A funding model for health visiting (part 2): impact and implementation

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Abstract
This is the second of two papers offering the information required to work out how to fund a health visiting service. The first paper gave the basic requirements, while this one identifies and explains the separate components of the service along with issues of scope and skillmix. In this way, it starts to describe the programmes embedded within a generic health visiting service, which is helpful in terms of what might be expected in terms of impact and outcomes. These are described with reference to the new Public Service Agreement targets and other relevant policy.

Key words
Funding model, service organisation, health visiting, universal service

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Background

This is the second of two papers prepared to assist in the planning and commissioning of generic health visiting services. The first set out the basic requirements of a model to calculate the funding needed for such a service, for infants up to one-year-old and their families.[1]

The model is designed to meet the tenets of progressive universalism, to be based on assessed need and on evidence of what works, as summarised in Box 1. It is not intended as either a basic minimum or a protocol for service delivery. Instead, it provides the specificity and flexibility needed for service planning and commissioning, through detailed guidance about the amount of staff time required to achieve these basic requirements.

This paper focuses on three background issues: service components, service scope and skillmix. Then, it highlights the impact and outcomes that might reasonably be anticipated from delivering the kind of service funded by this model.

Implementation issues

Service components

The overall health visiting service provides three interlinked forms of prevention – universal, indicated and selective.[1] This modern terminology differs from that traditionally used within health visiting circles, which have described 'core services' (universal prevention; also regarded as primary prevention), 'extra health visiting' (indicated prevention, often considered as secondary prevention) and 'specialist health visiting' (selective prevention, targeting established difficulties, tertiary prevention).

Traditionally, all these have been provided by the same health visiting team, or even the same person, which may still be the most efficient form of delivery in many areas. This level of integration is consistent with the government's commitment to integrated, personalised services[2], and offers the coherence and flexibility to engage with a wide range of other services. In England, for example, health-led local Sure Start programmes were more effective than programmes led by other agencies, probably because they offered better access to children and established health visitor networks.[3]

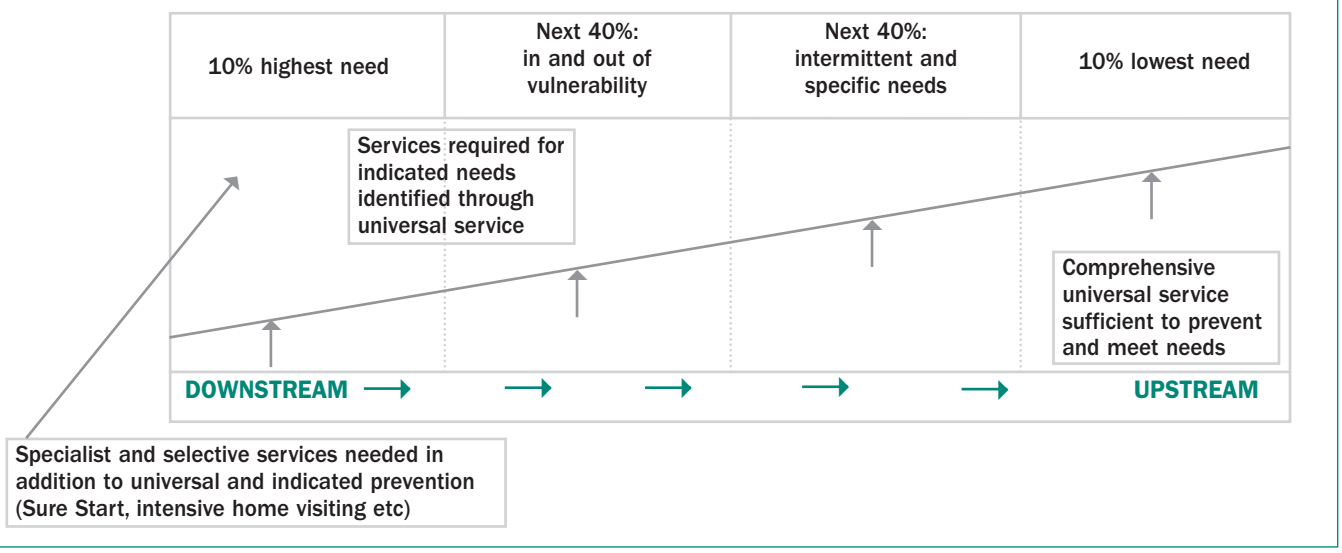
In another example, integration with tiers one and two mental health services proved to be a very effective mechanism for managing high levels of need in an area.[4] This form of collaboration is an essential part of the public health purpose of health visiting, but a time allowance is needed within the funding allocation.

