Why Health Visiting?
What are the benefits for public health from a universal service?

Sarah Cowley
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Two key themes

• Why a proportionate universal service? Focus on Foundation Years

• Why Health Visiting – or Maternal, Child & Family Health Nursing?
Inequalities in early childhood: proportionate universalism

- “Giving every child the best start in life is crucial to reducing health inequalities across the life course.

- “(We need) to increase the proportion of overall expenditure allocated (to early years, and it) should be focused proportionately across the social gradient to ensure effective support to parents, starting in pregnancy and continuing through the transition of the child into primary school.”

Marmot (2010 p 23) Fair Society, Healthy Lives
Focus on the Foundation Years

- Strong, expanding evidence showing the period from pregnancy to two years old sets the scene for later mental and physical health, social and economic well-being
- Direct links to cognitive functioning, obesity, heart disease, mental health, health inequalities and more
- Social gradient demonstrates need for universal service, delivered proportionately

- Foundations of health:\n  – Stable, responsive relationships
  – Safe, supportive environments
  – Appropriate nutrition

1 www.developingchild.harvard.edu
Both... and.. not.. either.. or.. 

- Universal *and* targeting
  - Need for targeted services delivered from within universal provision delivered to all
- Population assessment (service commissioner) *and* family/individual assessment (practitioner)
  - Different intensities and types of provision according to individual need
- Generalist health visiting (Child and Family Health Nursing) *and* embedded specific, evidence based interventions
- Take into account social gradient *and* prevention paradox
Social gradient

- Differences in health and well-being are graded throughout society.
- Health inequalities are particularly significant between the top (best-off) and the bottom (worst-off) of the gradient,
- ... but they run through the whole population, so each socioeconomic step, up or down and from the highest to the lowest, affects the child’s life chances.
Australian Early Development Indicators

• “a national measure of how well we are supporting our children’s development.”
• Data from 97.5% of all Australian children in their first year at school
• Five domains measured
  1. Physical health and well-being
  2. Social competence
  3. Emotional maturity
  4. Language and cognitive skills (schools based)
  5. Communication skills, general knowledge

www.aedi.org.au
Physical health and well-being

- Physical readiness for school day
- Physical dependence
- Gross and fine motor skills

Scores range 0-10
- <10th centile = developmentally vulnerable
- 10-25th centile = developmentally at risk
- >25th centile = developmentally on track

- Mapped by quintile: Australian Bureau of Statistics (ABS) Indexes for Relative Socio-Economic Disadvantage (IRSD)
Physical health and wellbeing

Base=247,232 5year-old children
Social competence

- Overall social competence
- Responsibility and respect
- Approaches to learning
- Readiness to explore new things

Scores range 0-10

<10th centile = developmentally vulnerable
10-25th centile = developmental at risk
>25th centile = developmentally on track

- Mapped by quintile: Australian Bureau of Statistics (ABS) Indexes for Relative Socio-Economic Disadvantage (IRSD)
Social competence

Base=247,189 5-year-old children
Emotional maturity

- Pro-social and helping behaviour
- Anxious and fearful behaviour
- Aggressive behaviour
- Hyperactivity and inattention

Scores range 0-10

<10th centile = developmentally vulnerable
10-25th centile = developmental at risk
>25th centile = developmentally on track

- Mapped by quintile: Australian Bureau of Statistics (ABS) Indexes for Relative Socio-Economic Disadvantage (IRSD)
Emotional maturity

Base=246,197 5-year-old children
Language and cognitive skills (school based)

- Basic literacy
- Interest in literacy/numeracy and memory
- Advanced literacy
- Basic numeracy

Scores range 0-10

- <10th centile = developmentally vulnerable
- 10-25th centile = developmental at risk
- >25th centile = developmentally on track

- Mapped by quintile: Australian Bureau of Statistics (ABS) Indexes for Relative Socio-Economic Disadvantage (IRSD)
Language and cognitive skills (school based)

Base=246,810 5 year-old children
Communication skills and general knowledge

- Single score based on teachers observations of broad developmental competencies and skills measured in the school context
- Children from language backgrounds other than English may be proficient in their home language

