

**Health Visiting
in England:
A Vision for
the Future**

**Health visiting -
Good practice case studies**

**First Edition
January 2020**



Foreword

“The World Health Organization (WHO) has designated 2020 as the International Year of the Nurse and Midwife, in honour of Florence Nightingale, a pioneer for public health and founder of modern nursing. The year-long celebration will provide numerous opportunities to shine a light on the vital contribution that health visitors, as part of this workforce, play in improving outcomes for children and their families.

Giving every child the best start in life remains a key government priority and we are delighted that this year will also see the refresh of the health visiting 4-5-6 model and the Healthy Child Programme. This much needed refresh will strengthen this vital area of government policy. Public Health England has reiterated that “health visitors are key in the delivery of essential early intervention preventative work” and reducing inequalities.

To support this work, the Institute of Health Visiting is delighted to publish this first edition of “Good Practice Case Studies”. The case studies in this resource are just a small representation of the great work that health visitors are doing throughout the country – they showcase high quality care in a number of different settings, demonstrating the “art of the possible”. The document is intended to help spread good practice by sharing experiences of those who are leading the way, often in difficult circumstances.

I would like to thank everyone who has shared their expertise so generously – you should be rightfully proud of your work. The authors of these case studies have shared their successes, as well as failures, to improve care as part of a learning culture. They provide some context and background to some of the challenges being faced by the health visiting profession, as well as the solutions that they have developed to drive quality improvement and ensure better, cost-effective outcomes for children and families.

My thanks to the team for collating this resource – in particular Alison Morton, our Director of Policy and Quality, and to Lisa Jacobs, our designer.

On behalf of the Institute, I am pleased to present this work to support local areas to achieve best possible outcomes”.

**Pamela Goldberg OBE, Chair
Institute of Health Visiting**



Document prepared by Alison Morton, Director of Policy and Quality, Institute of Health Visiting.
Design by Lisa Jacobs, Membership and Publications Coordinator, Institute of Health Visiting.
January 2020.

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Introduction

This supporting document to “Health Visiting in England: a Vision for the Future” contains a collection of peer-reviewed case studies. The case studies demonstrate positive examples of health visiting teams delivering high quality care in a number of different settings across the country. The document is intended to help spread good practice by sharing experiences of local quality improvement initiatives to support wider application of learning. The following case studies were provided by health visiting teams in England following a national call for best practice case study examples in autumn 2019.

The authors of these case studies have generously shared their experiences of leading change in practice, sharing their successes as well as failures to improve care as part of a learning culture. They provide some context and background to some of the challenges being faced by the health visiting profession, as well as the solutions that they have developed to drive quality improvement and ensure better, cost-effective outcomes for children and families.

Background

Every child deserves the best start in life and health visitors play a crucial role in achieving this ambition. On 10 October 2019, the Institute of Health Visiting published “[Health Visiting in England: a Vision for the Future](#)”. Our “Vision” sets out the breadth of the health visitor’s role in providing an important part of the solution to numerous key government priorities for children, which are aligned primarily to 15 High Impact Areas for the early years.

Health visitors lead the delivery of the Healthy Child Programme and work in collaboration with others in the health and social care system to improve outcomes for children and their families and reduce inequalities. Health visitors are Specialist Community Public Health Nurses with a preventative “upstream” approach that focuses on “health creating” (salutogenic) practice which builds on health assets.

The health visiting service is unique in its reach into all families and does not discriminate - it is offered universally to all families with a level of support personalised and proportionate to the level of need. Health visitors are a highly skilled workforce who are equipped to work in partnership with parents and communities to identify and support the physical, emotional and social needs of both children and their parents.

Health visiting practice has been criticised in recent years for working in isolation which has largely been driven by the lack of opportunities for sharing learning and meeting collectively. As a result, we run the risk of “reinventing the wheel” or reintroducing strategies that have been found not to work elsewhere. It is therefore important that a learning culture is fostered which enables health visitors to learn from each other to support excellence in practice.

Building on the past - looking to the future

The health visiting profession and the wider field of children’s public health currently face both considerable challenges as well enormous opportunities as set out below:

Challenges

-  Widening inequalities and poor state of child health and wellbeing
-  Unidentified need – “invisible children”
-  Public health grant cuts
-  Workforce challenges – training, recruitment, retention
-  Unwarranted variation in quality of health visiting services
-  Role drift from preventative public health
-  Perverse system incentives to “tick the box, but miss the point”
-  The cost of failing to intervene early is enormous

England 2019 - Inequalities are not inevitable but:

2.3 million children are living with risk because of a vulnerable family background

More than 1/3 are “invisible” (i.e. not known to services)

Highest rate of homicide for any age group is in babies under the age of 1

Estimated total long-term costs for perinatal mental illness is £8.1bn for each one-year cohort of births

Opportunities

- Health visitors are a highly skilled workforce equipped to address numerous government priorities for children and families 
- Early years lay the foundation for lifelong health and wellbeing 
- Investment in early childhood is a smart investment – the greater the investment, the greater the return 
- Inequalities are not inevitable. Early interventions make a difference 



England
2019

- Infant mortality rates have stalled
- Obesity rates are among the worst in Europe
- Breastfeeding is amongst the lowest in the world
- A&E attendance increased by 24% in 6 years
- 50% of children start school with SLCN* in areas of deprivation
- Loss of WHO measles elimination status

* Speech, language and communication need

It is important that the most effective use of public health funds is being achieved through innovative changes to service delivery and planning, rather than making cuts to the most important elements of an effective health visiting service.


Quality improvement methods are being applied to health visiting practice across the country – the best examples include strong co-production with children and families at the heart of service transformation. Introducing new ways of working, workload redistribution (particularly non-clinical functions) and applying ‘lean’ thinking to regular processes, for example, may allow health visiting teams to continue to deliver good quality services within their current resources.

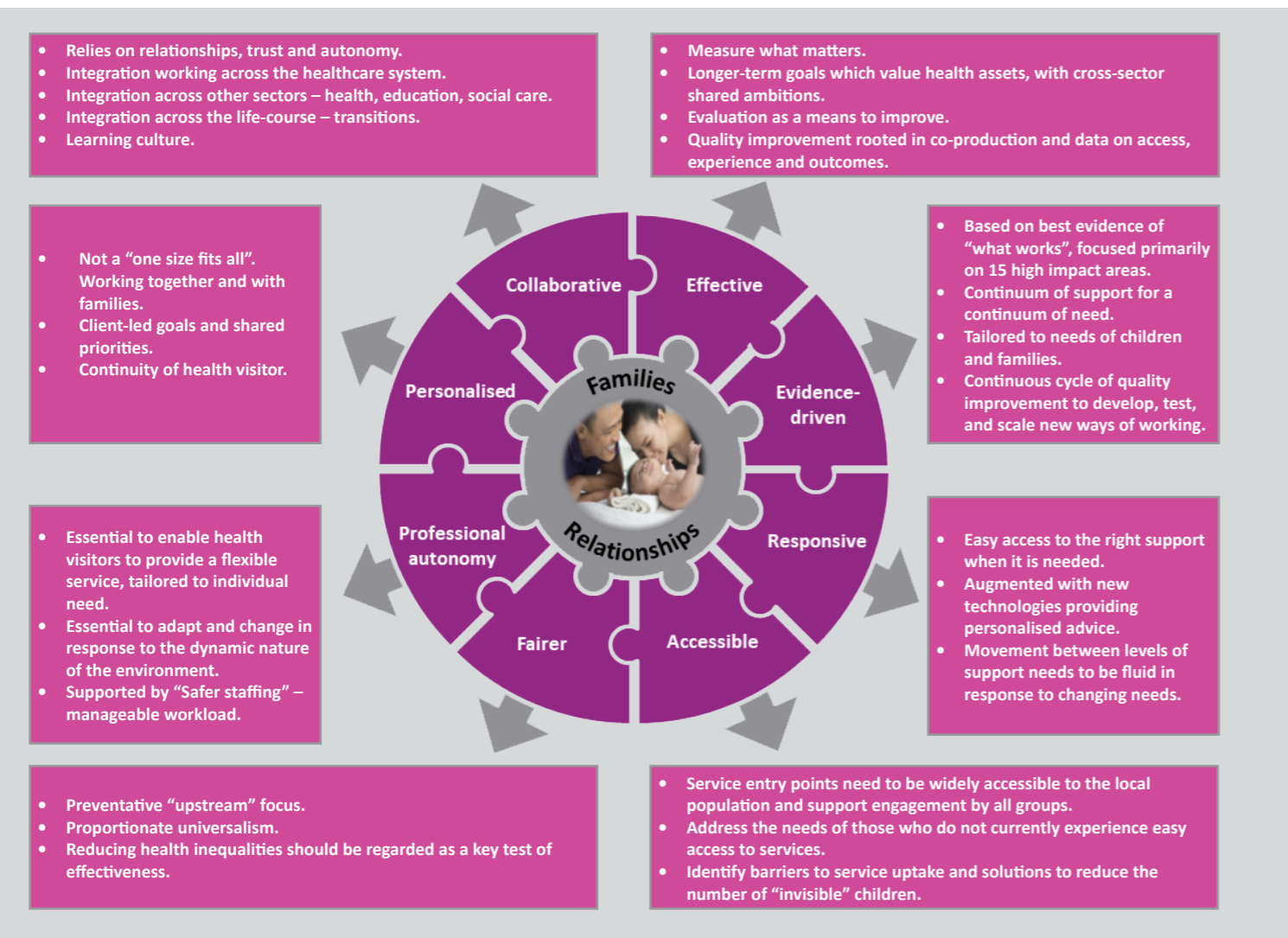
The valuable insight and experience of frontline clinicians to shape service redesign is crucial. It is them, not policy makers, who have current knowledge and experience on the ground to understand what is needed at a local level to deliver improvements for children and their families – and which of these may, as a result, maximise the value of the investment in them. However, their efforts will need to be backed by system-wide support, workforce modelling and adequate resourcing to ensure that the Healthy Child Programme, and more recent evidence on the most effective early interventions, can be delivered in full.

This document presents examples of successful initiatives that have sought to improve efficiency and outcomes in health visiting practice. Each case study focuses on one or more key elements of effective practice that are described in our “Vision” and centered on relationships and the needs of families.

What works?

A health visiting service centred on:

-  Relationships
-  The **needs** of infants, children and their families
-  **Eight key essential elements.**



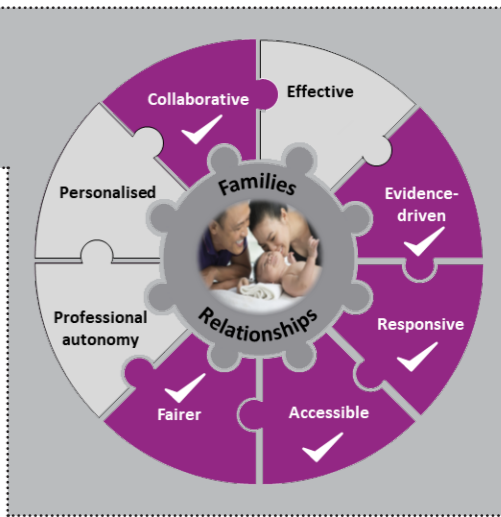
CASE STUDY 1 The development of an eight-contact universal health visiting offer

CONTACT DETAILS:		Region: North West
Name and Job Title:	Sarah Keighley, Team Leader HV/SN & Julie Carter Lindsay, Health Visitor	
Address:	Blackpool Teaching Hospitals NHS Foundation Trust	
Email Address:	sarah.keighley@nhs.net	

All case studies demonstrate that they are child- and family-centred and built on the importance of relationships as central to everything that health visitors do. In addition, this example demonstrates the following “Key elements” of the iHV “Health Visiting in England: A Vision for the Future”:

Background:

With the worst health indices in England, our aim is to improve the life chances of babies and children by delivering an increase in the use of preventative approaches in pregnancy and first three years of life. Increasing the number of home visits and reviewing content and methods, we are strengthening our therapeutic relationships with families, enabling parents to promote their child’s health and development so that they are happy and healthy, and ready to learn when they transfer to school.



Knowledge base:

With evidence of the importance of the first 1001 critical days, we recognised the benefits of early intervention on positive outcomes for children. We also drew on learning from Family Nurse Partnership (FNP) and their model of building therapeutic relationships and improved outcomes for the child and family.

The Scottish model was reviewed against the 5 mandated contacts in England and whether we could enhance our 6 contact Blackpool model within existing resource. The development of all elements of our transformed model, including the approach, content and assessments were all evidence based.

The aims:

Improved health and development outcomes, namely:

For the infant and family:

- Experience of secure early attachment
- Mental/emotional health needs of the mother/father are identified and addressed
- Optimum development (including speech, language and communication)
- Experience positive care-giving practices and have the ability to undertake personal care activities
- Becoming physically active
- Having a healthy weight
- Having good dental health
- Development of appropriate social and emotional responses

For the health visitor:

- Becoming a good communicator and listener
- Facilitate behaviour adaptation and change

Who was involved?**Collaborative:**

This has been a collaborative approach between different stakeholders: Local Authority Commissioners, Better Start and parents; led by the HV Team Leader and two specialist HVs seconded into Better Start as Development Support Officers, with support from ReNew (consultants) commissioned to guide the HV team through the process of development, implementation and first evaluation.