Overall, the aim of the funding model is to allow a service that succeeds mainly through universal prevention, using this as a mechanism for identifying health needs that require additional support and which, simultaneously, meets most of those needs. This promotes early interventions, encouraging a high preventive element within all universal services[2] and the Department of Health's strategic objective to "promote

Box 1. Basic requirements of a generic health visiting service

- Universal prevention providing support for all, with the intensity of support varying according to levels of need in the area (progressive universalism)
- Provision for selective and indicated prevention (specialist and extra health visiting)
- Assessment of need at two levels: area based, and in partnership with each family
- A minimum of 12 contacts (including home visits) over a period of at least 6-12 months, to promote family wellness and prevent child maltreatment in the first year of life
- A multi-component programme (centre-based services, groups, outreach and home visiting) using a strengths-based approach
- Specification of anticipated impact

Figure 1: relationship between need and service provision



better health and well-being for all.'[5]

It pushes towards the 'upstream' position in health promotion (that is, it fixes the bridge, rather than saves those who fall in the water) shown in Figure 1. The extent to which this is feasible will vary according to the level of an area's need which, in turn, is related partly to the extent of deprivation.

The overwhelming needs of asylum seekers, of homeless families and those living with high levels of family disadvantage[1], mean that there is likely to be a need for both specific, specialist services, and enhanced generic, universal health visiting in very deprived areas.

A wide range of health needs, which may be either hidden or very obvious, arise for children and families across the social gradient. Even if a problem is proportionately more common among lower socioeconomic groups, there are relatively fewer children in these groupings, so a smaller actual number of diagnoses will occur within them. Stewart-Brown details the example of childhood behaviour problems, particularly conduct disorders, which are noticeably more common in social classes IV and V than in I and II, but the majority incidence occurs in the middle (social class IIIM), simply because there are so many more children in this group.[6]

A similar pattern pertains to many other issues of concern. Disabilities, complex needs and domestic violence all cross the social divide; post-natal depression and social isolation are prevalent in all areas and there are increasing concerns about the use of illicit drugs and alcohol among middle class families. All of these have an effect on a child's health, future development and well-being.

Within any health visiting caseload, there is likely to be a relatively small number of families whose level of vulnerability is obvious and immediate, and a larger number able to cope well some of the time, but with a high need for support much of the time. At the other extreme, while there is likely to be a relatively small number of families whose need for the service is very low, there will be a larger number who require periodic support or advice for specific issues of concern. The exact distribution of need will vary from one caseload to another.

Deprivation is one key marker. Others include the extent to which an area is established or newly developed; major changes to employment, migration or mobility within an area; work patterns and housing costs; social cohesion and other local factors. Also, concepts used when designing services for the most hard to reach populations[5] help to ensure that hidden, hard to reach health needs can be identified, regardless of the social background of the families concerned (see Table 1).

In very deprived areas, where a range of children's services are established, health visitors may spend a great deal of time collaborating with colleagues, but also referring and enabling client families to engage with those services. In areas that have less obvious material deprivation, needs are likely to be more hidden, and time is required for health visitors to themselves provide a service for families' needs, since there may be no established Sure Start children's centres or any other services to which they can refer.

