the six high impact areas: breastfeeding; maternal mental health; early attachment; healthy weight; child development; and the management of minor illness/accident prevention.

All bids were supported by Health and Wellbeing Boards, Local Authority Directors of Children's Services and Directors of Public Health, Provider Director of Nursing and CCG children/ maternity commissioners.

Area Teams put forward a variety of projects reflecting the local needs within these bids. At this stage funding has enabled set up and initial development of all projects, with 2014-15 funding being made available to build on the local requirements and facilitate further development of health visiting, particularly outcomes and health visiting within the context of the 0-5 commissioning model.

Health visiting service transformation is a continual process and the 2013-14 funding released capacity in the system, and has enabled commissioners and providers to identify their priorities to meet local need. Lancashire AT summarised its evaluation saying:

"This transformation funding has been essential to ensure the delivery of the full scope of the Healthy Child Programme and transform the way the health visitor teams work to realign the delivery model and embed new ways of working where teams are accountable at a local level for key performance indicators (KPIs)."

Supporting an integrated approach to commissioning and provision of services for 0-5 years

Area Teams have recognised the importance of developing the necessary common ground on which to base strong partnership and integration. Stakeholder engagement events have created a shared understanding of the profession supporting key local players to explore the vision for the future, the challenges and opportunities and to consider next steps in preparation for transition.
Eight Area Teams offered training places to Children's Services operational staff as well as to Health Visitors providing opportunity for staff working with those aged 0-5 years to come together, discuss their roles and to gain a shared understanding and learning. This joined-up approach was vital to realising much-needed efficiencies in terms of capacity and resources by

1 http://www.local.gov.uk/documents/10180/11493/Letter+to+area+teams+writing+expressions+of+interest+for+health+visiting+transformation+funding/d21ffd36-4728-416b-a915-d23cfc832db5

avoiding duplication of effort and by ensuring seamless services are in place and will help smooth effective transfer as health visiting services and Family Nurse Partnerships as they move to local authority led commissioning from October 2015.

Six area teams' projects involved developing a number of integrated pathways ranging from a universal to universal plus, perinatal mental health, antenatal promotional guides and anonymised population data, to inform strategic needs and commissioning intensions.

Ensuring the service is using the latest evidence

The Healthy Child Programme 0 – 5 years: evidence review

Public Health England has commissioned a rapid review of the evidence base underpinning the Healthy Child Programme (HCP): Pregnancy and the first five years of life. The evidence base for the HCP was last updated in 2008. The evidence especially in relation to the 0-5 is continually being updated as the outcomes of research, in this area, is being published. It is important for local authorities that the new health visiting service is based on the latest evidence. The topics included within the scope of the review include:

- parenting skills
- parent/infant attachment
- nutrition including breastfeeding, weaning guidelines and healthy diet/reducing obesity, latest evidence/best practice on growth monitoring
- speech, language and communication
- parental emotional and mental health (notably impact on outcomes for the child)
- perinatal mental health – assessment and management
- smoking / alcohol /drug misuse
- domestic violence
- unintentional injury in the home
- dealing with neglect

New research in relation to identifying families in need of additional support (including implications for delivery of the programme for example, the number and timing of universal assessments, locality of visits, early identification / use of multiple or single risks, resilience and protective factors).

The implications from the evidence for delivery/effective implementation of the HCP at programme/service level and individual practitioner level including:

- the importance of the universal programme;
- the balance between universal and more targeted approaches;
- transitions in the delivery of the HCP, between midwives and HV (including when to start the transition/how many antenatal visits) and between HV and school nurses;
- assessment and delivery of specific interventions including motivational interviewing, brief interventions and behavioural insight, and

- how the HCP could be delivered in a more consistent manner

Learning points from the research examining the science of implementation in general and in relation to this programme. Any significant new implications/recommendations for workforce skills and training arising from new evidence should be highlighted.

The economic value/cost benefits of the HCP looking at both health and wider societal costs.