What did you do?

HV staff were engaged in the development of Logic Models, including short, medium and long-term outcomes, content and approach for each contact.

A training programme was developed encompassing:

- the approach and content of each contact
- the new assessments and interventions
- supervision model, including a train the trainer programme to ensure sustainability and quality for the future
- skills practice sessions

A Practice Handbook was provided to staff with the evidence base, approach, tools and assessments for each contact.

Responsive:

Early intervention with development of 4 contacts before a baby is 8-weeks old provides the ability to respond to needs of the families as they arise. An agile working model has been rolled out enabling HVs to access technology for use in client's homes to provide information as required.

Evidencing your practice has made a difference to children and families**Performance measures:**

A Quality Assessment Framework is being developed to ensure fidelity. This includes "peer to peer" accompanied visits, benchmarking against specific areas. Once evaluated this will be rolled out across the service. We aim to evaluate our new supervision model in the coming year.

Data:

Data is being collected but this is at population level and aggregated and too early for outcome data to be available.

The difference made:

We have a workforce well trained in the additional contacts with new skills and approaches in agenda matching, and use the elicit-provide-elicited framework in their approach.

Feedback:

From initial consultation to participation in our first evaluation, we have sought to engage with parents and the local community and are aware of the continued need to do this more effectively going forward.

Learning from what works**Costs and benefits:**

There has been no additional funding for our HV service, and has been undertaken with an initial reduction in contract value. Financial investment through Blackpool Better Start funded the external consultancy, resources and training.

Learning from the experience:

Staff engagement and co-production enables ownership of the model. Whilst we had excellent leadership resources, the expertise of practitioners 'on the ground' was invaluable with their vast knowledge of, and insight into, the problems and difficulties facing the families.

Canvass as many stakeholders as time allows. This gives a richer picture of the needs of the community, and other agencies, and of what they want to see as outcomes from the service, and to ensure that any changes made meet the needs of the population served.

Challenges present themselves along the way, but persevere and find ways around the obstacles. Prepare to be flexible where you can, and don't be afraid to negotiate to create 'win-win' situations.

Time for testing is immensely valuable. It provides an opportunity to identify strengths and weaknesses and make necessary adaptations before implementation. Likewise, ongoing evaluation to enable alterations to service delivery and in line with up to date evidence and NICE guidance.

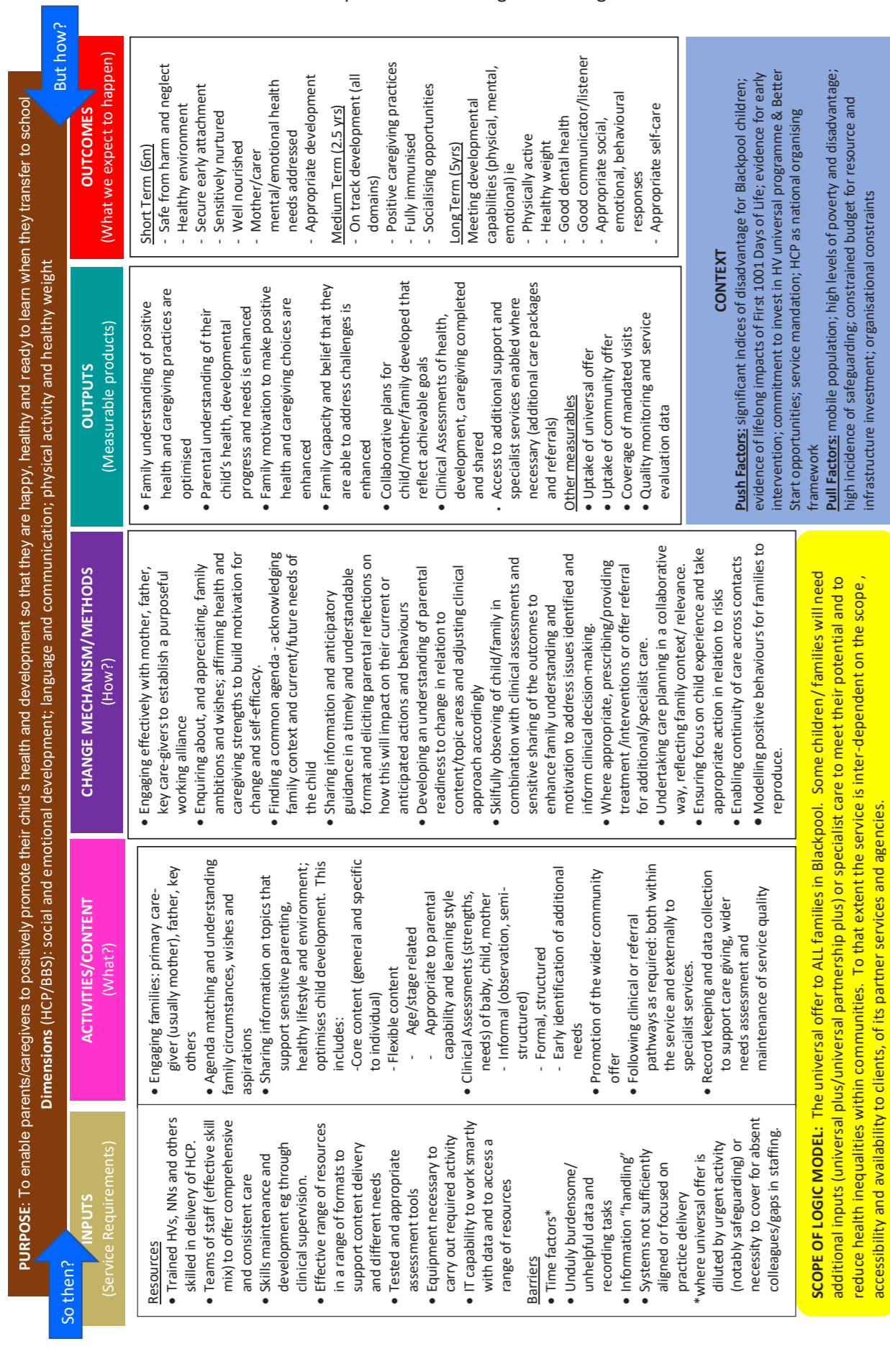
Challenges:

After so much change, training and expectations of fidelity, there is total commitment to our enhanced universal model, but there is also a levelling out of initial drive for change. This fits with any change cycle and the challenge is in moving forward to ensure quality and fidelity and so that we regain our early passion and excitement for our enhanced universal HV offer.



Engagement and co-production conferences and events were an important part of our change process

Blackpool health visiting model: Logic Model



People Centred Positive Compassion Excellence

CASE STUDY 2 Personalised health visiting interventions with client-led goal setting and outcome measures

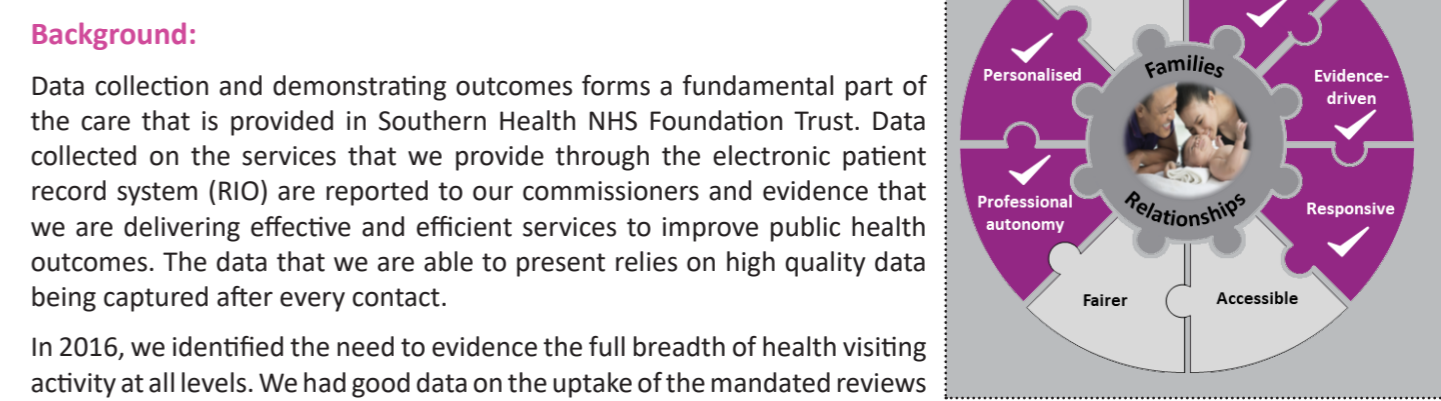
CONTACT DETAILS:

Name and Job Title:	Libby Evans, Health Visiting Professional Lead
Address:	Children & Families Business Unit, Southern Health NHS Foundation Trust
Email Address:	libby.evans@southernhealth.nhs.uk

Region: South East



This case study example demonstrates the following “Key elements” of the iHV “Health Visiting in England: A Vision for the Future”:



In 2016, we identified the need to evidence the full breadth of health visiting activity at all levels. We had good data on the uptake of the mandated reviews and were also able to identify, through electronic flagging, all activity related to children at risk (Subject to a Child Protection or Child in Need Plan). However, 59% of health visiting activity did not fit in either of these categories and was therefore “invisible” to commissioners – this was predominantly work at the universal plus level of the health visiting model.

We also wanted to develop our IT system and move away from the traditional “bean counting” data collection. We recognised a need to focus on utilising data to understand our service users and the efficacy of our services as a means to improve within a learning culture.

Knowledge base:

This programme of work was underpinned by the Family Partnership Model “Helping Process¹⁷” which provides a framework for personalised care to guide practitioners and parents through the complex process of helping. The overall purpose of the Helping Process is to enable parents to bring about lasting change that has a positive impact on child and family outcomes. However, our existing “tick box” electronic record-keeping templates did not align with this style of practice and were hampering our quality improvement initiatives.

- The aims:**
- To improve and demonstrate clinical outcomes by developing a care planning framework. Making the process as simple as possible. Integrating analysis into the clinical process of record keeping.
 - To improve service user experience and personalised care by improving how we listen to and engage with service users, their families and services, systematically learning from and acting on the feedback we receive.

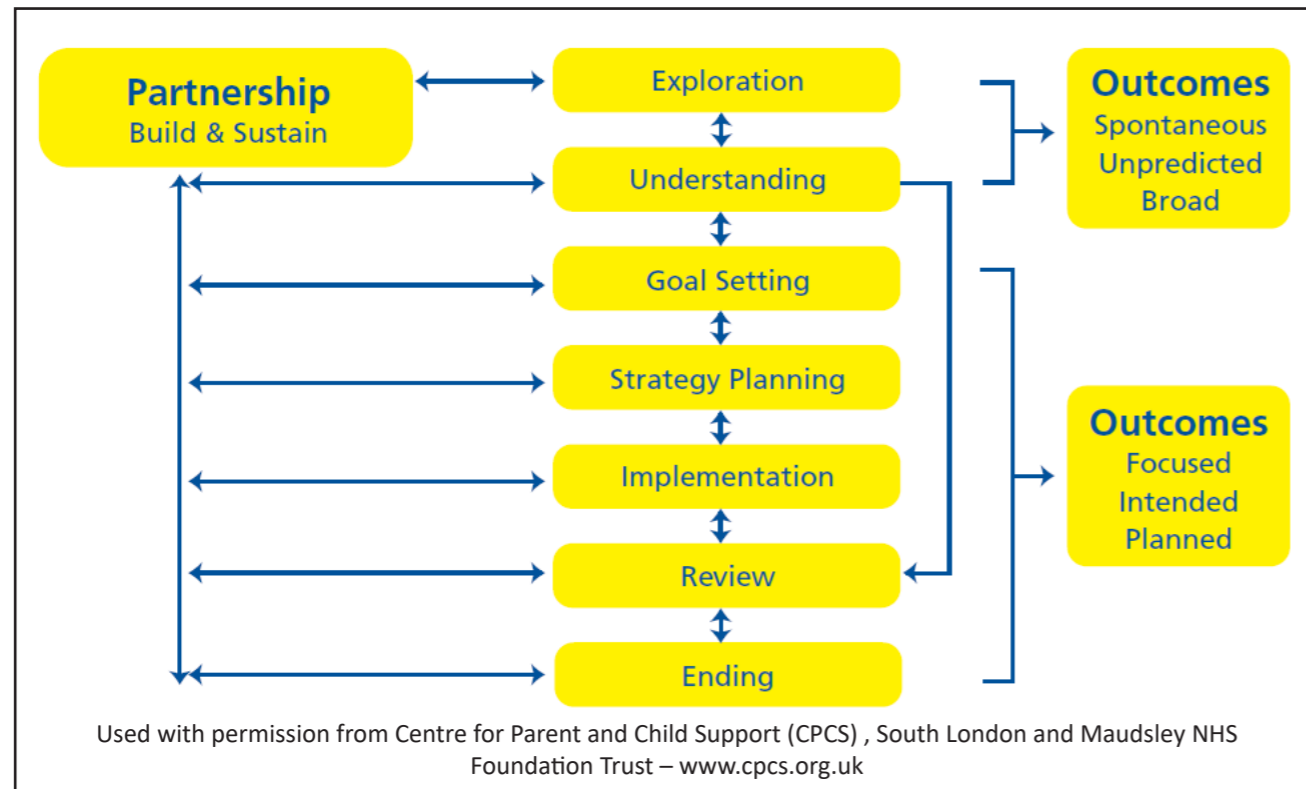
Who was involved?

