



Delivering Care Phase 4 Health Visiting

A Policy Framework for Nursing and
Midwifery Workforce Planning
in Northern Ireland



Department of
Health



**Health and
Social Care**

Introduction

Delivering Care aims to support the provision of high quality care which is safe and effective in hospital and community settings through the development of a framework to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities. This paper provides a summary of Delivering Care Phase Four which focuses on the health visiting service.

The health visiting service is driven by the implementation of the Department of Health (DoH) Child Health Promotion Programme (CHPP). Health visitors work with families and communities using health promotion, prevention and early interventions in order to give every child the best start in life and address inequalities in health. The service works across all four thresholds of need as defined within the Hardiker Model:

- Level 1: Children aged 0-4 years in receipt of CHPP
- Level 2: Children and families who require additional support from the health visitor when a health need is identified
- Level 3: Identified as 'Children in Need' as defined within The Children (Northern Ireland) Order 1995
- Level 4: The most vulnerable children, ie on the Child Protection Register and/or Children 'Looked After'

Children may move across levels of need based on their vulnerability at a point in time. It is therefore necessary that health visitors have regular contact with families so that they can respond to identified health needs as early as possible.

Context

The Northern Ireland (NI) health visiting workforce currently does not have the capacity to deliver the full universal CHPP (See Table 1) to all pre-school children and priority is therefore given to contacts in the first year of life and responding to complex child and family health needs. The service is also challenged by an aging demographic with 18 predicted retirements over the next eighteen months.

Table 1: The Universal Child Health Promotion Programme Contacts

CONTACT	AGE	VENUE
Ante natal visit	Post 28 weeks of pregnancy	Home
New Birth Contact	between 10-14 days (age)	Home
6-8 week contact	6-8 week contact	Home
12-14 weeks	12-14 weeks	Home
6-9 months	6-9 months	Home, clinic or community setting
1 year	1 year	Home
2-2.5 years	2 year	Home
over 3 years	3 year	Home, clinic or community setting
4 year pre-school	4 year	Telephone call, clinic or home visit

Indicator of Performance data (DoH June 2016) indicates that 14% of seven CHPP contacts (excludes antenatal and 3+ year contacts) are not being delivered and this has remained the case from March 2015-2016. Contacts are frequently delivered in clinics rather than home settings. Additional investment is required if the full delivery CHPP programme is to be delivered in keeping with DoH policy and professional quality standards and the broader role of health visiting in public health realised.

Regional health visiting capacity was increased in November 2015 by 34.9 WTE health visitors and 6.8 WTE supervisors as a result of £1.7m investment and the availability of 56 students completing their health visitor course. This achieved average health visiting caseloads of 1 health visitor per 250 children although workforce pressures including funded vacancies persist. Forty six students commenced training in September 2016.

Health visitors have three key areas of work:

1: Delivery of the Child Health Promotion Programme (CHPP) to all pre-school children and their families

All children and families are entitled to receive nine Level 1 CHPP health visiting contacts (Table 1) and additional interventions at Level 2 where a health need is identified, for example, in response to postnatal depression, parenting and child development concerns, challenging behaviour, breastfeeding, healthy weight and nutrition, infant jaundice, feeding difficulties, attachment and bonding problems.

Prevention and early interventions through the effective delivery of the health visiting can lead to a reduction of demand on high cost services including general practitioners, paediatrics, CAMHS and allied health professionals as well as multidisciplinary/agency services required at Level 3 and Level 4¹. Prevention and early interventions by public health nurses improve the long term health outcomes for children².

¹ Department of Health, Sept, 2015, *Universal Health Visitor Reviews*, London DH

² Olds, D. L., Henderson, C. R., Tatelbaum, R., & Chamberlin, R. 1988. Improving the life course development of socially disadvantaged parents: A randomized trial of nurse home visitation. *American Journal of Public Health*, 78, 1436-1445

2: Responding to the children and families with identified health needs, including safeguarding needs, in partnership with other disciplines and agencies

Responding to the health needs of children with complex and/or safeguarding needs is prioritised by health visitors given the detrimental consequences for those children with unresolved need or at risk of child abuse and neglect. The number of very vulnerable children and families requiring multidisciplinary support at Levels 3 and 4 has increased during the years when the health visiting workforce has reduced.

In 2015³:

- There were 23,834 children identified as 'in need' by social services childcare teams
- There were 28,420 domestic abuse incidents reported
- There were 2,875 children 'Looked After' of which 593 aged 0-4 years.

3. Population Health and Wellbeing

Participation in public health initiatives allows health visitors to promote health and wellbeing through community development initiatives, parenting programmes and public health campaigns. Health visitors, registered with the Nursing and Midwifery Council as specialist community public health nurses, have a key role in working with others to improve public health and address the challenges of disadvantage and inequalities. This is in keeping with the Northern Ireland's Executive vision articulated within the aim, principles and themes of the Making Life Better strategic framework.