Scope of the service

While the child is the primary focus of the health visiting service, the arrival of a new baby is a period in a family's life when all members are uniquely receptive to health promotion messages. This is important, at a time when the NHS is aiming to promote full engagement by the whole population in their own health.[8] Further, the environment in which the infant grows, including the family and local community, is a key influence on the child's future health and development.[9]

The first paper concentrated on funding requirements for commissioning a preventive child public health service for families with babies under one year of age.[1] Follow-up of children aged over one year also needs to be factored into the funding model, either as targeted or routine contacts at specified ages.

To reduce inequalities, proactive health promotion and prevention is recommended until at least the age of eight[9], after which developmental delays and disadvantage from the early years become more entrenched and harder to reverse.

Speech and language impairment is one of the commonest problems identified and referred for treatment by health visitors; if referral is delayed until the time of school entry, achievement at key stage one will be adversely affected. Some specific

Table 1: Hard to reach and hidden needs

	Highest need	In and out of vulnerability	Intermittent/specific needs	Lowest need
Home visiting	Thirty years of strong research evidence to support intensive home visiting, delivering the Olds' specific programme[7]	Includes many families that will develop significant needs. Home visiting helps to identify submerged and hidden needs, and thus supports early intervention	Home visiting required during period of need; promotes attendance at groups. Absence of wider services may mean scope of mainstream provision needs to be extended	Sufficient visits required for clients to understand scope and focus of services available when needed
Multi-component service	Wider services (beyond home visiting programme) required to meet needs identified through home visiting, such as drug misuse service and collaboration with criminal justice system	Additional services needed when people are vulnerable, and to aid early prevention; group and outreach activities influence community culture and help to develop social cohesion	Able to attend and support group and community activities to reduce social isolation. Provision required for early prevention when indicated.	Use of groups and/or services at clinic base may reduce the need for home visits
Professional/client relationships	Clients may have little experience of positive relationships, so the professional/client relationship provides role modelling	A positive professional/client relationship helps to identify submerged needs	Clients able to relate to a team of workers, if a single preferred/named professional is available when needed	Important to establish relationship at the start, so clients can be left to seek service for themselves when required
Continuity	This most needy population may reject service if worker changes, so it is important to maintain continuity	Continuity across episodes of vulnerability helps early identification and prevention, and avoids repetition. Service may be rejected if workers change.	Continuity of service and knowing what to expect are important; if not available, help may be sought from other, more expensive sources (GP, paediatrician)	Loss of continuity may inhibit appropriate use of service
Professional level	In Olds' studies,[7] Baccalaureate nurses, whose additional training includes/exceeds content of UK health visiting programme, achieved far better outcomes than 'para-professionals' delivering same programme	Dynamic and unpredictable nature of vulnerability means delegation must be used with care, except for specific programmes of activity (behaviour management, parenting groups, etc)	Professional level of assessment required for specific and indicated needs when they arise. Junior team members helpful in supporting on-going group and centre-based activities	Often more than a year between contacts, so a senior level assessment is needed on most occasions
Reputation	High-need families in US received visits from nurses because their good reputation was felt to increase acceptability (for example, 38% dropout rate with nurse visitors compared with 48% for paraprofessional visitors)[7]	A UK survey (FPI) shows that 76% of clients would prefer to receive parenting support from health visitors; only 33% wanted this from nurses.[11] The non-stigmatising nature of a universal service is important	Either reduced service quality or too infrequent contacts may harm the reputation of a universal service, leading to rejection by mainstream users and the stigmatising of those left	Use of service provides a marker of its reputation, and the legitimacy of seeking/receiving support at specific times (for example, in the first year of life)

disabilities, such as developmental co-ordination and autistic spectrum disorders, can only be identified after the child reaches around the age of two. So decisions are needed about the age range encompassed by the service, particularly with regard to pre-school children, for whom there is no other universal provision.

