

Needs Assessment for Health Visiting

Sarah Wallace, Public Health Registrar

Public Health Department London Borough of Hammersmith and Fulham, Royal Borough of Kensington and Chelsea, and Westminster

May 2016

Executive Summary

In the Three Boroughs the current health visiting contract runs until October 2017. The purpose of this document is to inform the recommissioning process for the health visiting service.

Health Visiting is the universal public health nursing service for 0-5 year olds and it is responsible for the delivery the pregnancy to 5 years healthy child programme. This is undertaken through both a universal service for all families, and the provision of support and intervention for families who require this.

The health visiting service has 6 defined high impact areas in the early years:

- Transition to Parenthood and the Early Weeks
- Maternal Mental Health (Perinatal Depression)
- Breastfeeding (Initiation and Duration)
- Healthy Weight, Healthy Nutrition (to include Physical Activity)
- Managing Minor Illness and Reducing Accidents (Reducing Hospital Attendance/Admissions)
- Health, Wellbeing and Development of the Child Age 2 – Two year old review (integrated review) and support to be 'ready for school'.

There is compelling evidence for outcomes investment in the early years. It is a period where we see interventions yielding the best long-term outcomes and the best return on investment, particularly with interventions which target those with greater need.

In 2014 there were approximately 6850 births within the Three Boroughs, but these numbers saw a sharp decline in the 4 years prior to that. The health visiting service works closely with other health and social care services within the Three Boroughs, particularly children's services and general practice. Both of these are undergoing a significant period of change currently, and the service will need to be flexible enough to work effectively within this changing environment.

There are huge inequalities, including both affluent and deprived areas within each borough. As in London as a whole and the Three Boroughs perform well in some areas of public health, such as low smoking and high breastfeeding rates, while in other areas, including dental health, immunisations coverage and childhood obesity, the performance is poor. It is vital that the new health visiting service can address these health priorities and are able to work more intensively with those families who need it, and the advantage that we have now that the service is commissioned locally is that we can design a service which fits these local needs and priorities.

The following recommendations were derived from the local need, an evidence review around delivery of health visiting and the six high impact areas, and from focus groups undertaken with local parents.

Priority Area 1: Reduce Health Inequalities through Proportionate Universalism

Recommendation 1: Vary caseload within the service depending on local need

Recommendation 2: Information must be available to families in a variety of languages as appropriate for the local population.

Priority Area 2: Prioritise Investment in the Early Years

Recommendation 3: Offer evidence based antenatal classes and include an emphasis on recruiting women with a higher level of need. The provider should be assessed on the proportion of women at increased need who attend the antenatal classes.

Recommendation 4: Include breastfeeding in the preparation for parenthood classes, physical, emotional and psychological wellbeing, and information about accessing help to all pregnant women.

Recommendation 5: Offer easily accessible breastfeeding support and health visitors should work in partnership with breastfeeding peer support groups. There should be specific interventions to target groups with low rates of breastfeeding.

Recommendation 6: Ensure that women are given information about the health visiting service, timeline of expected visits, health visiting roles and contact details during pregnancy.

Recommendation 7: The health visiting provider should deliver (or work with partners who offer), evidence based interventions in specific priority areas where the Three Boroughs are currently performing poorly, including dental health, vaccination uptake, childhood obesity and school readiness. Performance against relevant public health outcomes should be monitored and performance managed.

Recommendation 8: There must be a clear pathway for the identification and management of women with perinatal mental health problems and for infant mental health, written in consultation with the local perinatal mental health service. The pathway should describe the role of the health visitor in the management of perinatal mental health.

Recommendation 9: The health visiting service should ensure that parents are aware of recommended activities to promote development and 'school readiness', including pre-school education

Priority Area 3: Partnership working

Recommendation 10: The health visiting teams should be aligned to the children's services teams. This opportunity should be used particularly to identify and develop areas where children's services can impact factors which adversely affect health and wellbeing. It should be used to facilitate referrals and information sharing between the services.

Recommendation 11: Health visitors should attend the Connecting Care for Children Hubs where available

Recommendation 12: Health visitors should have an explicit role as a key link between health (particularly General Practice) and social care. This should include a close working relationship with both local services. The health visitors should be the main point of contact between the services, particularly in medically or socially complex cases.

Recommendation 13: Ensure robust pathways are in place to offer evidence based interventions to children who are identified as having developmental delay. Ensure that these are written and delivered with children's services so that families are offered intervention by the most appropriate professional.

Priority Area 4: Patient Centred, Flexible and Innovative Service Delivery

Recommendation 14: Health visitors should maintain continuity of care for families, with one health visitor allocated from birth until 5 years, and for all children within a family.

Recommendation 15: Where possible deliver health visitor led clinics and groups from children's centres combined with a stay-and-play (or similar) session.

Recommendation 16: The provider should offer provision whereby parents of 2-5 year olds can access health related help and advice, in times and settings that suit the families with children in this age group.

Recommendation 17: Offer a mixture of drop-in slots and appointment times for health visitor clinics.

Recommendation 18: The service should maintain an up-to-date online presence with evidence based information on health and development topics and with details of local offers, including children's centres and voluntary groups.

Priority Area 5: Rigorous and Up-to-date Staff Training

Recommendation 19: Ensure that all health visitors are trained in identification of perinatal mental health problems, from mild through to severe (including depression, anxiety and postpartum psychosis), and are comfortable in assessing both maternal and infant mental health.

Recommendation 20: Staff should be aware of NHS, council, private and voluntary sector services available in the area and should be able to direct clients to these as appropriate.

Recommendation 21: Require the provider to have or work towards achieving the WHO Baby Friendly Initiative.

Recommendation 22: Ensure health visitors have adequate training in identifying home safety behaviours and are able to offer appropriate advice.

Recommendation 23: Provide health visiting staff with specialist and up-to-date training in childhood nutrition and preventing obesity, so that they feel able to identify children at risk of obesity, discuss this with parents, and advise evidence based interventions.

Recommendation 24: Each borough team should have health visitors who lead in each of the six high impact areas. The role of these health visitors should include training, offering advice, maintain up-to-date evidenced based pathways and guidance, work with partner agencies and have excellent links with relevant agencies. If appropriate this post could also include specialist caseloads, such as a role for a specialist health visitor in perinatal mental health

Contents

Executive Summary	2
Contents	5
List of Figures	6
Purpose	7
Introduction	8
What is the Need?	11
What is the Current Service?	16
What is the Evidence?	19
Health Visiting Models	27
Focus Groups	29
Recommendations	32
References	34
Appendix 1: Health Visitor Partnership Group	37
Appendix 2: Health Visitor Clinics and Bases	38
Appendix 3: Appendix 3: Health Visitor Workforce calculation by 0-5 years population and deprivation	42
Appendix 4: Attendees of the Focus Groups	43

List of Figures

Figure 1: Graph to show number of live births, by year between 1991 and 2014

Figure 2: Graph to show the ethnic groups the Three Boroughs, London and the UK.

Figure 3: Levels of deprivation by LSOA across the three boroughs (Office for National Statistics, 2015)

Figure 4: Locations of health visitor team bases and clinics in the Three Boroughs. The base sites and host clinics.

Purpose

The purpose of this document is to support the recommissioning of the health visiting service within Hammersmith and Fulham, Kensington and Chelsea, and Westminster, which is planned for October 2017. It will help to ensure that the new service is evidence based and suits the needs of the local population in the Three Boroughs. It is intended for use by both commissioners and by provider organisations during the recommissioning process.

This needs assessment will look at the background to the health visiting service, the local needs and current service, and the evidence for different models and interventions in health visiting. It also includes experiences and recommendations from local services users. The recommendations for the new service will be based on the information in this document.

Introduction

A brief history of health visiting

Health visiting is the universal public health nursing service which covers 0-5 year olds. It has been in existence in England for over 150 years¹. The structure of the health visiting service has varied considerably in the years since, particularly since in 1974 when the service moved from the local authority to become part of the NHS.

Health visitors are nurses or midwives who have undertaken further training and qualifications in specialist community public health nursing.

In 2011 the Department of Health published 'The health visitor implementation plan 2011-2015: A call to action' which sets out plans to expand and strengthen the health visiting service², and was followed by a huge recruitment drive with an aim of increasing numbers of health visitors by 4,200. This was implemented by NHS England until October 2015, when commissioning responsibility passed to Local Authorities.

Aims of the health visiting service

A review of the role of health visitors was undertaken in 2007³. It concluded that the focus of health visiting should be,

'Early intervention, prevention and health promotion for young children and families as this is where their nursing and public health skills and knowledge can have the greatest impact.'

It also outlines the priorities in which health visitors need to play a lead role:

- Preventing social exclusion in children and families
- Reducing inequalities
- Tackling the key public health priorities, in particular obesity, smoking, alcohol, drugs and accident prevention

- Promoting infant, child and family mental health
- Supporting the capacity for better parenting through improving pregnancy outcomes, child health and development, parents' economic self-sufficiency, safeguarding children, addressing domestic violence, supporting parental relationships and fathers in their parenting role³

Health visitors are responsible for delivering 'The Healthy Child Programme: Pregnancy and the First 5 Years of Life'. This is a document which sets out 'the early intervention and prevention public health programme that lies at the heart of our universal service for children and families.' The programme is divided according to levels of need, into the universal offer and progressive elements for those families who need more support.⁴

Public health outcomes framework indicators which are relevant to health visitors include:

- Improving life expectancy and healthy life expectancy
- Reducing infant mortality
- Reducing low birth weight of term babies
- Reducing smoking at delivery
- Improving breastfeeding initiation
- Increasing breastfeeding prevalence at 6-8 weeks
- Improving child development at 2-2.5 years
- Reducing the number of children in poverty
- Improving school readiness
- Reducing under 18 conceptions
- Reducing excess weight in 4-5 and 10-11 year olds
- Reducing hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14
- Improving population vaccinations coverage

The health visiting service has 6 defined high impact areas in the early years⁵:

- Transition to Parenthood and the Early Weeks
- Maternal Mental Health (Perinatal Depression)
- Breastfeeding (Initiation and Duration)
- Healthy Weight, Healthy Nutrition (to include Physical Activity)
- Managing Minor Illness and Reducing Accidents (Reducing Hospital Attendance/Admissions)
- Health, Wellbeing and Development of the Child Age 2 – Two year old review (integrated review) and support to be ‘ready for school’.

Recommendation 24: Each borough team should have health visitors who lead in each of the six high impact areas. The role of these health visitors should include training, offering advice, maintain up-to-date evidenced based pathways and guidance, work with partner agencies and have excellent links with relevant agencies. If appropriate this post could also include specialist caseloads, such as a role for a specialist health visitor in perinatal mental health.

Delivery of the Health Visiting Service

There are 4 defined levels of the health visiting service:

- **Community:** health visitors have a broad knowledge of community needs and resources available e.g. Children’s Centres and self-help groups and work to develop these and make sure families know about them.
- **Universal:** every new mother and child should have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation.
- **Universal Plus:** families can access timely, expert advice from a health visitor when they need it on

specific issues such as postnatal depression, weaning or sleepless children.

- **Universal Partnership Plus:** health visitors provide ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition.⁶

The health visiting service is a universal service, and the universal element comprises 5 mandated elements:

- Antenatal health visit
- New baby review
- 6 to 8 week assessment
- One year assessment
- 2 to 2½ year review.

These mandated reviews do not encompass the whole role of the health visiting service, however they are opportunities to identify risk, emerging problems, and to enable early intervention and signposting. It is intended that issues are identified and tackled before they become more serious, impacting on families and requiring the input of costlier services.⁷

Investment in the Early Years

A wealth of evidence points to the importance of pregnancy and the early years in shaping an individual’s life course. The Wave Trust’s conception to age 2 report outlined the importance of these years in emotional wellbeing, capacity to form and maintain positive relationships with others, brain development (approximately 80% of brain cell development takes place by age 3), language development, and ability to learn. It also states that the most effective interventions are often those that are preventative instead of reactive.⁸

There is a persuasive economic case for investment in the early years; the Wave Trust’s report concludes that ‘The consensus from even the most cautious and circumspect non-UK randomised control trials suggested returns on investment on well-designed early years’ interventions significantly exceed both their costs and stock market returns.’ UK studies have found that social return on investment studies

showed returns of between £1.37 and £9.20 for every £1 invested.⁸ Generally targeted interventions provide the best financial returns.

