The role of health visitors in supporting the early intervention/prevention of cardiovascular disease (CVD):

Insights Report

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LET'S TALK HEART HEALTH

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- Philippa Bishop (Head of Training) - iHV
- Professor Dame Sarah Cowley - iHV Trustee
- Professor Crispin Day (King’s College London) - Family Partnership Model Lead
- Susan Tatsinkou (Southern Health NHS Foundation Trust) - Professional Lead - Children and Family Services
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Executive Summary

There is a plethora of evidence that highlights the importance of the early childhood years in influencing future life outcomes - what happens in the first 1001 days lays the foundations for the future[1]. The World Health Organization (WHO) estimates that non-communicable diseases (NCDs), including cardiovascular disease (CVD), are collectively responsible for 74% of all deaths worldwide[2]. CVD has its origins in-utero, early childhood and adolescence. It is driven by underlying social, economic, political, environmental and cultural factors, broadly known as ‘social determinants’ of health. Physical inactivity, unhealthy diets, exposure to alcohol and tobacco, and unhealthy environments are important risk factors and are often preventable.

The good news is that there is strong evidence that reducing risk factors, starting in the earliest years of life, can make a big difference to lifelong health and wellbeing and the reduction of health inequalities. Reducing CVD is not simply a matter of changing individual behaviour in isolation; broader changes in social, economic, environmental and cultural contexts are also needed.

Health visitors have unique access to families during pregnancy and the early years which provides timely opportunities for early intervention. These have the potential to help reduce the risk of CVD and identifies individuals most in need, to address disparities in health outcomes.

Despite this wealth of evidence, there remains a persistent evidence-practice gap. This hampers health visitors’ work on CVD prevention and is exacerbated by workforce shortages and difficulties accessing affordable and bespoke continuous professional development (CPD). To tackle the CVD crisis, and reach the vast numbers of high-risk families, practitioners need to be supported to use their time most effectively to make the biggest impact. There is strong evidence that simplistic advice giving, or 'telling people what to do', can leave people feeling judged, more likely to disengage in support, and less likely to make health changes. 'Poor communication' is consistently the highest recorded NHS complaint type, and practitioner's insensitive conversations with overweight people frequently hit the headlines. Conversely, treating people with dignity and respect, and equipping practitioners with both the 'key messages’ and the ‘helper skills' to support families to build on their strengths and make positive health improvements, can bring about lasting change.

The iHV was awarded funding from The Burdett Trust for Nursing to strengthen the skills of health visitors as leaders within the early years, to enhance their work with families to reduce the risk of CVD. This was achieved by developing an evidence-driven, blended online learning training programme for CVD prevention- based on an adapted version of the Family Partnership Model’s (FPM) strengths-based approach to working with families. The training programme was informed by the latest evidence and insights gathered from practitioners and families. This insight report summarises these key themes.

The insight themes were collated through:

- Scoping of current literature and evidence-based resources on the four major risk factors for CVD, drawing on iHV expertise in smoking, physical activity, alcohol and healthy weight/healthy nutrition
- A national survey of 246 practitioners
- Co-design groups with health visitors and parents

The key findings highlighted that health visiting practitioners felt that they had an important role to play in CVD reduction as an integral part of their public health and early intervention work with families. They reported a need and appetite for training that was tailored to health visiting practice, included all of the risk factors, and supported their skills development on how to engage families to make sustainable health changes.

The insights highlighted that practitioners felt more confident and had received more training on smoking, in comparison to the other risk factors. Practitioners described how supporting families to make health changes across all the risk factors was often not straightforward, as all families will have different needs. Many practitioners reported that smoking, alcohol, inactivity and unhealthy diets can sometimes be challenging or sensitive topics to cover with families. Having conversations about alcohol was considered to be more challenging than the other risk factors. At face value, some families may seem resistant to change, or defensive, and refuse to engage - having conversations with these families presented additional challenges that practitioners wanted more support to overcome in their practice.

A quarter of respondents reported having received no specific communication skills training on having conversations with families about supporting behaviour change at all, and of those who had, 39% had completed the training more than three years ago.

The evidence from all sources highlighted the importance of the relationship between the health visitor and the parent – this determines whether families will engage in conversations about these topics, and their level of disclosure about their personal circumstances, risk and resilience factors. The need to move away from tick-box approaches and offer a personalised response were all recognised.

The COM-B Behaviour Change Model[3] was used to inform thematic analysis of the scoping findings to identify the key barriers and enablers to support health visitors when working with families.

In summary, the scoping findings clearly validate the need for training for health visitors (not only on the four CVD risk factors highlighted: healthy diets, alcohol, smoking and physical activity) but more importantly, how to have conversations in a sensitive way, tailored to the specific needs and circumstances of the family. It was therefore recommended that the blended online training was developed as a programme comprised of e-learning, and interactive group discussions to enable learning and skills development between participants.

Contents

1. INTRODUCTION

1.1. Context

There is strong evidence that the first years of life provide an important foundation for future health and wellbeing, with well-documented associations of clinical risk factors, including childhood adiposity, blood pressure, and cholesterol, with the development of adult cardiovascular disease (CVD)[4]. The World Health Organization (WHO) estimates that non-communicable diseases (NCDs), including CVD, are collectively responsible for 74% of all deaths worldwide[2]. The rise of CVD has been driven primarily by four modifiable risk factors: tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diets[4]. The epidemic of CVD represents a significant health inequality which threatens to overwhelm health systems, with higher rates amongst disadvantaged groups, and devastating health consequences for individuals, families and communities[5].

Recent data indicate that childhood obesity rates increased substantially between 2019/20 and 2020/21 among both reception and year 6 age children, accelerating a trend which has continued for at least the previous 15 years[6]. Tackling rising levels of CVD risk is a public health priority and health visitors, through their universal reach to all families, have a significant and strategic role to play.

