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Original Research

What do health visitors do? A national survey of activities and service organisation

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Summary *Background*: Early interventions targeting health inequalities, and changing policies for mothers and pre-school children, have focused attention on existing interventions.
Objectives: To collect baseline data about current roles and activities undertaken by health visitors; and to understand the relationship between existing services and recommended practice shown in research about preventive programmes.
Methods: A national postal survey was used to collect data about current roles and activities undertaken by health visitors across the UK ($n = 1459$, 46% response rate).
Results: A description is provided of activities undertaken and the types of needs addressed by health-visiting services. The established health-visiting purpose of using a caseload of infants and pre-school children as a base from which to reach out to a wider community seems to be still in place, with difficulty. The major focus of their work was on primary and secondary prevention, but included provision for identified problems. Two main patterns of service provision were identified; one 'comprehensive' and one that was more restricted. The 'restricted service,' available in most places, was mainly reactive, with child protection and social factors predominant. Even the 'comprehensive services' were far lower in intensity than programmes shown, through research, to improve family wellness. In addition, less than half of respondents thought that it was always feasible to deliver services as planned.
Conclusions: The results question the premise, upon which universal provision rests, that all families receive a service offering proactive health promotion and the timely identification of additional health needs.

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Introduction

Public health programmes and services directed at improving health and reducing inequalities require a clear knowledge of existing services and capacity of public health workers operating at the 'grass-roots,' to avoid duplication or wasted effort in reinventing new roles. Health visitors have delivered services for well over a century in the UK.[1] However, robust information is lacking about what they do and how services are organised at the present time, as the last national survey of their activities was completed in 1982.[2] Reported in this paper is a survey of the work currently undertaken by health visitors in the UK, which may also be of interest in other countries where universal parent support or home-visiting programmes are being considered.

Health visitors are public health practitioners who operate in a way that is similar to public or community health nurses in some other countries; however, their origins lie in the philanthropic Victorian public health movement rather than within nursing. They have traditionally operated through home visiting and community outreach, providing a universal service to all mothers with pre-school children, and targeted services to other ages and populations according to need in local areas.[3] Recent legislation has changed their regulation and training, so that it is more closely linked to nursing, and less focused on children and families than previously.[4] A baseline is needed because of recent changes to national public health policies, to inform service commissioners and future research.

What needs doing?

Concerns about the rising costs of health care[5] and health inequalities[6,7] have focused public health attention onto the importance of prevention and early interventions,[8,9] with support for mothers, families and children forming a key strategy in national and international policies.[6–10] English Government policy sets out the expectation that health-visiting services will provide a universal child-health promotion programme and support for all new parents,[8,11] and a core service used to identify and assess the need of vulnerable children or families for additional services.[12,13] These will not necessarily be delivered in uniform ways, as local needs are supposed to guide the exact nature of services.[14] The picture is further complicated by variation in policies and implementation in the four parts of the UK (England, Northern Ireland, Scotland and Wales). No national guidance exists about the constitution of 'core' or 'universal' services in health visiting, and there is limited information about the actual combination of current activities across the country.

How should it be done?

Health visitors are expected to lead teams[15] that work in partnership with parents,[12] targeting from within a universal service to redress health inequalities. The 'family centred public health' approach advocated in policy[14,15] promotes the use of groups and centre-based community approaches, combined with some home visiting.

Despite limitations in the evidence, a recent 'review of reviews' suggested home-visiting programmes succeed in achieving a wide range of health outcomes for parents and children.[16] Combining home visits and centre-based services works well in complex community interventions directed at redressing health inequalities.[17,18] A meta-analysis of programmes to promote family wellness identified better results with multi-component programmes; lower effects were found if fewer than 12 visits were offered over a period of less than 6 months.[19] A London-based trial comparing community group support with monthly health visitor home visits, reported community group support uptake of only 19%, against 94% for home visits.[20] Also, professionals had more positive outcomes than paraprofessionals,[21] and intensive home-visiting programmes are particularly effective at reducing adverse child and mother outcomes in the most needy populations.[22]

Health visiting might capture some of the benefits shown in these programmes, but the intensity of home visits within health-visitor service delivery is usually far more restricted than within the research described above. Also, most of those programmes were delivered to targeted populations, predominantly from North America,[19,21–25] rather than from within a universal service in the UK. It is not known whether the aim of targeting additional provision to families identified through a universal service is successful, although the approach has been adopted in the new policy of 'progressive universalism'.[9]

Who should do it?