Inequalities

In 'Fairer Society, Healthy Lives', Marmot undertook a strategic review of the impact of health inequalities. It concluded that for reducing health inequalities, giving 'every child the best start in life' was the highest priority recommendation. The policy recommendations in this priority advocate 'increasing the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focussed progressively across the social gradient.' It is also recommended that there is support for families to achieve improvements in childhood development including parenting programmes, develop programmes for the transition to school and prioritising pre- and post-natal interventions which reduce adverse outcomes of pregnancy and infancy.⁹

What is the need?

Health visiting is a universal service; every child should be on the caseload of a health visitor from birth until they transfer to the school nursing service at around 5 years. However, health visiting delivers higher intensity input to families with greater need. Therefore in order to plan a new service which meets the needs of the local population, the overall demographics of the area are required, in addition to information about local vulnerabilities and health needs are required.

Population and Demographics

In 2014 there were over 34,500 children from age 0-5 registered as residents in the three boroughs. Kensington and Chelsea have the fewest, while Westminster has the greatest number. The age of mothers is relevant as currently children born to mothers who became pregnant under the age of 20 years should be offered the Family Nurse Partnership service up to the age of 2 years, rather than being under the care of the health visiting service.

	Year	London	Hammersmith and Fulham	Kensington and Chelsea	Westminster
Number of Children aged between 0 and <5 years ¹⁰	2014	628,587	11,807	8,969	13,789
Number of Births ¹¹	2014	127,399	2,440	1,821	2,604
General Fertility Rate ¹¹	2014	1.71	1.31	1.31	1.20
Median Age of Mothers (range), (years) ¹²	2014	-	33 (15-54)	33 (17-52)	34 (16-51)
Number Mothers aged <20 years at Birth ¹³	2014	-	29	10	16

Total populations in Hammersmith and Fulham are due to increase as a result of the housing developments being built in Old Oak and Earl's Court. From current plans we do not anticipate that either of these developments will significantly increase the number of children in the borough. However it is possible that this may change.

The total number of live births in all three boroughs rose until 2009/2010, but have seen a sharp decline following this. If this trend continues, it would have implications on planning of the future health visiting service.

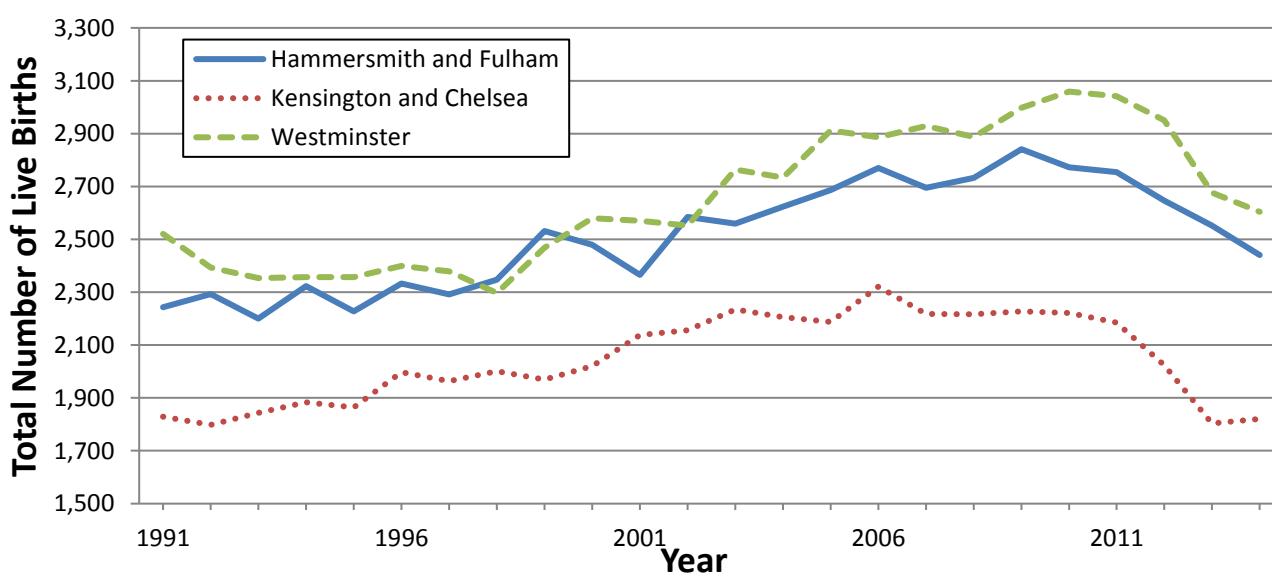


Figure 1: Graph to show number of live births, by year between 1991 and 2014. Source: Office for National Statistics. Live births by local authority of usual residence of mother, General Fertility Rates and Total Fertility Rates. 2015.

Ethnicity and Language

Different ethnicities may have different health needs or patterns of accessing health care; any service commissioned will need to take into account the ethnic mix within the Three Boroughs. Furthermore services will need to be able to cater for individuals who are not able to speak English, and this will have implications in how services are delivered.

As in London as a whole there is a greater ethnic mix in the Three Boroughs than in the UK.

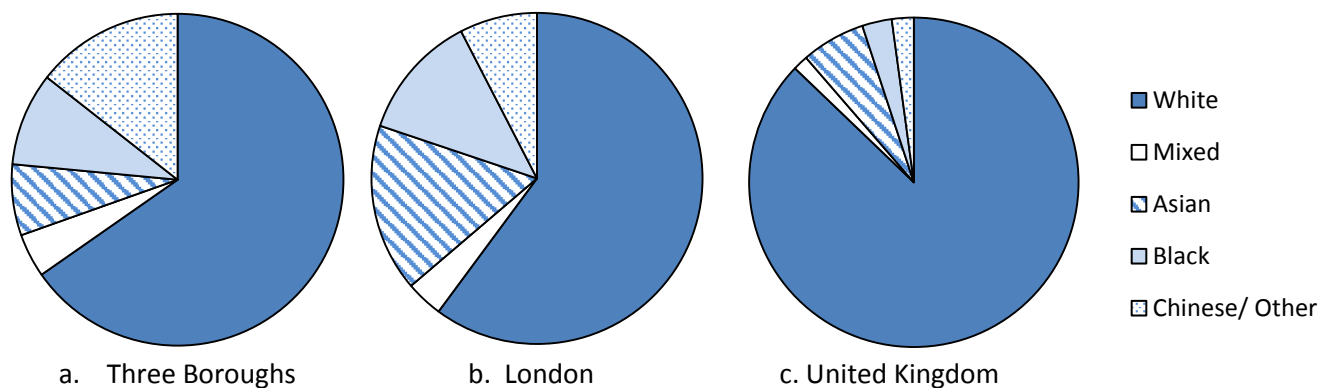


Figure 2: Graph to show the ethnic groups the Three Boroughs, London and the UK.

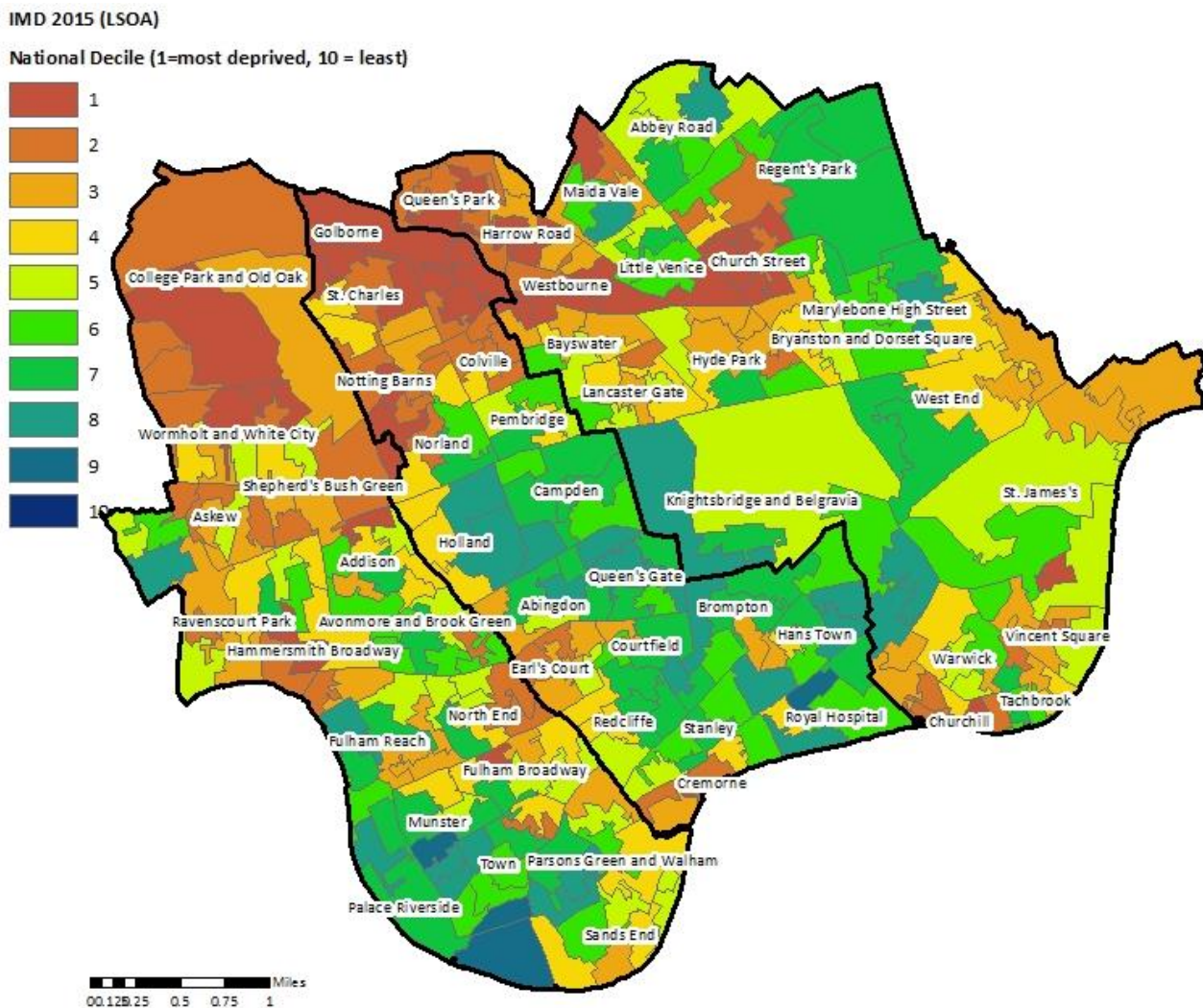
The percentage of people reporting English as a main language in the 2011 census was lower in the Three Boroughs (Hammersmith and Fulham 77.3%, Kensington and Chelsea 72.0%, Westminster 69.2%) than in London overall (77.9%);. This is in comparison to England where 92.0% speak English as a first language. The most common 'other' language spoken in Westminster was Arabic (5.7%), while it was French in Hammersmith and Fulham (3.1%) and Kensington and Chelsea (4.9%). (Source: ONS, 2011 Census: Main language (detailed), local authorities in England and Wales).

Recommendation 2

Information must be available to families in a variety of languages as appropriate for the local population.

Deprivation

The Three Boroughs have a huge variation in levels of deprivation and include both some of the most affluent and the most deprived Lowest Super-Output Areas (LSOA) nationally. We know that families in areas of greater deprivation are likely to need more health visiting input compared with those with those living in more affluent areas, and there for this has implications for numbers of health visitors needed in different areas. Marmot's recommendations to reduce health inequalities would also advocate increased resource allocation in these areas. Appendix 3 calculated estimated number of health visitors required by 0-5s population and deprivation, and also shows that in the Three Boroughs there are higher numbers of children proportionally living in the more deprived areas than in more affluent areas.



Source: <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015> (accessed 20/01/2016)

Contains National Statistics data © Crown copyright and database right 2016
Contains Ordnance Survey data © Crown copyright and database right 2016

Public Health Intelligence - Westminster | Kensington & Chelsea | Hammersmith & Fulham

Figure 3: Levels of deprivation by LSOA across the three boroughs (Office for National Statistics, 2015)

Recommendation 1

Vary caseload within the service depending on local need.

