DRAFT Report of the
Scrutiny Review into
Health Visitor Numbers

Draft v.2

March 2010
Contents

Foreword....................................................................................................................... 2
Executive Summary and Recommendations ................................................................. 3
History of the Panel’s interest ...................................................................................... 4
Terms of Reference ...................................................................................................... 4
Meetings held ................................................................................................................ 5
Membership of the Panel and Acknowledgements ...................................................... 6
Context and Background ............................................................................................. 7
  Background ................................................................................................................... 7
    Financial Background ............................................................................................... 7
  History and origins of health visiting ........................................................................ 10
  Health visiting service structure .............................................................................. 10
  Outcome measures and aims of the service ............................................................. 12
  Skills mix within the team ....................................................................................... 14
  Key risks associated with low health visitor numbers ............................................ 15
Recruitment and retention of health visitors ............................................................... 15
  Staff nurse pilot ....................................................................................................... 17
  Staff satisfaction ...................................................................................................... 17
  Staff sickness rates in 0-16 teams ........................................................................... 18
  Staff turnover .......................................................................................................... 18
  Impact of the creation of Hounslow & Richmond Community Healthcare ............. 19
  Links to other services – midwifery and children’s centres .................................... 19
  Population statistics .................................................................................................. 19
  How does a family/parent engage with the 0-16 service ......................................... 19
Main Findings ............................................................................................................. 21
  What is the right size for a health visiting caseload? ............................................... 21
Conclusions ................................................................................................................. 27
Table of recommendations .......................................................................................... 28
App XX – Glossary ....................................................................................................... 29
App XX – Typical Hounslow health visitor working day ............................................ 30
Appendix XX - Service User Consultation on the Staff Nurse Pilot (July 2009?) ....... 33
Foreword

Cllr Allan Wilson
Chair of the Children and Young People Scrutiny Panel

I am pleased to have the opportunity to introduce this important report from the … .

The panel has reiterated at several points its wish to pass on its appreciation for the work of all the practitioners and service managers for all their work in delivering a good service in challenging circumstances – financial and practical.
Executive Summary and Recommendations

1. The main findings

2.
History of the Panel’s interest

3. Health visitor numbers have come up as an issue for scrutiny several times over the last few years. It has been in the press locally and nationally on several occasions. In 2007: Hounslow Chronicle (9.8.07); Private Eye (31.8.07), and in Spring 2009: Private Eye (April 2009); Brentford and Isleworth Times (24.8.09); Hounslow Chronicle (26.8.09).

4. The dispute in the press was the discrepancy in the numbers of health visitors reported by the CPHVA (Community Practitioners and Health Visitors Alliance – part of the Unite union) and Hounslow PCT. (And after the commissioner/provider split, by NHS Hounslow and the local NHS provider arm, Hounslow Community Healthcare.)

5. Various topics of the Children and Young People Scrutiny Panel’s work programme have touched on this at different points e.g. teenage pregnancy, CAMHS, speech and language, and the review of children’s centres. The press articles, the Panel’s prior interest and the request from the Lead Member for Children’s Services and Families, Cllr Lin Davies, for there to be scrutiny of this, were the factors that led to the Panel’s decision to include a mini-review on health visitor numbers on their work programme for the municipal year 2009-10.

Terms of Reference

6. The following terms of reference set out the remit of the Panel’s work. These were agreed by the Panel by email prior to the main meeting on 21 October 2009 to consider this issue:

   a) To understand how many health visitors there are per child under five in Hounslow, and their workload and how this compares with other PCTs – particularly Hounslow’s closest statistical neighbours.
   b) To understand (actual and on average) how long mothers have to wait for health visitor appointments
   c) To understand what an acceptable caseload for health visitors is and, as to how that is defined and monitored.
   d) To understand how the health visitor/school nursing services (0-16 services) are funded and what the pressures in the budgets currently are.
   e) To understand how many school nurses there are in Hounslow and their workload in comparison with Hounslow’s closest statistical neighbours.
   f) To understand how health visitors/school nurses work and how they fit in with the work of other agencies e.g. the Early Intervention Teams, children’s centres, schools etc.
   g) To understand why there may be problems in recruiting and retaining health visitors and school nurses, and what is being done to address such.
## Meetings held

<table>
<thead>
<tr>
<th>Date</th>
<th>Meeting</th>
<th>Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Oct. 2009</td>
<td>Teleconference with Prof. Sarah Cowley, Professor of Community Practice Development, Florence Nightingale School of Nursing and Midwifery, King’s College London</td>
<td>Prof Cowley, Cllr Allan Wilson (Chair, Children and Young People Scrutiny Panel), Sunita Sharma (Head of Scrutiny and Performance), Jonathan Hill-Brown (Scrutiny Officer)</td>
</tr>
<tr>
<td>6 Oct. 2009</td>
<td>Focus group with Hounslow health visitors</td>
<td>Cllr Genevieve Hibbs (Member of Children and Young People Scrutiny Panel), Jonathan Hill-Brown, 8 health visitors/HV team leaders</td>
</tr>
<tr>
<td>6 Oct. 2009</td>
<td>Meeting with Unite/CPHVA</td>
<td>Cllr Allan Wilson, Cllr Genevieve Hibbs, Jonathan Hill-Brown, Dave Munday (Unite), 2 Hounslow health visitors (who were also Accredited Representatives of Unite).</td>
</tr>
<tr>
<td>21 Oct. 2009</td>
<td>Meeting of the Children and Young People Scrutiny Panel</td>
<td>Scrutiny Panel members; Sue Jeffers – Director of Commissioning, Primary and Community Care, NHS Hounslow; Jo Manley – Chief Operating Officer, Hounslow Community Healthcare; Natalie Douglas, Assistant Director for Children and Families, Hounslow Community Healthcare; Cheryll Adams – Lead Professional Officer, Unite/CPHVA; Sonia Shuter – Health Visitor and Accredited Representative Unite; Sarah Hamlyn – Health Visitor and Accredited Representative Unite; Sallie Winterbach – Health Visitor and Accredited Representative Unite</td>
</tr>
</tbody>
</table>
Membership of the Panel and Acknowledgements

Chair
Cllr
Cllr
Cllr
Cllr

Cllr
Cllr
Cllr
Cllr

Co-optees

Advisors
Prof. Sarah Cowley, Professor of Community Practice Development, Florence Nightingale School of Nursing and Midwifery, King's College London

7. The Panel would like to express its thanks to all those who have so readily agreed to take give up their time to advise panel members: Prof Cowley from King's College, CPHVA representatives, NHS Hounslow and Hounslow Community Healthcare managers, and Hounslow health visitors.
Context and Background

Background

Financial Background

8. The PCT invested an additional £125k into the service in 2009-10, and the Children’s Centre grant that comes in to the local authority paid for a further two specialist posts at a total cost of £75k per annum for two years to March 2011 (the point at which the guaranteed government children’s centre grant funding stream at the current level ends – it is not clear what the new levels will be). [It is not known what the current level of investment on the part of NHS Hounslow in the service is. Figures are still awaited. Requested 17 February 2010.]