Following an initial meeting with leading academics in the field of Child Health - to refine the brief, a tendering process was undertaken. The contract was been awarded to a consortium of academics led by Dartington Social Research Unit with Warwick and Coventry Universities. **A draft report subsequently went on to be produced in April, and the implications for policy, practice and commissioning are being considered.** The final report and recommendations are due to be completed and disseminated to key stakeholders in Autumn 2014 and will be covered in a future report.

Assessing progress & measuring impact of a transformed service

The 6 early years High Impact Area (HIAs) documents were developed to support the transition of commissioning to local authorities and to help inform decisions around the commissioning of the health visiting service and integrated children's early years services. They articulate the contribution of health visitors to the 0-5 agenda. **It is possible to take each one of the six high impact areas as a conduit through which progress can be assessed via themes of: access, experience, outcomes and (over time), the impact on inequalities**.

The Health Visitor Service Delivery metrics measure whether visits occurred and as such represent Health Visitor activity. Whilst activity figures are presented for England and the regions (see Annex B), these are based on the incomplete figures provided and as such may not be representative of the whole population where coverage is lower. Therefore, they should be interpreted with caution and alongside coverage figures giving the percentage of providers who have returned data passing the validation checks for each indicator (see Annex B).

Data coverage, which helps better illustrate the impact of a transformed service, has increased significantly since the earlier data collections – in quarter two 2013/14 the average coverage was 69% at national level; in Q4 2013/14, an average of 90% of providers was able to supply data which was validated for all the indicators.

**A complete set of metrics data for 2013/14 quarters 3 and 4 is available at annex B.*

HIA 1: Transition to Parenthood and the Early Weeks

A significant body of evidence demonstrates the importance of sensitive, attuned parenting.

● Access: as illustrated by the metrics data which shows:
- ***'Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above'*** was collected as a number, rather than a percentage, because of the difficulty in defining the population of women who should receive this contact in each area in each quarter. In quarter four, the reported number of contacts in England was 36,353 (based on returns from 94% of provider organisations).

- ***Percentage of New Birth Visits (NBV) completed.*** The percentage of NBVs undertaken within 14 days in England was reported to be 74% in quarter two 2013/14, and 73% in quarter four 2013/14. The percentage of NBVs undertaken *after* 14 days in England shows a similar pattern: it was 22% in quarter two and 21% in quarter four. This represents an increase in coverage in these two indicators from 77% and 74% of providers in quarter two 2013/14 respectively, to 96% of providers in both indicators in quarter four. So, whilst the percentage activity has not changed over the period, coverage has improved substantially to above 90% of providers.

● Experience: Feedback can be attained from service user experience questionnaires on satisfaction with antenatal and new birth review contacts via local commissioner and provider data.

● Outcomes: Generally, there are better outcomes when parenting programmes start in pregnancy. These will be demonstrated over time in development of the Public Health Outcomes Framework, and through use of the *Ages and Stages Questionnaire 3* (with its 5 areas of development).

● Inequalities: Preventative approaches and early intervention will over time, impact resilience, and physical, mental and sociological outcomes in later life.

Example of transformational activity:

Bristol, North Somerset / Somerset and South Gloucestershire Area Team: Communicating and engaging with teenage parents

In a service user survey, young parents expressed they wanted regular contact with health visitors who were friendly, knowledgeable and non-judgemental, but that this had not always been their experience. This project offers an education programme through a drama-based approach. It was a creative, thought provoking approach that focussed on developing empathy in participants and developing skills in communicating/engaging with teenage parents. Training reinforced the need for time for services to build trusting honest relationships with teenage parents.

HIA 2: Maternal Mental Health (Perinatal Depression)

Perinatal mental health is a key Government focus following robust evidence on the impact of maternal mental health during pregnancy and the first 2 years of life. Effective delivery is likely to be via development and implementation of local multi-agency pathways that set out evidence based assessments, identification and interventions for perinatal depression etc.

● Access: an indicator is in development related to the proportion of women who are asked about their mental health at (three) key points.