In addition to the HV Leadership Team, Dr Crispin Day – Centre for Parent and Child Support - worked with us to develop a bespoke workforce training programme based on the Family Partnership Model. Mark Hayter – Deputy Head of Information, Southern Health, and his team provided IT support.

What did you do?

1. Trained all our 0-19 public health nursing workforce in the Family Partnership Model “Helping Process”

This model clarifies the complex process of helping and aims to make it as effective as possible. It consists of eight inter-related tasks, (see model below). Each of the tasks of the Helping Process remain fundamental to enabling parents to achieve the very best outcomes for their children and themselves. For example, the mutual exploration of families’ lives, their strengths and difficulties, informs and influences the way in which a shared understanding between parents and practitioners develops. Similarly, the capacity of parents and practitioners to negotiate shared goals and identify realistic strategies underpins their ability to bring about changes through well-planned implementation that result in specific, shared outcomes.



2. Introduced “client-led goal setting” as part of the universal plus health visiting intervention

- All practitioners were trained in the use of care plans
- Care plans focus the care around service user needs and goals
- Care plans are a way of communicating with our service users
- Service users will not always remember all the conversation that practitioners have had with them and it is important that they know what to expect from our service and are empowered to self-care/ self-manage
- Care plans should be developed in partnership with parents and young people
- Care plans were linked to each of the High Impact Areas and additional local priorities where health visitors can make the greatest difference
- To support embedding in practice, it was important that all supporting material reflected the philosophy of the Helping Process – we developed Personal Child Health Record inserts to support the care planning process in partnership with parents.

3. Redesigned our electronic record templates to align with the care plans

The entry of care plans by staff onto the RIO system used to be laborious and clunky. In response to staff feedback, the process for entering onto the system has changed to be much easier and quicker for staff (whilst still keeping the data rich).

4. Improved our business intelligence support

The benefit of electronic recording of care plans is that it provides oversight of the vulnerability of the caseload and health visiting workload. Care plan activity is collated using Tableau® business intelligence software which supports workload management. Data is updated every 24 hours which enables us to be responsive to actual need in real time. We are able to identify teams/ individual practitioners with a high percentage of active care plans which can be mitigated by mobilising staff to cover areas of greater need. We have also used this intelligence to inform service planning - for example, we identified areas with high numbers of maternal mental health care plans which provided a case to provide an additional perinatal mental health support group, “Knowing me Knowing you group”, in the area.

Evidencing your practice has made a difference to children and families

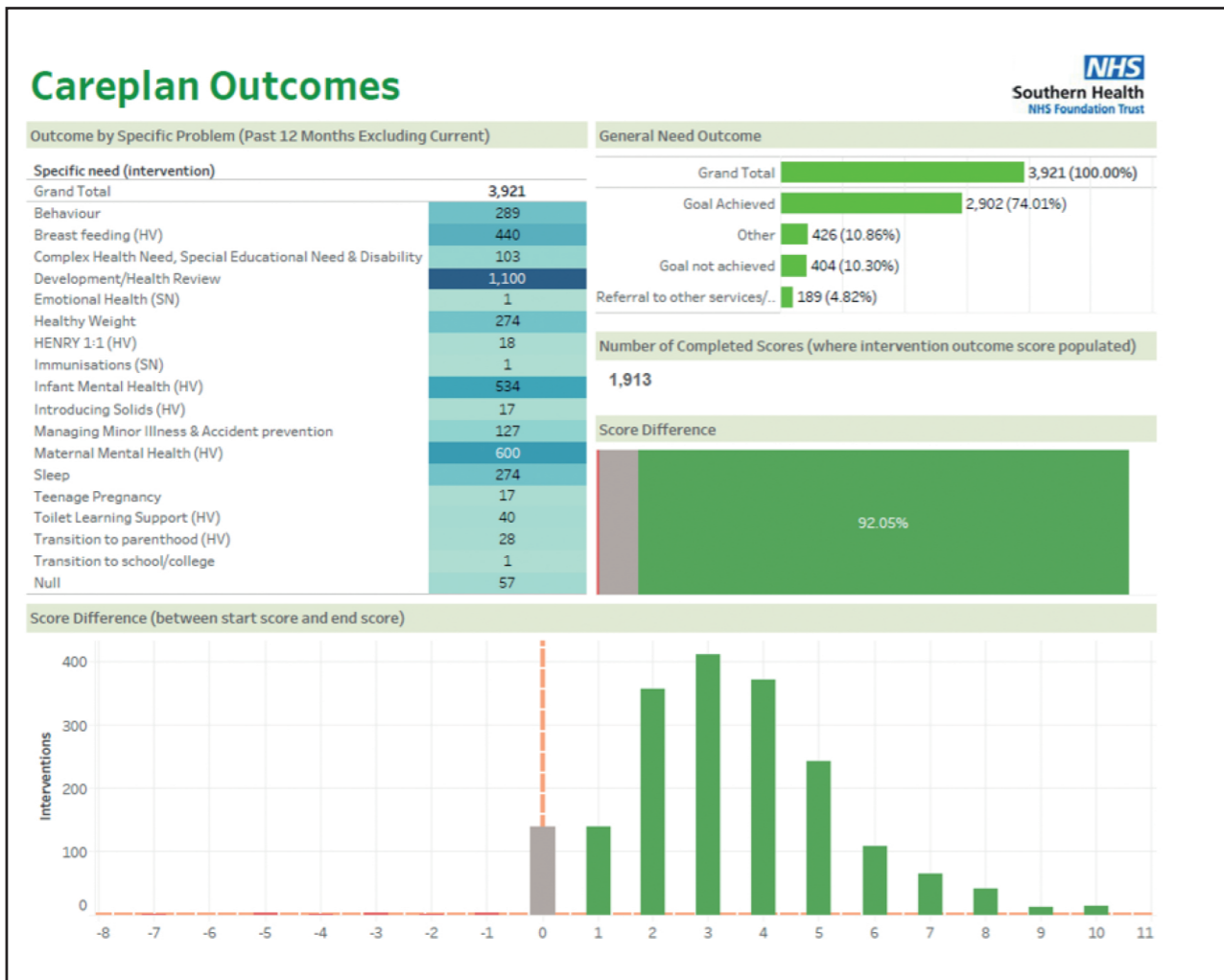
Performance measures

At the start of the health visiting intervention for an identified need, the service user is supported to identify their personal goals. A 10-point goal-rating scale is used to identify a “pre-intervention” score – i.e. “if 10 is goal achieved and 0 is as far away from your goal as possible, where would you rate yourself today?”

The health visitor then works in partnership with the family to plan a level of support that includes additional contacts. At the end of the period of intervention, the service user is asked to provide a post-intervention rating.

In May 2019, a review of 3921 care plans completed over a 12-month period for a range of public health priorities was completed. This demonstrated that:

- **92% of health visiting interventions at universal plus level had achieved a positive outcome** (care plans are routinely reviewed after 4 contacts)
- The service users’ goal had been fully achieved in 74% of cases and these families were returned to the universal caseload – the remaining cases either received ongoing support from the health visiting service to work towards their goal or were referred on to other services for more specialist support.



Feedback:

What do families think?

'The information provided to me was very beneficial. Working with the health visitors has made me more confident and gain more confidence in making decisions with regards to safeguarding children, routines, eating habits to more independent. Very helpful.'

'When I had my daughter I had postnatal depression and PTSD. If it wasn't for my health visitor this wouldn't of been picked up as soon. She was amazing and a life saver. I cannot fault it to be honest.'

'I feel listened to and taken seriously. All my queries and worries were fully resolved. I enjoyed when the health visitor came, very friendly.'

Learning from what works

Learning from the experience:

- Co-production with service users is key
- Draw on the evidence – in our case, the Family Partnership Model Helping Process to develop evidence-based practice
- Workforce training and supervision is crucial to upskill the workforce and support embedding in practice
- Take a “whole system” approach to embedding change – in our case, this included changing our IT templates and Personal Child Health Record inserts to ensure that outdated record keeping systems were not a barrier to best clinical practice.

References

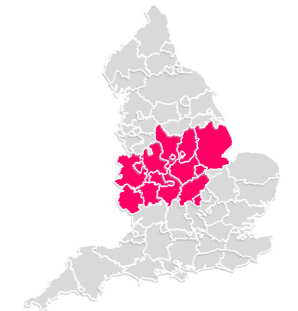
1. Day, C, Ellis M, Harris L, (2015) Family Partnership Model (FPM) Reflective Practice Handbook. Centre for Parent and Child Support - South London and Maudsley NHS Foundation Trust.

CASE STUDY 3 The use of a health visiting text messaging service to communicate with parents and carers

CONTACT DETAILS:

Name and Job Title:	Caroline Palmer, Digital Development Clinical Lead
Address:	Digital Development Team, Leicestershire Partnership NHS Trust
Email Address:	caroline.palmer@leicspart.nhs.uk

Region: Midlands



This case study example demonstrates the following “Key elements” of the iHV “Health Visiting in England: A Vision for the Future”:

Background:

Parents/carers told Leicestershire Partnership NHS Trust (LPT) that they wanted quick and easy access to their health visitor, saying they had busy working lives that made it difficult to access services. Others felt less comfortable with face-to-face access, as asking questions embarrassed them.

Knowledge base:

Research by NHS England (2017a) showed that people’s expectations of how they can access services have changed. It encouraged services to be accessible online, without diluting the importance of face-to-face care.

The NICE evidence for effectiveness framework suggests that messaging in public health can help provide timely and convenient advice to people who need it and can help improve the allocation of healthcare resources.

ChatHealth was successfully being used in school nursing for young people, providing an opportunity for it to be adopted by the whole 0-19 service, including health visitors for parents of newborns and under-fives.

The aims:

LPT decided to respond to the needs of parents/carers by using ChatHealth to offer the messaging service and provide more choice in how they accessed the health visiting service.

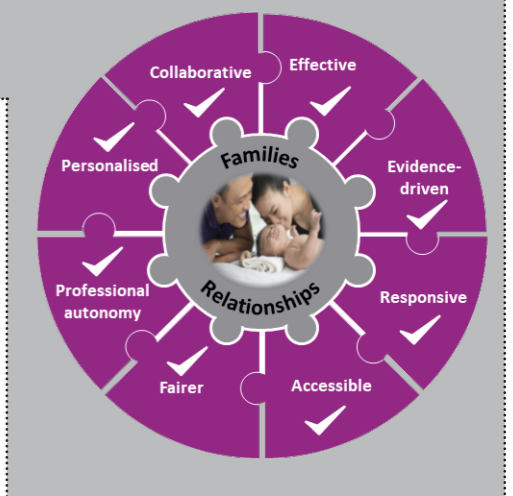
Who was involved?

Two health visitors were initially involved in the pilot of ChatHealth for parents/carers, who were supported by a school nurse already experienced in using ChatHealth.

Since then, health visitors at LPT and at other organisations nationwide have received training to confidently use ChatHealth and follow clinical procedure and information governance for both staff and service user safety.

What did you do?

ChatHealth was piloted by LPT for parents/carers in 2016/2017 before it was fully launched across the service and offered to similar services in other organisations nationwide to implement.



The service was promoted to parents/carers using business cards, stickers on the red book, posters and pens. Parents/carers could send text messages to the ChatHealth number from their mobile phones, asking questions anonymously if they wished to. The duty health visitors received alerts by either text or email when new messages arrived and responded to messages via the ChatHealth staff portal. Managing incoming messages on a duty system was found to be efficient and time-effective and only needed two health professionals to run it per day.

Evidencing your practice has made a difference to children and families

Performance measures:

The pilot's success was measured by the number of incoming enquiries, the total number of messages and the types of contacts. This continues to be a key performance measure for all services that have adopted ChatHealth.

ChatHealth's adoption rate is measured by the level of uptake by services across the country and the positive feedback gathered from both service users and staff users.

Data:

In the 2016/2017 pilot, the service was offered to the parents/carers of around 140,000 babies and children with access to support. The service received 1,448 enquiries and handled 5,124 messages.

More recently, one of our national teams became the first to receive over 1,000 messaging contacts in a single month.