Despite this wealth of evidence, there remains a persistent evidence-practice gap hampering health visitor work on CVD prevention, exacerbated by health visitor workforce shortages and difficulties accessing affordable and bespoke continuous professional development (CPD). In the 2021 iHV survey, 40% of health visitors who trained in the last 5 years reported that they did not feel equipped for their role - many had not been trained in approaches like the Family Partnership Model (FPM), or equivalent advanced communication skills.

To tackle the CVD crisis, and reach the vast numbers of high-risk families, practitioners need to be supported to use their time most effectively to make the biggest impact. There is strong evidence that simplistic advice-giving, or ‘telling people what to do’, can leave people feeling judged, more likely to disengage in support and less likely to make positive health changes. ‘Poor communication’ is consistently the highest recorded NHS complaint type, and practitioners’ insensitive conversations with overweight people frequently hit the headlines[7]. Conversely, treating people with dignity and respect, and equipping practitioners with both the ‘key messages’ and ‘helper skills’ to support families to make positive health improvements, can bring about lasting change.

FPM provides an internationally recognised exemplar of partnership practice for prevention, early intervention and the management of complex difficulties. It has a well-established research base, including prevention and early intervention studies conducted by the Centre for Parent and Child Support, and studies conducted by independent researchers. FPM’s structured and flexible relational, goal-orientated approach helps practitioners and parents openly discuss sensitive issues, such as weight and diet, and results in significant and sustained change[8].

FPM’s flexibility and adaptability are strengths for its use with families who have a diverse and wide range of needs. Therefore, this project aimed to address the above gaps by creating a blended online learning programme, to equip and upskill health visitors in the use of the FPM model and its application to CVD prevention.

1.2. Aims and objectives of the project

The project aimed to strengthen the skills of health visitors as leaders within the early years to reduce the risk of CVD, through the enhancement of skills, in a blended online learning programme. The programme was based upon 3 modules:

- Module 1: Introduction to CVD as a public health priority – key messages (brief overview of latest guidance on all 4 risk factors)
- Module 2: Family Partnership Model – theory and concepts
- Module 3: FPM in practice – 'helper process' in relation to CVD risk - split into 4 sections, one for each of the risk factors

Aims:

To equip health visitors with the 'helper skills' and trusted evidence-based resources needed to guide the complex process of helping families adopt healthier lifestyles to reduce CVD.

Objectives:

- To identify health visitor learning needs around supporting families to adopt healthier lifestyles, which inform the development of evidence-based training and resources.
- To refine the 'key principles' of the evidence-based FPM, Helping Process Framework and integrate evidence-based information and resources on the reduction of the four major risk factors for CVD.
- To use co-production and rapid-cycle evaluation methods throughout the project, to develop and test the blended learning programme (online and interactive) and resources to use with parents to reduce CVD risks and enable healthier lifestyles.
- To provide health visitors with access to the programme through a bespoke section of the iHV LEARN platform to equip them with the framework, skills and opportunities for social learning with peers.
- To disseminate the project outputs to the health visiting workforce through a communications plan including networking events, conferences and multi-media promotions.
- To ensure that the training programme achieves the aims and objectives of the project scope, Prince2 project management principles were used. The project was split into 5 stages: inception, scoping, development, dissemination and evaluation.

1.3. Inception

The project adopted a collaborative, partnership approach at all levels. The key partners were the iHV and Professor Crispin Day, Head of the Centre for Parent and Child Support, Consultant Clinical Psychologist - Family Partnership Model Lead at South London and Maudsley NHS Foundation Trust, King's College London Institute of Psychiatry, Psychology and Neuroscience. An Expert Advisory Group provided governance, strategic oversight, expert guidance and assurance of project delivery. The project was led by a project manager within the iHV and the Expert Advisory Group, comprising representatives of health visitors, field experts, academics and national organisations.

iHV development projects embrace the principles and practice of co-production. As this is a practice development project, it did not require formal ethical approval, however, NHS Ethics principles were applied in its approach. These were applied to the design and delivery of surveys, insight and co-design of group activities, as well as the review of intermediate and final outputs. The partner organisations supported the iHV to engage with families to inform the project. Families were consulted and involved throughout the project.

1.4. Scoping

A collaborative rapid review of policy and academic literature was undertaken, guided by the expert advisors. This informed the design of the surveys, the structure of the co-design groups, provided evidence for the training materials and supporting resources, and was incorporated into an annotated bibliography for reference purposes.

2. BASELINE SURVEY

An electronic survey was constructed via Survey Monkey, and co-developed with the Expert Advisory Group to gather baseline information on the practice, knowledge and confidence of health visitors on CVD and their experiences of sensitive conversations with families on the risk factors of CVD.

The survey ran from 15/11/2022 until 31/12/2022. The survey was disseminated through the iHV membership. The respondents were drawn from all four nations of the UK. A total of 246 practitioners completed the survey; their responses represented a range of views related to their knowledge and skills when working with families on reducing CVD risk factors. As the survey comprised a relatively small sample and a “snapshot” in time, the goal of data saturation was considered unachievable. Therefore, a considered approach to sampling was undertaken, keeping the survey open for an extended period of time with the aim of reaching a level of “data sufficiency” that would provide insight into the project’s aims and questions, with multiple views and a range of participant actions.

2.1. Respondents

Table 1 shows the job roles of those who completed the survey. As can be seen, the majority (60%) of respondents were SCPHN - health visitors. As there are practitioners from different backgrounds represented in the survey, the term practitioners will be used in the report to refer to all respondents throughout this report.

Table 1: Job Role of respondents

Job Role	% of respondents
Health visitor – SCPHN	60
Health visitor – team lead/manager	16.5
Specialist health visitor	10
Student health visitor	7
Health visitor team – nursery nurse	3
Health visitor team – staff nurse	2
Health visitor – practice educator	1
Family nurse	0.5

There was wide variation in the practice experience of practitioners completing the survey, from less than a year to more than 20 years of experience. The smallest group (15%) had less than a year of experience and the largest group (28%) had 2-5 years of experience.