9. At the Scrutiny Panel meeting in October 2009, NHS Hounslow’s Director of Commissioning pointed out that, despite the severe budgetary pressures the PCT was under, the budget for health visiting had not been touched. She said this was a clear commitment of the PCT Board.

What is a health visitor?

10. There are different definitions of health visitors. On the NHS careers website the role of a health visitor working with children is described as typically, for example working with “mothers of young babies - advising on such areas as feeding, safety, physical and emotional development and other aspects of health and childcare.”

History and origins of health visiting

11. Health visiting developed in the voluntary sector in the 19th century, becoming a statutory service under local government in 1929, before moving to the NHS in 1974. Services were initially organized in geographical areas, but attachment to primary care/general practice became the norm with integration into the NHS. This situation appears to be reversing, with roughly equal proportions of health visitors based in GP surgeries and community bases.

12. Witness for the Commons Health Select Committee report into Health Inequalities from 2008 found that “described the ‘early years’— and services provided to children and their families within this period—as potentially very important in tackling health inequalities.”

---

2 See p.8, in paper The Universal Health Visiting Service by Professor Sarah Cowley, Professor of Community Practice Development, Florence Nightingale School of Nursing and Midwifery, King's College London: http://www.unitetheunion.org/pdf/UniversalHealthVisitingService.pdf
early to prevent the infant from entering an adverse life trajectory, with established physiological and behavioural patterns, which might have been changed in the first months and years of life.\textsuperscript{4}

13. Some of the key factors in later health inequalities are issues that fall squarely within the role of health visiting: “Crucial factors include maternal smoking during and after pregnancy as well as alcohol and drug use; maternal diet during pregnancy; maternal obesity during pregnancy; infant and child nutrition; smoking in the family home; postnatal depression; and parenting skills. Breastfeeding was repeatedly emphasised by our witnesses—including the Secretary of State—as a top priority for reducing health inequalities, yet breastfeeding, in common with other lifestyle factors, follows a social gradient: only 67\% of women in routine and manual occupations initiate breastfeeding compared with 89\% of women in managerial and professional occupations. The differences are even more pronounced in terms of the duration of breastfeeding—only 32 per cent of women in the routine and manual socio-economic group breastfeeding beyond six weeks, compared with 65 per cent in managerial and professional groups.”\textsuperscript{5}

14. The role of health visitors increases as the numbers of midwives decreases. Evidence given to the Commons Health Select Committee inquiry into health inequalities by the Royal College of Midwives found that “Staffing increases in the NHS overall have largely passed midwifery by. Both the fulltime-equivalent number of midwives in England’s NHS fell in the last annual staffing snapshot (down 87 between 2005 and 2006) and the headcount number fell at both of the last two counts (down 375 between 2004 and 2006).”\textsuperscript{6} The report goes on say that “the result of this is that midwives are increasingly having to focus their limited time on labour and birth, the most ‘high risk’ part of maternity care, and may be devoting less time to antenatal and postnatal care, which offer the best opportunities for health promotion.”\textsuperscript{7}

15. Hounslow PCT measures the percentage of expectant mothers seen by a midwife at the 12 week stage of pregnancy. In 2008 Hounslow was achieving rates of 71\% against a national target rate of 52\%.\textsuperscript{8} [Are there more recent figures?] There is a national target that all pregnant women should be seen and assessed by 12 weeks of pregnancy. This is primarily a midwifery target, but is relevant for health visiting where the second and subsequent pregnancies are concerned (i.e. to promote timely attendance/presentation to services in a mother who is already known to health visiting).

\textsuperscript{4} p.89, http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/286/286.pdf
\textsuperscript{5} p.87, http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/286/286.pdf
\textsuperscript{6} p.87, http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/286/286.pdf
\textsuperscript{7} p.87, http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/286/286.pdf
\textsuperscript{8} http://www.hounslowpct.nhs.uk/documents/IHealthPerformanceReportAppendix1.pdf
16. The question as to the role of health visitors is actually quite a difficult question to answer, as it depends on whether one takes a so-called relationship based approach or an outcomes based approach. (And this in itself is one of four different ways of analysing health visitor services.)

17. Prof. Cowley has said that most widely promoted by health visitors is the first, i.e. the focus on a 'relationship centred' preventive approach. This is not necessarily the most widely used model, particularly since the diametrically opposed 'problem focused' view is more widely approved in the NHS, and is easier to measure. There is a summary of the key arguments on pages 239-240 of the Elkan et al systematic review of domiciliary health visiting. It is of note that both the very effective Family Nurse Partnership (Olds et al) and the Healthy Child Programme adopt a relationship centred approach, but Hounslow appear to be using a problem based approach. As stressed by Elkan et al, this does have implications for research/evaluation, because the problem based approach makes measurement much easier. That does not mean it is more effective in the long term.

18. Healthcare for London – the review conducted by Prof Sir Ara Darzi set out the ideal care pathway for maternity and newborn care:

---


10 Email from Prof. Cowley of 11 March 2010.

11 [www.nhshistory.net/darzilondon.pdf](http://www.nhshistory.net/darzilondon.pdf), p.47
19. Darzi’s report was not very forthcoming about where and how a health visiting service should sit and what it should look like. Other work carried out under the umbrella of Children and Young People workstreams of Healthcare for London have not been very forthcoming on the issue of how 0-5 non-acute services should be structured.  

**Health visiting service structure**

20. The health visiting service was reconfigured in 2006/7 and combined with the school visiting service to form an integrated 0-16 Child and Family Service divided into eight teams (plus the Beavers Children’s Centre/Sure Start team on the Beavers estate) covering different parts of the borough.