Now 20% of all public health teams in England offer ChatHealth to provide a messaging service to parents/carers, making it available to support over one million children.

The difference made:

The text messaging service for parents/carers is offered alongside traditional face-to-face support. Health visitors can provide advice in a more responsive way, to a much greater number of people, with minimal impact on other areas of work.

Parents/carers report that it is a convenient way to ask simple questions that they may have forgotten at a face-to-face appointment. Dads, who in particular are less likely to engage, feel it's a more comfortable way to get advice. It can help vulnerable and isolated families stay in touch as it is easier to make contact. As messages can be sent anonymously, it can reduce embarrassment in asking advice about sensitive topics.

Feedback:

Health visitors are encouraged to request feedback after every contact by text message. When asked 97% of respondents said they were satisfied or very satisfied with the care provided.

Feedback from parents/carers:



Learning from what works

Costs and benefits:

The costs for ChatHealth are based on annually recurrent costs per user with costs diminishing with each additional licence and there is a one-off setup cost. Organisations that implement ChatHealth are supported by an NHS team, the cost of the solution delivers good financial value.

Learning from the experience:

Given the choice, parents/carers will use a text messaging service as an additional option to seek timely health advice and support from health visitors that is personalised and responsive to their needs. Similarly, given a choice, staff may willingly participate in such an improvement to service.

The implementation process has been evolved and refined by the NHS-based ChatHealth support team to ensure it is as slick, straightforward and efficient as possible. In addition, robust processes are continually assessed and updated to ensure the clinical quality and safety of ChatHealth.

Challenges:

Some health professionals have felt that using messaging is a daunting prospect as it is a new way of working and different to how they have previously delivered care. With thorough implementation, training and ongoing support, ChatHealth staff users have embraced the new way of working. Feedback given is that it is quick and easy, improves job satisfaction, is time-efficient, safe and they feel supported in using it.


CASE STUDY 4 Supporting families to “parent effectively despite the difficulties they face in their day to day lives”: MECSH model for vulnerable families in Brent

CONTACT DETAILS:	
Name and Job Title:	Marie McLoughlin, Public Health Consultant
Address:	Brent Council, Brent Civic Centre, Engineer Way, Wembley, HA9 0FJ
Email Address:	marie.mcloughlin@brent.gov.uk
For general MECSH enquires, contact: Wendy Sumpton, MECSH-UK Implementation Consultant. E-mail:- mecshukws@gmail.com	

Region: London

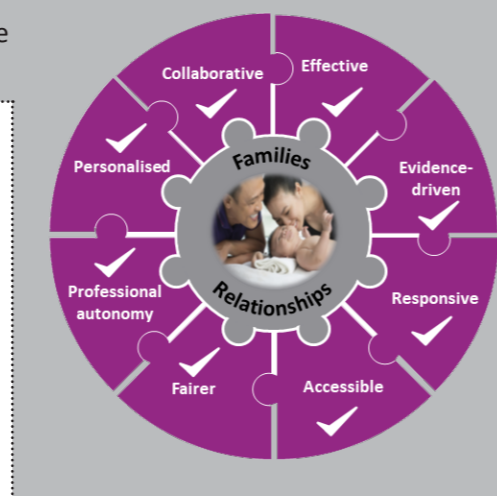


This case study example demonstrates the following “Key elements” of the iHV “Health Visiting in England: A Vision for the Future”:



MECSH[®] MISSION
Within a salutogenic (health creating) child-focused prevention model, support identified families with young children to adapt and self-manage in their parenting journey, and source the resources to parent effectively despite the difficulties and challenges they face in their day to day lives.

MECSH[®] FOCUS
Pregnant women (of any maternal age or with any number of children in the family) or parents with babies up to 6-8 weeks post discharge from hospital who meet eligibility criteria of having psychosociodemographic and/or health characteristics that place child at risk of poorer health and development; and lack the ability to adapt and self-manage.



Background:

Brent is a culturally diverse borough in North West London. The health and wellbeing of children in Brent is generally poorer than the England average. 24.8% of children (aged under 16 years) live in poverty in Brent, higher than the England average of 19.2%. There are significantly high levels of child obesity in some localities and cultural groups. Brent is committed to reducing poverty, redressing inequality and preventing exclusion. One action is implementation of the Maternal Early Childhood Sustained Home-visiting (MECSH) programme. MECSH can improve outcomes for the broad range of families dealing with adversity, serving 20-25% of the overall child population.

Knowledge base:

MECSH is an evidence-based programme of home visiting supported by group work and service integration, with effectiveness demonstrated in two randomized controlled trials^{1,2,3,4,5}.

The aims:

MECSH implementation aims to improve child and family health and development, with a particular focus on child communication development, obesity prevention, oral health, maternal mental health and wellbeing, and family violence.

Who was involved?

Brent Council commissioned a new 0-19 public health contract (health visiting and school nursing) in 2017 and this included the MECSH model. The new provider for this contract was Central London Community Healthcare NHS Trust (CLCH).

What did you do?

MECSH uses a ‘core and variation’ model, co-designed to provide an evidence-based, yet bespoke, programme. Strengths and concerns were identified locally and components to support and address them identified. The co-designed bespoke programme was then implemented by all health visitors in Brent for complex “Universal Plus” and “Universal Partnership Plus” families. Training was provided for staff in different settings such as Maternity, GPs, Social Workers, Children’s Centres and Early Years so they were aware of the new model and how to refer clients into the system.

Evidencing your practice has made a difference to children and families

Performance measures:

MECSH monitors uptake and retention, number of visits provided and families’ satisfaction with the programme. Families also report on whether MECSH helped them to care for their baby and themselves. To date, over 160 families have received the MECSH programme since it was introduced.

Data:

Over 75% of families reported they are very satisfied with the programme, and 80% reported they feel much more able to care for their child and themselves as a result of having MECSH. In 2020, outcomes including child development (as measured by ASQ-3™) and obesity (BMI) will be collated to assess population impact.

The difference made:

Families in Brent living with adversity, who are expecting or have a new baby, now receive the MECSH programme provided with continuity by their health visitor until the child is 2 years old. The health visitor works in partnership with the family, providing a structured yet flexible service to meet each individual family’s needs. The implementation of MECSH has also enhanced integration with the local Children’s Centre with a MECSH baby massage group established. Brent also established a specific MECSH parent group to support families who find participating in groups challenging. The Brent Universal Health Service and Partner agencies are also supporting the programme. Brent hosted the MECSH-UK National Conference in January 2018.

Feedback:

Families are encouraged to provide comments on feedback questionnaires, and health visitors and their clients provide case studies sharing their MECSH experiences. Families have commented on the value of the continuity of relationship: “It has been great having a consistent health visitor who knows and has observed my baby’s growth and development as well as my own improved health” and value the programme: “I wish I had this support with my first child. Great initiative.”

Learning from what works

Costs and benefits:

There is a one-off cost to buy the licence, which includes the assistance of the MECSH International Service in initial implementation, and the cost of training for staff and other partners and ongoing support. The programme is part of the Brent universal health visiting service, and only incurs minimal costs in materials to support the programme (approximately £15 per family). We expect financial benefit from the programme in reduced social care costs - 40% of families who commence the MECSH programme on a safeguarding plan have exited off the plan.

Learning from the experience:

The MECSH programme embeds quality monitoring data within the existing health visiting data system. This takes time and has the benefit of ongoing sustainability, however, getting the IT systems set up as soon as possible is helpful. MECSH also benefits from an active local implementation committee that drives the system changes needed.

Challenges:

Health visitors need support to fully embrace the model. Regular reiteration of the programme, and provision of clarity through ongoing training and supervision is needed. MECSH aims for sustainable implementation, which has been challenged through staff turnover of leadership and trained trainer positions. Further training of trainers has been needed. Another barrier is the issue of a very mobile population in London.



MECSH[®]
Maternal Early Childhood
Sustained Home-visiting

I would like to start by saying that before I met [MECSH Health Visitor] I felt lost and I thought I couldn't get help. When she started doing visits to my house she always was careful and understanding. I really appreciate[d] her support during my journey with postnatal depression...Every time that she came to my house or rang me she always reminded me how good I am as a mother and she always made me feel good... even I didn't believe I was a good mother she planted those words into my heart and now they are growing and finally I [am] starting to believe them. I just want to say thank you [MECSH Health Visitor] for being such a good professional and doing your job how you do it with love and passion... Last thing to say is thank you [MECSH Health Visitor] for being there when I felt the system let me down ... and you never did. I hope you continue helping women like me.

Quote from a Brent MECSH parent (postnatal start)

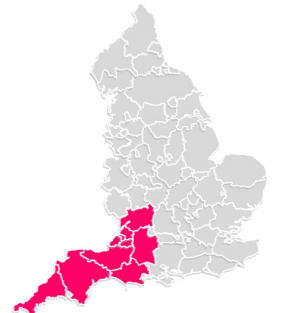
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CASE STUDY 5 Specialist health visitor intervention within Children's Social Care: an innovative practice model

CONTACT DETAILS:

Name and Job Title:	Dr Karen Rees, Senior Academic (Public Health and Health Visiting) Programme Lead Shirley Shailer, Specialist Health Visitor
Address:	Bournemouth University
Email Address:	krees@bournemouth.ac.uk Shirley.Shailer@nhs.net

Region: South West

This case study example demonstrates the following “Key elements” of the iHV “Health Visiting in England: A Vision for the Future”:

Background:

The early identification of children at risk of poor outcomes and the provision of early, targeted and evidence-based support to children and families is fundamental to the role of the health visitor (IHV 2019; Asmussen and Brims 2018; EIF 2018; DH 2009).

A Specialist Health Visitor was appointed who was co-located within Children's Social Care, working alongside social workers and offering an intensive 1:1 health visiting service to vulnerable families known to social care.

Knowledge base:

Responding to the recent Early Intervention Foundation report, ‘Realising the Potential for Early Intervention’ (EIF 2018), the Institute of Health Visiting has acknowledged that many vulnerable children are having their needs recognised late, therefore requiring much more complex and expensive interventions than if their families had received sufficient early support (iHV 2019).

Who was involved?

Shirley Shailer, Specialist Health Visitor Dorset Health Care Trust

Dr Karen Rees, SCPHN programmes lead, Bournemouth University

Poole Borough Council (now Bournemouth, Christchurch and Poole Council)

What did you do?

The Local Authority identified that the health needs of a number of families were not being fully met and championed the secondment of a specialist health visitor (SHV) into the ‘Families First’ team which offers social services support to families where the children meet the threshold for Child in Need status (Children Act 2004; DSCB 2015). The specialist health visitor offers an intensive 1:1 enhanced health visiting service to families within this team. All interventions offered to families focus on healthy attachment to support enhanced parenting capacity. The family health visitor continues to provide the local service offer.

Following referral from social workers, midwives and health visitors, the SHV carries out a robust assessment guided by the Early Help Assessment tool. Taking a strengths-based approach to the assessment of parenting capacity and capability enables an individualised and tailored package of evidence-based interventions to be negotiated with the family. This is underpinned by the Solihull philosophy of HV practice (Whitehead and Douglas 2005; Lee and Me 2015).



For those families who are pregnant, the SHV aims to start working with them from 24-weeks gestation and has developed a toolkit of evidence-based antenatal resources which can be used to support families in their transition to parenthood. The service offer consists of up to eight contacts, which explore in detail baby brain development, emotional containment, reciprocity, preparation for the demands of parenthood, infant feeding, baby 'states' and cues (please see Rees and Shailer 2019 for the full service offer/pathway).

For families with children aged 0 – 5 years, the service offer consists of three contacts focusing on brain development, emotional containment and reciprocity. In addition, further contacts are offered specific to individual needs. The SHV is a Video Interaction Guidance (VIG) practitioner and offers VIG as a tool for facilitating meaningful and sustained behaviour change and enhanced parent-child relationships (Kennedy et al 2011).

Evidencing your practice has made a difference to children and families

Performance measures:

A range of tools were utilised to help assess families' needs and provide key outcome indicators:

- Edinburgh Postnatal Depression Scale
- Generalised Anxiety and Depression Scale
- Revised Children's Anxiety and Depression Scale
- Karitane Parenting Confidence Scale
- Brockington Scale (post-partum bonding questionnaire)
- Early Help Assessment
- Video Interaction Guidance assessment tool
- Graded care profile
- Ages and Stages Social and Emotional questionnaire (ASQ SE2™)
- Ages and Stages questionnaire suite (ASQ™)
- Service user feedback questionnaires.

Data:

An action research methodology was utilised to enable a critical analysis of the qualitative and quantitative data sets gathered during service implementation.

The difference made:

- Early antenatal engagement with the target population
- Successful engagement of hard to reach families
- De-escalation of Child In Need status
- Development of Baby Brain (neuroscience) and attachment learning resources
- Improved parenting capacity and confidence demonstrated by self-report and Karitane Parenting Confidence Scale
- Demonstrable improvement in parental mental health
- Development of specialist professional expertise.