The average demographics of respondents are presented in Table 2. The sample included respondents from a diverse background including age, gender, ethnicity, and 12% stated they had a disability.

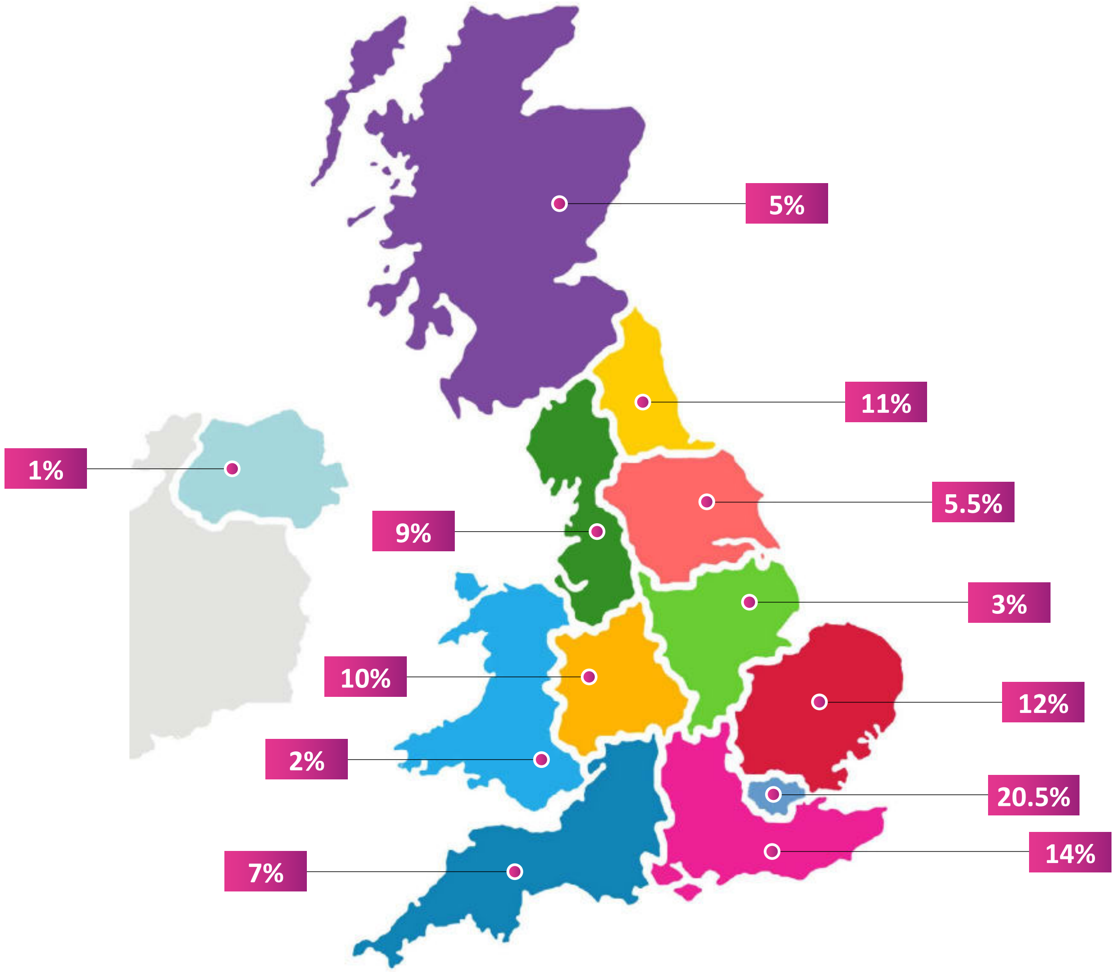
Table 2: Demographics of survey respondents

Demographic	Average response	% of respondents
Average age of respondents	45-64 years of age	68
Average gender of respondents	Female	92
Average ethnic group of respondents	White – English/Welsh/Scottish/Northern Irish/British	79
% of respondents who stated they didn’t have a disability	No	83

Figure 1 presents the geographical spread of respondents from across all 4 nations of the UK. The largest proportion of respondents (20.5%) came from London and the least from Northern Ireland (1%).

Where do you work?	
East Midlands	3%
East of England	12%
London	20.5%
North East	11%
North West	9%
Northern Ireland	1%
Scotland	5%
South West	7%
South East	14%
Wales	2%
West Midlands	10%
Yorks and Humber	5.5%

