Time and professional judgements are key

Dame Sarah reflects on the variety of guidance across the UK about how health visiting services should be delivered. Research suggests professional judgement is most important, but implementing clinical decisions needs time.

Two decades ago, a study about the guidelines issued to health visitors revealed great differences in style and content. To examine how health visitors applied them in practice, Appleton and Cowley (2004) chose three case study sites using different formats for their guidance. One linked completing a health profile of families with a core programme of contacts, while in the second, a structured vulnerability index was provided to determine which families would receive additional contacts. In the third site, the professional judgement of health visitors was stressed as the deciding factor. A key outcome of this research was that, regardless of the 'official guidance', the health visitors mainly reached decisions about whether or not families needed additional support through professional judgement; a remarkably consistent process, using considerable skill that benefited a wide range of families.

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Three current issues reminded me of this study. First, the Welsh Government (2016) has just issued new guidance about the kind of service all families should expect from their health visitor. It specifies eight to 10 contacts for each pre-school child, of which five must be home visits carried out by a health visitor, rather than a skill-mix team member.

In Northern Ireland (Department of Health, Social Services and Public Safety, 2010), eight health reviews are specified, also with guidance about which need a home visit or to be delivered by a health visitor. The Scottish Government's (2015) programme strongly emphasises the professional skills of the health visitor in delivering 11 home visits between pregnancy and school age.

In England, earlier detailed specifications for health visiting provision have given way to a series of guidance papers (Public Health England, 2016) for commissioners. The timing of five health reviews is specified, but not whether they should occur at home, nor whether a health visitor is needed to deliver them.

The statute mandating these five health reviews is due to expire in March 2017, but is currently under review; this is the second issue on my mind. Why are five reviews considered sufficient in England, when all other parts of the UK require so many more? The answer may be related to the professional autonomy that was so firmly emphasised in the *Health Visitor Implementation Plan*. If a health visitor decides a new mother needs additional visits for any reason, even if it is something ill-defined but concerning, then that decision should determine the course of action. In Appleton's research, this is what happened and the health visitors were well able to articulate the rationale for their professional judgements and actions, even if sometimes they seemed almost intuitive. Importantly, however, health visitors need sufficient time and the power to put their clinical decisions into practice.

This brings me to my third concern—there seem to be plans for extensive disinvestments from health visiting at present, driven by cuts to English public health budgets. The lesson from Appleton's research is that issuing new guidelines will not compensate for the threat to professional judgement that accompanies a lack of time to implement decisions. The new guidance from Wales, like that from Scotland and Northern Ireland, supports the view that health visitors with the time to follow up clinical decisions made on home visits, are key to successful outcomes—and that concurs with most current evidence. Will England please follow suit? JHV

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