● Experience: indicators are in development, Eg *'did you feel comfortable speaking to your health professional..?*'

● Outcomes: indicator in development, Eg centred around 'whilst you were pregnant/first year after child's birth, did you experience any problems with your mental health….?

● Inequalities: the impact can be demonstrated over time, Eg on the lack of recognition and awareness of mental health per se and how this manifests itself in some black and ethnic minority groups.

HIA 3: Breastfeeding (Initiation and Duration)

● Access: Implementation of evidence-based infant feeding policies
evidence of up to date, evidence-based multi-agency infant feeding policies set out best practice in relation to breastfeeding support.

● Experience: feedback from health visitor service user experience questionnaires on satisfaction with breast feeding support etc.

● Outcomes and links to impacting inequality: Public Health Outcomes Framework (PHOF) 2.2(ii) – breastfeeding prevalence at 6 – 8 weeks.

● Inequalities: Over time, the PHOF is likely to be able to demonstrate increased duration of breastfeeding among those otherwise least likely to breastfeed eg. those living in areas of deprivation.

HIA 4: Healthy Weight, Healthy Nutrition (to include Physical Activity)

● Access: use of up to date evidence-based multi-agency infant feeding policies including healthy weaning and nutrition in early years settings.

Metrics data below, refers to activity likely to include focus on healthy weight and as such, act as a proxy to indicate progress with access.

- ***Percentage of 12 month development reviews completed.*** The percentage of children in England who received a 12 month development review by the time they turned 12 months is reported to be 64% in quarter four 2013/14, with returns from 95% of providers. The percentage of children receiving this review has remained stable from quarter two 2013/14 (at 65%), thought latest figures are based on improved coverage - increasing from 73% in quarter two, to 95% in quarter four 2013/14.

- ***Percentage of 12 months development reviews completed by the time the child turned 15 months*****.** This indicator measures the percentage of children in England who received a 12 month review by the time they turned 15 months and adds to the percentage of children who received the 12-month review in the previous quarter. It is reported to be 73% in quarter four 2013/14, with returns from 84% of providers. It suggests a small increase in the indicator as the percentage of children in England who received a 12 month review by the time they turned 15 months in quarter three 2013/14 was reported to be 70% (with returns from 74% of providers).

● Experience: feedback from service user experience questionnaire on satisfaction with weaning etc.

● Outcomes: PHOF 2.06i. Percentage of children aged 4 – 5 classified as overweight or obese (4.0ii), mean severity of tooth decay in children aged five years (2.2ii), breast feeding prevalence at 6-8 weeks after birth – number of infants who are totally or partially breastfed at 6-8 week check via early years profiles.

● Inequalities: Addressing childhood obesity will impact a significant health inequality factor - with higher rates amongst children in disadvantaged areas and some ethnic groups.

HIA 5: Managing Minor Illness and Reducing Accidents (reducing hospital attendance/admissions)

● Access: coverage of universal elements of the HCP, as all visits include accident prevention, eg. note metrics data above from 12 month review/completed by 15 months.

● Experience: feedback from the health visitor service user experience questionnaire on satisfaction with delivery of the HCP via local commissioner/provider data.

● Outcomes: health episode statistics data on non-elective admissions for 0 – 4s. Indications too via NHS England's metrics data, (for example the 12 month development review latest data above).

● Inequalities: there is a strong link between unintentional injury and inequality – with the most disadvantaged families more likely to suffer injuries. Death rates and poisoning have fallen for all social groups except the poorest – where children are more likely to die.

HIA 6: Health, Wellbeing and Development of the Child Age 2 – Two year old review (integrated review) and support to be 'ready for school'.