In terms of skill-set and familiarity, at least in the UK, health visitors seem to be the most suitable workers to provide early interventions and home-visiting services. Although a universal

health-visiting service has existed since the early 20th century, there is little sound information about how services are currently organised in different parts of the UK. Also, the health-visiting workforce has diminished over the past 15 years,[26,27] with further reductions reported across the country.[28,29]

More research is needed to assess the effectiveness of targeting from within a universal service and combining the community (centre-based) and home-visiting strategies, particularly bearing in mind the low intensity of contacts compared with those in programmes that have been researched to date. As a first step towards developing such a study, a national survey was planned to collect baseline data about the current roles and activities undertaken by health visitors, and to understand the relationship between existing services and recommended practice shown in research about preventive programmes.

Methods

No suitable existing instrument was found, so a questionnaire was specifically designed for this survey (see Appendix in online version). Around 100 health visitors were involved in developing the questionnaire, first through cognitive testing[30] to develop the wording of questions, then a pilot undertaken with the help of the Community Practitioners' and Health Visitors' Association, whose committee members commented on early drafts and completed pilot instruments. After adjustments, the final questionnaire was divided into four sections: (1) workforce and demographics; (2) practice activities by caseload holders; (3) service organization and delivery; (4) perceptions of recent changes to education, regulation and policy.

In this paper, we concentrate on findings from Sections 2 and 3. Filter questions at the start of these sections directed respondents to the next sections if they were not caseload holders or had no current knowledge of local health-visiting services. Ethics approval was gained from the sponsoring university (King's College London, ref. 03/04-102, 5 July 2004). To maintain confidentiality, the Nursing and Midwifery Council, which is the regulating body for health visitors, mailed the questionnaire to a 15% sample ($n = 3200$), stratified by country (England, Wales, Northern Ireland and Scotland), of all the 21 682 registrants across the UK with a health-visiting qualification.

The sample size was derived partly to allow sufficient numbers from the smaller parts of the UK; only 4–500 health visitors work in Wales and Northern Ireland, for example. Also, the number of health visitors on the register does not equate to those in practice (e.g. because of retirement, career change), but the exact disparity was not known. On the basis of statistics of polling, we were advised that 1000 respondents would provide a 2% margin of error in results; we estimated that we needed a 50% response rate to achieve this for the major subsections.

Analysis

Data were analysed using SPSS software, for 352 variables generated from the survey forms. The database field structure was designed at the same time as piloting the questionnaire. The most common response mode was a five-point Likert scale (e.g. describing contacts with different population groups from 'not at all' to 'all the time'). Within each subsection of the form, the pattern of items ranked across respondents was profiled with Kendall's coefficient of concordance (W), and the correlation between individual items was examined with Spearman's rank correlation (Rho).

Some questions were categorical (e.g. Do you have clerical/administrative help? Yes/No), for which we used Chi-square or Fisher's exact test to analyse associations between items. Most of the analysis was planned before the full-scale survey, but some distinct patterns of service delivery emerged from a preliminary, descriptive analysis (e.g. distinctive in terms of their contact with pregnant women or with other age groups). In subsequent between-groups analysis, we used the Mann–Whitney U test (e.g. for the Likert scale rankings). Free text answers to some items (e.g. job titles) were grouped according to sentinel terms like 'health visitor', 'specialist' or 'manager'. Respondents' job title is the only open-ended question that is used as a grouping variable in this paper.

The relationship between scaled items from different sections of the form (e.g. working patterns, client groups and perceptions of the relationship between public health and health visiting) was investigated with factor analysis (principle components), with the limitation that a restricted range of answers or poor response rate to a few items excluded them from such analysis. These results are not reported in the paper, but the process proved important in identifying key variables across the dataset, such as frequency of functional activities (e.g. home visiting, primary prevention).