Feedback:

Feedback from families was essential to the evaluation and service refinement. Feedback was encouraged via the Trust's online system and a short questionnaire. Powerful positive feedback was received and VIG was particularly appreciated:

"Big help, especiallylearning all stuff about baby brain development and attachment...I am more aware of my role and behaviour as a parent".
Mother, aged 33 years

"I never realised how much a new born baby notices things going on around them".
Mother aged 17 years

"It has opened my eyes and increased my awareness.....interesting to see children's reactions.....we have learnt a lot through VIG".
Father aged 37

"In becoming more confident in my parenting, I am now able to go to groups, which I am enjoying and my baby is benefiting from".
Mother aged 24

Learning from what works

Costs and benefits:

Secondment of a band 7 practitioner into a social care team has demonstrable positive outcomes for family and child health. As a result of robust evaluation, the secondment has been funded for a further 2 years and an enhanced antenatal offer for UPP families is currently being piloted within the LA.

Learning from the experience:

Early intervention works! A combination of the Solihull and Video Interaction Guidance philosophies enables the SHV to be mindful of the power dynamics in her relationships with service users, and facilitate the containment of distress and discomfort often experienced by parents as they work through their own life experiences.

Challenges:

- Professional isolation was overcome through robust clinical and safeguarding supervision and peer supervision between the SHV and a family therapist in the same team.
- Frequent failed contacts, as families forgot their appointments, were overcome by professional tenacity and texting appointment reminders. This is not unique to our project as there is a significant body of evidence that the most vulnerable families are known to find it difficult to focus on their child's needs and are often less motivated to seek out, and more difficult to engage in, support services.
- Initial reluctance of some families to engage; this was overcome through professional passion and belief in the offer, promoting the benefit of the service without judgement of parenting practice or capacity.

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CASE STUDY 6

A whole system shared-learning approach to address increasing demand on children's urgent care: Healthier Together, Wessex

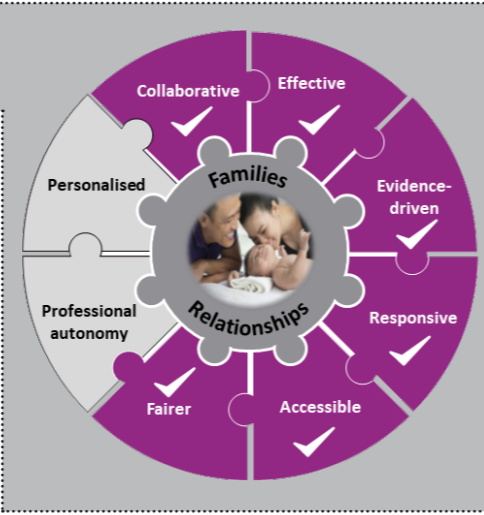
CONTACT DETAILS:	
Name and Job Title:	Dr Sanjay Patel, Paediatric ID Consultant, HT Project Lead and Clinical Lead, Children's Programme
Address:	Hampshire and Isle of Wight Sustainability and Transformation Plan (STP)
Email Address:	Sanjay.Patel@uhs.nhs.uk

Region: Wessex

This case study example demonstrates the following "Key elements" of the iHV "Health Visiting in England: A Vision for the Future":

Background:

2 million children aged 0-5 years attend A&E every year with rates increasing by 24% in the last six years¹, despite a falling birth rate and improvements in overall child health². Six high volume conditions account for half of all emergency and urgent care admissions for children³. The severity of many of these presentations will be relatively minor or self-limiting, and treatment elsewhere or self-care may be more appropriate^{4,5}. These visits tell us that parents are worried and are either unable or unsure how to access the reassurance or advice they need in other ways.

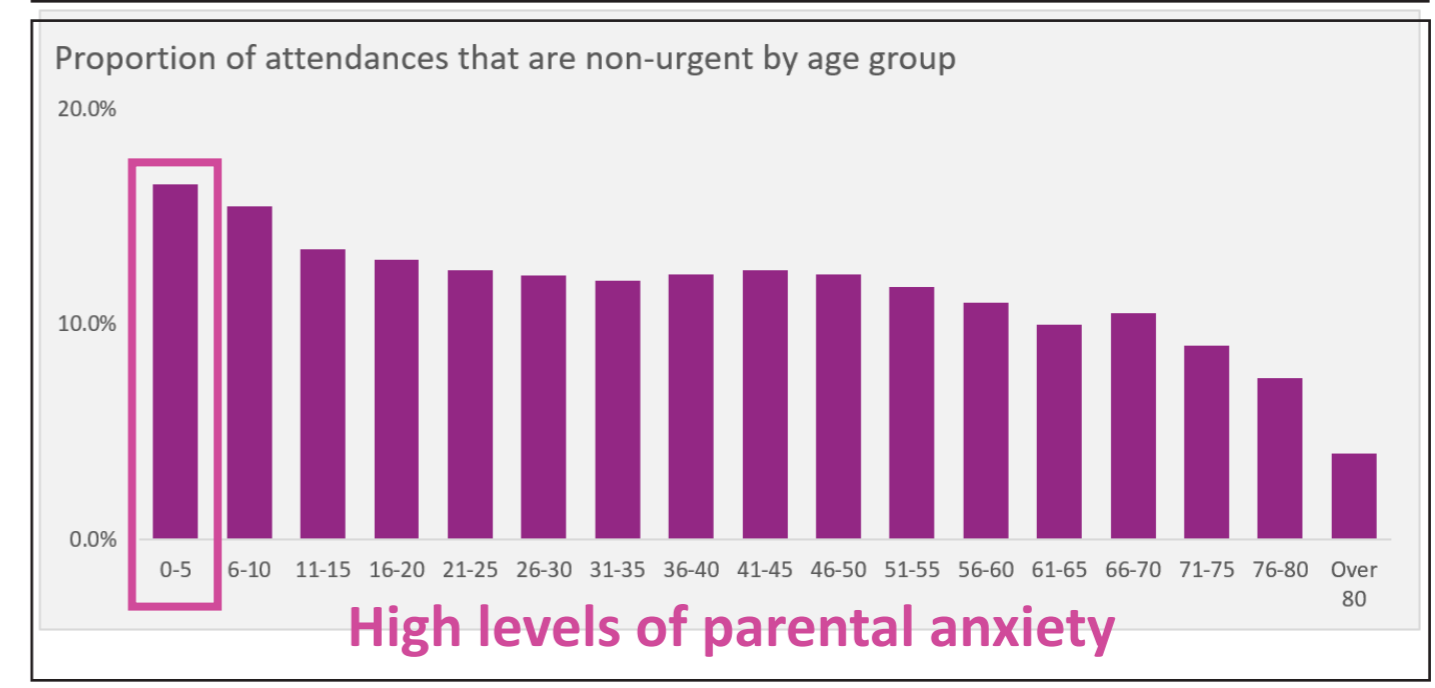
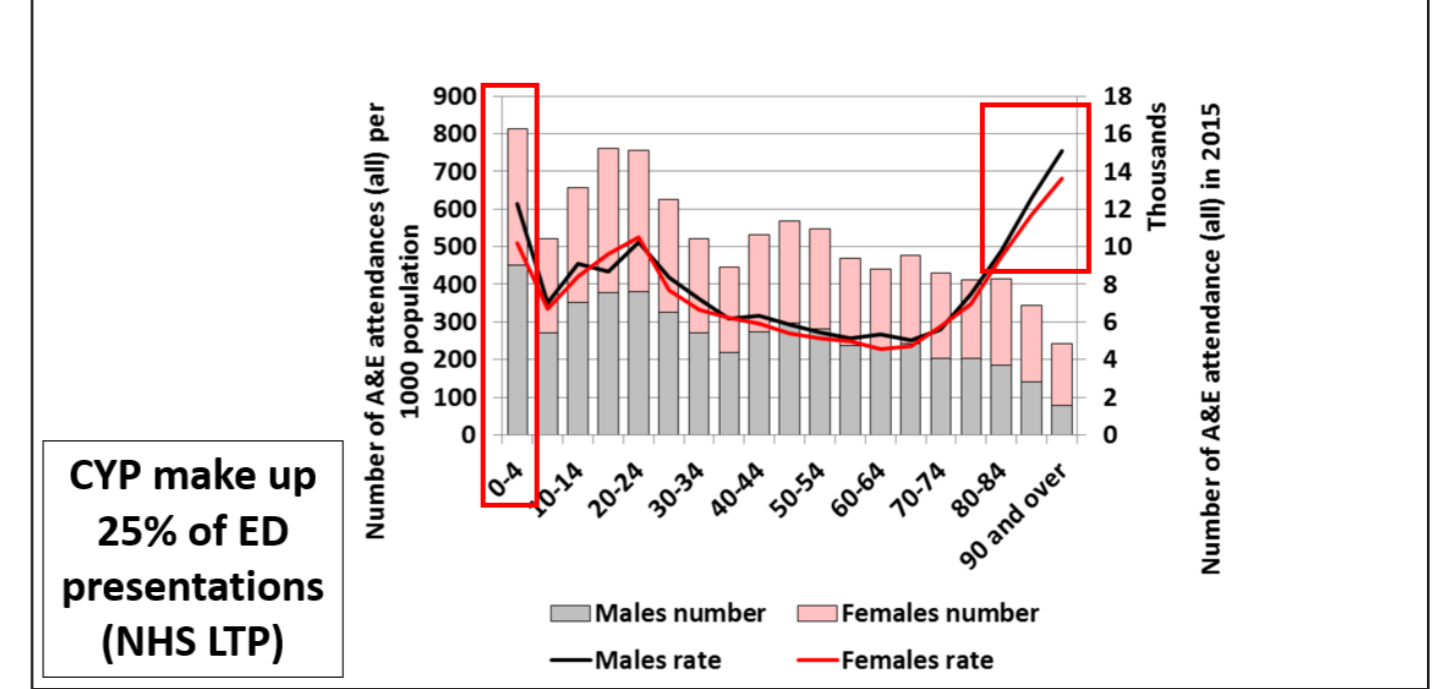


The Healthier Together programme was set up by Dr Sanjay Patel (Consultant in Paediatric Infectious Diseases) in 2014 and is founded on collaborative working across the healthcare system. Its aim is to improve the delivery of care to children and young people across Wessex (Hampshire, Isle of Wight and Dorset) through effective integration between local authorities (including health visitors and school nurses), primary and secondary care.

- Knowledge base:**
- Benefits of working across organisational boundaries:
- Quality Improvement initiatives focusing on one part of the system can have a major detrimental impact on other parts of the system. This can lead to resentment between providers.
 - Parents can access any part of the urgent care pathway. Users of the NHS perceive it as one organisation.
 - Variation in practice / inconsistent messages reduces parents' self confidence. This can impact on future health seeking behaviour and leads to increased activity.

Health visitors are in an ideal position to support parents' confidence and health literacy to recognise and manage minor illnesses in childhood to drive down rising A&E demand, including information related to antimicrobial resistance and the appropriate use of antibiotics.

Why focus on children? ED presentations



- Core objectives** – co-designed with parents, GPs, health visitors, community nurses, ED staff and paediatricians:
1. Parents feel empowered about whether and when they need to access the healthcare system.
 2. Parents are clearly signposted to appropriate healthcare services when required.
 3. At every point of contact, the practitioner should have a clear understanding of their own competence and where to seek advice.
 4. Parents should receive consistent and appropriate advice across the whole urgent care system.
 5. Clear local pathways should be in place across the whole acute care system which are understood by all practitioners.
 6. All professional groups are upskilled to deliver consistent advice with supporting web-based information for parents to facilitate shared decision making and improved health literacy.

What did you do?

Through the project focus groups, greater clarity on why parents seek a healthcare consultation was identified:

- Parents wanted a proper ‘health-check’ that removed any ‘health-threat’ - parents lack confidence to distinguish self-limiting illnesses from serious ones but believe that clinicians can
- Parents can experience a high level of anxiety even when there is a relatively low level of pathology
- Parents perceive a lack of communication between professionals
- Those living in areas of poverty felt more vulnerable
- Simple information was difficult to find online
- Implementing effective self-care strategies could yield significant rewards in the population.

Views were sought from health professionals (n=249) using a collaborative approach to develop a suite of resources to support them to manage acute paediatric illness in the community:

- Standardised web-based and downloadable resources for parents and carers about common illnesses
- Clearer guidance on local referral pathways
- Standardised guidance on assessing and managing common presentations with RAG rating and safety-netting advice.

Multi-disciplinary education and training was provided to frontline healthcare professionals, including health visitors, on clinical pathways/safety netting sheets which were RAG-rated to support clinical decision making and consistent advice.