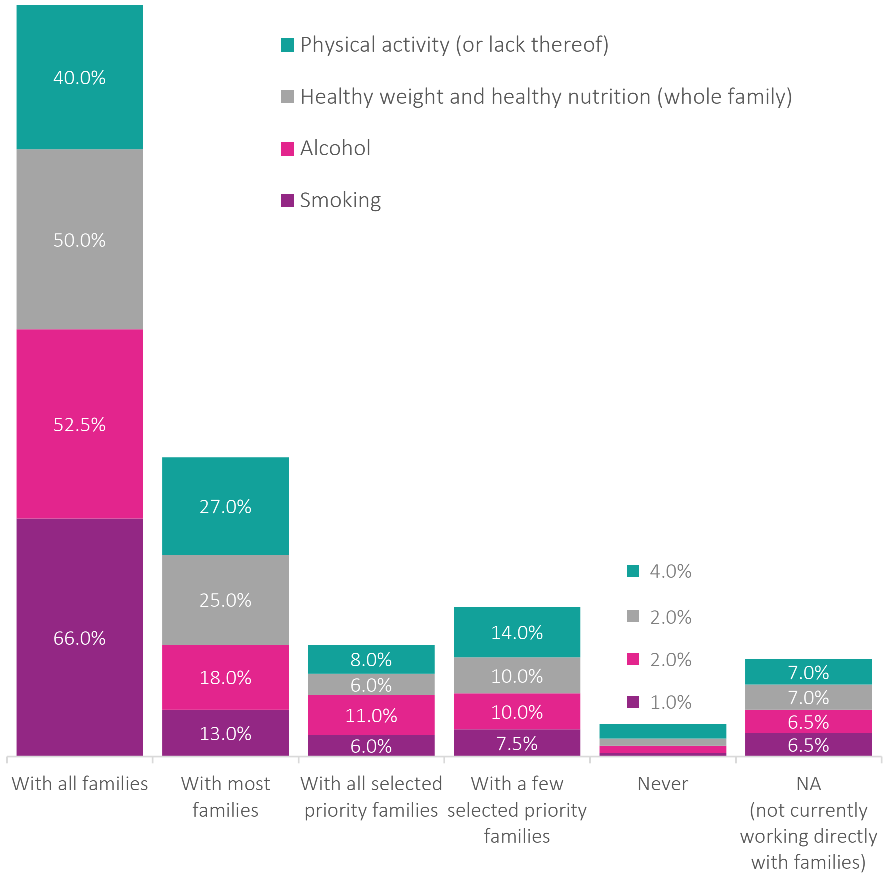
Figure 1: Geographical spread of respondents



2.2. Confidence and Knowledge in Practice

The first part of the survey aimed to gather insight into the current context of CVD conversations in health visiting, how health visitors are having the conversations, and how they determine whom to have the conversation with. This was split into the 4 different risk factors. Figure 2 shows how frequently practitioners have conversations about the 4 risk factors.

Figure 2: As part of your role, do you currently work with families to address the following contributory factors for CVD?



As can be seen in the graph, of the 246 respondents, 66% reported that they discussed smoking with all families, compared with 40% who discussed physical activity. 52.5% and 50% reported discussing alcohol and healthy weight and healthy nutrition (HWHN) respectively.

> *These are often discussed within a multitude of other health topics. With reduced health visitor contacts it is difficult to ascertain whether the information is retained and [health visitors are] unable to follow-up behaviour change.*

1% of respondents never discussed smoking with families, 2% never discussed healthy weight and healthy nutrition or alcohol, and 4% reported that they had no discussion at all about physical activity with families.

> *Poor capacity in the team. Large caseloads & increased vulnerability means health promotion cannot be prioritised*

The respondents were then asked to put aside the current workforce shortages in health visiting and to share their views on whether health visitors **should** have a role in CVD prevention and early intervention. The findings present a clear positive response across all 4 risk factors:

- **Smoking**
  74% of respondents strongly agreed that conversations about smoking were part of the health visitor's role, 12.5% agreed. 1% neither agreed nor disagreed, and 9% strongly disagreed, feeling that this was not part of the health visitor role.
- **Alcohol**
  70% of respondents strongly agreed that conversations about alcohol were part of the health visitor's role with a further 17% agreeing with this. Again, 9% strongly disagreed, feeling that this was not part of the health visitor role.
- **Healthy nutrition**
  86.5% either strongly agreed or agreed that having conversations about healthy nutrition, during pregnancy and postnatally, and enabling families' behaviour change should be part of the health visitor's role. 0.5% disagreed and 9% strongly disagreed in relation to this topic of conversation.
- **Healthy Weight**
  87.5% either strongly agreed or agreed that having conversations about healthy weight and growth for babies and children, and enabling families' behaviour change should be part of the health visitor's role. As above, 0.5% disagreed and 9% strongly disagreed in relation to this topic of conversation.
- **Physical activity**
  73% of respondents strongly agreed that conversations about safe physical activity for babies and children was part of the health visitor's role. In comparison, 60% selected strongly agreed, and 25% agreed, when conversations were about safe physical activity during pregnancy and postnatally. 3% neither agreed nor disagreed. 9% of those who responded strongly, disagreed that conversations about safe physical activity for babies and children was part of the health visitor's role. 9% either strongly disagreed or disagreed that conversations during pregnancy and in the postnatal period were part of the health visitor's role.

As the majority of respondents clearly saw these aspects of CVD prevention and early intervention as part of their role, it was important to understand why these conversations may not be happening routinely in health visiting practice. Respondents were asked about their perceived barriers to conversations with families about CVD risk factors.

Around a third of respondents (see Figure 3) felt that there were no barriers to their work with families around CVD and that they prioritised this topic. Importantly, this meant that between 60-70% did feel there were barriers, with physical activity representing the area with the most barriers reported by 75% of respondents.

Figure 3: % of respondents who do not think there are any barriers to CVD conversations with families