Key issues to be resolved are:

- In England, integrated children's services usually encompass a range of antenatal to 19 years' old. Health visiting services need to be developed with these wider age ranges – and the interface with colleagues serving them – in mind.
- The Child Health Promotion Programme (CHPP), set out in the Children's NSF[10] in 2004, specified very little contact apart from immunisations; it is currently being updated and expanded.
- More mothers are returning to work, full and part time, before the child starts school, so child care/children's centres are increasingly important
- Ages 1-4 years remain very critical in terms of food behaviour, social development, identification of developmental delay and disabilities, school readiness etc
- There is growing anecdotal evidence that children are reaching school with unidentified health problems, since the number of scheduled health visitor contacts with the pre-school age range has declined

Health visiting is a public health service, so time needs to be built into the funding model to allow for the 'influence on policies affecting health'[12], mainly through the kinds of liaison and collaboration across agencies (audit, planning meetings, etc) described above, but also for community profiling, collating information for health intelligence, clinical governance, and contributions to the health inequalities agenda. This time may be added pro rata per whole-time equivalent health visitor or as a percentage sum across the whole service. All health visitors need an opportunity to contribute, both to maintain the proactive basis of the service and to ensure their local knowledge is passed on to the relevant departments.

Skillmix and substitution

Health visiting services are those delivered and led by qualified health visitors, but provided in collaboration with colleagues, like children's centre staff and primary care teams. They include team members who are less highly qualified, such as community nursery nurses, administrative support workers and staff nurses, to whom specific activities may be delegated.

However, health visiting provision is delivered to an undifferentiated caseload, which is to say clients have not been previously assessed and referred by doctors, as is the case for many nursing and allied health services. This is important in terms of deciding which work can be delegated.

Distinctions between delegation, referral and collaboration are not always clear in the kind of multi-component service offered in most areas.[13] In the US, Olds' research showed that the delivery of intensive home visiting programmes by 'paraprofessionals', who had no formal preparation and in-service training only, led to outcomes that were far less effective than those delivered by highly qualified professionals[7]. On the other hand, research from Ireland[14, 15] and England[16, 17] suggests that, in programmes developed with, for example, the skills of community mothers or community workers in mind, they can be both effective in their own right and of considerable benefit to the health visiting team and local community.

A national survey of service organisation showed increased group provision (particularly parenting and behavioural support) where nursery nurses were employed in health visiting teams, and more comprehensive services where there was adequate administrative support.[18]

With regard to the substitution of less qualified staff for health visitors, there is a lack of research about its effect on health outcomes, and on staff stress, satisfaction or turnover. An audit of practice in one PCT[19] resulted in data on 1,036 home visits, clinic and group contacts.

Those completing the forms (including all grades involved) assessed that 22% of these contacts could have been completed by community staff nurses, nursery nurses or support workers. Exceptions included families with complex needs or safeguarding (except where defined programmes of work could be initiated), assessments and initial contacts where the family was 'unknown', including those not seen for more than a year. Discussions beyond this single area led to a general consensus that a ratio of one skillmix worker to four health visitors seems a suitable level for service planning and funding the generic programme. Skillmix staff are best used where they can be supervised (eg at the base where more senior staff are available if needed) or for home visiting in situations where:

Box 2. Finalising the funding model

- A specified number of hours required for universal prevention for all infants under one year old, as set out in 'Baseline Requirements' paper[1]
- A specified number of hours required for universal prevention, including CHPP,[10] for children over one year old.
- Agreed provision for indicated needs, delivered within generic health visiting service or in collaboration with other services
- Agreed specialist service provision for selective prevention, depending on local factors; again, delivered independently or in collaboration with other services

Time is also needed for other issues, including:

- Continued Professional Development, including statutory training
- Clinical supervision and management support
- Clinical governance: identifying, updating and auditing practice; practice development
- Travelling time: allowance needed for local factors, eg for high mileage in rural areas; congestion and difficult parking in densely populated areas
- Administrative time: more time needed for higher levels of safeguarding, special needs etc, and more professional time if administrative support is limited
- Preparation time for group and community outreach work (parenting education, postnatal support etc), and to collate evaluations
- Funding resources for group and centre-based activities (room hire, refreshments, basic equipment – DVD players, print flyers, etc)
- Standard service issues: sickness, maternity leave etc
- Workforce development: training students (health visitors and others)