The resources were embedded within existing practice and parents were supported to use them through role-modelling by healthcare professionals when seeking advice for childhood illnesses. In addition, health visiting teams included parent minor illness/ health literacy sessions within Transition to Parenthood groups. The resources were also promoted through schools via local authority public health teams and mental health education in schools

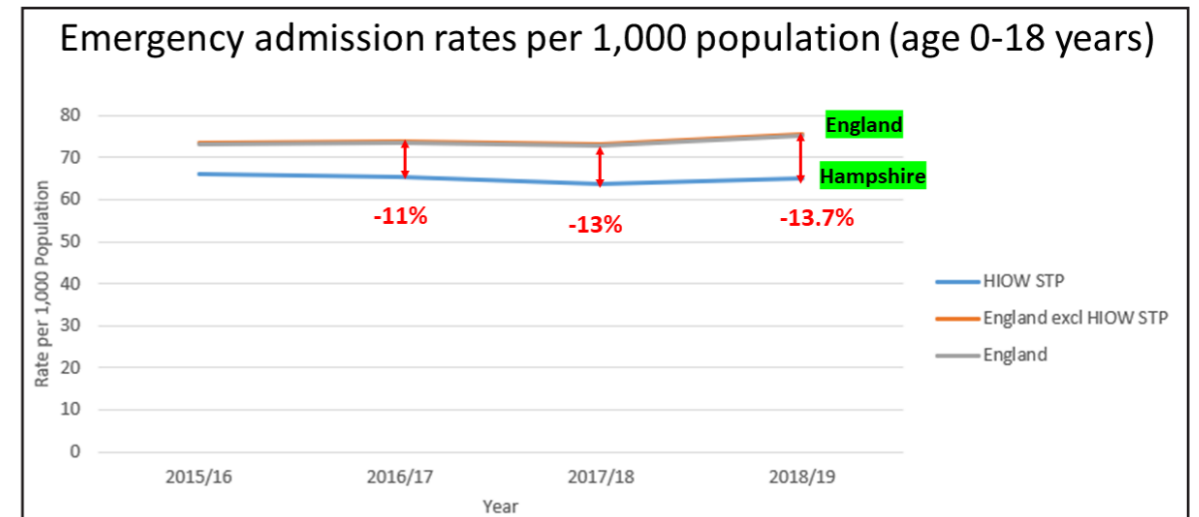
Examples of resources:

Evidencing your practice has made a difference to children and families

Impact data:

The programme has positive qualitative and quantitative findings:

- Practitioners report increased knowledge and confidence in managing early childhood illnesses and patients feel more in control of their own health
- The impact findings so far have demonstrated that when parents receive consistent, explicit safety-netting advice, they are less likely to re-attend A&E.



Feedback:

“Working collaboratively with the team behind Wessex Healthier Together has brought huge benefits – supporting professionals across the region to work together to improve care to children and families.

The opportunity for health visitors to work directly with paediatricians meant that we could benefit from their expertise and “up skill” our workforce, which has increased their levels of confidence in supporting families when they are concerned that their child is unwell.

We have developed new ways of working to make our service more responsive to parents’ needs, incorporating Healthier Together resources throughout our health visiting service, including our text messaging service “Chat Health”. Working in partnership offers a consistent approach across the region, providing a trusted, evidence based and extremely current source of help and advice our families can use 24/7 – the success of this programme has been endorsed by many multidisciplinary professional and parents across Wessex”.

Sascha Mullen – Area Manager, Southern Health NHS Foundation Trust.

Learning from the experience.

Key message/s.

- Engage users at an early stage. Ask their opinions and make them feel listened to. They will be far more receptive to your initiative if they feel part of it from the start
- Identify champions and develop networks. Although winning hearts and minds can be consuming, it is time well spent
- Behaviour change is hard; identify the levers for each group that you’re engaging with. People respond better if they feel that the initiative will personally benefit them as well as their patients
- Data collection is essential. Not only do you need to know if your initiative is working (and if it’s not, make sure you find out quickly and try something else), but you need to convey success to your stakeholders. Conveying the narrative is a key component to embedding a change in practice and facilitating the spread and scaling up of innovation and improvement.

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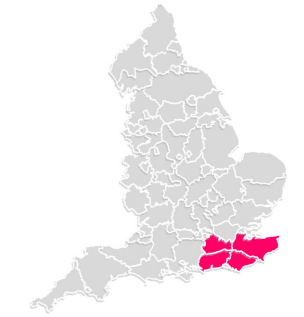
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CASE STUDY 7 Co-producing a film about breastfeeding with Slovakian Roma mothers – Healthy Communities Programme, Kent

CONTACT DETAILS:

Name and Job Title:	Philippa Burden, Health Visitor Facilitator, Healthy Communities Programme Kent
Address:	Westcliff House, Westcliff Gardens, Folkestone, Kent CT20 1SZ
Email Address:	philippa.burden@nhs.net

Region: South East



This case study example demonstrates the following “Key elements” of the iHV “Health Visiting in England: A Vision for the Future”:

Background:

As part of my Darzi Fellowship, a postgraduate certificate in health leadership, I had to carry out a service improvement project which demonstrated some of the innovative themes of my study. With my sponsor, Professor Sally Kendall (Centre for Health Services Studies [CHSS], University of Kent) leading on the Becoming Breastfeeding Friendly study for Britain, it made sense to focus on breastfeeding as my topic. Having a long-term interest in the local Eastern European Roma communities in South East Kent, I decided to link these together. I knew that breastfeeding, which would have been almost universal in the Roma countries of origin, had dwindled to a level below the local average. This appeared to be exacerbated by ill-informed beliefs about human milk often affecting infant feeding choices and mothers did not attend breastfeeding support groups.

Knowledge base:

I used available local trust data on breastfeeding figures which highlighted that the breastfeeding rates for Roma babies was lower than that of the general population average.

I drew on published evidence about Roma communities, their considerable health inequalities (Zeman et al, 2010), infant feeding (Condon, 2014, Condon et al, 2018) which suggested the value of this project. I also used Boyle and Harris's seminal work as a guide to working with co-production.

The overall aims were to:

- Find out more about infant feeding beliefs and improve breastfeeding initiation amongst Eastern European Roma mothers
- To work in a co-productive way, thus ensuring the mothers also took ownership of the project and had some future investment in its success.

Who was involved?

The importance and value of collaborative working was central to the success of this project. I worked with the mothers, with advice and support from local community development workers, Professor Sally Kendall and the academic team at CHSS, London South Bank University and the film maker. I also needed to fundraise, which was done through a local Roma development project, Kent Community Health Foundation Trust and its charity.



What did you do?

I began by scoping the situation, checking out my deductions from professional experience against the available evidence, then spending time getting to know the mothers, building trust and gaining their confidence. It was vital to have the support of the gatekeepers to the communities to be able to gain access to the mothers. Initially I went to small gatherings in three of Kent's coastal towns, asking the women about their experiences of breastfeeding. I gradually realised that they were passionate about the importance of breastfeeding and spoke about health benefits to their children and that they were also well aware of the decline in uptake amongst the young mothers in their communities. Knowing the importance of the elders' influence in the community and the universal appeal of visual media, the idea of making the film together gradually emerged.

I continually held the principles of co-production as guidelines, so this decision was made together as were decisions about form and content, what the film would attempt to demonstrate, its audience, its launch and its distribution. I was well aware that I potentially held the stronger power position, being professionally trained, able to access finances and the expertise to make the film. However, the women definitely decided on the content, as I did not even understand what they had said until after the film had been shot.

Once the film was made, we worked together to launch and distribute it using social media: for the Roma, their Facebook pages, my own Twitter network and then placing it on Vimeo and YouTube. Increasing hits on YouTube show that it has continued to be viewed long after its production, giving it a longevity, which other forms of dissemination, such as a breastfeeding promotion sessions would not have provided.

The film link is: <https://www.youtube.com/watch?v=Edn6Dy5ZLHk> or search "Roma Women Talk About Breastfeeding".

Evidencing your practice has made a difference to children and families

Performance measures:

The film has been viewed via the internet nearly 1700 times and has also been very well received by different public audiences. In particular, we have received positive feedback and interest in the innovative use of co-production methods to reach a community that is recognised as "seldom heard" and historically has worse outcomes than the general population.

The film has been shared with Roma communities throughout the UK, used as a teaching tool for health visitors, shared by Public Health England (PHE) during National Breastfeeding week which celebrated BAME mothers, and shown at the Institute of Health Visiting's annual Evidence-Based Practice conference, "Health for All Children Now", in May 2019 and at PHE's South East Migrant Health Conferences.

The difference made:

The film has enabled greater understanding of the Roma culture, beliefs and practices and it has resulted in, albeit early stages, a joint partnership between 'Daj La Daha' Mother to Mother breastfeeding peer support, midwives and health visitors.

The Roma mothers reported increased empowerment – two of the mothers in the film now have jobs in public services. The mothers also reported a strong sense of pride about taking part in the film.

Building on the momentum generated by the film, we have organised and piloted two 'Daj La Daha' Mother to Mother breastfeeding peer support training courses, and established links with midwifery services to support pregnant Roma mothers.

Feedback:

We collated feedback from all the women who participated in the Daj La Daha training using a participant feedback form. All the participants gave positive feedback which is captured in the representative quote below:

"I recommend to every mum to learn more about breastfeeding. This training gave me more knowledge even though I breastfed two children."

Learning from what works

Costs and benefits:

The film and launch costs were around £2000.

Learning from the experience/ advice to others:

Be bold! Follow your professional curiosity, learn more about the culture and beliefs of the communities you are working with, build trust and local contacts, visit local community spaces to get to know people.

Challenges:

The main barrier was having to raise the money to make the film. I had not really anticipated this, but it was a good learning curve having to apply for funding and to realise that there is money available and not to let this process be a barrier to carrying out an innovative project.



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CASE STUDY 8 Horizon Group – Perinatal Wellbeing Group, Somerset

CONTACT DETAILS:

Name and Job Title:	Phoebe Lee, Health Visitor
Address:	Orchard Medical Centre, Morse Road, Norton Fitzwarren, Taunton, TA26DG
Email Address:	PLee@somerset.gov.uk

Region: South West



This case study example demonstrates the following “Key elements” of the iHV “Health Visiting in England: A Vision for the Future”:

Background:

In 2015, the Somerset perinatal mental health guidelines informed health visitors to support parents with perinatal mental health needs by completing additional ‘listening visits’ and signposting to the GP and the Talking Therapies service.

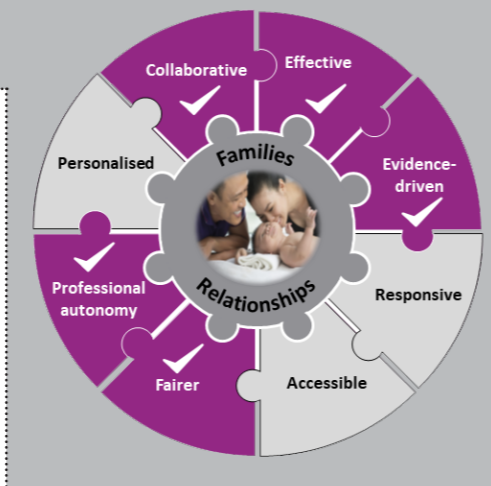
During this time, feedback from some parents suggested that telephone consultations from the Talking Therapies service did not meet their needs, and some health visitors did not always feel confident in their skills to support parents with perinatal mental health issues. Health visitors felt that their mental health colleagues didn’t always understand their role in supporting the perinatal attachment between parent and baby, child development and ensuring safety and wellbeing.

This highlighted a need to improve joint working between health visitors and Talking Therapies, to pool knowledge and skills and jointly provide an evidence-based intervention for parents experiencing perinatal mental health issues. Health visitors have been able to share their learning, knowledge and experiences on the parent-infant attachment, child development and the role of the health visitor; and Talking Therapies were able to share their skills and knowledge around evidence-based interventions in perinatal mental health, managing risk and delivering group-based sessions.

By working collaboratively in Somerset, health visitors and Talking Therapies have jointly developed and delivered a perinatal wellbeing group for parents with mild/ moderate perinatal mental health issues called the ‘Horizon Group’ since 2015. The Horizon Group has had positive outcomes and feedback from parents suggest that the benefits of peer-based support has extended beyond the programme, providing them with an ongoing support network in the community both during and once they have finished the course.

Knowledge base:

The programme was developed using the research and learning outcomes on perinatal mental health and NICE Antenatal and Postnatal Mental Health guidance which states that for a woman with persistent subthreshold depressive symptoms, or mild to moderate depression, in pregnancy or the postnatal period, consider group-based CBT therapy for people without a chronic physical health problem in relation to depression. The programme also drew on evidence on the first 1001 critical days, emphasising the importance of infant mental health.



The aims:

The aim for parents who attended the Horizon perinatal mental health Group was to create a safe space for them to feel listened to, accepted and supported by professionals and peers. The Horizon Group supported parents to understand more about their own mental health, the relationship they have with their baby and significant others.

The group supported parents to develop new strategies and techniques to manage depression and/ or anxiety using a Cognitive Behavioural Therapy model and to promote their child’s emotional wellbeing.