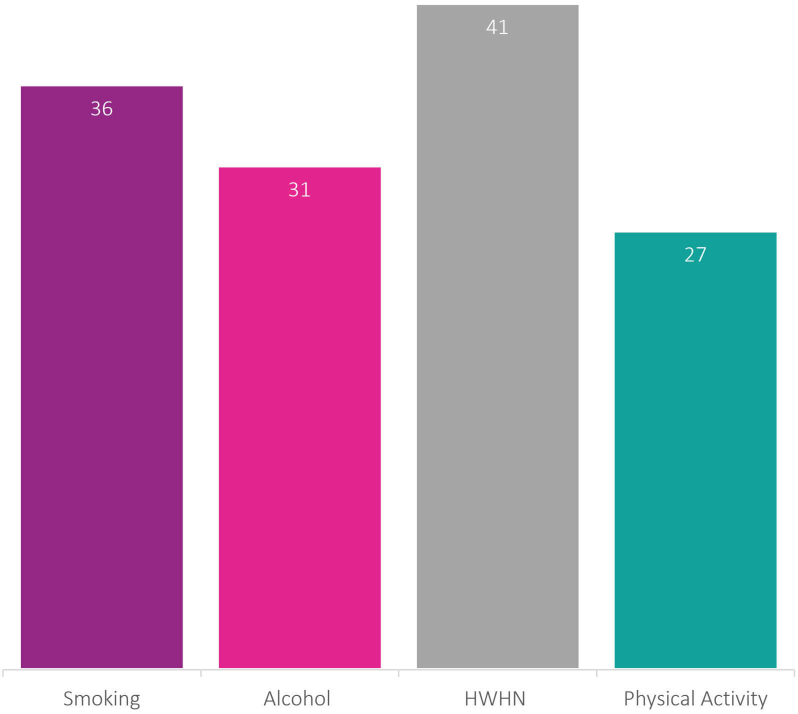
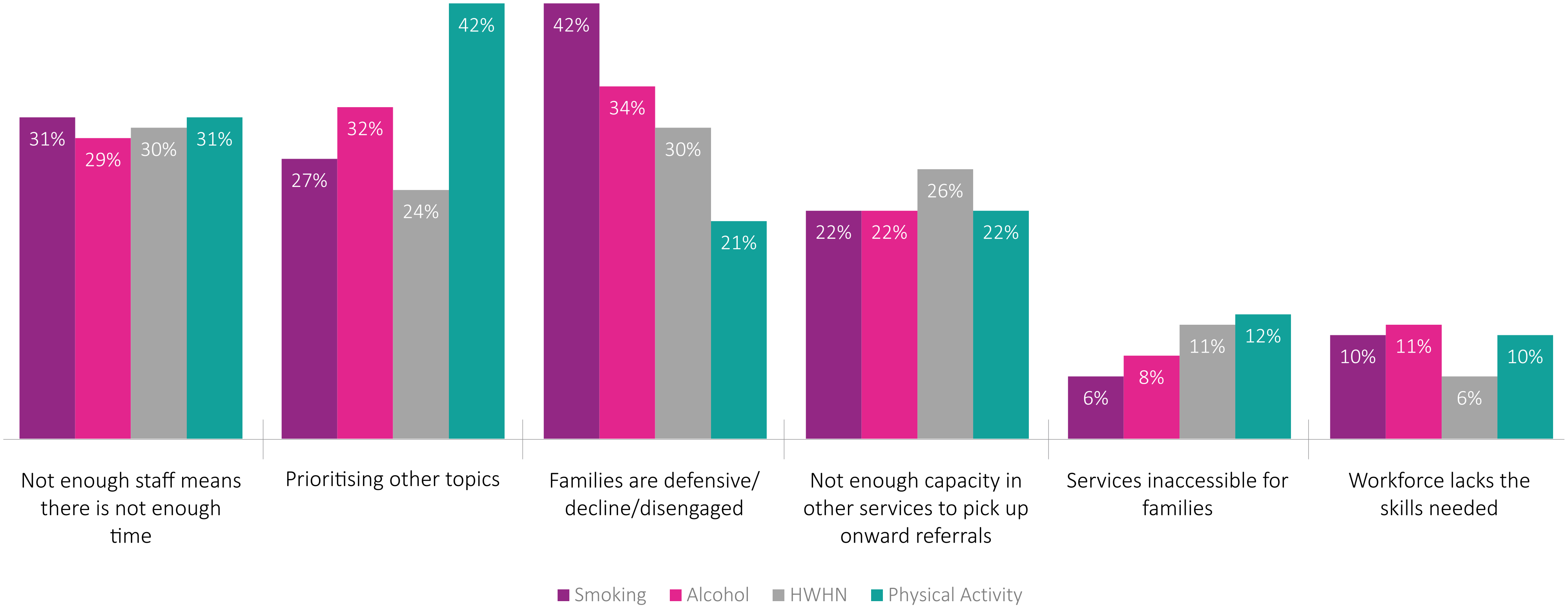


Figure 4: The barriers most frequently cited as influencing work with families around CVD risk factors of the remaining two thirds.



> *We have to concentrate on KPIs, so less time with staff shortages to review lots of these areas.*

> *Time to actually ask in the visit. So much now to cover. Have to prioritise with each family what you want to discuss.*

> *These conversations are better had when a therapeutic relationship has been established as they can be sensitive topics to discuss and rely on cycle of change and families feeling ready to engage. Making every contact count is what we use but I feel the most successful changes are made when you can spend more time with a family.*

2.3. Training

To gain an understanding of practitioners' knowledge, skills and confidence on CVD prevention and early intervention and how this is translated into practice, it was important for the survey to gather information on the training that practitioners had previously received on the four risk factors for CVD linked to this project. This enabled clearer understanding of what the training needed to focus on, to ensure that it met gaps in practitioners' knowledge and skill.

From the respondents, it was noted that there was a significant proportion who had received no training on these four topics. Although the percentage for each topic was different (see Table 3), almost half had not received training about alcohol and almost a fifth had received no training about HWHN.

