Department of Health

Happy, Healthy Families: the introduction of the 3 – 4 month contact

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Happy, Healthy Families: the introduction of the 3 – 4 month contact

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Purpose of Document

This case study focuses on an improvement in service quality, innovation or a new way of working, specifically along one or more of the strands of the health visiting service vision and family offer:

Community
Universal
Universal Plus and
Universal Partnership Plus.

Case Study Overview

In order to respond to the Health Visitor Call to Action programme, First Community Health and Care agreed that there was a need to introduce a family contact at 3ï 4 months. The main aim of this contact is to enhance earlier identification of any health needs in the family which may impact on longer-term outcomes. As the Department of Healthôs Healthy Child Programme (2009) describes, early intervention is paramount as it is during pregnancy and the first years of life that the foundations of future health and wellbeing are laid down. New information about neurological development and recognition of the importance of attachment all make early intervention and prevention imperative.

To enable us to introduce the 3ï 4 month contact, we first brought together a task and finish group to review the Healthy Child Programme and develop guidelines for the delivery of this contact. These were ratified by the Clinical Effectiveness Group and the project lead then disseminated the guidance to the practitioners in one team in preparation for delivery. The team began to offer these contacts in August 2012 and are currently delivering to 17% of eligible families. In order to manage the additional work, we have suggested that most Universal contacts will be carried out in a clinic setting. Early feedback shows that families have embraced this contact, valuing the planned access to their health visitor in a one-to-one situation

This contact has been introduced as a Universal service in one team initially. It will be implemented across three teams by March 2013, leading to 50% coverage. It is hoped that we will achieve full implementation by December 2013, as we increase our staff capacity.

Achievements

There have been a number of key achievements in the delivery of this project so far. We have succeeded in further developing our partnership work with Childrenôs Centres as we are delivering the contact in collaboration with them. An example of this is the remodelling of their clinics to allow women access to this contact in a private space.

We have also developed our joint working with the Parent and Infant Mental Health Service by liaising with them over the introduction of the 3ï 4 month contact, and the impact it may have on referrals to their service as practitioners revisit the National Institute for Health and Clinical Excellence (NICE) guidance on maternal mood assessment.

We have engaged with families in the development of the 3ï 4 month contact invitation. We have also asked them what they would like from this contact. This has informed our guidelines on what should be delivered. In addition we have asked families who have received this contact to give feedback. The value of this contact has been demonstrated by the fact that 100% of families offered a 3ï 4 month review accepted and attended the appointment.

Staff have embraced the importance of early intervention and see the 3ï 4 month contact as a vital tool in achieving better outcomes for the children and families they work with.

Benefits

The benefits to the organisation include being able to achieve the requirements of the new health visiting service model as set out in the Health Visitor Implementation Plan. The longer-term benefit to this organisation and wider services is the prevention of health-related issues and associated increased costs to the local health economy. This links to the current Quality, Innovation, Productivity and Prevention (QIPP) programme agenda of delivering cost savings.

For the local teams, there is an increase in staff morale as they feel more able to engage with families and offer a more robust, quality service. This is turns leads to a great productivity in service delivery and a greater engagement of practitioners.

The advantage for local families is they receive a more comprehensive service and so can build stronger links with their health visitor. There is a particular benefit to first-time parents in being signposted to all local services and provision, so empowering them to make healthy lifestyle choices. An example of this is the health visitor service-led programme on introducing family foods.

Challenges

The key challenge to implementing the 3ï 4 month contact has been the current staffing levels. This has impacted on our ability to fully deliver this level of service. While we have managed to achieve the number of contacts we aimed to deliver as stated in our project success measures, our limited staff capacity could affect our roll-out of this review in the future.

While we have managed to maintain our project timelines overall, some dates slipped slightly as our guidelines were scheduled for ratification in July 2012. We had not considered the impact of seasonal annual leave on this process and in fact there

were not enough practitioners at the Clinical Effectiveness Group for this forum to be quorate. We responded to this by calling an additional meeting to ensure that the guidelines were agreed in time for project implementation to begin.

As many services have found, space within Children's Centre premises is restricted and in high demand. While we have successfully secured space in one Children's Centre to deliver the 3ï 4 month contact, this represents a real challenge to the wider implementation of this service.

A final challenge is referrals to other services. As stated, we have linked with these services to raise their awareness of the introduction of the 3ï 4 month contact check and its potential impact on their service, but this does not overcome the issue of how already stretched services respond to additional demand. For example, the increased identification of postnatal depression represents a very real challenge to mental health services. However, this is not a reason to omit the maternal mental health assessment and the need for additional service capacity should be fed back to local commissioners.

Learning, Sharing and Sustainability

One of the main lessons in developing and delivering this project has been the challenges that exist in effectively engaging staff. The timing, approach and tone of an engagement strategy are key to how staff respond. When people feel that they are already working to maximum capacity, how you 'sell' the benefits of delivering an additional check and identify the 'wins' for staff are essential to securing their 'buy-in'

One positive lesson from developing the guidelines for the 3ï 4 month check is revisiting the Healthy Child Programme and finding the guidance in it to be clear. It was relatively easy to be able to draw upon the evidence within this document to underpin the content of this check. Utilising the guidance in the future will make drafting further guidelines more straightforward.

We also learnt the importance of user involvement. As well as helping to define the content of the 3ï 4 month review, involving families also helped to raise awareness of the introduction of the check and the reasons behind it. We believe this will increase uptake now and in the future.

In terms of wider sharing, we have already shared our progress on this project at Surrey-wide events: the Health Visitor Call to Action study day and the Health Visitor Forum for Practice Teachers and Team Leaders. We will be putting the project forward for wider dissemination at the Community of Practice meetings.

As stated, we plan to embed the 3ï 4 month contact across the service. Vital for the sustainability will be an increased health-visiting workforce. Without this there is a risk that the 3ï 4 month contact will replace the 6ï 8 week contact currently available

for all families. Given the essential difference between these two contacts, it is important that they remain distinct.

In order to support this sustainability we will need to develop advocates to promote the importance of the 3ï 4 month contact. These will be practitioners experienced in its delivery who will act as champions. We will mobilise them across teams to share the value of introducing this contact as well as ótop tipsô on how to do it.

We will equally need to ensure that we have ongoing links with our partner agencies. We cannot deliver the health visiting service offer in isolation. We need strong partners in order to signpost local families and provide an integrated, quality service.

Figure 1: Invitation for 3ï 4 month contact check