Public Health Outcomes Framework Indicators

For indicators relevant to health visiting, breastfeeding initiation, smoking status at the time of delivery, under 18 conceptions and hospital admissions due to unintentional and deliberate injuries are better than the national average in all 3 boroughs. The Three Boroughs generally show a similar trend to London compared to the average for England. There are proportionally higher numbers of children in poverty, levels of tooth decay and much lower levels of MMR coverage than the national average. School readiness is generally poorer than the national average, except in Hammersmith and Fulham. However, again these borough level outcomes will mask considerable variation between communities and between geographical areas, for example we know that undernutrition and obesity in preschool children are strongly associated with social deprivation.¹⁴

	Year	England	London	Hammersmith and Fulham	Kensington and Chelsea	Westminster
Under 18 conceptions (rate per 1000 women aged 15-17)	2013	24.3	21.8	21.3	19.0	9.6
School Readiness: children achieving a good level of development at the end of reception. (%)	2014/15	66.3	68.1	68.6	65.4	64.8
Children in Poverty (Under 16s) (%)	2013	18.6	21.8	23.8	20.3	29.8
Smoking status at the time of delivery (%)	2014/15	11.4	4.8	2.4	2.2	2.1
Breastfeeding Initiation	2014/15	74.3	86.1	86.6	87.8	87.9
Population MMR coverage – MMR for 2 doses (5 year old) %	2014/15	88.6	81.1	70.8	66.6	64.0
Tooth Decay in Children aged 5 (Mean Severity)	2011/12	0.94	1.23	1.15	1.26	1.72
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years). Rate per 10,000 residents.	2013/14	140.8	105.0	92.5	94.9	67.6
Excess weight 4-5 year olds (% classed as overweight or obese)	2014/15	21.9	22.2	22.6	21.5	22.7

Source: Public Health Outcomes Framework. (<http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000042/pat/6/par/E12000007/ati/102/are/E09000002/iid/90631/age/34/sex/4>). Accessed 22.3.2016

Colour coding is compared to outcomes for England.

Recommendation 7

The health visiting provider should deliver (or work with partners who offer), evidence based interventions in specific priority areas where the Three Boroughs are currently performing poorly, including dental health, vaccination uptake, childhood obesity and school readiness. Performance against relevant public health outcomes should be monitored and performance managed.

Perinatal Mental Health

Expected perinatal mental illness numbers have been estimated by the national child and maternal health intelligence network, using the number of births and the estimated prevalence of the mental health conditions. It is estimated that around 10-20% of women will experience some form of perinatal mental health problem in the perinatal period¹⁵ (pregnancy and the 1st year after birth). The numbers of women who are anticipated to have severe perinatal mental illness, such as postpartum psychosis, are smaller than the number who experience milder forms of depression and anxiety.

	Hammersmith and Fulham	Kensington and Chelsea	Westminster
Estimated number of women with postpartum psychosis	5	5	5
Estimated number of women with chronic serious mental illness	5	5	5
Estimated number of women with severe depressive illness	75	50	70
Estimated number of women with adjustment disorders and distress (lower-upper estimate)	240-355	155-230	230-345
Estimated number of women with mild-moderate illness and anxiety (lower-upper estimate)	355-710	230-460	345-690

Source: Chimat, Mental health in pregnancy, the postnatal period and babies and toddlers. Data 2013/14

Children's Social Services

There are small numbers of children in care and children on child protection plans in the three boroughs, however these children are vulnerable and need a high level of input from professionals, including health visitors.

	Hammersmith and Fulham	Kensington and Chelsea	Westminster
Number of Children on Protection Plans aged 0-4	33	26	26
Number of Children in Care aged 0-4	22	9	21

Source: Shared Services Children's Services, April 2016

What is the current service?

To plan the new service it is important to understand what service is currently offered in order to understand whether the current service fills the local need and what changes are required. Information about the current service offered by partners is relevant as the health visiting service relies on other partners to meet the needs of clients and are being encouraged to work ever more closely with these partners.

The following information was mostly obtained through the health visiting partnership group (Appendix Y).

Health Visiting Workforce

The current service within the 3 boroughs is provided by Central London Community NHS trust, and is provided as a 0-19 team including health visiting and school nursing. The health visiting element of the teams involve a mixture of qualified health visitors and nursery nurses.

	Hammersmith and Fulham	Kensington and Chelsea	Westminster
Health Visitors at the end of the 'Call to Action' (WTE) (on transfer)	30.0	25.5	37.3
Nursery Nurse staff (WTE) (on transfer)	1.0	5	7
Number of Teams	6	4	6
Family Nurse Partnership	4 wte family nurses and 1 supervisor across the 3 boroughs		

Health visitors provide a mixture of home visits and clinics. The health visitor bases and the clinics they hold are in a variety of settings across the 3 boroughs, and include children's centres, GP surgeries and health centres. The vast majority are in a health setting.

Clinics are usually generic baby clinics, which are drop-in sessions where parents can get their baby weighed and access health visitors for advice. Other specialist clinics include BCG clinics, breastfeeding clinics and baby massage sessions. The map below shows the locations of health visitor team bases and clinics. See Appendix 1 for addresses and descriptions of health visitor bases and clinics.

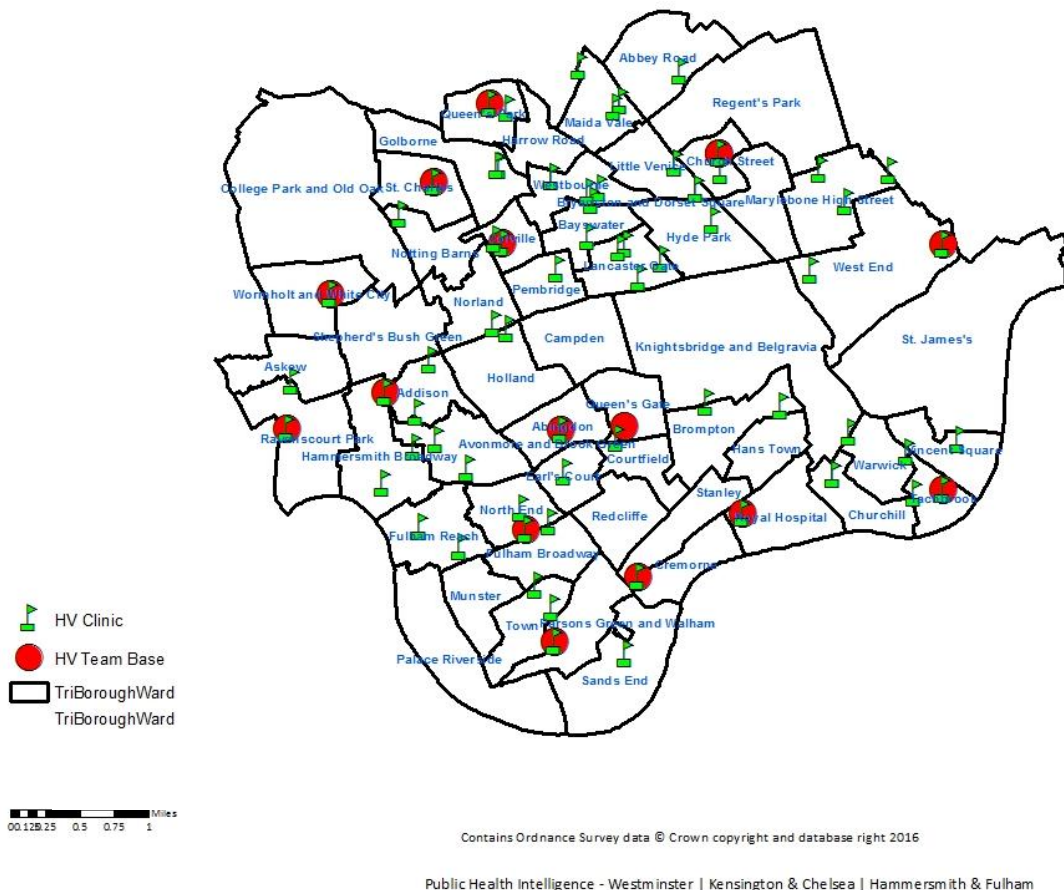


Figure 4: Locations of health visitor team bases and clinics in the Three Boroughs. The base sites and host clinics.

Primary Care

Health visitors are currently 'linked' to GP practices. Their role is to facilitate liaison, information sharing and joint working in the best interests of families. There is evidence from stakeholder engagement that there is a wide variation in the quality of these relationships across the service.

There are also multidisciplinary Connecting Care for Children (CC4C) hubs. These take the form of multidisciplinary meetings, including a consultant paediatrician, where complex children can be discussed. They are also linked to a clinic (before or after) where children can be seen. It was felt to be a valuable educational resource in addition for those clinicians attending. GP practices can currently only be involved if they have signed up to the hubs. Any healthcare professional attending can bring cases for discussion.

	Hammersmith and Fulham CCG	West London CCG	Central London CCG
GP Practices*	33	46	35
Connecting Care for Children Hubs	One only running at Parkview. Open only to children who are registered there. More are expected to start.	3 hubs in total, and children can be referred into any of them. They happen 6 weekly in each of the 3 locations.	8 hubs, however only 6 are currently operational.

*Source: HSCIC. GPs, GP Practices, Nurses and Pharmacies: May 2016 release

Recommendation 11
Health visitors should attend the Connecting Care for Children Hubs where available.

Children's Services

There is also a 'linked' health visitor for every children's centre, and also each nursery as part of the integrated 2 year review. Children's services (children's centres particularly), are undergoing significant changes in Hammersmith and Fulham and Westminster, detailed below.

	Hammersmith and Fulham	Kensington and Chelsea	Westminster
Children's Centres	13	9	12
Early Help Teams	2: North/South	3: East, West, South	3: North East, North West, South
Early Years Settings (private, voluntary and independent settings, excluding school nurseries)	69	62	74
Changes Planned within 0-5s children's services.	An integrated 0-19 model is being planned, with both children's centres staff and early help.	There are no change to the centres or services offered, but will clustered in 2 groups rather than the previous 3.	Developing a hub and spoke model. The hubs will be 0-19 'Children and Family Centres', while the spokes are being repurposed, and will generally be more childcare orientated (ie nurseries).

Perinatal Mental Health Services

There is considerable variation in the services offered within the Three Boroughs. Until now there has been no specialist service in Perinatal Mental Health funded in North RBKC.

Service Base	Borough Covered	Staff	Comments
Hammersmith Hospital Perinatal Mental Health Service, WLMHT	H&F (expanded recently into Ealing and Hounslow)	1x Consultant Perinatal Psychiatrist, 2x Nurses 1x Administrator, 0.3 wte x Clinical Psychologist	Also offers perinatal mental health services to inpatients in Hammersmith Hospital/ Queen Charlotte's Hospital. Recent extension to cover from antenatal period only, to preconception until 6 months post-partum. Do not cover infant mental health, but consultant formally trained in infant mental health and offers screening on parent infant relationship difficulties when necessary.
St Mary's Perinatal Mental Health Service	Westminster	1x Consultant Perinatal Psychiatrist, 1x Administrator	Specialist perinatal mental health specialist health visitor works with the team in North RBKC. Perinatal mental health services also provided for inpatients in St Mary's Hospital. Do not cover infant mental health
Chelsea and Westminster Hospital Perinatal Service	-	0.6wte and 0.4 wte x Psychiatrists	Assessment and treatment of psychological and psychiatric difficulties related to pregnancy, parenthood and infancy.
Talking Therapies	WLCCG area – Take time to talk LBHF - Back on Track Westminster – Talking Therapies		Provided by different organisations across the Three Boroughs. For over 18 year olds only.

What is the evidence?

In order to offer the best service to the local families, it is vital that the service is evidence based. The evidence in this area is vast, therefore for the purposes of this needs assessment, this section aims to describe some of the evidence around how the service should be structured and then to focus on evidence around the 6 high impact areas. For further information, comprehensive literature reviews were undertaken by Cowley et al in 2013 ('Why health visiting?')¹⁶ and Public Health England in 2015 ('Rapid Review to Update Evidence for the Healthy Child Programme 0–5')¹⁷.

How should health visiting be delivered?

There are 2 main models of deriving caseloads in health visiting; either geographically or directly from GP caseloads.