Scores range 0-10
- <10th centile = developmentally vulnerable
- 10-25th centile = developmental at risk
- >25th centile = developmentally on track

- Mapped by quintile: Australian Bureau of Statistics (ABS) Indexes for Relative Socio-Economic Disadvantage (IRSD)
Communication skills, general knowledge

Base=247,212 5 year-old children
Overall results: vulnerable on one or more AEDI domains: % children

Base=246,421 children (one domain) 246,873 (two domains)
Where Australian children live - 97.5% of all 5 year olds included in census

Base = 246,421 5 year old children
Number of children whose development is at risk (one domain) or vulnerable (two domains) in each quintile

Data pooled across 246,421 children (one domain) 246,873 (two domains)
Number of children affected by family disadvantage indicators in each centile

65% of Children - 864,465

35% of Children - 475,164
‘Prevention paradox’

- “A large number of people at small risk may give rise to more cases of disease than a small number of people at high risk”
- High risk groups make up a relatively small proportion of the population
- Need to shift the curve of the gradient and distribution of need across the whole population to reduce overall prevalence
- A universal service, delivered proportionately according to need, can achieve this


Source: Information Centre for Health and Social Care

Unconfirmed data – management figures
The National Health Visitor Plan:
progress to date and implementation 2013 onwards

Growing the workforce
Professional mobilisation
Service transformation
Bronfenbrenner’s (1986) concept of nested systems

Shifting focus of attention to need

Situation, resources to meet need

Simultaneous assessment, prevention, intervention
Health visiting practice

• Focus on situation and resources needed for prevention and promotion
• Community and caregiver capacity
• Foundations of health

Stable, responsive relationships
Safe, supportive environments
Appropriate nutrition

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Plan to Transform Health Visiting Services 2011

Achieving better health for children, families and communities: the health visiting contribution

Improving public health
(*Best health outcomes)

Developing community resources
(*Community capacity/Big society)

Maximising family resources
(*Supporting families)

Bridging family and services and primary health care services
(*General practice focus for health)

Accessing Specialist Services

Health Visitors
(*empowered professionals with more autonomy)

Health Visitors: skilled to improve health outcomes by:

- Providing family health services – more contacts and extended range care packages
- Champion of wider health and wellbeing, prevention and public health, building family and community capacity
- Utilising resource – leading teams delegating and referring
The Service Vision

Community and Public Health

Local people and community groups

All families
Universal HCP Service offer (with increased contacts)

Some families – some of the time
Specific additional care packages

Some families all of the time
Ongoing additional support

A few families
Intensive multi agency care package

Individual Health

Building and using community capacity to improve health outcomes

Leading and delivering healthy child programme
Lead Health Visitor and Health Visitor in Sure Start Health Teams

Vulnerable children and families

Safeguarding protecting children
4-5-6 model to explain transformed health visiting service

**“Transformed” Health Visiting Services**

**4 Level service model**
- Your Community
- Universal
- Universal Plus
- Universal Partnership Plus

**5 Mandated Elements**
- Antenatal health promoting visits
- New baby review
- 6-8 week assessment
- 1 year assessment
- 2 to 2 ½ year review

**6 High Impact Areas**
- Transition to parenthood and the early weeks
- Maternal (perinatal) mental health
- Breastfeeding
- Healthy weight, (healthy diet and being active)
- Managing minor illnesses & reducing accidents
- Health, wellbeing & development at 2 years & support to be ‘ready for school’

**Improved access**
**Improved experience**
**Improved outcomes**
**Reduced health inequalities**
This work was commissioned and supported by the Department of Health in England as part of the work of the Policy Research Programme. The views expressed are those of the authors and not necessarily those of the Department of Health.
‘Why Health Visiting?’ review of the literature

Overarching question

• What are the key components of health visitor interventions and relationships between the current health visiting service, its processes and outcomes for children and families?