- the skills of the worker are known
- the client's situation and needs have been assessed and a plan formulated
- delivery of the package of care is expected to follow a fairly predicable path

The skillmix worker can then be sufficiently well briefed about what to expect and what to do in the event of a variation from this anticipated path. In the case of a new client, or if more than a year has elapsed since a client has been seen by a health visitor, then the situation is not predictable, so health visitor assessment is required.

Deliverables and impact

The difficulties of identifying outcome measures for the health visiting service have been well rehearsed. Poorly developed and inappropriate health service information systems may take no account of families, communities or health promotion, focusing instead on individuals and specific diseases.[20] There is clear benefit to hard to reach families from the ability of health visitors to use a routine enquiry or single issue as the entry point to a family, before expanding their interest to encompass hidden or unrecognised health needs[21, 22]; but robust evaluation requires endpoints to be specified at the outset. The health visiting practice of 'therapeutic prevention' may help to identify previously hidden, measurable health problems or to (simultaneously) prevent minor concerns from becoming manifest as health problems, which will not be counted[23].

Despite these methodological challenges, much progress has been made, largely by learning from the experience of early intervention and home visiting programmes, which are multi-faceted. These set global rather than specific objectives at the outset, yet provide clear measures and indicators of the overall benefits accrued. Also, it has become more common for health services overall to measure progress against a set of broad targets, with a few specific indicators serving as markers along the way. Some of these are collated in Table 2(a-c), which summarises relevant indicators derived for the new Public Service Agreement (PSA) targets[24] with others laid down in government policy and guidance, such as the *Choosing Health* public health white paper[25], Children's NSF[10] and relevant NICE guidelines.[26, 27, 28]

Suggested 'markers' for success" are highlighted. The seven PSA targets identified as priorities in the government's response to the health visiting review[29] are placed first, as they are led by the Department of Health, either alone or jointly with the Department for Children, Schools and Families, so they will be of primary importance to NHS commissioners. Other important targets are also listed.

This paper, like the first[1], is intended to offer interim guidance prior to the completion of promised commissioning guidance from government sources. It moves towards specifying health visiting services in terms of programmes, which would help to improve evaluation and to identify which outcomes might be anticipated from provision of these services.

A full systematic review of evidence is urgently required, to identify the best programmes for both universal and indicated prevention. Also, new research is needed to clarify best skillmix and preferred forms of service organisation.

Until these are available, the two papers bring together information about relevant evidence and professional expertise in determining which forms of service organisation, planning and skillmix are regarded as good practice, along with the anticipated impact of health visiting service provision.

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Table 2(a): Targets and anticipated impact of services