The health visitor implementation plan emphasises the need to work closely with Sure Start children's centres, as a key part of the public health role of health visitors, but also states that it should be a 'best fit' for wider local services. It does however stress the importance of working in partnership with primary care, maternity services and other local partners in addition to children's centres.²

In 2003, health visitors and nursery nurses in Doncaster changed from being attached to GP practices to working geographically. They did a health impact assessment following the change where stakeholders were asked to give their views. Overall it was felt to have a positive impact in several areas, such as a greater knowledge of their areas, better distribution of resources, increased support for families in need and a reduced travelling time. However 2 negative impacts were identified: poorer links with general practice, and poorer communication between HVs and GPs.¹⁸

In 2007, Hoskins et al evaluated the change from GP caseload management to corporate caseloads in Glasgow. This involved amalgamating the caseloads from 7 GP surgeries and 10 HVs, with a named HV for all GPs and early years providers. The findings were

obtained from questionnaires, diary monitoring and qualitative interviews of HVs, clients, a manager and a GP. They concluded that there were immediate improvements in team working, staff communication and clinical reflection. However there was felt to be a lack of continuity of care resulting from the change.¹⁹

As part of the review of health visiting, the Nursing Research Unit undertook a qualitative study on service users' experiences of health visiting. They conducted semi structured interviews with clients at two early implementation sites in England. They found that one advantage in holding child health clinics and group activities at Children's Centres or health centres, was the availability of different professionals at these locations. Where these groups took place in Children's Centres, parents who used them were 'likely to meet others working with families and children, such as Family Support Workers, and take up the more extensive range of advice and support that the centres offer, for example with skills training, employment, finance and education'.²⁰

Recommendation 10

The health visiting teams should be aligned to the children's services teams. This opportunity should be used particularly to identify and develop areas where children's services can impact factors which adversely affect health and wellbeing. It should be used to facilitate referrals and information sharing between the services.

Recommendation 12

Health visitors should have an explicit role as a key link between health (particularly General Practice) and social care. This should include a close working relationship with both local services. The health visitors should be the main point of contact between the services, particularly in medically or socially complex cases.

Recommendation 15

Where possible deliver health visitor led clinics and groups from children's centres. centres combined with a stay-and-play (or similar) session.

Recommendation 20

Staff should be aware of NHS, council, private and voluntary sector services available in the area and should be able to direct clients to these as appropriate.

Caseload

The Community Practitioners and Health Visitors Association (CPHVA) state that caseloads for health visitors should be an absolute maximum of 400 with an average caseload being 250. Cowley et al advocate varying the caseload of health visitors according to deprivation levels. The proposed health visitor caseload size is between 100 for the most deprived areas and 400 for the least. The reason for this is that 'a higher number of contacts is routinely required where greater need is expected in more deprived areas.' The caseload size is however based on delivering 6-12 home visits, which is more than the 5 mandated visits currently.²¹

A health visitor survey carried out by Cowley et al (2007) indicated that in the mid-2000s, child protection activities and one-to-one client work dominated health visitors' practice, leaving less time for community engagement activities²².

Recommendation 1

Vary caseload within the service depending on local need.

High Impact Areas

1. Transition to parenthood and antenatal education

The healthy child programme states that preparation for parenthood should begin early in pregnancy and should include information on services, choices, parental rights and pregnancy related health information. It also advocates the universal provision of preparation for parenthood classes.⁴ The

Department of Health have created the 'Preparation for Birth and Beyond' course which covers the following themes:

- Our developing baby
- Changes for me and us
- Our health and wellbeing
- Giving birth and meeting our baby
- Caring for our baby
- People who are there for us²³

The Wave trust's 'Conception to Age 2' does however comment that 'the real challenge comes from the fact that many of the most vulnerable don't have the personal confidence to attend parentcraft classes so may be the least likely to receive this input through that channel.'⁸

Schrader Mcmillan et al did a 2009 review of antenatal education. They found that antenatal education had a positive effect on satisfaction with the birth experience, health promotion behaviours, and breastfeeding for specific interventions. The parenting programmes that focus on the transition to parenthood had a positive effect on maternal psychological well-being, parental confidence and satisfaction with the couple and parent-infant relationship in the post-natal period. It also advocated participatory classes and specific preparation for fatherhood classes as an adjunct to this. They found 'no evidence that participation in [antenatal education] prevents the onset of depression or is effective in its treatment', although 'group-based social support including antenatal preparation for parenthood classes can be effective in supporting women with sub-threshold symptoms of depression and anxiety.'²⁴

Studies which look at universal antenatal interventions appear to lead to little change in childhood outcomes as a result of the interventions. However there is evidence showing that targeted interventions to high risk populations may have some effect.

A Cochrane systematic review of 17 trials offering social support for mothers at increased risk of low birthweight babies, found that they were not associated with improved perinatal outcomes (including incidence of low-birthweight babies).²⁵

Brixval et al's 2015 systematic review also found insufficient evidence whether antenatal education in small classes affects parental obstetric or psychosocial outcomes²⁶. However evidence is very mixed. A large randomised controlled trial of 1047 women in the US used group based antenatal care where care was delivered from week 18 in 2 hour classes focusing on physical assessment, education and skills building, and support through facilitated group discussion²⁷. The participants had a mean age of 20.4 and 80% were of black ethnicity. The results found a 33% risk reduction of pre-term birth (effects were strengthened among black participants) and a higher initiation of breastfeeding.

In a non-randomised study, Bryan demonstrated an improved parent-child interaction and sensitivity to cues in the intervention group following 3 couple-based antenatal classes; "intervention ... was based on individual and couple changes in meaning/identity, roles, and relationship/interaction during the transition to parenthood. It addressed mother/father roles, infant communication abilities, and patterns of the first 3 months of life in a mutually enjoyable, possibility-focused way."²⁸

Recommendation 3

Offer evidence based antenatal classes and include an emphasis on recruiting women with a higher level of need. The provider should be assessed on the proportion of women at increased need who attend the antenatal classes.

2. Breastfeeding

The NICE Guidelines on maternal and child nutrition emphasises the importance of breastfeeding for infants, both to prevent infection in infants, especially gastroenteritis, and to prevent obesity. It also outlines the health benefits for the mother. They recommend implementing a multifaceted approach to increase breastfeeding rates which should include educations to raise awareness of breastfeeding benefits, peer support programmes, staff training and information in pregnancy and proactive support postnatally. Also to use UNICEF's 'Baby Friendly Initiative' as a minimum standard. A further recommendation is for a midwife or health visitor

trained in breastfeeding management to provide an informal group session in the last trimester of pregnancy, which should focus on how to breastfeed effectively by covering feeding position and how to attach the baby correctly.²⁹

In the UK, while there is a high rate of initiation of breastfeeding, many women stop breastfeeding quickly; in 2010 the infant feeding survey reported that "the prevalence of breastfeeding fell from 81% at birth to 69% at one week, and to 55% at six weeks."³⁰

Studies of the effect of antenatal education on breastfeeding have again shown very mixed results. Studies where a high proportion of women planning to breastfeed were given antenatal education seem to show no difference in duration of breastfeeding^{31,32,33}, although there may be some effect on timing of weaning and confidence.^{32,33} However, one trial of black ethnicity, low income women in Chicago (a group with low breast feeding rates), showed significantly improved breast feeding rates post intervention³⁴, suggesting that targeting women with low breast feeding rates may be more effective.

A 2012 Cochrane review looked at lay and professional support for breastfeeding, across 14 countries including the UK. There was a beneficial effect on the duration of any breastfeeding up to six months with the implementation of any form of extra support. Of particular interest was that exclusive breastfeeding was significantly prolonged with use of WHO/UNICEF training.³⁵ The importance of training was shown in a 2006 study in Glasgow (where there were low breast feeding rates), which compared health visitor practices to breastfeeding duration in individual children found that, "infants being breastfed at the first visit were significantly more likely to be fed infant formula at the second visit if their health visitors had had no breastfeeding training in the previous two years."³⁶

Hannula et al's 2008 systematic review found that "Interventions expanding from pregnancy to the intrapartum period and throughout the postnatal period were more effective than interventions concentrating on a shorter period. In addition, intervention packages using various methods of education and support from well-trained professionals

are more effective than interventions concentrating on a single method.”³⁷

Recommendation 4

Include breastfeeding in the preparation for parenthood classes, physical, emotional and psychological wellbeing, and information about accessing help to all pregnant women.

Recommendation 21

Require the provider to have or work towards achieving the WHO Baby Friendly Initiative.

Recommendation 5

Offer easily accessible breastfeeding support and health visitors should work in partnership with breastfeeding peer support groups. There should be specific interventions to target groups with low rates of breastfeeding.

3. Health, Wellbeing and Development of the Child Age 2 – Two year old review (integrated review) and support to be ‘ready for school’.

School readiness is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally.

One of the aims of the healthy child programme is to promote ‘readiness for school and improved learning.’ At the 2-2.5 year health review is expected to include an assessment of development, promotion of language development through book sharing and other means and to provide encouragement to take up early years education.⁴

There are many factors which affect child development and school readiness. The Avon Longitudinal Cohort Study has found that there are large early learning variations associated with socioeconomic factors such as parental education, family income, and maternal age. Although there are many confounding factors, as many of these are linked with each other eg teenage pregnancy and low educational attainment. However environment was also found to be important; parental teaching and reading was found to have a significant impact on both behaviour and educational attainment. They

also reported that the mother’s mental and physical health, especially stress, anxiety and self-esteem, and low quality relationships between parents are strongly related to poor child behavioural outcomes.³⁸

The Public Health England review concluded that the most promising interventions for speech, language and communication development are reading and language/literacy focused, or are aimed at supporting teachers to work more effectively.¹⁷ This included a meta-analysis by Camilli et al which found that significant positive effects on cognitive and social development were found ‘for children who attend a preschool program prior to entering kindergarten. Although the largest effect sizes were observed for cognitive outcomes, a preschool education was also found to impact children’s social skills and school progress.’³⁹ There were also good outcomes for parent led interventions, but limited evidence for the effectiveness of home visiting services.

For social, emotional and cognitive interventions however, home visiting has been found to be effective. The NICE guidelines on social and emotional development advocates that health visitors or midwives should offer a series of intensive home visits by an appropriately trained nurse to parents assessed to be in need of additional support. Activities during each visit should be based on a set curriculum which aims to achieve specified goals in relation to:

- maternal sensitivity (how sensitive the mother is to her child's needs)
- the mother–child relationship
- home learning (including speech, language and communication skills)
- parenting skills and practice.⁴⁰

Recommendation 13

Ensure robust pathways are in place to offer evidence based interventions to children who are identified as having developmental delay. Ensure that these are written and delivered with children's services so that families are offered intervention by the most appropriate professional.

Recommendation 9

The health visiting service should ensure that parents are aware of recommended activities to promote development and 'school readiness', including pre-school education.

4. Accident prevention

Injuries are the leading cause of childhood death in the UK between after the age of 1.⁴¹ The healthy child programme has 'keeping safe' and 'reducing sudden infant death' within the universal offer⁴. Public Health England's reducing unintentional injuries in the under 5s paper recommends that "health visitors should have appropriate training that will enable them to identify home safety behaviours, make well-informed decisions and offer appropriate advice."⁴²

NICE guidelines PH29 and PH30 for accident prevention are targeted at a wide range of professionals. They recommend that health visitors are aware of families which might benefit from injury prevention advice and a home safety assessment through alerts when a child or young person repeatedly needs medical treatment for unintentional injuries. Health visitors should also be integrating home safety advice into home visits undertaken for other reasons. It recommends a role for health visitors in water safety education.^{43, 44}

The Cochrane review of home safety education and provision of safety equipment for injury prevention in under 19s concluded that there was some evidence that interventions may reduce injury rates, and greater reductions were found for interventions delivered in the home. There a lack of evidence that home safety interventions reduced rates of thermal injuries or poisoning. It was effective in improving some safety practices in the home. Interventions providing free, low cost or discounted safety

equipment appeared to be more effective in improving some safety practices than those interventions not doing so⁴⁵

There is some evidence from the United States among vulnerable populations that intensive home visiting (in the family nurse partnership programme) can lead to reduced hospital attendances with injuries and injestions.^{46,47}

However within the UK, there is little evidence of interventions in demonstrating effective reduction in accidents. One cluster randomised trial in Nottingham in 36 general practices looked at safety advice at child health surveillance consultations, provision of low cost safety equipment to families receiving means tested state benefits, home safety checks, and first aid training on frequency and severity of unintentional injuries in children at home. They found no significant difference in their primary outcome of frequency of at least one medically attended injury.⁴⁸

Recommendation 22

Ensure health visitors have adequate training in identifying home safety behaviours and are able to offer appropriate advice.