21. The nine 0-16 teams are overseen by four team managers i.e. each team manager has 2-3 teams to supervise.

22. The teams are based on the extended school/children’s centre clusters:

<table>
<thead>
<tr>
<th>0-16 Child and Family Team*</th>
<th>Extended schools cluster</th>
<th>Early Intervention Team</th>
<th>Composition of team</th>
<th>Numbers of children on team caseload</th>
</tr>
</thead>
</table>

---

12 See documents here: [http://www.healthcareforlondon.nhs.uk/project-documentation-3/](http://www.healthcareforlondon.nhs.uk/project-documentation-3/)
Heston | | 3.0 wte HVs; 1 nursery nurse; 1 staff nurse | 2,780 under fives
[and where based?] | | |

* The Head of Children’s Services has said data is only available for the Heston team. This has been questioned by Hounslow health visitors who have said that: “The teams collect data on a monthly basis and I am puzzled about the only data being available is for Heston alone.”

23. Members are very concerned that this data is not readily available to service managers. They do not understand how service management and planning is possible if it is not know what the caseloads across the different teams are.

Health visitor numbers over last five years

24. [historic figures for Hounslo w have been requested.] In Greater London, according to a response in the Commons the numbers of health visitors has dropped from 1,876 in 1997 to 1,577 on 30 September 2008, though the Government’s response stressed that part of the reason for this was the changes that had led to “child health being delivered by a range of practitioners.”

Current health visiting establishment

25. At the meeting of the Children and Young People Scrutiny Panel on 21 October 2009, members were told that the current establishment of the 0-16 Child and Family Service was as follows:

<table>
<thead>
<tr>
<th>Staff category</th>
<th>Whole Time Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health visitors</td>
<td>29.22</td>
</tr>
<tr>
<td>Community staff nurses</td>
<td>9.46</td>
</tr>
<tr>
<td>Nursery nurses</td>
<td>10.58</td>
</tr>
<tr>
<td>Support workers</td>
<td>10.55</td>
</tr>
</tbody>
</table>

(It was Prof Cowley’s view that having barely 50% of the health visiting staff qualified as health visitors is “far too diluted”. She believed it should be at least 70% qualified.14)

Current health visiting establishment vacancy levels

13 See Commons debate of 24 November 2009: http://www.publications.parliament.uk/pa/cm200910/cmhansrd/cm091124/debtext/91124-0003.htm
14 Email from Prof Cowley, 11 March 2010. It should be made clear that Prof Cowley does not object to skill mix teams per se.
26. As at October 2009 Hounslow Community Healthcare reported the following vacancy levels:

<table>
<thead>
<tr>
<th>Staff category</th>
<th>Whole Time Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health visitors</td>
<td>4.65</td>
</tr>
<tr>
<td>Community staff nurses</td>
<td>2.43</td>
</tr>
<tr>
<td>Nursery nurses</td>
<td>1.0</td>
</tr>
</tbody>
</table>

27. [Historic vacancy figures have been requested but have not been forthcoming. The service head has said it would require a significant piece of work to obtain these figures.]

Outcome measures and aims of the service

28. The aims of the service are linked closely to the targets and aims of Hounslow’s Children and Young People’s Plan 2007-10 and nationally to the Child Health Promotion Programme (2008) and the Child Health Strategy (2009). This translates into four key aims on the ground for Hounslow’s health visiting service:

- **Breastfeeding** (increase breast-feeding maintenance rates following discharge from hospital by 10% by 2009).  
  
  It is very difficult to establish what the targets for breast feeding are. [During 2004/05, 79.2% of mothers in Hounslow initiated breastfeeding, which is significantly higher than the England average. (p.20, [http://www.hounslow.gov.uk/children_young_peoples_plan.pdf](http://www.hounslow.gov.uk/children_young_peoples_plan.pdf)]. The promotion of breastfeeding has been central to activity aimed at improving maternal and infant health. Over the last year there have been significant improvements in identifying infants and recording whether or not they are being breastfed, in line with breastfeeding coverage targets. Coverage at March 2009 was 69% against a target of 85%. Of the 69% of women recorded, 45% were fully or partially breastfeeding at 6 to 8 weeks post delivery. Work continues with general practice and health visitors to improve the coverage rate. Coverage at March 2009 was 69% against a target of 85%. Of the 69% of women recorded, 45% were fully or partially breastfeeding at 6 to 8 weeks post delivery. Work continues with general practice and health visitors to improve the coverage rate. The Family and Parenting Survey outcomes (April 2009) shows the borough to have a ratio of one health visitor for 685 children under five, which does not compare favourably to similar and neighbouring boroughs. 37% of assessments take place within the 10 – 14 time scale. These late contacts, in conjunction with the teams only being able to offer a highly prioritised, targeted service, has a considerable effect on breastfeeding rates, parental coping mechanisms and identification of postnatal depression. (p.8, [http://www.hounslow.gov.uk/cypp_review0809.pdf](http://www.hounslow.gov.uk/cypp_review0809.pdf)); What are our key areas for development and priorities for 2009-10? We recognise that: There are significant barriers to mothers receiving timely support for breastfeeding due to a lack of health visiting capacity. Too few birth contacts are being achieved within the nationally prescribed standard of 11 to 14 days as a result. (p.13, [http://www.hounslow.gov.uk/cypp_review0809.pdf](http://www.hounslow.gov.uk/cypp_review0809.pdf)).]

- **Childhood obesity** (the 2006 National Child Measurement Programme data showed that, from the children measured, Hounslow had an average of 22.9% in Reception Year and 32.3% in Year 6 children who were classified as being either overweight or obese. The DH, in conjunction with DCSF, has recently set prevalence targets relating to childhood obesity rates to be achieved by 2010. In Hounslow the required rate of
A decrease has been set at 0.6% for Reception age children and 1.1% for Year 6 against the 2006 results.

- **Teenage pregnancy**  (Borough target to reduce rate of teenage conception in the base year 1998 [49.6 conceptions] of under 18 year olds per 1000 15-17 year olds to 24.8 conceptions by 2010 in order to be with the Government’s national target. Latest provisional figures from 2008 are for 46.6 conceptions.\(^{16}\) This represents a drop of 6.1% against the target for 2010.)

- **Early intervention**  (It is not clear if there are any local data or targets for this in terms of the work of the 0-16 Child and Family Service. Specific targets have been lacking at a national level. In 2004, the National Service Framework stressed ‘Promoting health and well-being, identifying needs and intervening early’. This was picked up in the Child Health Promotion Programme and Healthy Child Programme, but there were still no specific targets.)

29. The Healthy Child Programme emphasises the importance of carrying out an antenatal visit. This does not appear to be part of the XXX. In other areas (still controversially) staff nurses carry out the NBV, where the health visitor has seen and assessed family antenatally. [Need clarification from Prof Cowley on this. This essentially is the situation in Hounslow.]

30. However, from the above it is not immediately apparent how this translates into a service delivery model on the ground. Please see the section below on lack of information about the ideal pathways for children and mothers/families engaging with the 0-16 service.