PSA delivery agreements	PSA indicators	Related targets	Contribution of health visiting services	Markers of success
12: Joint Department for Children, Schools and Families (DCSF) and DH lead: Improve the health of children and young people	Indicator 1: Prevalence of breastfeeding at 6-8 weeks.	Choosing Health[15] priority area: obesity targets	Increase uptake by: Promoting at community level Guiding parents to choose breast feeding Individual expert support to sustain breast feeding Focusing on disadvantaged families	Year on year improvement in breastfeeding at six weeks and six months
(link with PSA 10 & 11 below)	Indicator 3: Levels of childhood obesity National target for 2020	Choosing Health[25] priority area: obesity and activity target. Child Health Promotion Programme (CHPP) in Standard 1 of Children's NSF[10]. NICE guidance on obesity[28]	Guiding parents in healthy eating Parent-child relationships and targeted support for problems Identification of at-risk families in pregnancy and first years of life Delivery of evidence-based early intervention as part of CHPP Monitoring of growth and population levels Focusing on disadvantaged and hard-to-reach families Raise awareness and understanding at community level Training and leadership of wider children's workforce	Measurement of weight and length/height at two years and school entry Uptake of activity groups/advice sessions Year on year improvement in prevalence of obesity at school entry
Link with mental health of parents; (see PSA 19 below)	Indicator 4: Emotional health and wellbeing, and child and adolescent mental heath services (CAHMS)	Choosing health[25]: mental health is a priority area. Mental health NSF: prevention and mental health promotion priority NICE guidance for antenatal and postnatal mental health[27]	Assessment of attachment, parenting and relationships and identification of those at risk of poor outcomes The promotion of infant mental health through evidence based early intervention in pregnancy and first years of life Universal prevention/ development and behaviour management through infancy and toddler years Targeted, short term support for relationship and behaviour problems individually or through group work Promoting access to parenting support services (eg provided in Children's Centres [CCs])	Number of children with emotional and behavioural issues supported through tiers 1-2 integrated mental health and health visiting teams Uptake of family support services Improved school readiness at foundation stage assessment Number of high-risk families in intensive programmes
	Indicator 5: Parents' experience of services for disabled children and the 'core offer'	Children's NSF[10]: Standard 6 for disabled children and young people and those with complex needs Cabinet Office: One in 20 children under 16-years-old is disabled; increasing numbers of children with complex needs[30]	Timely identification of special and complex needs required as a basis for establishing the core service. Aiming high for disabled children On-going support through specialist health visiting services for children with special needs All affected children provided with specific Down's syndrome pages for Personal Child Health Record	Measuring timeliness of identification: identified pre-school; length of time problems existed prior to diagnosis Percentage of children with disabilities identified, compared with numbers expected

Table 2(b): Targets and anticipated impact of services

PSA delivery agreements	PSA indicators	Related targets	Contribution of health visiting services	Markers of success
13: DCSF lead: Improve children and young people's safety	Indicator 3: Hospital admissions of children with injuries	Choosing Health[25]: priority on reducing inequalities	Leadership of early intervention and prevention programme to promote child safety, including safety equipment loan Assessment of risk and protective factors Improve care-giving through intensive evidence-based programmes Build safe communities for children	Year on year reduction in hospital admissions, and in A&E attendance Improvement in play spaces and in first aid knowledge
	Indicator 4: Preventable child deaths as recorded through child death review panel processes	Children's NSF[10]: Core Standard 5, safeguarding and promoting the welfare of children and young people.	Universal prevention through the CHPP Early identification of children at risk of harm Lead, deliver or participate in care package for most vulnerable children Delivery of programmes to at-risk children Identification of domestic violence, and supporting families in achieving safety	Children identified as at risk of significant harm recorded on the child protection register. Families of concern identified
10: DCSF lead: Raise educational achievement of all young people 11: DCSF lead: Improve educational achievement in disadvantaged children	Indicator 1: Early Years Foundation Stage (EYFS) attainment Indicator 1: Achievement gap at EYFS	ECM: Enjoy and achieve[31] Children's NSF[10]: Core standard 1: identify needs and intervene early Choosing Health[10] Inequality as a priority area	Identify early those children most likely to have poorer outcomes in later life Improve school readiness (behaviour, language, social and emotional development) through evidence-based interventions Promote early literacy projects Promote access to parenting and family support services within children's centres Identify early those children with special educational needs and developmental delay	Improvement in EYFS attainment and in uptake of early learning initiatives Timely referral for special educational needs Successful tier 1 and 2 support for conduct problems
14: DCSF lead: Increase the number of children and young people who find the path to success	Indicator 1: Reduce the percentage of 16-18 year-olds not in education, employment or training (NEET)	Connects to Every Child Matters (ECM) outcomes[31]	Promote positive parenting and enable parents to meet their aspirations for the child during pregnancy and the first years of life Promote awareness that early years experience profoundly influences adolescence Enroll the most at-risk families in evidence-based programmes known to have positive long-term outcomes Promote access to wider parenting education and family support services (eg within CCs) Contribute to integrated children's services Promote resilience through strengths-based practice Enable access to family planning services Provide specialist/selective health visiting services Collaborate with other specialist services	Audit of contributions across 0-19 years children's services Evaluations for dedicated/specialist services
	Indicator 2: More participation in positive activities	Participation and resilience – government policy watchwords		Uptake of services by all parents Participation in group provision
	Indicator 3: Reduce the proportion of young people using illicit drugs and alcohol	Choosing Health[25] to reduce harm and encourage sensible drinking		Contributions across children's services Evaluations for dedicated/specialist services
	Indicator 4: Reduce the under-18 conception rate	Choosing Health[25] as part of a broader strategy to improve sexual health		Reduced conception rate for under-18s, and improved birth spacing
	Indicator 5: Reduce number of first-time entrants, aged 10-17 years, to criminality	Children's NSF[10]: promoting the welfare of children and young people		Number helped by parenting education or referred for specialist help