● Access:

> ***Percentage of 2-2.5 year reviews completed*.** The percentage of children in England who received a 2-2.5 year review by the time they turned 2.5 years is estimated to be 67% in quarter four 2013/14, a 4 percentage points increase over quarter two. This represents returns from 88% of providers in quarter four (up from 74% coverage in quarter two).
>
> ***Percentage of Sure Start Advisory Boards with a health visitor present*.** This is measured as the number of sure start advisory board meeting in the quarter with a health visitor present as a percentage of all meetings. In England the percentage of sure start advisory boards with a health visitor presence is estimated to be 92% in quarter four 2013/14, slightly lower than 94% in quarter two. This represents returns from 77% of providers in quarter four 2013/14, a big increase from 57% in quarter two 2013/14.

● Experience: Parents will be able to actively participate in their child's development/reviews through use of the *Ages and Stages questionnaire* and other assessment tools.

● Outcomes: The Public Health Outcomes Framework includes (in development), 2.5i – proportion of children aged 2 – 2 and a half receiving a HCP assessment or an integrated

review. Sub indicators are based on use of the ASQ tool and include areas of development such as communication, gross/fine point motor and problem solving etc.

● Inequalities: As with the other HIAs, the programme will continue to evidence progress through existing measures of outcome, access, effective delivery and experience. In this case, intervention offered by way of the review will inform discussions with parents about their child's progress. Facilitation of early intervention and support for families will help deliver a reduction in inequalities in children's outcomes.

Example of transformational activity:

Shropshire and Staffordshire Area Team:

This project has been instrumental to support delivery of:

• the 2 year indicator detailed in the new health visitor service specification, with the workforce using evidence-based quality assessment tools;
• a standardised universal 2 year review offer to all two year olds, thus supporting equity of service delivery;
• engagement of families, with the service and contributing to the development of their child;
• ASQ3 informing the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategies where it is offered universally.

Professional development and mobilisation

A range of professional leadership initiatives have been undertaken to support transformation within the service, these include:

● **Integrated workshops between early years staff and health visitors** - to enhance joint working and to increase understanding of each other's professional roles. These enabled teams to consider how they could improve outcomes through innovative service delivery, integrated working and increased partnership approaches. They have also provided an opportunity to discuss what hinders and what improves partnership working and have provided an opportunity to explore solutions.

● A series of **question time events with student health visitors** have been delivered to increase their understanding of the expectations of the new health visiting service, and to enable students to raise concerns and queries directly with national leaders. In addition, these events have also informed national bodies of potential problems or issues, enabling a rapid response and support approach to be possible at a local level.

● **Engagements via conferences, regional events and national forums** have been helpful both for continuing to raise the profile of health visiting and for highlighting case studies and best practice.

● Work has been progressing to **enhance the role of the practice teacher** and to **improve the quality of clinical placements**. A suite of tools/guidance documents are

currently under development and will be launched later in the year – this will support transition and transformation of the health visitor service at a time when over 50% of the workforce will be inexperienced.

- Work has taken place with a wide range of **stakeholders** to:
  - establish policy links/respond to areas of shared interest.
  - ensure partners are able to contribute the professional voice to documents and interlinked policy areas, eg. work with *4Children* strategic partners, the armed forces, SEND partners and Department for Education. There has been ongoing dialogue with the NMC to ensure that newly qualified health visitors are registered with the NMC in a timely manner and to clarify issues relating to return to practice and other registration issues.

- Professional leadership is being maintained with **health education institutions** – this has been helpful in shifting agendas and adapting programmes to meet the needs of the current and future service.

- **Professional advice and support** has been maintained through a range of media and contacts, including webinars, for information sharing and debate purposes.

- Work has continuing on the ***Education Initiative*** to support the transformation and enhance the skills and knowledge within the workforce. Work is also progressing on the delivery of the integrated review and the development of a training package for staff of using *Ages and Stages* questionnaire.

- Other streams of professional leadership work include:
  - delivery of a number of commissioned pieces of work to strengthen leadership, including the introduction of *Health Visiting Fellowships*
  - a number of research/critical evaluation projects to strengthen the knowledge base of effective health visiting practice.

Refreshing the pathways guidance documents

- A group made up of key professionals was established to review/refresh the guidance pathways, published since the start of the programme. The review focused on:
  - feedback on pathways
  - how are they being used
  - any gaps or key changes
  - any new resources, guidance or policy that needs to be reflected.