31. One of the key activity as opposed to outcome measures for the service is the number of new birth visits completed within the 10-14 day window. As at February 2010 this figure stood at 10%:

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage of home birth visits(?)/assessments(?) carried out within:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10-14 days</td>
</tr>
<tr>
<td>February 2010</td>
<td></td>
</tr>
<tr>
<td>October 2009</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td></td>
</tr>
</tbody>
</table>

[Get national/statistical neighbour comparator information.]

32. Only 6% of new birth visits were completed in 10-14 days of the birth as at October 2009. The latest statistics from the service show that, as at February 2010, 10% of new birth visits are completed in the 10-14 day window. The Head of Children’s Services reported that there was no historical comparative data on visits completed within the 10-14 day window, nor any data readily available on the length of time it can take for a first visit to take place, if it is later than 14 days. It only became a figure that provider organisations have had to report on in 2009.

Skills mix within the team

33. Panel in October 2009 was told the following:

<table>
<thead>
<tr>
<th>Staff category</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health visitors</td>
<td>Health visitors hold a specific specialist qualification, which is regulated through the Specialist Community Public Health Nursing part of the Nursing and Midwifery Council register. At present, a nursing or midwifery qualification is required for entry to the training, which is one year full time, or equivalent part time. It is, minimally, at degree level and increasingly at Masters level.</td>
</tr>
<tr>
<td>Community staff nurses</td>
<td>Community staff nurses support individual families under the supervision of health visitors and deliver health promotion activities into school settings e.g. childhood obesity, sexual health.</td>
</tr>
<tr>
<td>Nursery nurses</td>
<td>Nursery nurses support individual families under health visiting supervision but also run a number of post natal support groups around parenting support.</td>
</tr>
<tr>
<td>Support workers</td>
<td>Some inputting of non-clinical records on to the RIO case management system. (Inputting of clinical assessments still needs to be done by health visitors as they have clinical responsibility for this.) Sending out appointments. Helping run clinics.</td>
</tr>
<tr>
<td>All staff</td>
<td>All staff have mandatory training and undergo additional training to ensure they are skilled and competent to deliver the services.</td>
</tr>
</tbody>
</table>

18 This information provided by Prof. Cowley, email, 11 March 2010.
Key risks associated with low health visitor numbers

34. Service managers have said that they are acutely aware of the risks and all stakeholders locally and nationally had been informed of them. In line with national figures, there were locally fewer referrals to speech and language therapy services from health visitors (this is Anne Breaks’ explanation for the increase in school referrals – get data from Anne xxxxx), fewer referrals for CAFs.

35. Nationally, there has been a fall in pre-school referrals to speech and language therapy from health visitors from around 50% of all referrals received to 15%. It is a cause of concern, in that children’s ‘readiness to learn’ on school entry is closely linked with their ability to communicate. In due course, this affects their adult health, so health inequalities and life chances. For Prof Cowley, this is an extremely important risk factor.

36. The Panel probed in some depth the issue of risks – particularly in regard to children’s safeguarding – at their meeting in October. They were told that an assessment tool was being developed to ensure that key risk families were prioritised for a visit by a health visitor, as opposed to an initial visit by a staff nurse. [The head of service has said she would send through the template of the assessment form used. This has not yet been received. She has said it is not available electronically and is therefore difficult to make available to members.]

37. The Panel members wish to register their concern that this assessment form cannot be made available to them in hard copy or electronic form despite the request being outstanding for almost one month.

Recruitment and retention of health visitors

38. The shortage of health visitors is recognised as a national and a London problem. The Hounslow service head said that, interestingly,

---

19 See comments made by Prof James Law to the Health and Sport Committee of the Scottish Parliament carrying out their Inquiry into child and adolescent mental health and well-being in 2009: "The universal service that has been provided is beginning to slip away. As an illustration, I can tell the committee that traditionally about half - 40 or 50 per cent - of referrals to speech therapists in the pre-school period used to come from health visitors. The Royal College of Speech and Language Therapists carried out a review at the end of last year about how much had changed post "Health for all Children 4", and it found that the figure is now about 15 per cent." [http://scotparliament.com/s3/committees/hs/reports-09/her09-07.htm](http://scotparliament.com/s3/committees/hs/reports-09/her09-07.htm)

20 Email from Prof. Cowley, 11 March 2010.

21 See for example this ministerial response to questions in the Commons about health visitor numbers of 24 November 2009: [http://www.publications.parliament.uk/pa/cm200910/cmhansrd/cm091124/debtext/91124-0003.htm](http://www.publications.parliament.uk/pa/cm200910/cmhansrd/cm091124/debtext/91124-0003.htm)

Richmond – despite much lower ratios for health visitors to 0-4 population – had similar problems with recruitment and retention.

39. For map showing the fall in health visitor numbers across the English regions between 2005-7 see Appendix XX.

40. The Director of Commissioning at NHS Hounslow said that they would be willing to look at the business case for more health visitors once the current vacancies were filled. However, she said that if a business case were to be made it would be against an approved, evidenced model, based on a growth model for the numbers of children born. It would also be based on the outcomes which were best for the family. All this information would be helpful for the business case. She also made clear that if they were able to fund the model establishment suggested, as commissioners the PCT would still like to see a skill mix in the schemes available so that teams included Nursery Nurses, administrators and Staff Nurses.

41. She went on to say that the outcomes model would possibly include immunisation rates, obesity levels, breast feeding rates. In terms of children at high end of need, percentages of children going to A&E could possibly be used as an indicator of the effectiveness of the service.\(^{23}\)

42. The Panel was told in October 2009 by the CPHVA representative that their research showed that nationally 20% of health visitors were over 55 and 40% were over 50. Locally the service manager said they were expecting the big wave of retirement in around 5-10 years’ time.\(^{24}\)

43. In terms of retention, the Panel was told in October 2009 that the service had a sickness rate of 2%, which was below the average of 6% [is that for the rest of the PCT? Or other health visiting services across the country? Xxxx]

44. The Head of Children’s Services has said that during 09/10 they negotiated with NHS London to increase the number of student health visitor places from 3 to 4, as there is a limit as to how many students can be taken on due to a shortage of Community Practice Teachers (CPT). Therefore they also negotiated to increase CPT training places

\(^{23}\) In his review into health inequalities Michael Marmot and team suggest mainly having a target for what they term ‘school readiness’, as it covers all over early years development. See pages 18 and 19 Exec Summary: “Investing in the early years, thereby improving early cognitive and non-cognitive development and children’s readiness for school, is vital for later educational outcomes. Once at school, it is important that children and young people are able to develop skills for life and for work as well as attain qualifications. […] Without life skills and readiness for work, as well as educational achievement, young people will not be able to fulfil their full potential, to flourish and take control over their lives.”

http://www.ucl.ac.uk/gheg/marmotreview/FairSocietyHealthyLivesExecSummary

\(^{24}\) This is mirrored for the figures for the numbers of midwives who will be retiring in the next 5-10 years. [Get figures from Healthcare for London docs]
from 1 to 2 to support this, as well as recruiting a permanent CPT in addition.  