Parents who attended the group were expected to complete Patient Health Questionnaire 9 (PHQ9) and Generalised Anxiety Disorder (GAD) screening tools before the start of every session to monitor mood and/ or anxiety and assess risk. The aim of the Horizon Group was for parents’ mental health to improve; this was demonstrated by reduced scores at the end of the treatment.

Who was involved?

The Horizon Group consists of one Psychological Wellbeing Practitioner (PWP) from Talking Therapies and either one or two health visitors to deliver and facilitate each session.

The Horizon Group is now well established in four areas across Somerset to ensure effective and timely accessibility for parents.

There is a monthly steering group which receives feedback from each area and evaluates outcomes in order to develop and adapt the programme. PHQ9 and GAD scores are also collated to evaluate service delivery.

What did you do?

The Horizon Group material was developed and tailored to parents experiencing perinatal mental health issues by Talking Therapies and planning and training sessions were delivered with the health visitors and PWPs prior to the commencement of the group.

The referral process for the group was shared amongst healthcare professionals working with parents experiencing perinatal mental health issues, ensuring timely and effective assessments were completed and support given in the interim.

A maximum of 12 parents per session were invited to the group by Talking Therapies and parents were able to bring their babies to promote attachment, attendance and breastfeeding (if chosen method of feeding). Health visitors and PWPs met before and after the group for debriefing and supervision purposes.

The Horizon Group delivered a total of 8 x 2-hour sessions, held on a weekly basis. One session was tailored for partners only to attend and all parents were given a follow up telephone call 4 weeks after the group ended.

Evidencing your practice has made a difference to children and families

A monthly steering group receives feedback from each area and evaluates outcomes and feedback in order to adapt the programme. Changes have been made following these steering groups regarding the materials we use, referral processes and criteria, information sharing with the wider multi-disciplinary team and identifying learning needs within health visiting and Talking Therapies.

PHQ9 and GAD scores are collated to evaluate service delivery quantitatively, and question-based feedback forms are used to evaluate the service qualitatively. Most parents’ PHQ9 and GAD scores decreased towards the end of the Horizon Group.

The feedback received following the Horizon Group has mainly been positive; parents report that they are implementing more effective coping strategies learnt in the group to manage depression and/or anxiety, improved bonding with their baby, improved self-esteem, partners’ understanding of perinatal mental health, etc. The parents who attended the group also benefitted from ongoing support once the group had ended, as parents established a support network with other group participants.

Learning from what works

The groups are held in community venues which have either a small cost or are free to use. Health visitors and PWP's are required to have some protected time to prepare, deliver and feedback on the groups. At present, there is no creche available for the groups due to lack of funding and parents are invited to bring their child to the group if they are non-mobile to encourage attendance.

Collaborative working brings mutual benefits for practitioners though shared learning - health visitors and PWP's have a more improved understanding of each other's roles and benefit from supervision throughout the duration of the group. Health visitors have an improved understanding of perinatal mental health and confidence in delivering group-based interventions and PWP's have an improved understanding of parent-infant attachment and child development.

There have been some challenges in delivering the groups, one of which involves managing safeguarding risk if these arise during the group. Referrals are now processed via Talking Therapies who use a risk assessment tool before referring parents to the group. Health visitors and PWP's discuss confidentiality and their safeguarding responsibility at the start of each session and health visitors have support from safeguarding nurses, with additional supervision when needed.

CASE STUDY 9 Creating health visiting Baby Friendly Champions and a Baby Friendly Culture

CONTACT DETAILS:

Name and Job Title:	Julie Peris, Infant Feeding Lead, CNWL Harrow 0-19 Service
Address:	Milmans Resource Centre, Grove Avenue, Pinner, Middlesex, HA5 5PF
Email Address:	j.peris@nhs.net

Region: London



This case study example demonstrates the following "Key elements" of the iHV "Health Visiting in England: A Vision for the Future":

Background:

Until recently, our health visiting service worked quite separately from our Baby Feeding Support service. Health visitors usually referred mothers who were struggling with breastfeeding to a support group which were run mainly by the Infant Feeding Coordinator and enthusiastic Peer Support Volunteers.

It was evident that health visitors could become deskilled if not regularly involved in supporting feeding and that, while mothers liked the camaraderie of the peer supporters, they often needed reassurance from a healthcare professional.

It was felt that health visitors would benefit from their own peer support: Someone who was fulfilling the workload of a health visitor but also prioritising the importance of baby feeding and relationship building - A Health Visiting Baby Friendly Champion! There needed to be one in each team to be a constant source of support.

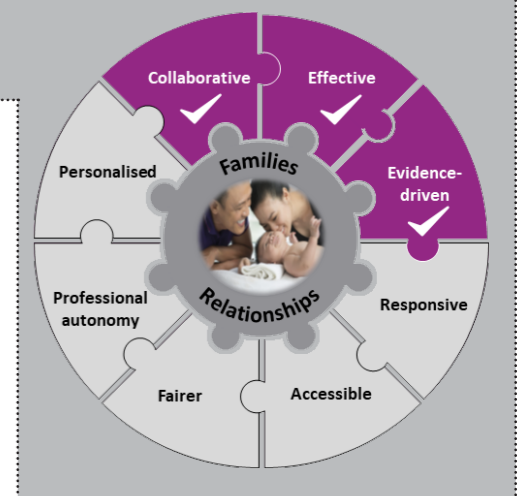
Other health visiting areas had Breastfeeding Champions but these were staff who had often been instructed that they must take on this role and the focus was solely on breastfeeding. We wanted a Champion who had some inklings of interest in the importance of those highly influential first hours, first days, first weeks, first months, which we could then nurture together. We hoped the Champions could then nurture their fellow team members.

The aims:

It is now very clear that when babies feel safe, secure and loved they make hormones which optimise their brain development. If their first relationship in life is a positive one, it lays a template for all the ensuing relationships. The importance of this first relationship simply can't be overstated. We wanted the culture of these Baby Friendly themes to permeate throughout the entire health visiting team. It was felt this would therefore reach all of the families in the community we serve, and each health visiting contact would be more influential, empower more families and change the lives of parents and babies. This in turn would change the lives of the children those babies became and in turn change the lives of the adults those children became, until we were seeing generational change and widespread societal recognition of the profound importance of early experiences in life to shape parental health and wellbeing.

Who was involved?

Infant Feeding Coordinator, the Children's Clinical Service Lead, Children's Clinical Service Manager and the two Health Visiting Team Leads.



What did you do?

We hold regular Baby Friendly Strategy meetings and discussed the potential role of the Champion. We have two health visiting teams and we hoped to have a Champion in each team.

We decided that we would invite all health visitors to send expressions of interest and encouraged them to share their vision of a Champion. As the role evolved, the eventual Champions took on a number of roles with far-reaching effects:

- They advocated for Baby Friendly at all team meetings
- Provided enhanced care for families on their caseload
- Taught their peers about baby feeding and relationship building following attendance at the Baby Friendly Conference
- Supported volunteers at the Baby Feeding Groups
- Helped families with feeding issues at the support groups
- Supported the health visiting students and pre-registration students.

Evidencing your practice has made a difference to children and families

Performance measures:

Health visitors are now more engaged with the Baby Friendly Initiative and we recently passed our Baby Friendly reassessment and accreditation at Stage 3. Stage 3 assessment is a highly regarded measure of quality of breastfeeding support by a health visiting service – this involves assessing that mothers are supported with their feeding, given useful and accurate information and that parents are supported to recognise the importance of relationships and how to build these.

Health visitors in our service were confident with the care they had given families and were able to provide families for the Baby Friendly Assessors to interview.

Health visitors now attend the Baby Feeding Support groups and support the volunteers. They recognise that this builds their feeding support skills which are crucial in every New Birth Visit and 6-8 week contact.

Data:

Our Baby Friendly Audit Tool results have significantly improved; specifically around families recalling support with hand expression of breastmilk and the importance of closeness and comfort when building a relationship with their baby. Families also speak of how their health visitor supported them with formula feeding and cite knowledge of the First Steps Nutrition resource which their health visitor provided them with.

In the recent Baby Friendly Reassessment, 90% of staff demonstrated understanding of how to support formula feeding families with making up feeds and the use of first stage milks. This significantly exceeds the 80% standard required to pass.

81% of staff were able to demonstrate and describe how they would support a mother with hand expression of breastmilk. This improvement demonstrates significant progress when compared to previous results for this standard.

Feedback:

We collect anonymous feedback from families who attend our Baby Feeding Support groups. Mothers speak positively about their experiences of the group and also about individual health visitors. The feedback is mostly very positive.

Feedback from our most recent survey include:

“It was all really helpful and supportive. My Health visitor came for extra visits at the beginning as I was struggling with breastfeeding”.

“[the health visitor] had such a good attitude, very upbeat and positive. Also very kind which is just what you need when you’ve had a baby. I really appreciated her”.

“I am incredibly grateful for the support I received. [The health visitor] was incredibly empathetic, helpful and encouraging and enabled me to continue to breastfeed despite numerous challenges that had left me both emotionally and physically drained”.

Learning from what works

Costs and benefits:

The Baby Friendly Champions were funded to attend the Baby Friendly Conference and gave really positive feedback to the teams. This information was shared with the wider team by the Champions teaching staff who attended their annual Baby Friendly updates – thereby providing a cost-effective mechanism to share the latest evidence and support best practice.

Learning from the experience:

This project has been about building on little ripples of change. We wanted health visitors to feel really confident and secure when discussing Baby Friendly themes.

Experiential learning is important and it was recognised that health visitors will also draw from their own experiences of birthing and feeding where this was applicable. To support this type of learning during the training and supervision sessions, we facilitated a safe space for health visitors to share their own experiences and reflect on why things happened the way they did. Some health visitors expressed regret or sadness when they reflected back on their own experiences. They spoke often about not having support available and not being able to breastfeed for as long as they wished. We often paraphrased Maya Angelou’s beautiful words:

‘We do the best we can with what we know at the time. When we know better we do better’.

We hope that when health visitors are supported to make sense of their experiential learning they are able to recognise the importance of the support they give mothers and how life changing it can be. The experiences of some of the health visitors who had their children decades ago are still echoed today. We know from the Infant Feeding Survey 2010 that 63% of women who stopped breastfeeding said they would have liked to breastfeed for longer.

We were aware that some health visitors may prefer to speak to the Baby Friendly Champions in their own team about these sensitive issues rather than the Infant Feeding Lead. Health visitors have been constantly reassured that the role of the Baby Friendly Champion is to provide support, reflect on practice and share learning through supervision.

Challenges:

Some staff were naturally apprehensive and hesitant about the changes proposed and occasionally some health visitors were hesitant about providing breastfeeding support. To address this, we listened to their concerns and realised it wasn’t that they didn’t like breastfeeding; their anxiety stemmed from a lack of confidence in their own knowledge and skills. So we listened and developed at their pace, kept communication channels open, expressed our appreciation for the great work they do and tried to instill confidence over time.

CASE STUDY 10 Universal Partnership Plus (UPP) Offer – Enhanced Health Visiting Support Pathway using evidence-based practice tools and approaches

CONTACT DETAILS:	
Name and Job Title:	Jacky Syme, Service Development Manager Children’s Services
Address:	Bedfordshire Community Health Services
Email Address:	jacky.syme1@nhs.net

Region: East of England



This case study example demonstrates the following “Key elements” of the iHV “Health Visiting in England: A Vision for the Future”:

Background:

A routine annual audit of the universal partnership plus (UPP) caseload at the point of decommissioning of the Family Nurse Partnership Service in Bedfordshire showed that there was a wide variety of approaches being used within health visiting practice to work with vulnerable families; with differing timescales and levels of intensity, often with little analysis or rationale for the approach taken. Outcomes achieved for families were not clear or always identified.

There is however recognition that early intervention in the early years, with targeted approaches, can prevent more complex need evolving during the lifespan. Health visitors were recognised in Bedfordshire as being key professionals to work with families implementing early interventions.

Knowledge base:

In order to tailor the work of the health visitor (HV) to families who are vulnerable and have complex needs, a model of interaction which achieves the individual desired family outcomes is useful for HVs to employ. The HCP (Healthy Child Programme, 2009) recommends the use of the Family Partnership Model (FPM) or the Solihull Approach (HCP pg. 23) which are internationally recognised, evidence-based and have a structured but flexible approach. The Family Partnership Model is currently partially embedded (following workforce training) into the format of the HV assessment through the use of the Promotional Guide materials championed by the model. The model relies on relational partnership working and goal orientation to achieve best possible outcomes. It is based in family strengths and uses the practitioner’s expertise, skills and qualities to achieve the outcomes required (Day Ellis & Harris, 2015). To achieve outcomes for children from families with complex needs, a proactive rather than reactive approach to support is more effective (Kemp 2013).

The aims:

The aim was to ensure that vulnerable families and their individual needs were recognised early and that an equitable and effective framework would be available to assist practitioners in their UPP work.