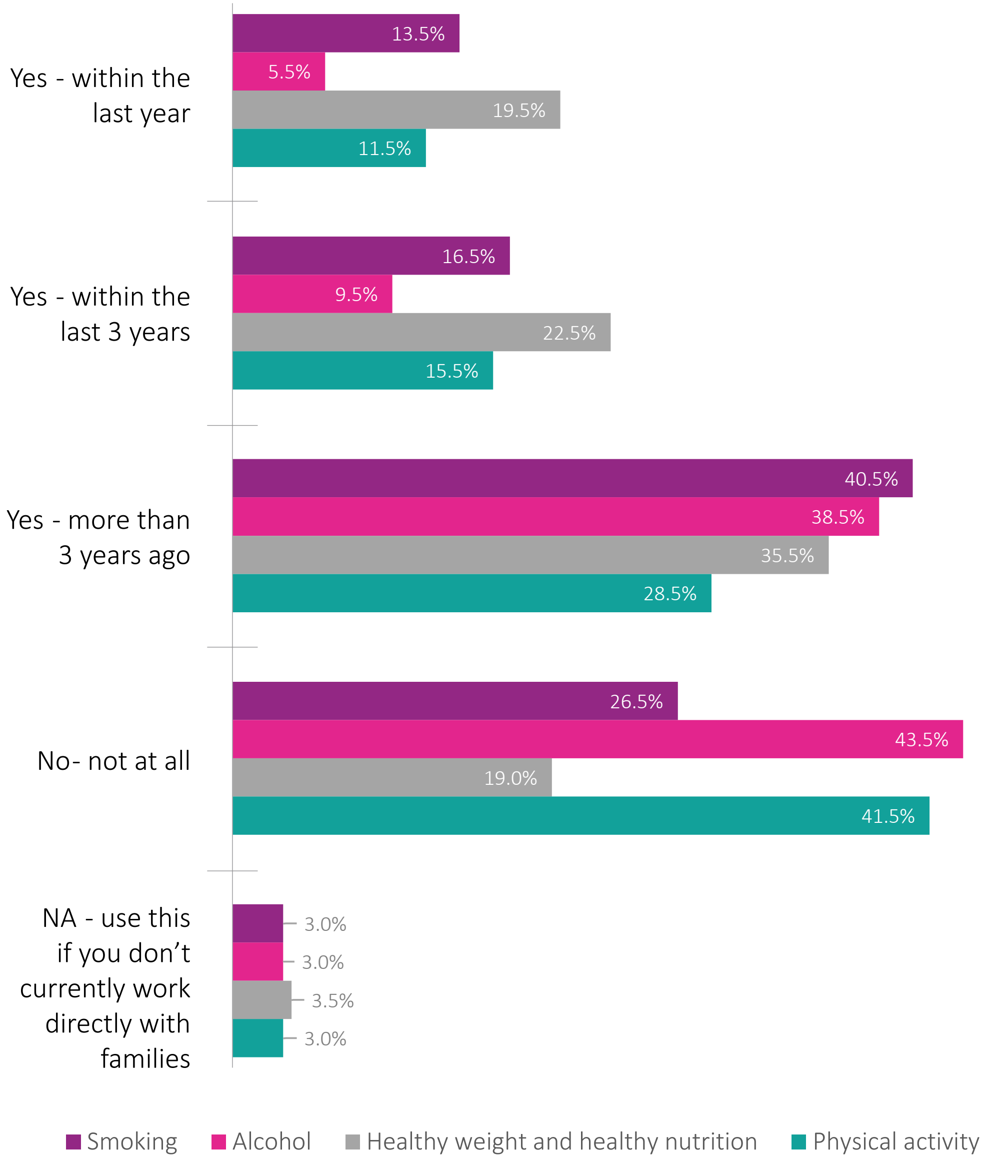
Table 3: % of respondents who have received no training on CVD topics

Have you had specific evidence-based training to develop your knowledge on?	% of No - not at all
Alcohol	43.5
Physical Activity	41.5
Smoking	26.5
HWHN	19

The remaining respondents reported receiving some training on each of these topics. However, for many their training had taken place more than 3 years ago as shown in Figure 5. For those who had received training, 4% stated that their training had formed part of their SCPHN training.

> *[I] could do with further training regarding exercise in pregnancy.*

Figure 5: When did you last receive training on the 4 CVD risk factors?



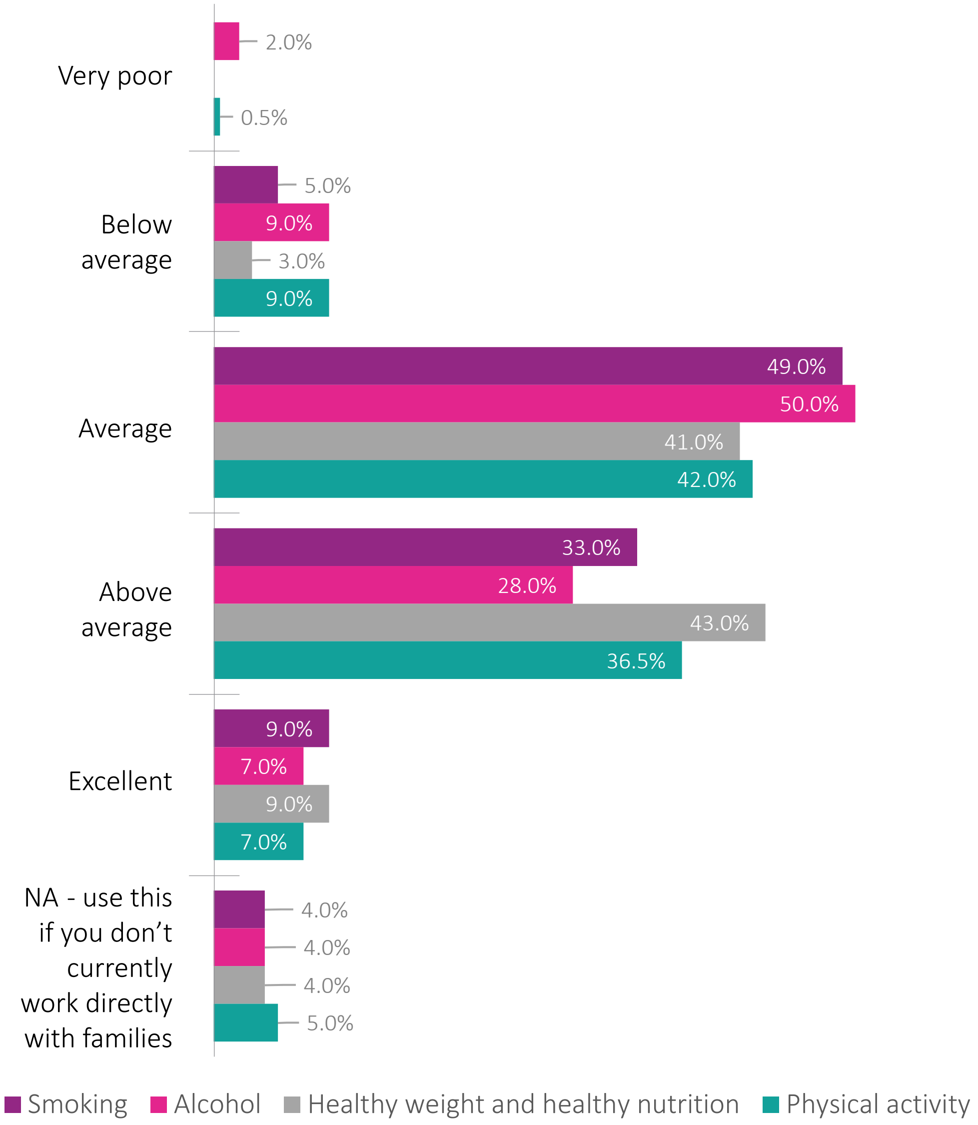
The survey also asked what training respondents had received on communication skills and, in particular, how to have successful behavioural change conversations. When asked about specific communication skills training on having conversations with families about supporting behaviour change in general, 25.5% of respondents reported having received no training, 39% received training over 3 years ago, and 35.5% had received training within the last 3 years.