Table 2(c): Targets and anticipated impact of services

PSA delivery agreements	PSA indicators	Related targets	Contribution of health visiting services	Markers of succes
18: DH lead: Promote better health and wellbeing for all	Indicator 2: Starting with children aged under one year, to reduce, by 2010, by at least 10% the gap in mortality between the "manual" socio-economic group and the population as a whole	Choosing health[25]: reducing inequalities as a major priority Children's NSF[10]: Standard 1. Promoting health and well-being, identifying needs and intervening early	Early identification of risk and protective factors (from early in pregnancy) Intensive evidence-based programmes for the most at-risk Universal prevention based on a model of progressive universalism Supporting families to improve economic and social resources Building community awareness Promoting uptake of wider services Promoting uptake of immunisations	Year on year improvement in infant mortality Post-neonatal (4 weeks to one year) mortality is of key significance to HV services' Immunisation rates. Mortality is of key significance to health visiting services
	Indicator 3: Smoking prevalence	Choosing health[25]: Target to reduce, by 2010, adult smoking rates to 21% or less, and in routine manual groups to 26% or less	Identify early in pregnancy women who smoke and support them to quit Identify all family members who smoke in early years of child's life. Collaborate with or deliver clinics/groups dedicated to stopping smoking	Year on year reduction in number of pregnant women and parents who smoke
19: DH lead: Ensure better care for all	Indicator 1: The self-reported experience of patients/users	NICE guidance for routine postnatal care[26] NICE guidance for antenatal and post-natal mental health[27] Choosing health[25]: mental health is a priority area	Availability, accessibility and continuity of universal services Early identification and support of mothers and fathers with mental health problems Availability of post-natal support groups for prevention of mental health problems Evidence-based listening visits, one-to-one or group support for post-natal depression Identification of need and support following bereavement	Percentage of parents engaged in home visiting, clinics and attending groups Percentage of parents with mental health problems supported in primary care (tiers 1 and 2)
	Indicator 4: Number of women who have seen a midwife or maternity healthcare professional by 12 weeks of pregnancy		Central for all pregnant women, but health visiting services particularly involved with second and subsequent babies	Year on year improvement overall, including rate for second and subsequent babies
	Indicator 6: GP services, including primary care teams		Primarily an indicator for general practice Establish user liaison committee for health visiting services	Ability of clients to access health visitors via general practice Quality of liaison with general practice
21: Department for Communities and Local Government: Build more cohesive, empowered and active communities	Indicators 1-4: Percentage of people who get on well with locals from different backgrounds, who feel they belong to their neighbourhood and can influence local decisions		These indicators are particularly relevant to the public health function of health visiting Outreach and development activities, especially in deprived areas Community groups operating for all parents in an area may actively promote more cohesive and empowered communities	Percentage of health visitors involved in community liaison committees Engagement of families in group and community activities Measures of social capital in area