Working in partnership with other agencies to support families is, by the nature of the support required, resource heavy and more intensive if a positive impact is to be made. However, the unique contribution which health visitors make is specific and focused on the health outcomes for the child. These are set out clearly in the HCP and require an emphasis on:

- supporting sensitive parenting

- child development milestones
- child behaviour management
- enhancing healthy behaviour.

It was recognised that for families with or without safeguarding concerns, a programme which has an emphasis on anticipating parenting needs and supporting consistent parental mindedness of their child will have more effect than a reactive approach to problem solving. **However, it was clear that this would require an increased programme of contacts/ home visits than the universal programme designates and would need clarity of the intended purpose of the intervention.**

For families with complex needs, a multi-agency approach to ensuring that children reach their aspirational goals was thought to be optimal.

Continuity of practitioner and consistency of interaction style was also identified as a requirement to ensure the relationship is one of trust, honesty and understanding between the HV, parents and children.

Who was involved?

Jacky Syme – Service Development Manager 0-19 Service BCHS
Public Health Bedfordshire
Bedford Borough Council Children’s Services
Central Bedfordshire Council Children’s Services

What did you do?

The health visiting service worked to identify purpose, evidence, intervention and outcomes when working with vulnerable families. The clarity for health visitors, regarding possible outcomes and tools to ensure support with parental sensitivity, child development, child behaviour and healthy lifestyles, were outlined in a pathway schedule and the supporting documents were developed.

Figure 1: Simplified version of the UPP visiting schedule

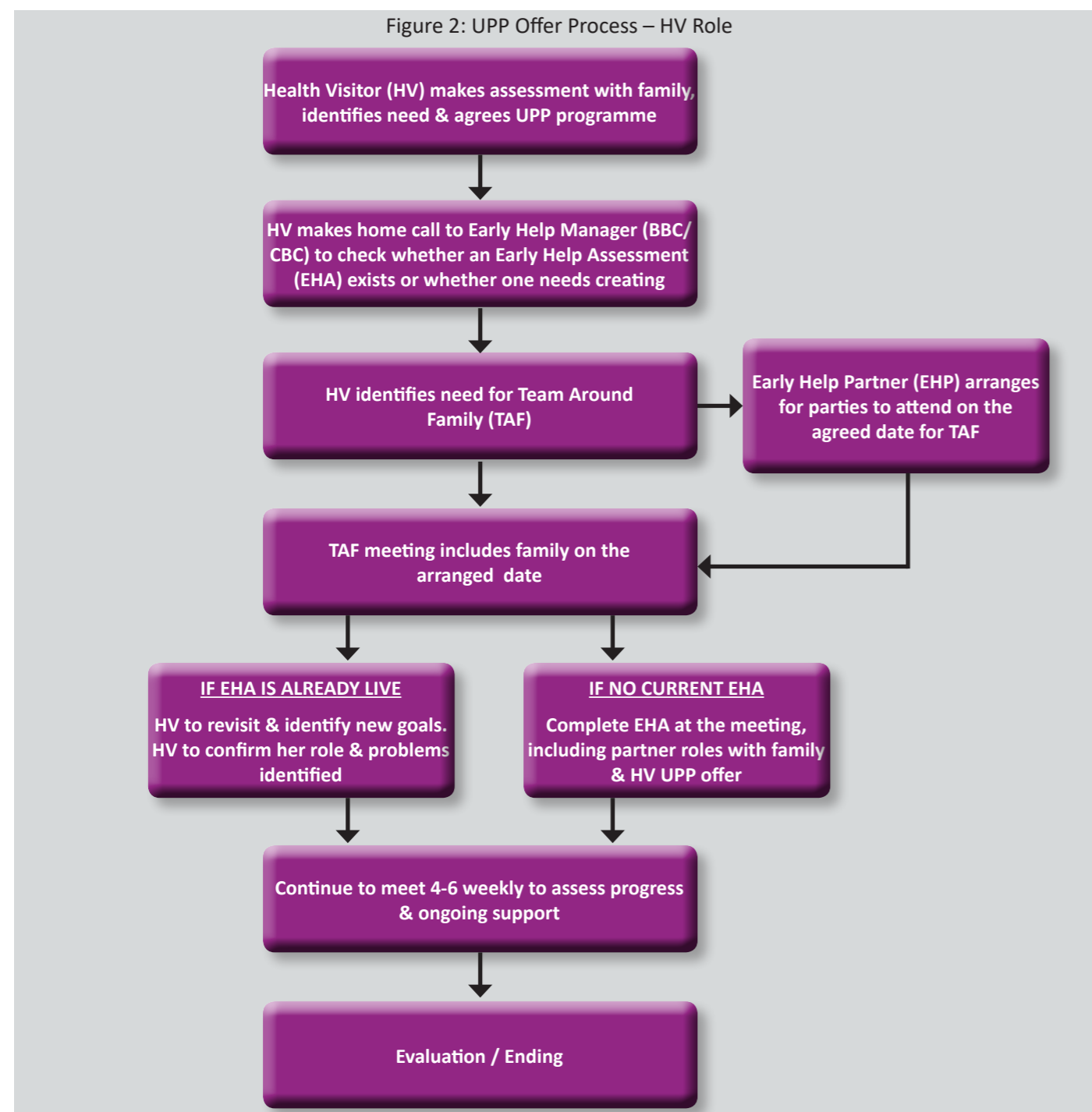
Schedule of visiting for UPP families.		Behaviour	Attunement	Health promotion	Development
Stage	Type of contact	Provided by	Content		Outcomes expected/referrals on
Pregnancy 24weeks	Notification of pregnancy	Maternity Services	Patient identifiable info from Maternity Services sent by electronic data schedule		HV service aware of vulnerabilities
24-28 weeks	Home Visit	Health Visitor	Relationship building, Needs/Strengths analysis, MECC		Signed up to Antenatal programme LA offers
36 weeks	Home visit	Health Visitor	Relationship building. Health promotion. Goal Setting		Mental Health Score Stop smoking referral, breastfeeding CAF.
Birth – day 6	Telephone contact	Health Visitor	Introduction, infant feeding assessment. Liaison with MW		Breastfeeding at 10 days
Day 10-14	Home Visit	Health Visitor	New baby review, Mental health assessment, Feeding assessment. NBO, Parenting support. Goals setting		Breastfeeding status Mental health Score
Week 3	Home visit	Health Visitor	New baby review, NBO, Feeding support, MECC Goal review		NBO screen /referral where required
Week 4	Home visit	C. Nursery nurse	Baby review, MECC, home safety		Referral to Mums group
Week 6-8	Home visit	Health Visitor	Feeding assessment, MH assessment, Goal review NBO		Breastfeeding at 6-8 weeks, PHQ9/GAD7 score, GP Assess achieved
Week 9	Home visit	Health Visitor	Parental skills review, Goal review NBO		Referrals to required agencies
3-4 months	Home Visit	Health Visitor	ASQ3, SE Review strategies and goals. PNIMH assessment. Infant feeding review.		Breastfeeding at 12 weeks MH referral Imms. Referral to solid food workshop.
6 months	Home visit	C. Nursery Nurse	ASQ3 SE Review Goals. Health Promotion, minor illness.		Imms. complete. Breastfeeding status
9 months	Home Visit	Health Visitor	Health and development review ASQ3, SE. Growth. Maternal MH, Safety, Health promotion. Review needs/strengths		ASQ cut off scores Referrals where appropriate
12 months	Home visit	Health Visitor	ASQ3, SE parent skills review		Referrals where appropriate. Breastfeeding at 12 months
15 months	Home visit	Health Visitor	ASQ3, SE, MECC, health promotion, safety. Imms. review		Imms. achieved
18 months	Group/Workshop	C. Nursery Nurse	Early development goals. SLT, Continence, healthy eating, exercise, dental, sleep and behaviour		Referrals where required
24 months	Home visit	C. Nursery Nurse	Follow up from workshop at 18 months		Referrals where required
27 months	Home or Early years setting	Health Visitor	Health and development review ASQ3, SE. Growth monitoring. Health Promotion. Review goals. School readiness, Solihull and ASQ support materials		Referrals where required. Developmental milestones ASQ report
30 months	Home visit	Health Visitor	Review parental sense of development and behaviour. Future access to 0-19 service is clear to parents. Goals review.		Parents are confident to contact the 0-19 service for support and advice
39 months	Small group	C Nursery Nurse	Integrated 3 year health and development review. ASQ3 SE		Referrals where required or sign off from programme.

Working with partners from Children’s Centres, Early Help, maternity services, Early Years provision, social care, voluntary groups, GP and other health services enables an integrated offer for children and families for a range of needs-led UP care packages to be delivered in partnership with families in and amongst the UPP scheduled contacts. These may be delivered through further home visits or groups, if more appropriate. Equally, when outcomes are met prior to the end of the schedule, a shared agreement is reached between the HV and the family to end the programme earlier than 39 months.

Investment in training and education to support health visitors and their skill mix colleagues to offer a range of strength-based interventions (Family Partnership Model, Solihull Approach, Five to Thrive and more recently Newborn Behavioural Observations) were commissioned in the development timeframe.

The pathway was launched initially through team-based awareness sessions and practitioners were asked to use the scheduled approach for all families that were identified by them as needing UPP support. Following audit, all staff have attended update/refresher sessions to strengthen the use of the pathway in practice; learn more about adverse childhood events and their impact across the lifespan and understand that early help preventive support of this kind is key in changing the life course of families and children.

Figure 2: UPP Offer Process – HV Role



Evidencing your practice has made a difference to children and families

Performance measures:

The audit of using the approach undertaken after the first year showed some positive successes in those families who had participated in this schedule of support. The audit also demonstrated areas of learning and further development of the pathway and schedule for vulnerable families to improve outcomes.

All practitioners have six restorative supervision sessions per year where their use of the Family Partnership Model in their work with families is explored, explained and encouraged.

Evidence-based assessment tools are used that can be reviewed for improvement during and after the relevant intervention:

- The Patient Health Questionnaire (PHQ9)
- General Anxiety Disorder screening tool (GAD7)
- Ages and Stages Questionnaire (ASQ-3™ and ASQ-SE™)
- Family Partnership model assessments and outcome tools.

Data:

As part of the Outcomes Framework, through which the HV Service is monitored, currently case studies are used to report effective outcomes for families. We are also developing methods to capture use of goal-based outcomes in a quantitative and qualitative way with the Centre for Parent and Child Support (see datasets for quantitative outcome measures in Figure 1).

The difference made:

Health visitors and their skill mix colleagues now have an equitable way to offer a schedule of support visits for their vulnerable families where they have guidance about when to visit and the focus on early intervention; with the ability to also offer short-term UP work in a bespoke way.

Once the service level of support is identified as UPP, practitioners are able to offer the family enhanced support throughout their early years, for as long as they need it. Being a strengths-based and goal-focused approach, the length of time that each family may spend on the enhanced pathway will differ; but this is part of the continual assessment/evaluation process.

Feedback:

All families are encouraged to use feedback questionnaires to indicate their satisfaction with any interventions given (Chi Esq; Friends and family test: bespoke questionnaires via electronic systems). The model used encourages practitioners to ask for personal feedback for reflection and relationship building within the preventative, early help based approach.

Learning from what works

Costs and benefits:

The investment in the FPM and NBO training for HVs and skill mix was funded by Public Health Bedfordshire. The HV universal offer has been modified to release time from home-based Universal mandated visits and uses some clinic-based appointments with the view that extra support for vulnerable families would then be possible.

The benefit in creating a schedule of enhanced support visits that grow trusted relationships and incorporate the skills and techniques of the workforce in a consistent and equitable way has already been shown to produce positive outcomes for families.

Learning from the experience:

It was crucial that the service vision, training and education investment, and the model employed for the offer were based on strengths and goals, and enabled a consistent yet personalised approach; this meant that the workforce became competent and confident with the FPM model and were clear about meeting outcomes using the named tools when supporting families.

It would have helped to co-produce this approach with our service users and involve practitioners more during development, and this may have prevented the early poor take up that was identified in the audit. Our co-production lead is now working with families for the future to support further development.

Challenges:

An important barrier was trying to encourage a quality and time-intensive approach at a time when resources, both locally and nationally, were facing considerable cuts. Additionally, this approach required the workforce to adapt to a new way of working as they had traditionally-confined intensive work to families with Safeguarding concerns. Prior to this programme, these vulnerable families that did not reach the threshold for safeguarding intervention had not benefitted from early intervention which had the potential to make positive improvement to measurable outcomes.

Through restorative supervision and update/refresher training sessions, the focus is moving from a reactive approach to a more “upstream”, proactive approach which includes goal setting and early intervention. Practitioners are embracing the opportunity to work with families to improve outcomes through shared decision making and the delivery of enhanced support to their vulnerable families in a preventive and early help-based way.

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Institute of Health Visiting

A Registered Charity Number 1149745

c/o Royal Society for Public Health, John Snow House, 59 Mansell Street, London E1 8AN

Telephone: +44 (0) 207 265 7352 | Email: info@ihv.org.uk

www.ihv.org.uk