Specifically, we were interested in discovering if it was possible to identify one or more coherent service descriptions or 'models' of service delivery from the patterns revealed in the data.

A multi-agency advisory board, including professional bodies (Community Practitioners' and Health Visitors' Association and Nursing and Midwifery Council), helped with initial planning, developing the survey design and questionnaire, and to validate preliminary results through extensive discussion and review.

Results

Sample and workforce characteristics

After one reminder, 1459 replies were received by March 2005, representing a 46% response rate overall. The sample consisted of three main groups: 72% ($n = 828$) were practising health visitors, with another 8% ($n = 90$) in related roles, such as child protection advisors, service managers or development workers, or in academic posts linked to health visiting. The remaining 20% ($n = 231$) worked in unrelated roles; 308 were not working at present. Overall, 70% ($n = 741$) held substantive (permanent) posts, predominantly in English Primary Care Trusts. Most worked part time; only 31% ($n = 437$) worked more than 35 h a week, against 34% ($n = 483$) working between 15 and 34 h a week; others worked fewer or irregular hours, and 10% ($n = 113$) were self-employed.

Organisational features

Of 980 caseload holders, including those working in fields other than generic health visiting, the most commonly cited source for their caseload was from a general medical practice list (73%, $n = 682$). A geographical area was the next most common, at 7% ($n = 64$); 5% ($n = 47$) were operating mainly by self-referral. Most (60%, $n = 582$) held sole responsibility for their caseload, but 35% ($n = 334$) operated a system of team or corporate accountability. Most of the caseload holders led a skill-mix team; only 27% ($n = 269$) had nobody to whom they could delegate work. Team compositions varied widely, with 47% ($n = 458$) delegating some work to a nursery nurse or trained family support worker (similar to those described elsewhere as 'paraprofessionals',[29] with subdegree training), 33% ($n = 323$) to a registered general nurse, 20% ($n = 195$) to a clinic assistant and 20% to a variety of other workers. Some teams included more than one type of junior worker. Adequate administrative support was available for 30% ($n = 299$) of the caseload holders; 55% ($n = 540$) said they had some but not enough and 15% ($n = 153$) had none.

Patterns of practice

This part of the analysis was based on the 980 caseload holders who held 'continuing responsibility for a defined client group or population,' including the largest subset who were 791 health visitors in practice, and others who held a variety of specialist posts like health-visitor consultant, nurse practitioner or practice nurse. We asked about the frequency of their work with particular populations and needs, and about the activities in which they engaged personally. Likert scales ranked frequency of contacts with different population groups, and activities undertaken. Numerical values such as percentages or hours per week proved unworkable in the pilot because of the diversity of working arrangements, so five descriptors (from 'all the time' to 'not at all') were used instead.

Population groups

The distribution of contacts is shown in Table 1. A highly consistent pattern emerged of frequency of contact across eight age groups ($n = 789$, coefficient of concordance $W = 0.526$, $P < 0.001$). The most frequent contacts were with babies under 1 year old, and the least frequent with older people. Frequency of contact with nine vulnerable groups also showed a highly consistent pattern ($n = 842$, $W = 0.338$, $P < 0.001$), with families of concern having the most and the travelling community the least contacts.

Activities

Table 2 shows the activities described by caseload holders, first in relation to individual clients on a one-to-one basis, then to community or centre-based activities. The caseload holders described five individually focused (one-to-one) activities, of which the most common was 'home visiting' and the least common 'developmental checks' ($n = 942$, $W = 0.131$, $P < 0.001$). Seven types of community work were described, of which the most common was 'liaison and collaboration' and the least common 'community development' ($n = 820$, $W = 0.185$, $P < 0.001$).

Table 3 shows 30 types of functional activity, 10 related to primary prevention, 10 to early interventions (secondary prevention) and 10 dealing with established problems (tertiary prevention).

Table 1 Contact with different population groups[a].