5. Healthy Weight, Healthy Nutrition

The NICE guidelines on Maternal and Child Nutrition (PH11) outlines action to 'improve the nutrition of pregnant and breastfeeding mothers and children in low-income households'. It focuses on child nutrition, including breastfeeding, weaning and activities to promote healthy eating, maternal diet, healthy start vitamins, weaning and monitoring of weight.²⁹

The healthy child programme advises that the certain input is likely to help to prevent obesity:

- making breastfeeding the norm
- delaying weaning until around six months of age, introducing children to healthy foods and controlling portion size
- identifying early those children and families who are most at risk
- encouraging an active lifestyles

- for some families, skilled professional guidance and support. The health professional should work in partnership with the family – setting small goals, using strength-based methods and exploring family relationships and earlier life experiences.⁴

The NICE guidelines state that “the evidence suggests that dietary interventions which recognise the specific circumstances facing low-income families, teenage parents and mothers from minority ethnic or disadvantaged groups are likely to be more effective than generic interventions.”²⁹

The Cochrane review on interventions for preventing obesity in children found that interventions were most effective between the ages of 6 and 12 years. The authors undertook a sub-group analysis of 0-5 year olds, which included 8 studies which targeted children in this age group; some included dietary modifications and some physical activity or a mixture of the two. The authors found a trend towards a positive intervention effect, although it just failed to reach statistical significance (P=0.05). The authors concluded that in this age group interventions set outside education settings are more effective. There was however concerns about the long-term effectiveness of any of these programmes.⁴⁹

There is little rigorous evaluation of health visitor specific intervention in nutrition and obesity prevention.

There is evidence that excess weight gain in infancy is a predictor of obesity in adulthood⁵⁰, however Lakshman et al undertook focus groups around this topic and found that health visitors tend to use ‘growth charts to assess adequate weight gain rather than to identify excess weight gain.’⁵¹ Other health professionals are likely to view infant feeding advice as the role of the health visitors. However health professionals report a lack of confidence in discussing infant weight management with parents, as well as prioritising their relationship with parents over best practice in infant feeding⁵².

There are several programmes which aim to tackle obesity in this age group. The EMPOWER (Empowering Parents to Prevent Obesity at Weaning: Exploratory Research) intervention is delivered by specially trained health visitors to parents with babies

at high risk. It uses a strength based and solution focussed way of working with families, and has been found to be acceptable to families and increased knowledge of appropriate nutrition.⁵³

Recommendation 23

Provide health visiting staff with specialist and up-to-date training in childhood nutrition and preventing obesity, so that they feel able to identify children at risk of obesity, discuss this with parents, and advise evidence based interventions.

6. Perinatal Mental Health

The healthy child programme guidelines state that there should be an assessment of ‘risk factors for health and wellbeing’ including identification of a family history of mental health, and that family mental health needs should be assessed. Furthermore parenting programmes should include the topic of recognising and addressing mental health problems in either parent.⁴

According to the 2014 NICE guidelines (CG192) the following questions (Whooley Questions) should be asked ‘early in the postnatal period’ as screening questions:

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

If a patient answers yes to either of these questions, this should then be followed with a more in-depth assessment, such as with the Edinburgh Postnatal Depression Scale and onward referral if appropriate. There are also screening questions for anxiety which are advised for use (GAD-2).⁵⁴

A 2015 meta-analysis which looked at the use of Whooley questions for depression in general (rather than specifically post-natal depression) found that the pooled sensitivity was 0.95 (CI 0.88 to 0.97), and specificity was 0.65 (CI 0.56 to 0.74). However the

studies included were restricted to ‘major depression’ rather than mild to moderate depressive symptoms.⁵⁵

A questionnaire of health visitors in one NHS trust on the use of the Whooley questions found that although there was ‘some agreement that the questions were clear and easy to use, did not require extra time and were considered to be acceptable to women, there was a lack of confidence in the ability of the questions to detect perinatal depression. A wide variation in practice around administering the questions was highlighted’.⁵⁶

There is some evidence that maternal mental health problems are under-recognised in some ethnic groups living in the UK, such as black Caribbean women.⁵⁷

Clear pathways of systematic follow up of all positive screening results with a diagnostic procedure and access to effective treatment are centrally important both for the clinical effectiveness of screening and for health system costs.⁵⁸

NICE Guidelines (CG192) advise an initial treatment of facilitated self-help or other psychological interventions for sub-threshold, mild or moderate depression or anxiety.⁵⁴ The NICE guidance for depression (CG90) in adults defines the low-intensity psychosocial interventions as: individual guided self-help based on the principles of cognitive behavioural therapy (CBT), computerised cognitive behavioural therapy and/or a structured group physical activity programme.⁵⁹ Most of the evidence and guidelines focus on perinatal depression rather than other mental health problems which occur in pregnancy.

The healthy child programme recommends the following interventions for maternal depression:

- Eight listening visits or referral for brief cognitive behavioural or interpersonal therapy. (Listening visits are defined as unstructured, client-led discussions involving the counsellor in: active listening; reflection; providing empathic responses; encouraging the expression of experiences and accepting the emotions expressed; and not offering information or advice.)

- Use of dyadic therapies to increase maternal sensitivity, e.g. infant massage, interaction guidance.
- Postnatal parent–infant groups with enhanced components for fathers. Sessions should address and respond to the specific concerns of fathers, including support to partner, care of infants, and emotional issues arising from fatherhood. Enhanced postnatal support can include separate sessions with fathers and for fathers only.
- Recognition and referral of women with serious mental health problems.⁴

A 2007 Cochrane review looked at psychosocial and psychological interventions for postpartum depression, including interpersonal therapy and psychodynamic therapy. It concluded that ‘although the methodological quality of the majority of trials was, in general, not strong, the meta-analysis results suggest that psychosocial and psychological interventions are an effective treatment option for women suffering from postpartum depression.’ The long-term effectiveness remains unclear.⁶⁰ Barlow et al’s systematic review concluded that ‘Inter-personal psychotherapy, cognitive behavioural therapy or listening visits in the home are effective for women who have developed symptoms of depression. One-to-one therapy appears to be more effective than group work.’⁶¹

Morrell’s 2011 cluster randomised controlled trial compares health visitors who were trained in identifying depressive symptoms and in delivering sessions based on cognitive behavioural therapy or person centred principles for an hour a week for 8 weeks. The intervention group displayed a statistically significant reduction in postnatal depression score compared with routine care, and there was no difference between the two methods.⁶²

There is little data on which of the psychological approaches are most effective for the treatment of postnatal depression. A 2014 review looked at thirteen trials which used psychosocial support in the treatment of perinatal mental health problem. Interventions included peer support, partner support, non-directive counselling, home visits by mental

health nurses, and collaborative models of care. They found that 'owing to methodological limitations of the included trials, the effectiveness of most psychosocial approaches for the treatment of postpartum depression is equivocal' and large randomised controlled trials are needed to address this question.⁶³

There is poor evidence around health visitor delivered 'listening visits'. It is reported that women find them beneficial but that they often need other interventions in addition to this. They are also very dependent on how the intervention is delivered and by whom.^{64,65}

While infant mental health is not specifically named in the high impact areas, it is known that 'parental mental health (before and after birth) is a key determinant of the quality of [the child and primary care giver's] relationship.' In turn therefore this affects infant mental health which can lead to lifelong adverse impact.⁸ A small 2008 pilot study showed that health visitors are not consistent in their professional assessments of parent-infant intervention.⁶⁶ One possible screening tool is the Parent-Infant Interaction Observation Scale (PIIOS).⁶⁷ Public Health England's 2015 'Rapid Review' identifies

several diverse interventions which could be used by health visitors to improve parent-child attachment; these included home visiting, group work and brief intensive interventions. Many use video feedback. There is very little evidence comparing one intervention to another.¹⁵

Recommendation 8

There must be a clear pathway for the identification and management of women with perinatal mental health problems and for infant mental health, written in consultation with the local perinatal mental health service. The pathway should describe the role of the health visitor in the management of perinatal mental health.

Recommendation 19

Ensure that all health visitors are trained in identification of perinatal mental health problems, from mild through to severe (including depression, anxiety and postpartum psychosis), and are comfortable in assessing both maternal and infant mental health.

Health Visiting Models

There are many different methods of delivering health visiting services to children, some are universal and others are targeted. Currently in the Three boroughs the health visiting services are delivered as part of a 0-19s model, although the Family Nurse Partnership is offered to all women who become pregnant under the age of 20. Other areas use different models, and it is important to consider these as a new service model is being planned.

Family Nurse Partnership

This is an intensive targeted home visiting service for first time mothers of less than 20 at the last menstrual period. It originated over 30 years ago in the United States. The programme begins antenatally, and women are ideally recruited by 16 weeks pregnancy, but must be recruited by 28 weeks. Visits occur weekly antenatally and following birth, although they later drop to fortnightly. The programme ends when the child is 2 years old, when the family are handed back to the health visiting service. The aim is to build up a relationship of trust between the family nurse and the young mother.

3 large randomised controlled trials have been performed in the United States since 1978; in addition to improved outcomes for the mothers, they demonstrated improved school readiness, improved emotional and behavioural development and reduced child neglect and abuse.⁶⁸

Integrated 0-5s Model: Brighton and Hove

Brighton and Hove have adopted complete integration of health visiting and children's services; the health visiting and family nurse partnership team have been seconded into the council (via a Section 75 agreement). The integrated children's centre teams are led by health visitors, who supervise outreach workers, and specialist services are then provided in addition to this, for example breastfeeding services and services for traveller and asylum seeker families.

Both antenatal and postnatal services are delivered from the children's centres. Health visitors register families at the children's centre at the new birth visit, therefore all children under 5 are reached by this integrated service. They share data and have 'aligned reporting systems', but still have 2 different IT systems.

The number of children achieving a good EYFSP (early years foundation stage profile) score when they start school has increased across the city from 33 per cent in 2008 to 55 per cent in 2011, and parental satisfaction at the last citywide survey was 95 per cent.^{69,70}

Maternal Early Childhood Sustained Home Visiting Programme (MECSH)

This is a licensed service system which is delivered within universal services under the principle of proportionate universalism. It was originally developed in Australia as a structured program of sustained nurse home visiting for families at risk of poorer maternal and child health and development outcomes. MECSH is now offered in the Jersey and some English sites.

The 5 core elements of the programme are:

- Supporting mother and child health and wellbeing
- Supporting mothers to be future oriented and aspirational
- Supporting family and social relationships
- Additional support in response to need
- Child development parent education

For women who are identified as fitting the criteria for the enhanced services, antenatal visits are undertaken fortnightly to monthly visits. Postnatally, visits are weekly for the first 6 weeks and decreasing in frequency as the child gets older until the child is 2 years old, and there are parenting themes which are covered during this time.⁷¹

A 2011 randomised controlled trial of 208 women was conducted in Sydney; the one positive outcome was a significantly higher duration of breastfeeding in the intervention group. Other outcomes were not statistically significant, but the sample size was small.⁷²

0-19s Model

Bristol and South Gloucestershire plan a 0-19s integrated service. In the service specification the 0-5s and 5-19s roles are maintained but both groups will be managed in area teams with one management hierarchy. The service will be structured in line with children's services. They state that as 'the resource available for the 0 - 5 programme is significantly larger than that available for the 5-19 programme; this means that although it is a universal service a targeted

approach will need to be taken to ensure that the best use is made of the workforce, ensuring the right people are doing the right thing at the right time and in the right place.'⁷³

Community Nursing

In 2006 the Scottish Executive reviewed the role of nurses in the community, and following this proposed the merging of district nursing, health visiting, school nursing and family health nursing into a single community health nurse role (CHN) role. The new role was piloted in three areas across Scotland. However, following evaluation it was abandoned in favour of returning to traditional roles but promoting more integrated working. There was found to be concern around the model from the frontline staff.⁷⁴

Focus Groups

In order to plan a new service, it is vital to understand the experiences and priorities of local families for their health visiting service. Local service users were asked to input their opinions of the current service and suggestions for a future service.

There have been 2 focus groups held within the 3 boroughs. Appendix F describes the locations and attendees of these groups. In total we spoke to 13 mothers and 1 father and asked for their experiences of health visiting any suggestions they had for changes in the service.

The following summary of the discussion in the focus groups have been structures around the following main themes:

Settings of clinics

Many of the mothers reported that within the baby weighing clinics, run by the health visiting service, they were not seen privately, but instead in a room with several other families. They felt that this meant that they didn't want to discuss personal matters with the health visitor as they would be overheard. Some felt that they would like to have a private room during these clinics, however others were happy with a communal area for their needs.