45. The intention was to recruit student health visitors to place them on part-time courses (over 2 years rather than 1) thereby increasing the number of staff within the service. However, in the end they were only able to recruit to 3 of the 4 student places and all of these wanted the 1 year only courses.

46. In addition they also tried to attract staff nurses to undertake training but unfortunately the candidates did not meet the academic criteria for entry this year. Therefore they will be working with these and other staff nurses to ensure that they are ready to make applications for the 2010/11 intake. The PCT has retained 1 of the 2 student health trainees for this year.

47. For Prof Cowley this represents a degree of risk to “recruit staff nurses who do not meet the criteria for entry to training, then ask them to do the work usually requiring full qualification as a health visitor (i.e., New Birth Visit).”

48. Facilitated clinical supervision sets have also been established to help support the health visitors. [Do staff have time to attend? To be clarified by Head of Service.]

Staff nurse pilot

49. In October 2009 the Scrutiny Panel was told about the staff nurse pilot that is operating in two sites in Hounslow. The service head said that the pilot was about sponsoring staff nurses through health visitor training and retaining them in the workforce as a ‘grow your own’ method of increasing health visitor numbers. While training to become fully fledged health visitors, the staff nurses would, after training based on core competencies, carry out the early contact visits with families.

50. The service head that this model was also aimed at responding the desire of families and feedback from mothers saying they wanted contact early on as they could otherwise feel isolated.

51. The Head of Children’s Services has said that the evaluation of the pilot will not be available until April 2010 and has said she will send it through once finalised.

Staff satisfaction

---

25 Student health visitors spend 50% of their learning in practice, based with a qualified Community Practice Teacher (CPT). Email from Prof Cowley, 11 March 2010.
26 Email from Prof. Cowley, 11 March 2010.
52. Results of staff surveys [requested from Linda Graves at PCT. It is currently embargoed by the Care Quality Commission and should be released w/c 15.3.10.] Comparison with previous years.

Staff sickness rates in 0-16 teams

53. Staff sickness rates improved overall in the 12 months September 2008 to August 2009 with a peak in February/March 2009. [are more recent stats available?]

![Sickness Absence 0-16 teams 2008-9](image)

Staff turnover

54. In the 12 months to September 2009 10 staff left the service meaning that the cumulative turnover for the service to date was 15.4%. The reasons for leaving were:

- Relocation (1)
- Promotion (3)
- Pregnancy (1)
- Not known (5)

55. Members were very reassured by the comments made by the Director of Commissioning at NHS Hounslow at the Panel meeting in October 2009, that once the vacant posts had been filled, the provider i.e. Hounslow and Richmond Community Healthcare, could make the business case for an increase in posts and that NHS Hounslow would then give this business case serious consideration.

56. However, they believe that there should be a proper needs assessment in the first place as it does not make sense to wait for the posts to be filled. With 15.4% turnover there will always be vacant posts. The case should be made first – as much by the commissioners as by the
provider arm for the correct number of posts across the 0-16 teams to meet the needs of the population in Hounslow.

Impact of the creation of Hounslow & Richmond Community Healthcare

57. Members asked about the potential impact of the merger of the two provider arms of the local NHS services. They were told at the meeting in October 2009 that this would have no impact. There would be a separate contract for the two boroughs, even if the service had one manager. Prof Cowley said that in her view this should come with the caveat that there has been no immediate impact.27

Links to other services – midwifery and children’s centres

58. When scrutiny members were carrying out their review into children’s centres it was pleasing to hear that good links are being forged with the 0-16 teams. A referral form has been set up. Health visitors (and staff nurses and other 0-16 team staff??) fill this form in and pass it on to the children’s centre central team. The referral details are then passed on to the children’s centre for that catchment area.

59. More could possibly be done by the 0-16 team to signpost to children’s centres. Letters are sent to parents explaining that the new birth home assessment visit will be delayed. Mention is made in the template that members have seen signposting to drop-in child health clinics run by health visitors – and some of these are held in children’s centres. However, greater attempts could be made in these letters to advertise the sort of activities and support that is offered in children’s centres. A leaflet could also be enclosed for example.

Population statistics

60. The Scrutiny Panel was told at its meeting on 21 October that: “The birth rate was increasing with 380 births every month, so each team had an average of 40 new births to visit, with approximately two health visitors per team and other pressures such as the health visitor’s involvement in Child Protection Plans. Only 6% of new birth visits were completed in 10-14 days of the birth.”28

61. Get the other stats for population stats and projections

62. Stats for autism – get figures and references for local increase in numbers. xxx

How does a family/parent engage with the 0-16 service

27 Email from Prof Cowley, 11 March 2010.
63. There are different stages and different client groups for the 0-16 service. The typical/expected pathway for a client with a newborn child in Hounslow would be as follows (The Director of Commissioning agreed to send through information about ideal pathways etc.):

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Which professional?</th>
<th>Which client group?</th>
<th>When?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>New birth contact</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>New birth assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Main Findings

What is the right size for a health visiting caseload?

64. This is not an easy question to answer. Prof Sarah Cowley opens her paper “Controversial questions (part one): what is the right size for a health visiting caseload?” with the statement that: “Questions are often asked that illustrate a lack of understanding about the nature of health visiting services. One example is the question of what constitutes a suitable ‘caseload size’ for a full-time health visitor – there is sometimes frustration at the lack of a single benchmark figure that is defined and accepted nationally. More hostile inquisitors question whether the notions of ‘caseload’, or even ‘health visiting services’, are helpful.”

65. The Scrutiny Panel was told at its meeting on 21 October by the service head that: “In respect of the caseload, CPHVA guidance stated that Health Visitors should have responsibility for approximately 350 children. This varied according to deprivation indicators but the historic guidance did not allow for the support given by multi disciplinary teams. With a population in Hounslow of over 17,000 under 5s, this equated to one health visitor to 600 families.” (It must be pointed out that, as at October 2009, there was a vacancy rate of 4.65 health visitors which would mean that the ratio was 1:729 under 5 year olds.)