Public health practice is responsive to local need and the views of the public. This includes partnership working with voluntary/community groups, Sure Starts and Family Support Hubs, as well as responding to emerging issues such as childhood obesity, child sexual exploitation and refugees. The public health role has been adversely affected by insufficient health visiting capacity and needs to be developed if key strategic population priorities in relation to prevention and early intervention are to be achieved.

Evidence

Determining an appropriate health visitor caseload size has been a complicated process due to the range of variables affecting children such as the child's developmental and health needs, environmental factors, parenting capacity, family and community resources and geographical factors.⁴

The limited research evidence available, and the views of health visitors and their managers across the five HSC Trusts, in relation to caseload size and skill mix, suggests that health visiting caseloads should vary depending on the level of need and inequalities

³ Please see: <https://www.gov.uk/government/collections/statistics-children-in-need>

⁴ National Health Service England, 2014. *National Health Visiting Service Specification 2014/15*, NHS England

experienced by those in receipt of the service. As a result of the deficit in health visitor numbers, 29% of health visitors report that caseloads are so large that they are losing track of vulnerable families⁵.

The importance of home visiting and early intervention cannot be over-emphasised. Families value a relationship with a trusted health professional⁶. Dr David Olds et al⁷ provides evidence that home visiting interventions provided by highly skilled nurses can result in better outcomes for children and families and, indeed, society. In a YouGov survey, 76% of parents stated they wanted support and advice on child health and development specifically from a trained health visitor with up-to-date health care knowledge⁸.

A range of factors impact on demand for the health visiting service such as parenting styles and attitudes, increased caseload size, increasing levels of child and family poverty, family complexity, increasing mental health issues (infant, perinatal and adult) and families whose first language is not English.⁹ There is strong evidence to support the important public health role that health visitors have in promoting child, family, community and population health¹⁰.

Research evidence has highlighted that when families live in areas of poverty and deprivation there are lower levels of breastfeeding, increased levels of smoking, higher risks of chronic disease and reduced health outcomes for children and these families need an enhanced service¹¹. Evidence also shows that young children who have poor quality maternal/child relationship have 2.5 times higher rates of adolescence obesity¹². The cost of perinatal mental health problems in the UK is £8.1 billion each year with nearly 72% of the cost relating to adverse impacts on the child rather than the mother¹³. Evidence from the National Childbirth Trust suggests that approximately 32% of mothers experience bonding problems¹⁴ and of the 25,273 births in 2011, 2,527 women developed postnatal depression, the majority of which are mild to moderate, and are supported by primary care services including health visiting¹⁵.

⁵ Family and Parenting Institute, 2008. *Health visitors – an endangered species*, London, FPI

⁶ Regulation and Quality Improvement Authority, (2016). *Every Child Counts Regional Audit of the Child Health Promotion Programme*, Belfast RQIA

⁷ Olds, D. L., Henderson, C. R., Tatelbaum, R., & Chamberlin, R. 1988. Improving the life course development of socially disadvantaged parents: A randomized trial of nurse home visitation. *American Journal of Public Health*, 78, 1436–1445.

⁸ YouGov survey on behalf of Family and Parenting Institute, 2007, 'Parents of Under 5s', The sample size totalled 5,422 respondents who were asked to tick all that applied for this question.

⁹ Department of Health, 2011, *Health Visitor Implementation Plan 2011–15*, London DH

¹⁰ Olds, D. L., Henderson, C. R., Tatelbaum, R., & Chamberlin, R. 1988. Improving the life course development of socially disadvantaged parents: A randomized trial of nurse home visitation. *American Journal of Public Health*, 78, 1436–1445

¹¹ HM Government, 2010, *Healthy Lives, Healthy People: Our strategy for Public Health in England*, HMSO

¹² Joseph Rowntree Foundation, 2007. *Parenting and Outcomes for Children*, Joseph Rowntree Foundation

¹³ London School of Economics and Centre for Mental Health, Bauer, A. Parsonage, M. Knapp, M. Lemmi, V. Adelaja, B. 2014, *The costs of perinatal mental health problems*, London, Centre for Mental Health

¹⁴ <https://www.nct.org.uk/press-release/difficulties-baby-bonding-affects-third-uk-mums>

¹⁵ http://www.publichealth.hscni.net/sites/default/files/IMH%20Plan%20April%202016_0.pdf

Key Drivers

The model proposed in this paper provides a flexible, considered approach to determining health visiting staffing establishments within a changing model of provision so as to achieve outcomes in keeping with the **Transforming Your Care**¹⁶, **Making Life Better**¹⁷ the Delivering Social Change **Early Intervention Transformation Programme** and **Healthy Futures**¹⁸ strategies. These strategies and programmes place emphasis on the need to give every child the best start in life and the importance of encouraging and facilitating healthy living.