They did not feel strongly whether the clinics should be held in a children's centre or in a health setting (GP surgery or health setting), and the most important factor was ease of access. Most parents said that the priority for them was having a clinic close by. When the option of holding the baby clinic in the context of a 'stay and play' session was discussed the mothers were very positive about this. Drop-in clinics were usually favoured, although some parents felt that a mixture of drop-in and appointments would be helpful.

Recommendation 15

Where possible deliver health visitor led clinics and groups from children's centres combined with a stay-and-play (or similar) session.

Recommendation 17

Offer a mixture of drop-in slots and appointment times for health visitor clinics.

Health visitors as information givers

'They need to know what is going on in their area for mums and babies'

There are many local services on offer and many people are unaware that these are available, and only hear about them from others who use them. They felt that health visitors should know the services in a local area and should direct parents to these. Some parents were directed to resources such as children's centres or peer support breastfeeding clinics but other parent's health visitors never mentioned them. Parents generally felt that it would be extremely useful to have information about groups, play sessions etc on offer locally, and this was particularly emphasised by one mum who felt very socially isolated having just moved into the UK.

"They were easy to approach...not a GP but someone to ask about small problems."

One mother particularly valued health visitors as a source of information on minor ailments and non-urgent problems, which she would not necessarily need to see a GP about. This was particularly the case as she reported that it was much easier to access the health visitor than book a non-urgent appointment with her GP.

One theme which came up was that parents can often be given different and conflicting advice from different healthcare professionals, and that this can be unhelpful. The importance of health visitors being up-to-date was mentioned, particularly as parents as

information found on the internet can cause confusion.

Health visitors were often felt to be an enormous amount of written information with them as a 'tick box exercise' instead of highlighting the important bits of information. One mother who reported an excellent relationship with her health visitor, said that she was encouraged to give the health visitor a ring if there were any problems as '*she knew I wouldn't have time to read them*'. Some parents felt that a website with all the information would be more useful than the leaflets.

Parents also felt unsure around particular milestones e.g. weaning, toilet training etc, and would like opportunities to find out from both professionals and discussions with other parents such as informal groups.

Recommendation 18

The service should maintain an up-to-date online presence with evidence based information on health and development topics and with details of local offers, including children's centres and voluntary groups.

Help for parents of 2-5 year olds

'It would be nice to have some back-up sessions for older children'

Some of the mums stated that they felt isolated and like they didn't have anyone to go to once their children were older than 2. This was often concerns with behavioural issues. They did not feel welcome to approach their health visitors, and at baby weighing clinics felt inappropriate. They felt that it would be really useful to have dedicated sessions for children of age 2 to 5, and that these sessions should be at a convenient time so that they don't have to take their child out of nursery. Also that health visitors should highlight to parents that they can come for help and advice until their child is age 5, or undertake follow-up calls during this period.

Recommendation 16

The provider should offer provision whereby parents of 2-5 year olds can access health related help and advice, in times and settings that suit the families with children in this age group.

The importance of a good relationship with the health visitor

One mother wrote,

'The health visitors I have encountered have been brilliant: in supporting, giving information. Their listening and observations have helped me and my family enormously.'

A theme which was frequently mentioned was the importance of a good relationship and trust between the mother and their health visitor. Some mothers said that it was difficult to get to know their health visitor as they kept changing. However some mothers reported excellent experiences. One mother who had suffered from postnatal depression reported how their health visitor had spent a lot of time with her, listening to her.

Other mothers described how they felt concerned about telling mothers the truth about things that they were struggling with, in case it led to the health visitors involving social services.

Recommendation 14

Health visitors should maintain continuity of care for families, with one health visitor allocated from birth until 5 years, and for all children within a family.

Help and advice in pregnancy and early on in the postnatal period

It was felt that first children are a particularly difficult time and that it is very important that new parents know what to expect, and should be given the information before birth. There was enthusiasm for the pilot of antenatal classes when it was discussed.

Some felt there was a gap before the health visitor's new birth visit (at around 2 weeks), and that at this time they were not sure of who to call or when to call for help. However others felt that there was a lot of visits from different health professionals.

A greater knowledge of the role of health visitors would have been helpful, as many were initially unsure of who they were and what their role was. It was suggested that a timeline of expected visits should be provided.

Breastfeeding was an area where mothers particularly reported that they felt that they needed help and advice, but were not sure who they could obtain this from. There were mixed experiences of health visitor input in this area. Some of the mothers were still not aware that health visitors are trained in breastfeeding.

Recommendation 6

Ensure that women are given information about the health visiting service, timeline of expected visits, health visiting roles and contact details during pregnancy.

Recommendation 4

Include breastfeeding in the preparation for parenthood classes, physical, emotional and psychological wellbeing, and information about accessing help to all pregnant women.

Recommendation 5

Offer easily accessible breastfeeding support and health visitors should work in partnership with breastfeeding peer support groups.

Set times for visits

It was commented that sometimes home visits could take up a large part of the day as no set time was offered, and a visit time would have been appreciated.

First aid course

The community champions stated that as parents they would be very keen to be offered a first aid course so that they would know what action to take in the case of an accident.

Recommendations

These recommendations will be used to inform the recommissioning process for the new service specification.

Priority Area 1: Reduce Health Inequalities through Proportionate Universalism

Recommendation 1: Vary caseload within the service depending on local need

Recommendation 2: Information must be available to families in a variety of languages as appropriate for the local population.

Priority Area 2: Prioritise Investment in the Early Years

Recommendation 3: Offer evidence based antenatal classes and include an emphasis on recruiting women with a higher level of need. The provider should be assessed on the proportion of women at increased need who attend the antenatal classes.

Recommendation 4: Include breastfeeding in the preparation for parenthood classes, physical, emotional and psychological wellbeing, and information about accessing help to all pregnant women.

Recommendation 5: Offer easily accessible breastfeeding support and health visitors should work in partnership with breastfeeding peer support groups. There should be specific interventions to target groups with low rates of breastfeeding.

Recommendation 6: Ensure that women are given information about the health visiting service, timeline of expected visits, health visiting roles and contact details during pregnancy.

Recommendation 7: The health visiting provider should deliver (or work with partners who offer), evidence based interventions in specific priority areas where the Three Boroughs are currently performing poorly, including dental health, vaccination uptake, childhood obesity and school readiness. Performance against relevant public health outcomes should be monitored and performance managed.

Recommendation 8: There must be a clear pathway for the identification and management of women with perinatal mental health problems and for infant mental health, written in consultation with the local perinatal mental health service. The pathway should describe the role of the health visitor in the management of perinatal mental health.

Recommendation 9: The health visiting service should ensure that parents are aware of recommended activities to promote development and 'school readiness', including pre-school education

Priority Area 3: Partnership working

Recommendation 10: The health visiting teams should be aligned to the children's services teams. This opportunity should be used particularly to identify and develop areas where children's services can impact factors which adversely affect health and wellbeing. It should be used to facilitate referrals and information sharing between the services.

Recommendation 11: Health visitors should attend the Connecting Care for Children Hubs where available.

Recommendation 12: Health visitors should have an explicit role as a key link between health (particularly General Practice) and social care. This should include a close working relationship with both local services. The health visitors should be the main point of contact between the services, particularly in medically or socially complex cases.

Recommendation 13: Ensure robust pathways are in place to offer evidence based interventions to children who are identified as having developmental delay. Ensure that these are written and delivered with children's services so that families are offered intervention by the most appropriate professional.

Priority Area 4: Patient Centred, Flexible and Innovative Service Delivery

Recommendation 14: Health visitors should maintain continuity of care for families, with one health visitor allocated from birth until 5 years, and for all children within a family.

Recommendation 15: Where possible deliver health visitor led clinics and groups from children's centres combined with a stay-and-play (or similar) session.

Recommendation 16: The provider should offer provision whereby parents of 2-5 year olds can access health related help and advice, in times and settings that suit the families with children in this age group.

Recommendation 17: Offer a mixture of drop-in slots and appointment times for health visitor clinics.

Recommendation 18: The service should maintain an up-to-date online presence with evidence based information on health and development topics and with details of local offers, including children's centres and voluntary groups.

Priority Area 5: Rigorous and Up-to-date Staff Training

Recommendation 19: Ensure that all health visitors are trained in identification of perinatal mental health problems, from mild through to severe (including depression, anxiety and postpartum psychosis), and are comfortable in assessing both maternal and infant mental health.

Recommendation 20: Staff should be aware of NHS, council, private and voluntary sector services available in the area and should be able to direct clients to these as appropriate.

Recommendation 21: Require the provider to have or work towards achieving the WHO Baby Friendly Initiative.

Recommendation 22: Ensure health visitors have adequate training in identifying home safety behaviours and are able to offer appropriate advice.

Recommendation 23: Provide health visiting staff with specialist and up-to-date training in childhood nutrition and preventing obesity, so that they feel able to identify children at risk of obesity, discuss this with parents, and advise evidence based interventions.

Recommendation 24: Each borough team should have health visitors who lead in each of the six high impact areas. The role of these health visitors should include training, offering advice, maintain up-to-date evidenced based pathways and guidance, work with partner agencies and have excellent links with relevant agencies. If appropriate this post could also include specialist caseloads, such as a role for a specialist health visitor in perinatal mental health

References

1. Department of Health. Health Visitors: A positive start for every family. 2012 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213109/health-visiting-information-brochure.pdf Accessed 18.3.2016)
2. Department of Health. Health Visitor Implementation Plan 2011-2015: A call to action. February 2011.
3. Department of Health. Facing the Future: A review of the role of health visitors. 2007
4. Department of Health. Healthy Child Programme: pregnancy and the first five years of life. 2009
5. Department of Health. Overview of the six early years high impact areas. 2014
6. Department of Health, NHS England, Public Health England. Health Visiting Programme and 0-5 Commissioning of Public Health Services. 2014
7. Department of Health. Universal Health Visitor Reviews: Advice for local authorities in delivery of the mandated universal health visitor reviews from 1 October 2015. 2014
8. Wave Trust. Conception to Age 2 - The Age of Opportunity. 2013
9. Marmot M et al. Fair Society, Healthy Lives: The Marmot Review. 2010
10. Office for National Statistics (ONS) Population Estimates, Borough and Ward. Mid-year population by single year of age(SYA) and sex, for each year 1999 to 2014. (Accessed via GLA Website <http://data.london.gov.uk/dataset/office-national-statistics-ons-population-estimates-borough> 4.3.2016)
11. Office for National Statistics. Live births by local authority of usual residence of mother, General Fertility Rates and Total Fertility Rates. 2015. (Accessed via GLA Website <http://data.london.gov.uk/dataset/births-and-fertility-rates-borough/resource/1eb3c512-9abc-4392-8e87-5f7df3e24cc3> 4.3.2016)
12. HSCIC, Births 2014
13. ONS. Live births (numbers and rates): age of mother and administrative area of usual residence, England and Wales, 2014.
14. Armstrong J, Dorosty AR, Reilly JJ et al, Coexistence of social inequalities in undernutrition and obesity in preschool children: population based cross sectional study. *Archives of disease in childhood*, 2003;88(8):671-675
15. PHE, National Child and Maternal Health Intelligence Network. Mental health in pregnancy, the postnatal period and babies and toddlers. (<http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=66&geoTypeId>) Accessed 22.4.2016.
16. Cowley S, Whitaker K, Grigulis A et al. Why Health Visiting? A review of the literature about key health visitor interventions, processes and outcomes for children and families. National Nursing Research Unit. 2013.
17. Public Health England. Rapid Review to Update Evidence for the Healthy Child Programme 0–5. 2015
18. Carlisle et al. The health impact of changing to geographical working. *Community Practitioner* 2004;77(10):376-380
19. Hoskins et al. Corporate solutions to caseload management – an evaluation. *Community Practitioner*. 2007 80(9):20-24
20. National Nursing Research Unit. Health visiting: the voice of service users. Learning from service users' experiences to inform the development of UK health visiting practice and services. 2013
21. Cowley, S. Bidmead C. Contrroversial Questions (part one): what is the right size for a health visiting caseload? *Community Practitioner*: 2009;82(6):18-22.
22. Cowley S, Caan W, Dowling S, et al. What do health visitors do? A national survey of activities and service organisation. *Public Health*. 2007 121(11):869-79
23. Department of Health, NHS. Preparation for Birth and Beyond. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215386/dh_134728.pdf (Accessed 7.4.12)
24. Schrader McMillan A, Barlow J, Redshaw M. Birth and beyond: A Review of the Evidence about Antenatal Education. University of Warwick. 2009.
25. Hodnett ED, Fredericks S, Weston J. Support during pregnancy for women at increased risk of low birthweight babies. *Cochrane Database Syst Rev*. 2010
26. Brixval CS, Axelsen SF, Lauemøller SG, Andersen SK, Due P, Koushede V. The effect of antenatal education in small classes on obstetric and psycho-social outcomes - a systematic review. *Syst Rev*. 2015
27. Ickovics JR, Kershaw TS, Westdahl C, Magriples U, MD, Massey Z, Reynolds H, and Rising SS. Group Prenatal Care and Perinatal Outcomes: A Randomized Controlled Trial. *Obstet Gynecol*. 2007; 110(2 Pt 1): 330–339
28. Bryan AA. Enhancing parent-child interaction with a prenatal couple intervention. *MCN Am J Matern Child Nurs*. 2000; 25(3):139-44
29. NICE. Maternal and child nutrition: Public health guideline (PH11). 2008