Frequency of contact? (Percent responses)	All the time	Very often	Often	Sometimes	Not at all
	N %	*N* %	*N* %	*N* %	*N* %
Age groups					
Under 1 year	440 (46)	363 (38)	57 (6)	45 (5)	43 (5)
Pre-school children	343 (36)	376 (40)	139 (15)	56 (6)	36 (4)
Parents for own needs	153 (16)	332 (36)	256 (27)	156 (17)	37 (4)
Children 1–14 years[b]	62 (7)	166 (19)	224 (25)	354 (40)	81 (9)
School-aged children[c]	30 (3)	94 (10)	181 (20)	181 (60)	558 (7)
Young people	30 (3)	79 (9)	133 (15)	439 (50)	199 (23)
Adults of working age[d]	41 (4)	64 (7)	91 (10)	381 (41)	351 (38)
Older people	50 (5)	83 (9)	79 (8)	304 (33)	420 (45)
Vulnerable population groups					
Families of concern	191 (20)	303 (32)	250 (26)	166 (17)	45 (5)
Pregnant teenagers	71 (8)	152 (16)	222 (24)	408 (43)	90 (10)
People with drug or alcohol problems	57 (6)	146 (15)	220 (23)	463 (49)	68 (7)
Adults or children with disabilities	58 (6)	136 (14)	256 (27)	474 (49)	38 (4)
Looked after children[e]	33 (4)	119 (13)	227 (24)	459 (49)	102 (11)
Homeless families	16 (2)	68 (7)	134 (15)	483 (53)	218 (24)
Refugees/asylum seekers	41 (4)	86 (9)	92 (10)	310 (33)	400 (43)
People who need interpreters	48 (5)	98 (10)	75 (8)	476 (50)	253(27)
Travelling community	7 (1)	23 (3)	43 (5)	360 (40)	462 (52)

[a]All 980 caseload holders (valid responses per item ranged from 880 to 965).
[b]In household with pre-school children.
[c]Not in household with pre-school children.
[d]Not seen as parents.
[e]Children in public care.

Across the caseload holders, a consistent pattern of activities emerged ($n = 799$, $W = 0.185$, $P < 0.001$). The top 13 activities, clustered above the group median, were predominantly activities directed at child protection or social factors. Overall, much less activity was related to tertiary than to primary or secondary prevention.

Patterns of service provision

Respondents were asked if they knew about how health-visiting services were planned and delivered in the area. Those who reported knowing this information included practitioners and others such as service managers, development leads, educational staff and various specialists, such as named nurses for safeguarding children ($n = 968$).

Universal (core) health visiting

The new birth visit (98% of services) was the cornerstone of the universal (core) health visiting service described by respondents (Table 4). Availability of antenatal home visits predicted more postnatal home visits and more frequent group and community-based activities. For example, where an antenatal visit was offered by the service, there were significantly more postnatal visits (median values = three vs. two visits; Mann–Whitney *U* test, $P < 0.001$).

A positive rank correlation was observed between the frequency of home visiting reported by caseload holders and the frequency of their baby clinics (rho = +0.661; $P < 0.001$), and with more frequent contact with babies less than 1 year old (rho = +0.551, $P < 0.001$). A negative correlation was found between the frequency of contacts with 'older people' and a health visitor's frequency of home visiting (rho = −0.158, $P < 0.001$).

At the level of the local health-visiting service, we looked at types of scheduled home visit (median three different types, range 0–7) and at types of community groups or services available (median three different types, range 0–7), as shown in Table 4. The number of

Table 2 Frequency of different activities[a].

Different activities? (Percent responses)	All the time	Very often	Often	Sometimes	Not at all
	N %	*N* %	*N* %	*N* %	*N* %
One-to-one activities					
Home visiting	503 (52)	306 (32)	63 (7)	45 (5)	52 (5)
Telephone consultations	420 (43)	372 (38)	114 (12)	57 (6)	12 (1)
Child health clinics	354 (37)	342 (36)	108 (11)	40 (4)	107 (11)
Consultation at clinic/base	326 (34)	334 (35)	137 (14)	123 (13)	46 (5)
Developmental checks	321 (34)	287 (30)	149 (16)	80 (8)	115 (12)
Community/centre-based activities					
Liaison and collaboration	215 (23)	255 (27)	237 (25)	176 (19)	63 (7)
Support groups	80 (9)	179 (19)	184 (20)	279 (30)	203 (22)
Parenting groups	67 (7)	134 (15)	150 (17)	267 (30)	282 (31)
Antenatal parent-craft	64 (7)	129 (14)	144 (16)	233 (26)	334 (37)
Health education	69 (7)	133 (14)	196 (21)	366 (39)	173 (19)
Community development	35 (4)	80 (9)	143 (16)	346 (39)	286 (32)
Caseload profiling	64 (7)	106 (11)	168 (18)	421 (45)	169 (18)