Benchmarking

Workforce benchmarking provides an opportunity to make comparison with workforces in other countries and health authorities. Relevant information has been taken from official government websites for England, Wales and Scotland in order to benchmark the NI health visiting service with other regions in the United Kingdom (UK) (July 2016). Benchmarking indicates that the NI health visiting service has a lower ratio of health visitors per 0-4 year old population than either England or Scotland.

Northern Ireland: The health visiting service following additional investment in November 2015 is commissioned on the basis of one health visitor WTE: 250 children

Scotland: 1 WTE : 221 children – there is an investment plan in place to achieve approximately 1:160 ratio (1316 WTEs for 291,174 0-4yrs + 2015 investment plan underway to achieve 500 additional HVs)¹⁹

England: 1 WTE : 238 with investment plan to achieve an additional 4200 HVs (11,955 WTE HVs: 2,847,332 births over 4 years 2011-14).

There is however significant regional variation²⁰:

- Doncaster 1:160
- Sunderland 1:190
- Hull 1:199
- Manchester 1:225
- Surrey 1:570
- Coventry 1:597

Note that in relation to **Wales:** Information is not readily available on caseloads. However, it is understood that health visitors providing the Flying Start programme to vulnerable families should not have a caseload in excess of 110 children (Welsh Assembly)²¹.

¹⁶ Department of Health Social Services and Public Safety/Health and Social Care Board. 2011. *Transforming Your Care. A Review of Health and Social Care in Northern Ireland*. Belfast, DHSSPS.

¹⁷ Department of Health Social Services and Public Safety/Health and Social Care Board, 2014, *Making Life Better 2013 – 2023*, Belfast, DHSSPS.

¹⁸ Department of Health Social Services and Public Safety, 2010. *Healthy Futures 2010-2015*, Belfast, DHSSPS.

¹⁹ <http://news.scotland.gov.uk/News/500-new-health-visitors-ddc.aspx>

²⁰ Conservative Research Department, 2011, *Helping New Families*

²¹ <http://www.childreninwales.org.uk/our-work/early-years/flying-start-network/>

Staffing Model

Application of the Delivering Care Framework Phase 4, including benchmarking, the development of a caseload weighting system for health visiting service (eCAT) and CHPP compliance monitoring, has resulted in a recommendation that there should be a regional average one WTE health visitor per 180 children aged 0-4 years old with a skill mix of 90% registered staff and 10% non-registered staff. The proposed staffing ratio allows for one session per WTE health visitor to be allocated to public health activities over and above those required to deliver the core child health promotion programme.

Evidence from professional bodies in relation to caseload size and the opinion of health visitor service managers and practitioners in Northern Ireland suggests that universal health visiting caseloads should range from one WTE health visitor : 100 - 225 children. This range allows caseload sizes to vary in order that there is a higher level of health visiting contacts where demographic, deprivation, local challenges and specific health needs of families require this.

In 2009, a regional steering group was set up to develop, test and pilot a 'health visiting caseload weighting tool' in order to define a 'busy but fair' health visiting caseload. The development of this tool, including the electronic version eCAT, has been informed by the views of health visitors and health visiting service managers; evidence available on health visiting caseloads; the need for a caseload weighting system that is sensitive to the complexity of health visiting practice and demographic variables; the role of health visiting services across Hardiker levels of need; the views of national and local experts, and, the opinions and experiences of health visiting teams in all five Health and Social Care Trusts. The caseload weighting tool has been piloted and tested using all caseloads held by health visitors in NI and is considered by the workforce to be effective and useful.

The caseload tool uses a scoring matrix based on the Hardiker Level of Need and demand on the health visiting service and an optimal caseload weighting score. The most complex family circumstances requiring a frequent visiting pattern are allocated the highest score. Children receiving the core CHPP programme only receive the lowest score. To create a caseload score the total score allocated to children receiving the CHPP and families receiving additional interventions are divided by the health visitor's available caseload hours. **The optimal caseload score for a 'busy but fair' caseload is 16.** The appropriateness of this score is being tested during 2016/17.

The average caseload score in Northern Ireland is 21.18 (April 2016) (see Table 2).

	HSCT A	HSCT B	HSCT C	HSCT D	HSCT E	Region
Caseload Score April 2016	20.7	20	24.2	20.5	20.5	21.18

The application of the caseload scoring matrix supports local management of a HSC Trust health visiting service. The size of any given caseload within an optimal score of 16 may fluctuate depending on the levels of need within the caseload.