30. McAndrew F, Thompson J, Fellows L et al. Infant Feeding Survey 2010. HSCIC. 2012
31. Forster D, McLachlan H, Lumley J, Beanland C, Waldenström U, Amir L. Two mid-pregnancy interventions to increase the initiation and duration of breastfeeding: a randomized controlled trial. *Birth*. 2004; 31(3):176-82.
32. Noel-Weiss J, Rupp A, Cragg B, Bassett V, Woodend AK. Randomized controlled trial to determine effects of prenatal breastfeeding workshop on maternal breastfeeding self-efficacy and breastfeeding duration. *J Obstet Gynecol Neonatal Nurs*. 2006; 35(5):616-24.
33. Kronborg H, Maimburg RD, Væth M. Antenatal training to improve breast feeding: a randomised trial. *Syst Rev*. 2015; 4:20
34. Kistin N, Benton D, Rao S, Sullivan M. Breast-feeding rates among black urban low-income women: effect of prenatal education. *Pediatrics*. 1990; 86(5):741-6.
35. Britton C, McCormick FM, Renfrew MJ, Wade A, King SE. Support for breastfeeding mothers. *Cochrane Database of Systematic Reviews* 2007, Issue 1. Art. No.: CD001141. DOI: 10.1002/14651858.CD001141.pub3.
36. Tappin D, Britten J, Broadfoot M, McInnes R. The effect of health visitors on breastfeeding in Glasgow. *Int Breastfeed J*. 2006;1:11
37. Hannula L, Kaunonen M, Tarkka M. A systematic review of professional support interventions for breastfeeding. *J Clin Nurs*, 2008;17(9):1132-43
38. CPMO research team, University of Bristol. Up to Age 7: Family Background and Child Development Up to Age 7 in the Avon Longitudinal Survey of Parents and Children (ALSPAC). 2006
39. Camilli G, Vargas S, Ryan S, et al. Meta-analysis of the effects of early education interventions on cognitive and social development. *Teachers College Record*, 2010;112(3):579-620.
40. NICE. Social and emotional wellbeing: early years (PH40). 2012.
41. Royal College of Paediatrics and Child Health. Why Children Die. 2015 <http://www.rcpch.ac.uk/improving-child-health/child-mortality/child-mortality> (Accessed 28.4.16)
42. Public Health England. Reducing unintentional injuries in and around the home among children under five years. 2014.
43. NICE. Unintentional injuries: prevention strategies for under 15s (PH 29). 2010
44. NICE. Unintentional injuries: interventions for under 15s (PH 30). 2010
45. Kendrick D, Young B, Mason-Jones AJ et al. Home safety education and provision of safety equipment for injury. *Cochrane Database of Systematic Reviews*. 2012
46. Kitzman H, Olds DL, Henderson CR Jr, Hanks C, Cole R, Tatelbaum R, McConnochie KMSidora K, Luckey DW, Shaver D, et al. (1997) Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing. A randomized controlled trial. *Journal of the American Medical Association* Aug 27;278(8):644-52.
47. Kitzman, H. J., Olds, D.L., Cole, R.E. et al (2010) Enduring Effects of Prenatal and Infancy Home Visiting by Nurses on Children – Follow up of a Randomized Trial Among Children at Age 12. *Arch Pediatr Adolesc Med*. 2010;164 (5):412-418
48. Kendrick D, Marsh P, Fielding K. et al. Preventing injuries in children: Cluster randomised controlled trial in primary care. *BMJ*. 1999; 318:980-983.
49. Waters E, de Silva-Sanigorski A, Burford BJ, et al. Interventions for preventing obesity in children. *Cochrane Database of Systematic Reviews*. 2011
50. Bjerregaard LG, Rasmussen KM, Michaelsen KF et al. Effects of body size and change in body size from infancy through childhood on body mass index in adulthood. *International journal of obesity* 2014;38(10):1305-1311
51. Lakshman R, Landsbaugh JR, Schiff A, et al. Developing a programme for healthy growth and nutrition during infancy: understanding user perspectives. *Child: care, health and development*. 2012;38(5):675-682
52. Redsell SA, Atkinson PJ, Nathan D. Preventing childhood obesity during infancy in UK primary care: a mixed-methods study of HCPs' knowledge, beliefs and practice. *BMC family practice*. 2011. 12:54., 1471-2296
53. Barlow J, Whitlock S, Hanson S, et al. Preventing obesity at weaning: parental views about the EMPOWER programme. *Child Care Health Dev*. 2010;36(6):843-9.
54. National Institute for Health and Care Excellence. Antenatal and postnatal mental health: clinical management and service guidance (CG192). 2014.
55. Bosanquet K, Bailey D, Gilbody S, et al. Diagnostic accuracy of the Whooley questions for the identification of depression: a diagnostic meta-analysis.: *BMJ open*, 2015;5(12) e008913, 2044-6055
56. Beauchamp H. What factors influence the use of the Whooley questions by health visitors? *Journal of Health Visiting*. 2014;2(7);378-387
57. Edge, D. Perinatal depression: its absence among Black Caribbean women. *British Journal of Midwifery*, 2006;14(11); 646-652

58. Milgrom J, Gemmill AW. Screening for perinatal depression. *Best Practice & Research Clinical Obstetrics & Gynaecology*. 2014;28(1):13-23
59. National Institute for Health and Care Excellence Depression in adults: recognition and management (CG90). 2009 (reviewed 2015).
60. Dennis CL, Hodnett ED. Psychosocial and psychological interventions for treating postpartum depression. *Cochrane Database of Systematic Reviews*. 2007. Issue 4.
61. Barlow J, Schrader McMillan A, Kirkpatrick S et al. Health-led Parenting Interventions in Pregnancy and Early Years. 2008. Research Report DCSF-RW070
62. Morrell C, Slade P, Warner R. Clinical effectiveness of health visitor training in psychologically informed approaches for depression in postnatal women: pragmatic cluster randomised trial in primary care. *BMJ*. 2009;338: a3045.
63. Dennis, C. Psychosocial interventions for the treatment of perinatal depression. *Best practice & research. Clinical obstetrics & gynaecology*, 2014; 28(1):97-111, 1532-1932
64. Shakespeare J, Blake F, Garcia J. How do women with postnatal depression experience listening visits in primary care? A qualitative interview study. 2006; *Journal of Reproductive and Infant Psychology*. 2006;24(2):149-162
65. Turner KM, Chew-Graham C, Folkes L et al. Women's experiences of health visitor delivered listening visits as a treatment for postnatal depression: a qualitative study. *Patient Educ Couns*. 2010 Feb;78(2):234-9
66. Appleton JV, Harris M, Oates J. A pilot study to evaluate the accuracy of health visitor assessment of the quality of mother-infant interactions. 2008. Burdett Trust for Nursing
67. Svanberg PO, Barlow J, Tigbe W. The Parent-Infant Interaction Observation Scale: reliability and validity of a screening tool. *Journal of Reproductive and Infant Psychology*. 2013;31(1)
68. Department of Health. FNP Evidence Summary Leaflet 2011.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215542/dh_128008.pdf
69. Local Government Association. Bright futures: local children, local approaches. Good practice in children's centres 2013
70. Sussex County Council. Brighton & Hove Integrated Children's Services, powerpoint presentation. Accessed via Early Intervention Foundation. (<http://www.eif.org.uk/event/3rd-early-years-integration-workshop-structures-and-processes/> Accessed 4/2/16)
71. Early Childhood Connect: Investing in Strong Beginnings. (<http://www.earlychildhoodconnect.edu.au/home-visiting-programs/mecsh-public/mecsh-trial-outcomes> Accessed 4/2/16)
72. Kemp L, Harris E, McMahon et al. Child and family outcomes of a long-term nurse home visitation programme: a randomised controlled trial. *Arch Dis Child*. 2011; 96(6):533-40.
73. Service Specification: Bristol and South Gloucestershire 0 – 19 Service, January 2016
https://www.bristolccg.nhs.uk/media/medialibrary/2016/02/Specification_for_019_years_Public_Health_Nursing_January_2016.pdf (accessed 4.4.2016)
74. Elliot L, Kennedy C, Rome A. Study of the Implementation of New Community Health Nurse Role in Scotland. Scottish Government Social Research. 2012

Appendix 1: Health Visitor Partnership Group

The health visitor partnership group has been meeting since October 2015.

The aims of the group include:

- To provide senior level leadership expertise and support to the redesign and re-commissioning of the service as planned between now and October 2017
- To ensure maximum alignment with the Best Start in Life and the Connected Care for Children integrated approaches
- To update on and oversee the current provision of services

Stakeholder members of the group include representatives from the current health visiting provider organisation (Central London Community Healthcare NHS Trust), children's services, the three local CCGs, local GPs, midwifery, healthwatch, safeguarding representatives and a patient representative.

The following themes have been covered during the meetings:

- Antenatal offer
- Working with general practice
- Working with children's services
- Integrated 2 year review
- Transition from health visiting to school nursing
- Perinatal mental health

The information gained during the health visiting partnership group has been used to form much of both the information on the service and helped to inform the recommendations.

Appendix 2: Current Health Visitor Bases and Clinic Locations

Hammersmith and Fulham

Team Base	Description
Parkview Centre for Health and Wellbeing, W12 7FG	Health centre, GPs also based here.
Richford Gate Medical Practice, W6 7HY	GPs and other healthcare professionals
Park Medical Centre, W6 0QG	Health Centre
Norman Croft Community School, W14 9PA	School (Fulham children centre run sessions here as well)
Parson's Green Health Centre, SW6 4UL	Walk in centre (GPs soon to be based here)

Setting	Clinic	Team Cluster	Frequency
Health Centre	Parkview Centre for Health and Wellbeing, W12 7FG	1	2 per week
GP Practice	Richford Gate Medical Practice, W6 7HY	1	1 per week
GP Practice	Park Medical Centre, W6 0QG	2	1 per week
GP Practice	Hammersmith Surgery, W6 9DU	2	1 per week
GP Practice	Ashchurch Surgery, W12 9BP	2	1 per week
GP Practice	Brook Green Medical Centre, W6 7EG	3	1 per weekly
GP Practice	Sterndale Surgery, W14 0HX	3	1 clinic fortnightly
GP Practice	Brook Green Surgery, W6 7BL	3	1 clinic fortnightly
GP Practice	The Bush Doctors, W12 8PP	3	1 per week
GP Practice	North End Medical Centre, W14 9PR	4	1 per week
GP Practice	The Lillie Road Surgery, SW6 1TN	4	1 per week
Nursery	James Lee Nursey, W14 9BH	4	1 per week (term time only)
Children's Centre and Nursery	Bayonne Nursery and Rouzanna Children's Centre, W6 8PF	4	1 per week
School	Norman Croft Community School, W14 9PA	4	1 clinic and 1 breastfeeding clinic per week
Health Centre	Parson's Green Health Centre, SW6 4UL	5 and 6	5 clinics per week and 1 BCG clinic fortnightly
GP Practice	The Surgery, SW6 5BQ	5	1 per week
Children's Centre	Melcombe Children's Centre, W6 9ER	5	1 per week
Children's Centre	Fulham Central Children's Centre, , SW6 5PG	5	1 per week (term time only)
Children's Centre	Ray's Playhouse, SW6 2PR	6	1 per week