[a]All 980 caseload holders (valid responses per item 890–975).

types of home visit was strongly correlated with the variety of groups delivered in the same service (rho $= +0.744$, $P < 0.001$). Respondents who reported home visiting 'all the time' ($n = 503$) worked in services where a broader range of community groups was also offered to families, compared with other health visitors ($n = 462$). The mean difference was an extra 0.58 groups per service (95% CI 0.85–0.30 types of group). In line with intuition, those health visitors who engaged in home visiting 'all the time' worked in services with a broader variety of visits (mean difference 0.93 types per service, 95% CI 1.17–0.70) compared with all the other caseload holders.

Teamwork delivering core service

The core service was delivered, in most instances (79%, $n = 761$), by the health visitor in conjunction with others, including members of the wider primary care team. Where health visitors led skill-mix teams, fewer scheduled home visits occurred, but there were more group and community activities overall. For example, having a nursery nurse in the team was associated with availability of specific community groups, such as postnatal support, parenting and baby massage (Fisher's exact test, $P \leqslant 0.001$, 0.004 and < 0.001, respectively).

Extra health visiting

Services offered to individuals once a specific need had been identified, often known as 'extra health visiting,' varied in the different areas described. Services included additional home visits by health visitors in 96% ($n = 929$) of areas and by other team members in 71% ($n = 687$). People with postnatal depression could be offered a programme of visits in 83% ($n = 804$) and support groups in 37% ($n = 359$) areas. Breast-feeding advisers were available in 66% ($n = 636$) of areas; parenting education in 68% ($n = 657$) and sleep or behaviour groups in 54% ($n = 528$). 'Young mums' (teenage parents) groups were run in 47% ($n = 454$) of places, and stop smoking groups in 71% ($n = 690$).

Health visitors described a wide range of other services in open responses, including domestic violence, drug users and support, menopause, weight management, men's health, language support (for asylum seekers), speech and language development (children), learning difficulties, mental health, multiple births, rural health and sexual health. Local Sure Start programmes featured in many responses. Health visitors ($n = 984$) also acted as gatekeepers, enabling clients to access other services by referral to social workers (94%), speech and language therapists (89%), audiologists (85%), orthoptists (77%), community paediatricians (74%), child and adolescent mental health services (70%), community dietician (68%), counsellors (61%), clinical psychologists (40%), educational psychologists (36%).

Comprehensive and restricted service provision

Fig. 1 summarises two types of service elicited from the analysis. Antenatal visits were part of the core

Table 3 Functional activities in order of frequency given five response options from 'all the time' to 'not at all'.

Most frequent	Median response
Primary prevention for physical health in children	Very often (= 29% answers)
Secondary prevention (early interventions) for child protection	Very often
Primary prevention for child protection	Very often
Tertiary prevention (established problems) for child protection	Often
Secondary prevention for physical health in children	Often
Primary prevention for social factors	Often
Secondary prevention for social factors	Often
Established problems for social factors	Often
Primary prevention for mental health in adults	Often
Secondary prevention for mental health in adults	Often
Secondary prevention for mental health in children	Often
Tertiary prevention for physical health in children	Often
Primary prevention for mental health in children	Often
Tertiary prevention for mental health in adults	Often
Primary prevention for physical health in adults	Often
Tertiary prevention for mental health in children	Often
Secondary prevention for physical health in adults	Often
Tertiary prevention for physical health in adults	Sometimes
Primary prevention for sexual health	Sometimes
Secondary prevention for sexual health	Sometimes
Secondary prevention for acute illness	Sometimes
Primary prevention of chronic illness	Sometimes
Primary prevention of acute illness	Sometimes
Secondary prevention for chronic illness	Sometimes
Tertiary prevention for disabilities	Sometimes
Primary prevention for disabilities	Sometimes
Tertiary prevention chronic illness	Sometimes
Secondary prevention for disabilities	Sometimes
Tertiary prevention for acute illness	Sometimes
Tertiary prevention for sexual health	Sometimes (= 50% answers)
Least frequent	