The pathways/guidance being refreshed during the second part on 2013/14 were:

- Midwifery to Health Visiting
- Health Visiting to School Nursing
- Safeguarding
- Youth Justice.

Perinatal mental health champions and domestic violence and abuse training

A number of training programmes and support materials have been developed to enhance the skills of all health visitors, these have included;

- perinatal mental health and,
- domestic violence and abuse training and e-learning materials, and a range of guidance documents and leaflets.

Specifically, a successful suite of ten 2-day workshops were delivered on Domestic Violence and Abuse between January and March 2014, (a further stage in facilitating spread of this training has begun, with three interactive e-learning modules due to be launched on the e-Learning for Healthcare portal in respect of Domestic Violence and Abuse).

6. Communications

Communications continues to be an important focus of the programme to reinforce messages to key stakeholders as well as responding to issues around the forthcoming transfer of 0-5 commissioning role in October 2015. This has included supporting positive messaging to health visitors and providers and links between programme stakeholders.

Key developments in 2013/14 Q3/4 have included development of a plan to better use partners' communications channels (eg. effective use NHS England Area Teams for onward dissemination of messages to providers of health visiting services and local authorities); further growing, including use as a means of debate and sharing of practice, the programme's Webinars; development of programme and 0-5 transfer FAQs; continued growth of NHS England's case study database; and greater links with LGA to develop a series of support materials that better communicate the programme aims, objectives, progress, and outputs in the frame of local authority strategic priorities.

By the end of Q4, and in the context of the confirmation of commissioning of 0-5 children's public health services transferring to local authorities on 1 October 2015, it was agreed that the programme would seek more streamlined, consistent messaging and as such, would establish a communications (comms) editorial board. The intention is that through 2014/15, this collaborative arrangement would better serve delivery of key messaging to the right audiences across all of the programme's workstreams (eg. on workforce expansion, recruitment, transformation and transition), and be joined-up across partners.

7. Health Visitor Taskforce

The Health Visitor Taskforce, set up in 2011 has continued to champion the vision for the Health Visitor Programme and it met in both of the last quarters of 2013/14. Chaired by Dame Elizabeth Fradd, the Taskforce has provides strategic challenge to the delivery of the Government's commitment to improve services and health outcomes in the early years for children, their families and the community. It acts independently as a critical friend, with membership drawn from the voluntary and community sector, parent representatives groups and professional organisations who sit alongside national and local members from public health and the NHS with strategic direction set by key partners such as the Department of Health, NHS England, Public Health England and the Local Government Association. Together members provide a wealth of experience and expertise.

The Taskforce recognises its range of membership and its key role of champions, which puts them in a unique position to offer advice and support to the health visiting community. As such, during quarters 3 and 4, they have been invaluable in supporting delivery of the Health Visitor Programme.

The general role of the Taskforce has continued to be important as the programme of transformation gathers pace and the transfer of 0-5 children's public health commissioning to local authorities (October 2015) moves closer. Members have continued to show enthusiasm as they undertake visits to those providers that deliver health visiting services offering them help and advice during a period of change, particularly to those sites that may face the biggest challenges, feedback received confirms the benefits and value placed on these visits, where, in the main, all participants, including students, gain something.

The Taskforce will continue into 2014/15 sitting alongside other groups leading the progression and delivery of change'.

8. Transfer of commissioning of 0-5 years children's public health services to local authorities

The Children's Health and Wellbeing Partnership is overseeing the safe and effective transfer of commissioning responsibilities for age 0-5 public health services from NHS England to Local Authorities on 1 October 2015. These services will then be commissioned alongside 5-19 children's services, which were transferred to local authorities in April 2013.