66. Prof Cowley has said that the guidance assumed a 20% skill mix, rather than the 50% pertaining in Hounslow. See above.

67. The service head has said that with 17,500 0-4s in Hounslow and with the number of HVs that would currently equate to 1:800 per health visitor caseload. However, she said that the reality was that the health visitors looked after those with child protection plans and others in greatest need and that the average actual health visitor caseload would be 1:50-100. [The service head said she would send through the breakdown of the CP numbers per team and those who are have needs that are just below the threshold of CP.]

68. Prof Cowley has said that the figure of 1:50-100 is “far too high, if they are all ‘high risk’ families. Compare this with social work caseloads, or with Family Nurse Partnership, where a ratio of 1:25 families is expected. Key here is to look at the actual responsibility held by the health visitors. Even if they are delegating work to staff nurses, they remain accountable for their work, so it is not reasonable to somehow

---

29 P.19, Volume 82, Number 6, Community Practitioner, June 2009, paper by Professor Sarah Cowley, Professor of community practice development, Florence Nightingale School of Nursing and Midwifery, King’s College London: Controversial questions (part one): what is the right size for a health visiting caseload?

suggest that those families are no longer part of the health visitors workload, caseload or whatever term is used.\textsuperscript{31}

69. However, the CPHVA’s guidance would suggest that their most often quoted figure is an average of one health visitor to 250 pre-school children, with a maximum of 1:400 in the most affluent areas and 1:100 in the most deprived.\textsuperscript{32}

70. Lord Laming has confused matters slightly by saying in his report of March 2009 that: “The number of health visitors has dropped by 10 per cent in the last three years and case-loads are significantly higher than the recommended 300 families or 400 children, with 40 per cent of health visitors handling case-loads of over 500 children and 20 per cent over 1,000 children.”\textsuperscript{33}

71. Comparison with statistical neighbours plus Richmond upon Thames, as at December 2009.

<table>
<thead>
<tr>
<th>Local authority</th>
<th>Under fives population</th>
<th>Number of FTE health visitors</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hounslow</td>
<td>17,915 (2009 GLA projection figures for 0-4’s)</td>
<td>29.22</td>
<td>1:613</td>
</tr>
<tr>
<td>Richmond upon Thames</td>
<td></td>
<td></td>
<td>1:300</td>
</tr>
<tr>
<td>Ealing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hillingdon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slough</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redbridge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barnet</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

72. Hounslow PCT’s public health team sent through the following information with comparative data with statistical neighbours plus Richmond upon Thames. It is not entirely clear what counts as a qualified nurse, and whether e.g. all West Middlesex University Hospital midwives have been included in these statistics.

<table>
<thead>
<tr>
<th>PCT</th>
<th>&lt; 5 years population</th>
<th>*Number of Health Visitors, Qualified Nurses and Midwives (FTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hounslow</td>
<td>17700</td>
<td>143</td>
</tr>
<tr>
<td>Richmond upon Thames</td>
<td>12800</td>
<td>155</td>
</tr>
<tr>
<td>Ealing</td>
<td>23100</td>
<td>272</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>18100</td>
<td>206</td>
</tr>
<tr>
<td>Slough</td>
<td>10400</td>
<td>342</td>
</tr>
</tbody>
</table>

\textsuperscript{31} Email from Prof Cowley, 11 March 2010
\textsuperscript{32} GET REFERENCE FOR THIS. XXX
<table>
<thead>
<tr>
<th>Redbridge</th>
<th>19100</th>
<th>202</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>23500</td>
<td>338</td>
</tr>
</tbody>
</table>

Source of data: ONS Mid-2008
Population Estimates: Quinary age groups and sex for local authorities in the United Kingdom (April 2009)
*Source of data: NHS Information Centre for Health and Social Care (2008)

73. In her papers Professor Cowley argues that, since health visitors are, in order to be effective, working more than with children and parents but with “families, groups and communities”, a reduction to “Service provision tied solely to caseloads of pre-school children can therefore inhibit the flexibility of the service.”

74. In terms of responsibility for the well-being of 0-5s it is local authorities who possibly carry a greater statutory responsibility. Prof Cowley says that “PCTs are required to co-operate with the planning and delivery of children’s services, but they do not have to provide a universal health visiting service. However, all NHS organisations have a statutory responsibility in relation to safeguarding and promoting the welfare of children. In practice, this is fulfilled largely through the health visiting and school nursing services.”

75. The importance is perhaps a common definition of health visiting services nationally that they are ‘universal but not uniform’.

76. In terms of tackling health inequalities and addressing needs there are debates nationally about health visitors’ role in this. Whether health visitors should remain as a universal service, or whether they should concentrate on those in greatest need. There is a model which is developing across the country within the universal health visiting service to offer all new mothers a core service and, if the contact during this core service proves it necessary, to increase this to more targeted support for those families.

34 P.19, Volume 82, Number 6, Community Practitioner, June 2009, paper by Professor Sarah Cowley, Professor of community practice development, Florence Nightingale School of Nursing and Midwifery, King’s College London: Controversial questions (part one): what is the right size for a health visiting caseload?

35 P.20, Volume 82, Number 6, Community Practitioner, June 2009, paper by Professor Sarah Cowley, Professor of community practice development, Florence Nightingale School of Nursing and Midwifery, King’s College London: Controversial questions (part one): what is the right size for a health visiting caseload?
77. The key for Prof Cowley is the need for the numbers of health visitors to be appropriate for the different levels of need in the community. Simple measures of how affluent an area is are not effective in those terms. Place of residence does not protect against disadvantage factors. The seven key factors of family disadvantage are:

a) No parent is in work;

b) Family lives in poor quality or overcrowded housing;

c) No parent has qualifications;

d) Mother has mental health problems;

e) At least one parent has longstanding, limiting illness, disability or infirmity;

f) Family has a low income below 60% of the median;

g) Family cannot afford a number of food or clothing items.

[Add additional factors from the Healthy Child Programme]

NB The service head has said that while they collate the numbers of newbirths per team each month it will take some time to collate how many are first children. As mentioned above, the numbers of child protection plan children and their spread across the teams was promised.

78. Two complicating factors in determining health visitor numbers: a) local service context; and b) local working patterns. By local service context, Prof. Cowley means the availability of other services. In her paper she argues for more health visitors in more affluent, ‘older’ areas where alternative services for 0-5 year olds could be long distances away. It may be some distance to the nearest clinic, GP or children’s centre. By local working patterns Prof Cowley is referring to skill mix teams.