Respondents were asked to provide information on the training that they had received to gain an understanding of whether any specific tools, theories or programmes were widely used, including any background in the FPM, which is to be the focus of the blended online learning programme. Table 4 (see page 15) details these responses.

Only 38 respondents provided examples of previous training. The training most frequently cited was FPM and Motivational Interviewing, with a third of the 38 citing these 2 programmes. Other examples (cited by 5 or less respondents) included Maternal Early Childhood Sustained Home visiting (MECSH), HENRY, Family Nurse Partnership (FNP), Promotional Guide and Making Every Contact Count (MECC).

Respondents were asked to rate their current knowledge and understanding of the evidence-based factors contributing to CVD, and how these impact health and wellbeing of the whole family. As can be seen in Figure 6, smoking was the factor contributing to CVD which the respondents felt their knowledge and understanding of the evidence base was highest, with over 90% feeling their knowledge was average, above average or excellent. Alcohol and physical activity were the factors in which the respondents felt their knowledge and understanding was less comprehensive, although this was still a high percentage, with 85% feeling their knowledge was average, above average or excellent.

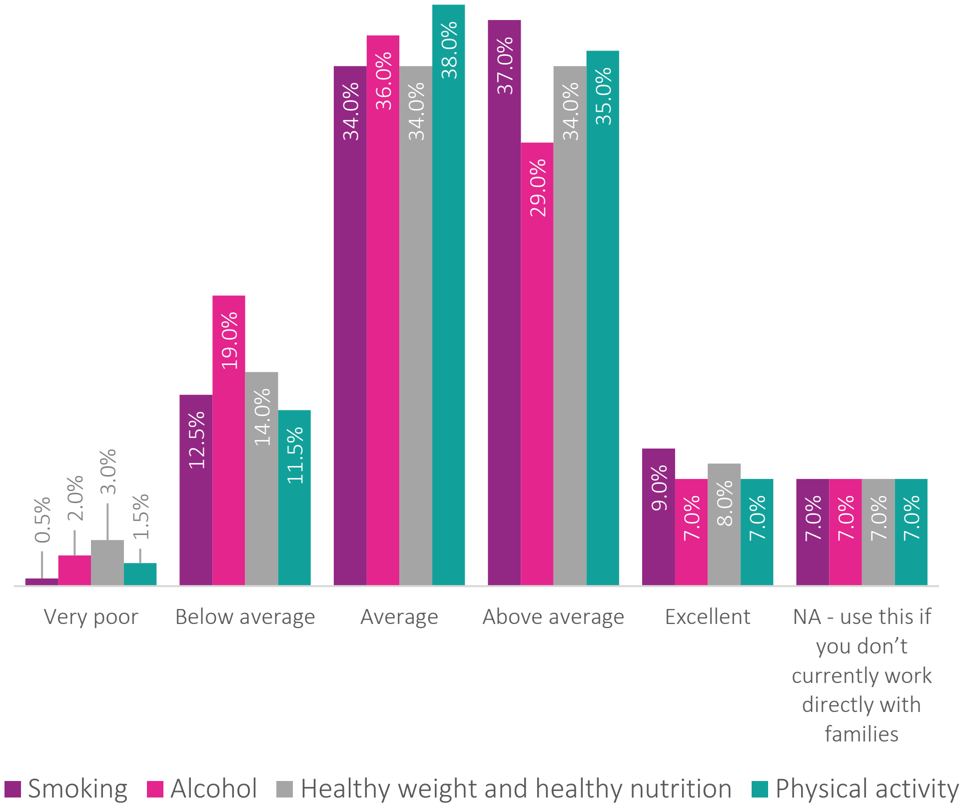
Figure 6: Understanding of the 4 evidence-based factors contributing to CVD, and how these impact health and wellbeing of the whole family



2.4. Conversations with families

The next part of the survey sought to understand respondents’ perceived difficulty of having conversations with families about CVD prevention related to each of the 4 risk factors. Figure 7 shows how difficult, on average, a conversation is with families about the 4 risk factors. The respondents indicated that conversations about alcohol use were the most difficult to have with families, with 21% feeling that conversations about alcohol were difficult or very difficult, which increased to 55% where families were not engaged.

Figure 7: Practitioners’ perceived difficulty in having conversations with families about the contributing factors for CVD, and supporting behaviour change



Having these conversations when families were resistant to change, defensive or had differing priorities were perceived as more difficult by many practitioners – the survey findings are presented in Table 4, with over 40% of health visitors reporting this as difficult or very difficult.