The first 13 activities were more common across the whole dataset than the overall median Rank, whereas the last 17 activities (shaded) were less common than the median Ranking (Concordance test, df29). The percentage of respondents who did each activity 'all the time' ranged widely, from 24% to 3%, with **each** of the three 'Most frequent' activities, above, done 'all the time' by 24% of our sample.

service plan in 57% ($n = 547$) of the areas described. As outlined above, antenatal visits predicted more postnatal visits, and more group and community-based activities. This suggested a relatively comprehensive core provision in these areas of four to five home visits, group and clinic-based services, along with responsive, additional services ('extra health visiting') where specific needs were identified. In areas offering these 'comprehensive services', respondents were more likely to report having enough administrative support, compared with areas that only offered antenatal visits to 'targeted families' ($P = 0.015$, Fisher's exact test).

A more restricted service was available in the remaining areas where a single visit was scheduled a fortnight or so after the new birth, with follow-up predominantly through invitation to baby clinics. This core service was considered insufficient to meet the needs of at least half of the clients to whom it was offered, by 43% ($n = 392$) of respondents. In addition, 44% ($n = 399$) felt it was not always feasible to deliver this restricted core service. Responsive additional services were available if a problem was detected, such as child protection, domestic violence or drug misuse (Fig. 1).

It was judged more feasible to deliver responsive ('extra health visiting') services in areas that offered the comprehensive pattern of service provision ($n = 527$) compared with areas offering a restricted service ($n = 385$), Mann–Whitney U test, $P < 0.001$.

Table 4 Universal (core) health-visiting service ($n = 968$).

	Frequency	%	Valid responses	Comments
Scheduled home visits (core service)				
Antenatal visit	547	57	968	2% targeted
New birth visit	951	98	951	85% at 10–14 days; 7% between 2 and 5 weeks
Postntal depression screening	701	73	964	Postnatal depression screening at home or clinic
Routine visits 2–8 weeks	639	67	957	27% schedule one routine visit and 17% schedule two at this time; others vary number of visits according to need
Weaning visit	448	47	962	3% targeted
Scheduled visits after 8 weeks	173	18	952	19% targeted
Removal in visits[a]	822	86	957	If change of health visitor, because of moving house or changing GP
Child health promotion programme				
8 months			890	
Face to face	805	90		
Telephone	10	1		
Post	28	3		
Not scheduled	47	5		
3 years			867	Added comments indicate this age is regarded as 'school entry' in many places
Face to face	486	56		
Telephone	24	3		
Post	157	18		
Not scheduled	199	23		
Pre-school			818	
Face to face	318	39		
Telephone	58	7		
Post	69	8		
Not scheduled	373	46		
Other scheduled core services				Available to all
Well baby clinics	942	98	966	
Antenatal/parentcraft	702	73	966	
Postnatal groups	633	65	967	
Breast-feeding support	717	74	967	
Baby massage	591	61	966	
Parenting groups	521	54	966	
Sleep and behaviour groups	430	45	966	

[a]Not included in statistical analysis, as not all parents move, so not all receive this visit.