Method

• A scoping study and narrative review of the research about health visiting practice to distil information from diverse forms of evidence: 348 papers reviewed in full, after screening title & abstracts of 3000+ papers
Orientation to practice to enable positive ‘service journey’

Older and more recent research papers were consistent in the way practice was described as:

- Salutogenic (health-creating),
- Demonstrating a positive person-centred approach (human valuing),
- Recognising the person-in-situation (human ecology)
Service delivered through a single, purposeful process

This orientation underpinned delivery of the service through three core practices:

• health visitor-parent relationships,
• health visitor home visiting and
• health visitor needs assessment.

• *Empirical study showed that parents also value health visiting outside the home*
  
  *(Donetto and Maben 2014)*
Salutogenic (health creation)  
Person-centred  
Person-in-context
For families - universality should mean:

- **Universal ‘offer’ of:**
  - Five mandated contacts: everyone gets this
  - Healthy Child Programme (HCP)
  - Service on their own terms

- **‘Service journey’**
  - Meet/get to know health visitor: trust relationship, partnership working – ‘relational autonomy’
  - Services *delivered to all* – i.e., home visits (HCP)
  - Health visiting outside home – well baby clinics, groups etc, in conjunction with others (e.g. Children’s Centres)

- **‘Open secret’ of safeguarding/child protection**

‘Universal Plus:’ simultaneous prevention and treatment

• Across six high priority areas and more, e.g.
  - Specially trained health visitors can simultaneously prevent Brugha et al 2010, detect and treat post-natal depression through ‘listening visits’ Morrell et al 2009
  - Identify who needs parenting support; refer to and deliver successful parenting programmes Whittaker and Cornthwaite 2000, Stewart-Brown et al 2004
Mental health

• Post-natal depression (PND)
  • Early identification and treatment with listening visits
    Morrell et al 2009
  • Prevention of PND Brugha et al 2010


• Improved mother/infant interaction Davis et al 2005, Barlow et al 2007

• Special needs: Reduced children’s ADHD symptoms and improved maternal well-being, by HV working in specialist team Sonuga-Barke et al 2001
Universal Partnership Plus: Maternal Early Childhood Sustained Home Visiting (MECSH)

- Designed to capitalise on what is known about successful programmes
- Sufficient intensity and duration: home visits + groups
- Strengths based practice using ‘family partnership model’ - FPM (Davis et al 2002)
- Two generational (parent and child) and multi-faceted/community based
- Highly skilled professionals
- And to add in:
  - Support and develop existing, generic service
  - ‘Shift the curve’ by targeting ‘worst-off’ 20% or more

Health visitor research programme

- Literature - evidence of benefits, if sufficient staff, skills, knowledge
- Health Visitors’ desire to *make a difference* for children and families
- Parents’ desire to be ‘known’, listened to and ease of access

Shared desire for:
- Others to value their knowledge and contribution
- Respectful, enabling relationships
- Flexible service (varied intensity + type, e.g. home visits and centre-based) to match need
What is needed?

Organisational support
• Conflicting demands (relationship vs. public health)
• Population needs (e.g., Key Performance Indicators, targets) vs. individual/family needs

Sufficient time
• Staffing levels
• Equipment for job

Sufficient skills
• Education:
  — Qualification/pre-registration programme – needs longer
  — Continuous professional development
Health and Inequalities: universal focus on the Foundation Years

- Known importance of
- Caregiver and Community Capacities
- Foundations of Health
- Biology of Health

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Emerging understandings:
- what is necessary (required) for child development
- what is foundational: ie, other elements will not work without it
- how to measure foundations and requirements (assets/capacity)
- which outcomes are appropriate and helpful to measure
- connections that exist between problem-based (prevention) and capacity-building (promotion) approaches
- how to delineate attribution
Thank you!
sarah.cowley@kcl.ac.uk
‘Why Health Visiting’ References

Reports on NNRU website: http://www.kcl.ac.uk/nursing/research/nnru/publications/index.aspx


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Published papers


Donetto S & Maben J (2014) ‘These places are like a godsend’: a qualitative analysis of parents’ experiences of health visiting outside the home and of children’s centre services Health Expectations (online/earlyview) doi: 10.1111/hex.12226


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