Kensington and Chelsea

Base	Borough Region	Description
Colville Health Centre, W11 1PA	North	Health Centre, including GP practice
Emperor's Gate Centre for Health. SW7 4HJ	South	Health Centre, including GP practice
Abingdon Health Centre, W8 6EG	South	Health Centre, including GP practice
St Charles Family Centre, W10 6DZ	North	Health Centre, including GP practice and walk-in centre
Violet Melchett Health Clinic SW3 5RR	South	Children's Centre and Health Centre, GPs also based here
Worlds End Health Centre, SW10 0UD	South	Health Centre, including GP Practice

Setting	Clinic	Team Cluster	Frequency
Health Centre	Colville Health Centre, W11 1PA	Colville HV Team-North	2 clinics per week (3 more Health Review clinics starting in May) and BCG Clinic-Tuesday mornings fortnightly
GP Practice	Pembridge Villas Surgery, W11 3EP	Colville HV Team-North	1 per week
Children Centre	Clare Gardens Children Centre, W11 1EG	Colville HV Team-North	1 per week
GP Practice	Portland Road Practice, W11 4LA	Colville HV Team	1 per week
GP Practice	Westbourne Green Surgery, W2 5ES	Colville HV Team- North	1 per week
Health Centre	Worlds End Health Centre, SW10 0UD	WE HV Team-South	2 per week
GP Practice	Knightsbridge Medical Centre, 71-75 Pavilion Rd, SW1X 0ET	VM HV Team-South	1 per week
Children Centre	Violet Melchett-Flood Walk, SW3 5RR	VM HV Team-South	3 per week
Children Centre	St Quinton's Children Centre, W10 6PN	St Charles HV Team- North	1 per week
Children Centre	Holmfield House Children Centre, W10 5PE	St Charles HV Team- North	1 per week
GP Practice	St Charles Family Centre, Dr Raman, W10 6DZ	St Charles HV Team- North	1 per week
GP Practice	St Charles Family Centre, Dr Tahir, W10 6DZ	St Charles HV Team- North	1 per week
GP Practice	Dr Ramasamy-Golborne Medical Centre, W10 5 PG	St Charles HV Team- North	1 per week
Children Centre	St Cuthbert's Children Centre, SW5 9NE	Abingdon/Emperor' Gate HV Team- South	1 per week
Health Centre	Abingdon Health Centre, W8 6EG	Abingdon/Emperor' Gate HV Team- South	1 per week
GP Practice	Emperor's Gate, SW7 4HU	Abingdon/Empower' Gate HV Team-South	1 per week
GP Practice	Holland Park Surgery, W11 3SL	Abingdon/Emperor' Gate HV Team-South	1 per week

Westminster

Base	Borough Region	Description
Woodfield Road Medical Centre, NW8 8EG	North West	GP Practice
Queen's Park Health Centre, W10 4LD	North West	Health Centre, including GP practice
Lisson Grove Health Centre, NW8 8EG	North East	Health Centre, including GP practice
Soho Square Centre for Health, W1D 3QS	North East	Health Centre, including GP practice
Bessborough Centre, SW1V 2JD	South	Children's Centre/Health Centre

Setting	Clinic	Team Cluster	Frequency
GP Practice	Dr Cobb, W2 1ND	Lisson Grove HV Team-North East	1 per week
Health Centre	Dr Purcell and Partners, W2 1LQ	Lisson Grove HV Team-North East	1 per week
Children Centre	Portman Children Centre, NW8 8DE	Lisson Grove HV Team-North East	1 per week
Medical Centre	Woodfield Road, Dr Ahmed, W2 1ND	Lisson Grove HV Team-North East	1 per month
Health Centre	Lisson Grove Health, NW8 8EG	Lisson Grove HV Team-North East	Health Review Clinics per week and BCG Clinic once every fortnight
GP Practice	Lanark Medical Centre, W9 1NZ	Brampton House HV Team-North East	1 per month
GP Practice	Lanark Medical Centre, W9 1NZ	Brampton House HV Team-North East	1 per week
GP Practice	Randolph Surgery, W9 1NH	Brampton House HV Team-North East	1 per month
Medical Centre	Brampton House Medical Centre, Dr Charkin, NW8 9NH	Brampton House HV Team-North East	1 per week- Baby Clinic; Health Review Clinics- 4 per week
GP Practice	Paddington Green Surgery-Dr Purcell and Partners, W2 1LQ	Lisson Grove HV Team-North East	1 per week-Baby Clinic; Health Review Clinics- 2 per week
Children Centre	Maida Vale Children Centre, NW6 5SN	Lisson Grove HV Team-North East	2 Health Review Clinics per month
Medical Centre	Newton Medical Centre,W2 5LT	Medical Centre HV Team-North West	1 per week (only those registered with GP)
Medical Centre	Woodfield Road Medical Centre, W9 3XZ	Medical Centre HV Team-North West	1 per week (only those registered with GP)
Medical Centre	Garway Medical Centre, W2 6HF	Medical Centre HV Team-North West	Every 2 weeks (only those registered with GP)
Medical Centre	Lancaster Gate, W2 3ET	Medical Centre HV Team-North West	Every 2 weeks (Only those registered with GP)
Medical Centre	Bayswater Medical Centre, W2 3QA	Medical Centre HV Team-North West	Every 2 weeks (Only those registered with GP)
Children Centre	Westbourne Children Centre, W2 5TL	Medical Centre HV Team-North West	1 per week
Health Centre	Grand Union Health Centre, W2 5 EH	Medical Centre HV Team-North West	1 per week (Only those registered with GP)
Medical Centre	Woodfield Road Medical Centre, W9 3XZ	Medical Centre HV Team-North West	3 Health Review Clinics per week
Children's	Hallfield Children Centre (Queensway	Medical Centre HV Team-	2 Health Review Clinics

Centre	Children Centre) W2 6JJ	North West	per week
GP Practice	Dr Shakarchi, SW1W 8NA	Bessborough HV Team-South	Every 2 weeks
GP Practice	Pimlico Health at the Marven, SW1V 3EB	Bessborough HV Team-South	1 per week
GP Practice	Millbank Medical Centre, SW1P 4EN	Bessborough HV Team-South	1 per week
GP Practice	Belgravia Surgery, SW1W 9PY	Bessborough HV Team-South	Every 2 weeks
GP Practice	Victoria Medical Centre, SW1V 1SN	Bessborough HV Team-South	1 per week
GP Practice	Dr Victoria Muir, SW1W 8NA	Bessborough HV Team-South	1 per week
GP Practice	Imperial College Health Centre, SW7 1LY	Bessborough HV Team-South	Every 2 weeks
Health Centre	Bessborough Health Centre, SW1V 2JD	Bessborough HV Team-South	8 Health Review Clinics per week
Health Centre	Queens Park Health Centre, W10 4LD	Queens Park HV Team-North West	1 Baby Clinic per week, 1 Health Review Clinic
Children Centre	Queens Park Children Centre, W9 3AL	Queens Park HV Team- 1 North West	1 Baby Clinic per week, 2 Health Review Clinics
Health Centre	Lee Place Medical Centre, W1K 6LN	Soho HV Team- South	1 per month
Health Centre	Cavendish Health Centre, W1G 9TQ	Soho HV Team- South	1 per week
Health Centre	Soho Health Centre, W1D 3HZ	Soho HV Team- South	1 per week
Health Centre	Marylebone Health Centre, NW1 5LT	Soho HV Team- South	1 per week
Children Centre	Micky Star Children Centre, W2 1QR	Soho HV Team- South	1 per week
Health Centre	Fitzrovia Medical Centre, W1 6EU	Soho HV Team- South	2 per month

Appendix 3: Health Visitor Workforce calculation by 0-5 years population and deprivation

Cowley et al suggested that health visitors in the most deprived 10% of PCTs should have caseloads of 1-100, those between the 70-90th percentile should have 101-150, those between the 40-70th percentile should have 151-300 and the least deprived 30% of PCT's should have a caseload of 301-400.²¹

Assuming that each health visitor has the maximum caseload advocated above, the following calculation estimates the number of health visitors needed to fulfil this recommendation using the index of multiple deprivation (IMD) decile and populations of 0-4s by lower super-output area (LSOA).

IMD (where 1 is the most deprived)	Recommended maximum caseload (children per health visitor)	Hammersmith and Fulham		Kensington and Chelsea		Westminster	
		Number of Children, 0-4 years	Number of HVs needed (WTE)	Number of Children, 0-4 years	Number of HVs needed (WTE)	Number of Children, 0-4 years	Number of HVs needed (WTE)
1	100	1,071	10.71	1,010	10.10	2,678	26.78
2-3	150	3,354	22.36	1,995	13.30	4,373	29.15
4-7	300	6,256	20.85	4,717	15.72	6,146	20.49
8-10	400	1,126	2.82	1,247	3.12	592	1.48
Total		11,807	56.73	8,969	42.24	13,789	77.9

Sources: Department for Communities and Local Government, English Indices of Deprivation 2015 for London, and ONS LSOA mid-year estimate 2014. There have been used to calculate numbers of health visitors required according to Cowley et al's suggested caseload sizes.²¹

This can be compared to the figures which were calculated in 2011 in the 'Health Visitor Implementation Plan for Inner Northwest London PCTs', included in the table below.

	Hammersmith and Fulham	Kensington and Chelsea	Westminster
Estimated Health Visiting workforce needed (WTE) using the NHS London Model	58.0	45.1	59.1
Estimated Health Visiting workforce needed (WTE) using the CLCH Workforce Calculator	44.9	33.9	49.3

Source: Health Visitor Implementation Plan for Inner Northwest London PCTs, 2011-2015

Appendix 4: Attendees of the Focus Groups

The focus groups were held in different settings across the 3 boroughs:

1. Maternity and Community Champions, Stowe Centre, North Westminster, 14.3.2016

Who attended: 8 mothers

2. Stay and Play session at Melcombe Children’s Centre, Hammersmith and Fulham, 27.4.16.

Who contributed: 5 mothers and 1 father

3. Mum’s Forum at the St Cuthbert’s with St Matthias Children’s Centre, Royal Borough of Kensington and Chelsea, 17.5.2016

Who attended: 2 mothers

Attendees

In total 16 parents contributed to the focus groups, of whom 15 were mothers and 1 was a father. The age range of children were 0-24, although all attendees had a child of 4 years or under. Of the 16 attendees, 8 had a English as a first language which is English, and the remaining 8 had a first language which was not English.

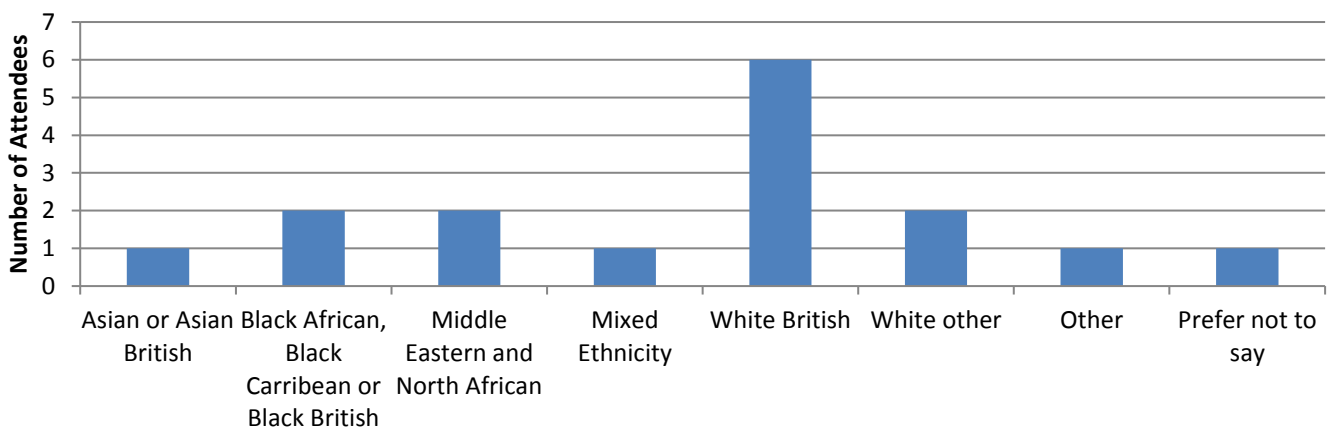


Figure: Graph to show the ethnicity of attendees of the focus groups.