Discussion

Roles and activities

The patterns of practice and service delivery described by individual practitioners suggest that the established health-visiting purpose of using a caseload of infants and pre-school children as a base from which to search for health needs across a wider community and age range[3] is still in place. This was not without difficulty, as revealed in the analysis of service provision. The activities in which the health visitors engaged also followed a pattern of starting from a base of home visiting and support for individuals, reaching out from there to a wider range of group and community activities. The major focus of the work was on primary and secondary prevention, but it included provision

Comprehensive health visiting service	Restricted health-visiting service
Core (universal) service • Programme of four to five home visits over 6 months, starting antenatally • Child health (well baby) clinic • Wide range of open access groups and clinic-based community activities • Child health promotion programme; ○ Home and clinic based ○ Combined with group activities for parents and children	Core (universal) service • Programme of one to two home visits, starting postnatally • Child health (well baby) clinic • Limited number of open-access groups and clinic-based community activities • Child health promotion programme ○ Face-to-face: clinic based ○ Postal questionnaire/telephone contact
Additional services as required, include • Parenting education and support • Child protection: proactive and responsive • Mental health: ○ Specific programme for postnatal depression ○ Support groups • Additional home visits tailored to need • Collaboration across sectors and services	Additional services as required, include • Specific programme for postnatal depression • Child protection: mainly responsive • Additional home visits tailored to need • Liaison across sectors and services

Fig. 1 Health-visiting services: comprehensive and restricted provision.

for identified problems, and enabled access by referral to a range of other, needed services.

Most of the health visitors led teams. Nursery nurses (paraprofessionals) were more widely used than registered general nurses, and contributed significantly to an increase in group work; however, more team work resulted in fewer scheduled home visits. This may reflect the greater ease with which junior team members may be supervised at a clinic base. Nonetheless, all team members carried out some home visits.

Service organisation

Specification of what constitutes either a comprehensive or a restricted core health-visiting service allows a clear benchmark for what may be considered 'a universal service'. In effect, the restricted service was reactive, being largely focused on child protection and vulnerable families. There was little time for the proactive public health activities of early intervention, primary prevention and support for all mothers and children. This restricted form of provision seemed to be on offer in most places, with many reported variations. Even in areas offering a 'comprehensive' service, the prescribed number of contacts was low, with four to five home visits over a 6-month period. However, the associated range of centre-based clinics and group activities allowed easy access and increased contacts when deemed necessary by mother or health visitor. Less than half the respondents reported this level of service.

Strengths and weaknesses of the study

We believe that this was the largest, and most comprehensive, survey about health-visiting practice and service organization for at least 25 years. As most respondents were employed in English Primary Care Trusts, results cannot be generalized to other parts of the UK, although the response rate represents around 7% of those on the health-visiting register altogether. We have no independent estimate of the reliability of this postal survey, but preliminary results were comprehensively reviewed and supported by a multi-agency advisory board. Also, the patchiness of health-visiting services has been identified elsewhere.[31] At a time of great change in the UK health service, it provides a valuable baseline from which future developments can be evaluated, and a programme description from which a population-based funding model could be developed. It also provides commissioners with an accurate description of activities undertaken and the types of needs addressed by health-visiting services.

Implications for proactive services

Around half of the respondents perceived that it was not always feasible to deliver the core service as planned. In addition, only about a quarter of

respondents (half of those providing the comprehensive programme) were confident that they could deliver a service that, in their own estimation, would meet the support needs of around half the families on their caseloads. This calls into question the premise, upon which 'progressive universalism'[9] rests, that all families receive a sufficient service for proactive health promotion, and for additional needs to be identified in a timely way.

Reducing scheduled home visits did not seem to free up time for practitioners to develop group and community work. Instead, the more home visits that were scheduled, the more likely it seemed that groups would be developed, usually with the assistance of junior colleagues. Programmes using paraprofessionals have proved less effective than those delivered by professionals,[21,32] so the effect of this substitution needs evaluation.

Need for future research

The 'comprehensive service', providing four to five scheduled visits over 6 months, is far less intense than the 12 visits over a year identified in successful programmes of family well-being reviewed by Macleod and Nelson.[19] It may come close to an effective level of contact, given the extent of group and clinic-based activities on offer to parents, but this needs evaluating in research. Also, the existence of additional services, deployed when a specific need is identified, may boost the effectiveness of this level of programme intensity and support the notion, so far untested, of 'targeting from within a universal service'. Finally, this survey provides a baseline of health-visiting service provision at the start of 2005; it could usefully be repeated at 2–3 year intervals to track the effect of changes in policy and practice.

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