As reported at Q1, a dedicated task and finish group co-chaired by DH and SOLACE with representatives from LGA, NHS England, PHE, DH, SOLACE, ADCS, ADPH and DCLG was convened in June 2013 to co-design a comprehensive transfer plan for children's 0-5 public health commissioning responsibilities which include health visiting and family nurse practitioners. The aim is to support service stability, build on and support continuing service

transformation and integration, and ensure that local authorities have the funding, capability and capacity to commission effectively. A smooth transfer to the new commissioning arrangements is the desired outcome.

A number of sub-groups underpin the work of the task and finish group (and its successor Programme Board). These include: *preparedness* – ensuring NHS England is ready to handover its commissioning responsibilities and local authorities are ready to receive them; *finance* – ensuring the right resource is in the right place for 2015/16 commissioning and that there is a smooth transition of provider contracts; *mandation* – ensuring an agreed legal framework is in place for the commissioning of the universal elements of the 0-5 Healthy Child Programme from 1 October 2015; *information* – ensuring that local authorities have the information they need to commission effectively and realise the intended benefits of services being more focussed on local need; and *communications* – making sure that the system has a shared understanding of the transition and continues to focus on the benefits that the Health Visitor Programme and Family Nurse Practitioner Programme are delivering.

The Government intends to mandate the delivery of the key child assessment elements of the Health Child Programme which are led by health visitors, healthcare professionals and their teams. This will allow for the service to be shaped locally, whilst ensuring continued delivery of the assessments in the context of a national, standard format (or specification) for the services, and hence that families can be confident they will receive continuing health visiting support.

9. Conclusion

The health visitor programme had, at the end of Q4, operated for a full year in the context of the new health and social care landscape established in April 2013. The changes altered the way the programme was delivered, but have not detracted from progress across a range of objectives. This is supported by effective collaborative working from the programme partners. As usual, the programme's dual focus has been on both expanding the health visitor workforce and on continuing momentum around service transformation.

Alongside this, the confirmation in January 2014 that the commissioning of 0-5 children's public health services will transfer to local authorities on 1 October 2015, kicked off increased work to establish a parallel, but intrinsically linked area of work. This has involved programme partners liaising with both the NHS and local government to ensure local authorities are ready to receive new 0 – 5 years public health commissioning responsibilities (including health visitor services) – in addition to their existing early years and children's services responsibilities – and that such a transfer is smooth and effective.

The report's four joint authors, hope that its audience will continue to engage actively with the range of information sources and interfaces with which they will be increasingly familiar, as these will be a sound platform from which the programme can maintain progress.

Annex A

Health Visitor numbers (full time equivalents): May 2010 – March 2014 and plan 2014/15 (graph page 10 refers)

	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11
Qualified HVs	8092	8027	7965	7907	8017	8098	8144	8125	8142	8114	8054	7886
HV-MDS												
Plan												
	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Qualified HVs	7886	7851	7803	7714	7677	7941	8004	8065	8065	8141	8207	8199
HV-MDS												
Plan												
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Qualified HVs												
HV-MDS	8396	8384	8303	8287	8284	8692	8932	9000	9025	9069	9113	9133
Plan												
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Qualified HVs												
HV-MDS	9076	9149	9124	9103	9066	9550	9770	9920	9959	10124	10267	10383
Plan												
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Qualified HVs												
HV-MDS												
Plan	10365	10379	10352	10344	10306	10642	11345	11482	11507	11723	12028	12348

Annex B

NB: **Data coverage**, which helps better illustrate the impact of a transformed service, **has increased significantly** since the earlier data collections – in quarter two 2013/14 the average coverage was 69% at national level; in Q4 2013/14, an average of 90% of providers was able to supply data which was validated for all the indicators.