79. This still leaves the question as to how many health visitors Hounslow should have.

80. [As stated above, the service head has said she would send through the assessment form template that is then used as a screening tool to determine which families got the more intensive support.]

81. The results of the user consultation from July 2009 on the use of staff nurses instead of fully qualified health visitors can be found at Appendix XX

---

36 P.20, Volume 82, Number 6, Community Practitioner, June 2009, paper by Professor Sarah Cowley, Professor of community practice development, Florence Nightingale School of Nursing and Midwifery, King’s College London: Controversial questions (part one): what is the right size for a health visiting caseload?

37 P.22, Volume 82, Number 6, Community Practitioner, June 2009, paper by Professor Sarah Cowley, Professor of community practice development, Florence Nightingale School of Nursing and Midwifery, King’s College London: Controversial questions (part one): what is the right size for a health visiting caseload?
Clarity on role of health visitor

82. It has not been made explicit to the Scrutiny Panel members yet what the role of the health visitor is within the skills mix team, or rather the leadership role of the health visitor has not been fully spelt out. This is what is set out in the Healthy Child Programme (HCP) from the Department of Health, issued in October 2009 (replacing the Child Health Promotion Programme). There it states that the Healthy Child Programme needs to move:\textsuperscript{38}

\begin{table}[h!]
\centering
\begin{tabular}{|l|l|}
\hline
\textbf{From …} & \textbf{To …} \\
\hline
A programme delivered by health practitioners & One led by health visitors, drawing on a range of practitioners, and delivered through general practice and Sure Start children’s centres \\
\hline
A lack of clarity about who is responsible for the quality and outcomes of the HCP & Health visitors leading the delivery of the HCP for a defined population across a range of services and locations. The HCP is commissioned, monitored and evaluated locally, and overseen by the PCT or children’s trust in partnership with general practice, including population outcomes \\
\hline
\end{tabular}
\end{table}

83. The HCP goes on to set out that: “the health-visiting workforce is central to the delivery of the HCP. This was recognised in the review of the future role of the health visitor, Facing the Future (DH, 2007b), which recommended that health visitors should focus on young children and families, where their public health nursing expertise can have greatest impact.”\textsuperscript{39} And that the role of the health visitor should be two-fold:

84. Include results of Ofsted: http://www.ofsted.gov.uk/oxcare_providers/la_download/(id)/5161/(as)/LAC/lac_2009_313.pdf

**Recommendation 1**

That the Boards of NHS Hounslow and Hounslow and Richmond Community Healthcare, and relevant commissioners and service managers note the scrutiny panel members’ significant concerns about the lack of key service management information that is readily available.

**Recommendation 2**

That rather than wait for 100% of posts in the 0-16 teams to be filled before making a business case for any additional posts, there should be better planning on the part of both trusts as to the required size of teams to meet the needs of Hounslow’s population.

**Recommendation 3**

That there be clear development of ideal pathways for the different categories of users and families i.e what service does a high need family require, what is the 'basic' service that a family with fewer needs receive and when and who should deliver it.

**Recommendation 4**

That NHS Hounslow and service managers of Hounslow 0-16 teams work with the Scrutiny Panel next municipal year to develop a model for testing ideal pathways for clients coming into contact with the 0-16 teams.
Conclusions
Table of recommendations

<table>
<thead>
<tr>
<th>Number</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
### App XX – Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAF</td>
<td>Common Assessment Framework. A multi-agency approach to dealing with a child or young person ensuring consistent and co-ordinated approach to interventions.</td>
</tr>
<tr>
<td>SEN</td>
<td>Special Educational Needs</td>
</tr>
</tbody>
</table>
App XX – Typical Hounslow health visitor working day

The Chair of the Scrutiny Panel asked for the diary of a typical day in the life of a Hounslow health visitor

One day in October 2009

<table>
<thead>
<tr>
<th>Time</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.30</td>
<td>Arrive</td>
</tr>
<tr>
<td>7.35</td>
<td>Messages from clients left after 6 pm the night before, return calls</td>
</tr>
<tr>
<td>7.50</td>
<td>switch pc on, check emails</td>
</tr>
<tr>
<td>8.00</td>
<td>start Rio* diary for today</td>
</tr>
<tr>
<td>8.10</td>
<td>Phone Health Visitor in another base re. transfer in of another client</td>
</tr>
<tr>
<td>8.30</td>
<td>midwives phoned re new birth visit – problems</td>
</tr>
<tr>
<td>8.40</td>
<td>GP pops in to give referral re. post natal depression</td>
</tr>
<tr>
<td>9.00</td>
<td>finish Rio entries from yesterday</td>
</tr>
<tr>
<td>9.10</td>
<td>Liaison with community nursery nurse re phone message left for her, distressed client, toddler taming requested.</td>
</tr>
<tr>
<td>9.17</td>
<td>Collect car, set off for 1st new birth visit baby aged 5 weeks. (1st baby.)</td>
</tr>
<tr>
<td>9.30</td>
<td>Arrive at house.</td>
</tr>
<tr>
<td>10.45</td>
<td>Leave visit, check mobile for messages from the office. Return call to social worker, leave message with admin to state I am returning call.</td>
</tr>
<tr>
<td>10.58</td>
<td>arrive for 2nd new birth – late should have been there 10.30. Mother has given up breast feeding as she has had no home support between midwives finishing and Health Visitor visiting. Baby is now almost 6 weeks.</td>
</tr>
<tr>
<td>12.10</td>
<td>Leave new birth visit. Head back to the office via children’s services to drop off information about a parenting course for a parent.</td>
</tr>
<tr>
<td>12.30</td>
<td>Arrive at the office.</td>
</tr>
<tr>
<td></td>
<td>• Return phone calls to clients, social worker, community nurses.</td>
</tr>
<tr>
<td></td>
<td>• Look up client information on Rio for social worker, reply to emails.</td>
</tr>
<tr>
<td></td>
<td>• Phone named nurse for child protection regarding a case conference.</td>
</tr>
<tr>
<td></td>
<td>• Try to phone Health Visitor in another trust regarding notes for a child.</td>
</tr>
<tr>
<td>1.30</td>
<td>Child Health Clinic, see approx 40 children. Over run by one hour, clinic finishes at 4.30</td>
</tr>
<tr>
<td>4.30</td>
<td>clean mats, pack away.</td>
</tr>
<tr>
<td>4.35</td>
<td>reflect on clinic with colleagues and a cup of tea</td>
</tr>
<tr>
<td>4.45</td>
<td>GP comes in to inform about a baby’s 6 week check and her worries</td>
</tr>
<tr>
<td>4.55</td>
<td>Check emails and return phone calls from this afternoon.</td>
</tr>
<tr>
<td>5.10</td>
<td>Start Rio for 2 new birth visits.</td>
</tr>
<tr>
<td>5.45</td>
<td>Lock up and leave. Wave goodbye to colleagues still in the office.</td>
</tr>
</tbody>
</table>

Lunch eaten on the go. No break

Add priorities to do today to tomorrow’s pile:
• A& E slips [what is this? Simply a referral from A&E?]
• Move ins [what is this? Someone moving into the borough from elsewhere?]
• Form 78s [Child coming to notice of police]
• Interagency [what does this mean?]
• Ante-natal

* Rio is the NHS case management system
Appendix XX – Changes in whole time equivalent HV Numbers in England 2005-7


Source: NHS Information Centre

http://www.nursingtimes.net/Binaries/0-4-1/4-1987724.pdf
Appendix XX - Service User Consultation on the Staff Nurse Pilot (July 2009?)