Skill Mix

The Delivering Care Phase 4 Framework will facilitate a regional approach to the use of skill mix within health visiting teams. 90% of practitioners in the health visiting service will be registered nurses on the NMC register and 10% will be non-registered child health assistants.

The 90% of registered nurses will be made up of **a minimum of 85% health visitors** who are required to take responsibility for health visiting caseloads aligned to general practitioner practices and **a maximum of 5% Band 5 Public Health nurses** who will work with the supervision of a health visitor. This reflects the public and professional view that the CHPP offers an opportunity for parents to benefit from a relationship with a trusted and highly skilled public health practitioner who is accessible to them and that there is a need to develop an evidence base about the role and effectiveness of staff nurses within health visiting teams.

Child health assistants (Band 3) will deliver family health interventions delegated and supervised by a Health Visitor. They will also provide support to ensure the service is efficiently delivered and information for the purpose of an outcomes based accountability framework is available and reported.

One supervisory WTE team leader/manager (who does not hold a caseload) is required per 12 health visitors (WTE). Health visitors will provide supervision to non-registered staff.

One Band 7 practice teacher per 16 health visitors is required to teach up to two student health visitors on placement; to facilitate other student placements within the team/HSCT and to promote a learning culture within the health visiting service. The practice teacher will have their caseload reduced to reflect one day per week allocated to teaching and learning that is not available to working with children and families in their caseload.

Influencing Factors

There are a number of factors that need to be considered by service managers and teams when determining local health visiting staffing levels (Table 3).

Table 3: Influencing Criteria

Influencing Factors	Impact of staffing
Workforce	<ul style="list-style-type: none"> ➤ Number of part time staff ➤ Availability of skill mix opportunities ➤ Recruitment affected by student HV numbers ➤ Age and experience profile – ratio of recently qualified and experienced HVs
Environment and support	<ul style="list-style-type: none"> ➤ Geographical location (rural/urban) ➤ Clinic, school & community facilities ➤ GP alignment and local partnership arrangements ➤ Population profile (e.g. demography, deprivation, BME) ➤ Interface with other services e.g. FNP, Sure Starts, Family Support Hubs, Child Development Clinics, social work ➤ Lone working ➤ Team Size ➤ Access to technology
Activity	<ul style="list-style-type: none"> ➤ All 4 Hardiker Levels of Need: Caseload Scoring Range 100-225 ➤ Uni-disciplinary, multi-disciplinary & interagency health plans ➤ Child Health Promotion Programme ➤ Population and public health initiatives ➤ Involvement in service developments and risk management ➤ Supporting pre/post-registration students
Professional regulatory requirements	<ul style="list-style-type: none"> ➤ Delegation to Public Health Staff Nurses and Child Health Assistants ➤ Supervision of Public Health Staff Nurses and Child Health Assistants ➤ Mentorship and supervision including safeguarding children supervision ➤ Revalidation and time allocated to support HV in their practice, supervision, preceptorship are regulatory standards that are incorporated into the planned and unplanned absence allowance of 24% for N.I.

The final staffing for health visiting teams in each HSC Trust will be agreed following a discussion with the Trust Workforce Lead, Health Visiting Head of Service, Public Health Agency (PHA) Public Health Nurse Consultant and Commissioning Nurse Consultant.

Implementation

Implementation will be directed and supported regionally by the HSCB/PHA commissioning/professional team and in keeping with health visiting workforce availability. The PHA will ensure a regionally consistent approach to implementation. Implementation Reports will be provided to Healthy Futures Programme Board on a three monthly basis.

Monitoring

The Executive Director of Nursing, in all cases, must provide assurances about the quality of care to families/children and the efficient use of resources through internal and external professional and other assurance frameworks, including KPI dashboards and other evaluative methods such as the 10,000 Voices work of the PHA in Northern Ireland.

Caseload data on eCAT will be updated at least monthly by health visitors. This data will be used by HSCTs and the PHA as part of the local and regional monitoring and quality assurance processes. Core qualitative and quantitative datasets will be agreed regionally with the PHA and will include information provided by service users.

Health visitor team leaders/managers/supervisors will ensure that the model is being applied consistently through practice supervision. Records will be audited against allocated scores awarded per child and families. Caseload data information will be shared and analysed at team meetings and this analysis will be used to inform managerial decisions including caseload allocation.

Information in relation to Key Performance Indicators (KPIs) including compliance with the CHPP will be collected three monthly as a minimum. Additional KPIs may be identified and will be agreed regionally.

The Outcomes Based Accountability framework developed as part of the Delivering Social Change Early Intervention Programme (Work Stream 1) will be implemented and developed. This includes feedback from service users and practitioners.

Review

The Delivering Care Phase 4 Model will be reviewed annually for the first three years, thereafter three yearly.