Coverage (percentage of providers that passed validation checks), England, Quarter 2 to Quarter 4: 2013/14

Indicators	2013/14 Q2	2013/14 Q3	2013/14 Q4
First antenatal visit at 28 weeks or above	74%	88%	94%
New birth visit within 14 days	77%	91%	96%
New birth visit after 14 days	74%	90%	96%
Development review at 12 months	73%	87%	95%
Development review at 12 months completed by 15 months	54%	74%	84%
Development review at 2-2.5 years	74%	83%	88%
Sure start advisory board with health visitor present	57%	78%	77%

Source: NHS England

Health Visitors activity, England, Quarter three: 2013/14

	First antenatal visit at 28 weeks or above	New birth visit within 14 days	New birth visit after 14 days	Development review at 12 months	Development review at 12 months completed by 15 months	Development review at 2-2.5 years	Sure start advisory board with health visitor present
North	14,082	69%	23%	73%	78%	76%	92%
Midlands & East	5,980	82%	15%	72%	82%	72%	92%
London	1,533	81%	12%	39%	54%	45%	100%
South	11,250	66%	27%	54%	58%	61%	98%
England	**32,845**	**74%**	**19%**	**63%**	**70%**	**67%**	**94%**

Health visitors activity, England, Quarter four: 2013/14

	First antenatal visit at 28 weeks or above	New birth visit within 14 days	New birth visit after 14 days	Development review at 12 months	Development review at 12 months completed by 15 months	Development review at 2-2.5 years	Sure start advisory board with health visitor present
North	14,780	68%	28%	74%	82%	74%	85%
Midlands & East	7,480	83%	13%	73%	85%	75%	95%
London	1,811	81%	13%	44%	55%	44%	100%
South	12,282	**62%**	**28%**	**55%**	**60%**	**58%**	**95%**
England	**36,353**	**73%**	**21%**	**64%**	**73%**	**67%**	**92%**

Source: NHS England

Annex C

Description of images on page 8 and page 14

“Health Visitor programme: the professional and service transformation journey” (page 8)

In the context of the report’s focus on organisational responsibilities and programme governance (p 8, section 3) a chart is included depicting the programme’s development over time. It is structured around four key phases showing the journey from: foundation in 2010; its implementation (2011/13); system wide implementation (2013/15); to the current focus on ensuring sustainability beyond 2014. The **key undertakings from each phase are described in the box summary below.**

Foundation 2010	• original commitment and related policy • understanding political context/intention • designing and developing service vision • engagement of profession & related stakeholder

Initial Implementation 2011 to 2013	• ’Call to Action’ launched, early implementer sites set up in two phases • professional development • stakeholder building • professional mobilisation and leadership • initial workforce planning and trajectory development

System wide implementation 2013 to 2015	• national core specification • performance management • early years profiles • DH and HEE commissioned professional development/support for innovative practice. • NHS England’s commissioner led service transformation

Sustainable future 2014 onwards	• 6 high impact areas • 2015/16 spec. in partnership with NHS England/LAs • HV fellowships & HV champions • HEE works with LAs to sustain service • CPD programmes • ongoing workforce planning via HEE (involves PHE & LGA) • rapid review of evidence for HCP **Transfer to local authorities:** • 0 - 5 transfer agreement • mandation finalised • agreeing funding • programme board constituted

“Health Visitor programme: how the parts fit” (page 14)

This chart illustrates how the programme’s partners work together, building on an integrated approach to embedding health visitor transformations. The chart illustrates the levers’ relationship thus: items at (1) when added to those (2) deliver the transformed service components at (3). When these are combined with the transfer of commissioning role (4), they are seen to deliver the ‘better outcomes’ listed at (5).

1) **4,200 extra health visitors** (from 8,092 in May 2010 baseline) to 12,292 (at April 2015)

2) **Professional and service transformation –** through evidence, professional mobilisation, commissioning and system levers and improved metrics.

3) **Transformed HV service (redesign and new capacity)**

- improved access to evidence based services
- progressive models of health visiting
- improved experience for children and families

4) **Transfer of 0 – 5 public health commissioning to local authorities**

5) **Better outcomes**

- Improved reach and delivery
- locally sensitive commissioning
- Integrated 0 – 5 services (efficient and effective)
- 0 – 19 years joined up public health commissioning
- Sustainable place based family services
- Improved public health and wellbeing outcomes for under fives
- Reduction in health inequalities