Purpose of Service User Consultation:
Difficulties in recruiting qualified health visitors have made it challenging to achieve the 10-14 days statutory target for a new birth visit. The problems and risks have already been managed in Hounslow by offering new birth appointments in clinic, sending letters inviting parents to attend the baby clinic and by prioritising according to a risk assessment protocol.

The employment of staff nurses to undertake new birth contacts was initially considered a controversial solution to the problem. Service user consultation aimed to understand views and perceived risks so that the pilot could be mindful of them.

Method of consultation:
We consulted with new mothers some of whom have received a visit 10-14 days and some of whom received a late new birth or no new birth at all. We spoke with parents at Heart of Hounslow, Chiswick and Feltham, which have very different social population profiles.

Reasons for suggesting a change to the way the service is delivered was communicated to families who participated in the consultation at the three sites in the form of a letter and verbally. They were given a questionnaire about the new birth visit and were asked to take part in a scenario based discussion. The scenario based discussion was effective because there were a number of clients with English as a second language particularly in Heart of Hounslow. It also elicited rich qualitative data, story telling and ideas about how staff nurses could be used to support universal services. As a result only 10 questionnaires were returned, but 32 parents took part in discussions and interviews. These broke down as 14 in Heart of Hounslow, 11 in Feltham and 7 in Chiswick.

The difference between staff nurses and health visitors:
The first question we asked was whether or not they knew the difference between a health visitor and a staff nurse. In most of the consultation discussion groups the parents did not know the difference. The career progression from staff nurse to HV and the skill difference was explained. What was important to most parents was that they had access to the right level of knowledge either directly or indirectly. They felt that as long as a staff nurse went back and researched a question with their HV or other professional and could come back to them with an answer it was OK.

Value in the new birth visit:
Clients were complimentary about the service. In particular they felt that the service was motivating towards mothers focusing on what they did well as a new mother, facilitating bonding with baby and access to services. They greatly valued the new birth visit, preferring this to be at home. Mothers who
had received a visit 10-14 days felt confident about coming to the clinic. While mothers who had not received a new birth visit for anything up to 12/16 weeks felt it was difficult to engage with the service and to come to clinic. They made less use of the health visiting service at clinic, being less likely to share feelings of depression and were more likely to feel rushed. Mothers who had not received the statutory new birth visits were more likely to strongly support the use of staff nurses under the management of HVs where a few of those who had received a visit 10-14 days said they could have waited for a HV to come later.

**Getting the right information:**
A few mothers in one area reported being told by the midwife that they couldn’t go to baby clinic until the baby was 6 weeks old. These mothers felt it was vital to have good information directly from the health visiting service early on. Generally mothers felt that staff nurses working under indirect supervision of the health visitor could provide them with up to date information on a range issues such as feeding, prevention of cot death, immunisations, pelvic floor exercises, family planning, colic, services available etc as well as being the person that captures basic administrative information from them.

**Building confidence:**
Some mothers described a lack of confidence with feeding in the early weeks which went unmanaged because they had not seen anyone until week 8-10. This potentially led to feelings of isolation and depression. As soon as they were seen by the service they were able to get help either directly or indirectly from the person they saw. These few mothers also felt that early contact with someone from the service who could refer to the qualified HV where necessary was more important than having the qualified HV do the first contact if this was going to be later.

**Facilitating networks:**
Mothers recognised that information can flow easily across well set up networks of parents. This was particularly true in Chiswick where mothers naturally run their own informal networks in the form of text messaging and coffee mornings. It was suggested that the role of a staff nurse could be to facilitate people at the new birth contact into such networks and continue to provide up to date information about feeding, colic, infant immunisations etc through those networks.

**Concerns:**
Mothers wanted to be sure that the person coming to see them was a qualified clinician and knew more than they did and that the nurses were receiving additional training and support from a qualified HV.

One group of mothers in Feltham brought up the media coverage of Baby P and wanted to be sure that a staff nurse doing the first contact wouldn’t mean a case like this would be missed. The conclusion of this group of mothers was that special (safeguarding) training was essential for the staff nurses and that the nurse must report their concerns into a HV.
Conclusion:
Parental views on the use of staff nurses to support new birth contacts were positive overall. Parents highly valued the new birth contact and were concerned with receiving it earlier rather than later. They all valued their health visiting input and recognised with sympathy the difficulties in recruitment and the challenges this posed for existing health visitors. They highlighted the fact that the person making the first contact needed to be a trained nurse with appropriate skills, knowledge and awareness and that the communication between them and the HV had to be excellent. If all these factors were in place service users supported the change.

Quotes:
“I was worried about my baby’s weight and I didn’t want to feel silly going to the GP. I didn't realise I could just drop into the baby clinic.”

“The new birth visit was mostly paperwork and giving me leaflets about various things. But as a result I started coming to clinic”

“Some support is better than none…..I didn't know if feeling so tired was normal or not. It would have been nice to have someone take the time to find out how I was feeling.”

“As long as the staff nurses have been equipped with the basic skills and knowledge needed for the new birth contact and can answer questions.”

“Breastfeeding help when it came was simple and problems were sorted out quickly. I didn’t know to come to clinic. It would have been so helpful and made all the difference in the first few weeks. But it was worth the wait.”

“Just need simple initial advice from a professional and then for more complex issues you can see your HV.........in clinic you’re under pressure to do so much in a short time. You forget things. It’s better to see someone at home the first time.....It’s a good idea what you’re proposing.”

“It’s a good idea to use staff nurses. They can flag up quickly if a mum needs extra support early on and then a HV can go in.”

“Most important is that the person who comes can answer basic questions about caring for and feeding your baby.”