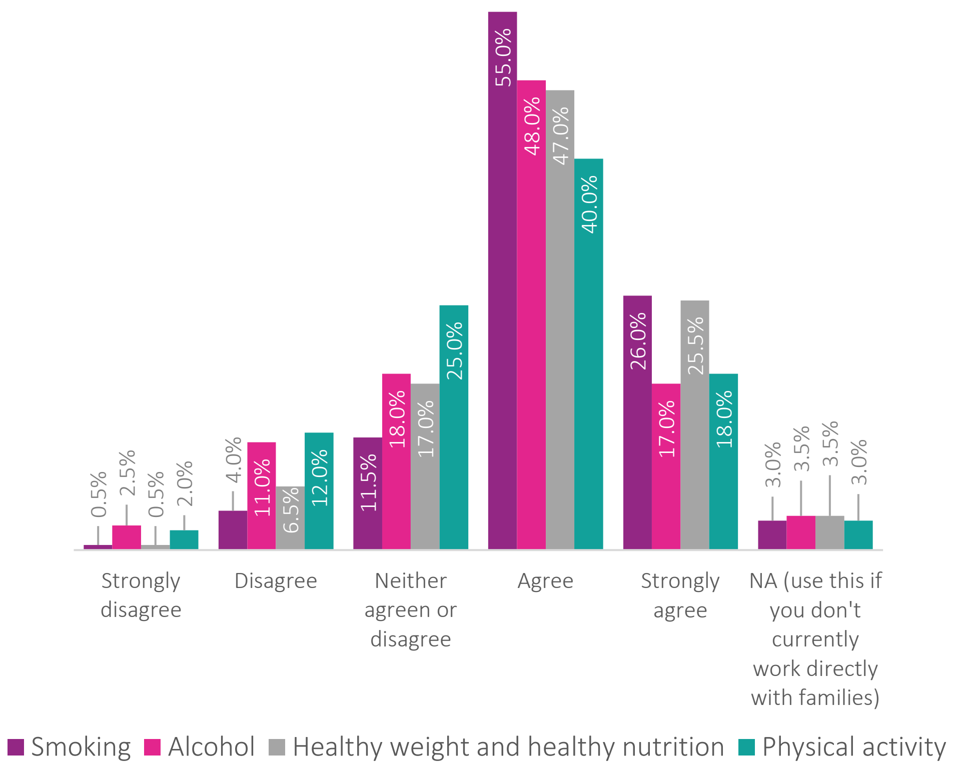
Table 4: How easy or difficult is it to have conversations about the 4 risk factors with families who are resistant to change, defensive, or have differing priorities.

	Very easy	Easy	Neutral	Difficult	Very Difficult
Smoking	4%	11%	26%	39%	12%
Alcohol	4%	9%	24%	42%	13%
Physical activity	3.5%	14%	28%	35.5%	12%
HWHN	3%	14%	28%	36%	12%

2.5. Support for families

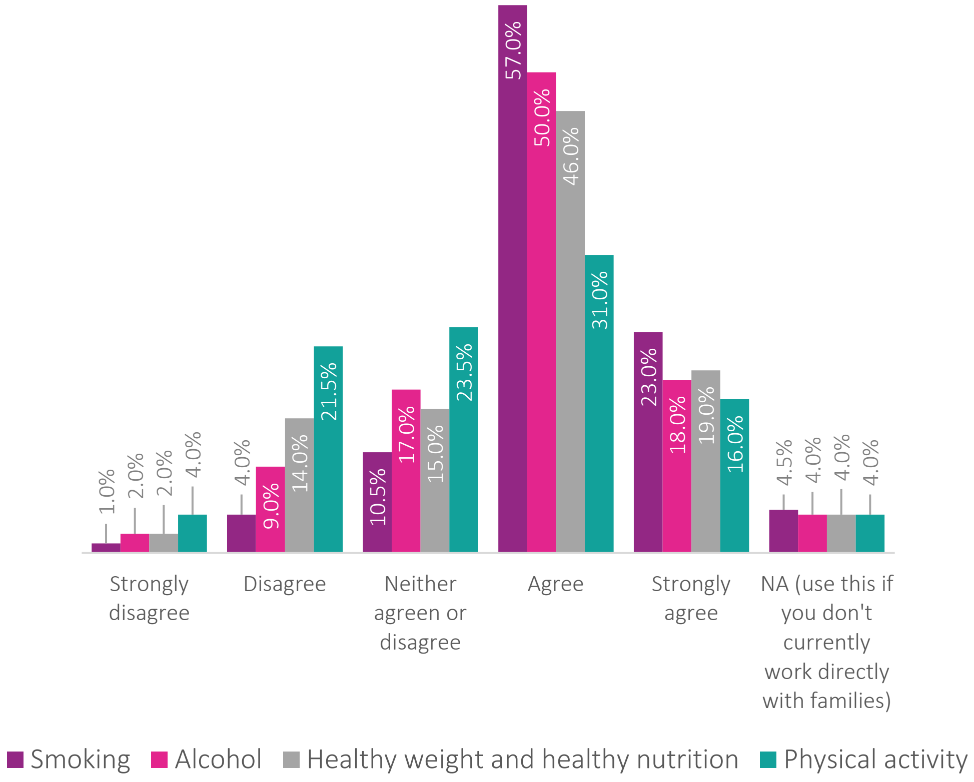
The survey sought to understand the ongoing support that health visitors gave to families. This included knowing where to signpost families to and refer on for further support. Over 40% of respondents reported that they knew where to signpost families for more information. However, over 10% were unsure where to signpost families to when the discussion centred on alcohol use or physical activity. Figure 8 details the breakdown of respondents' knowledge of where to signpost families to for accurate up-to-date information on the 4 risk factors.

Figure 8: Knowledge when asked 'I know where to signpost families for accurate up-to-date information on the 4 risk factors'



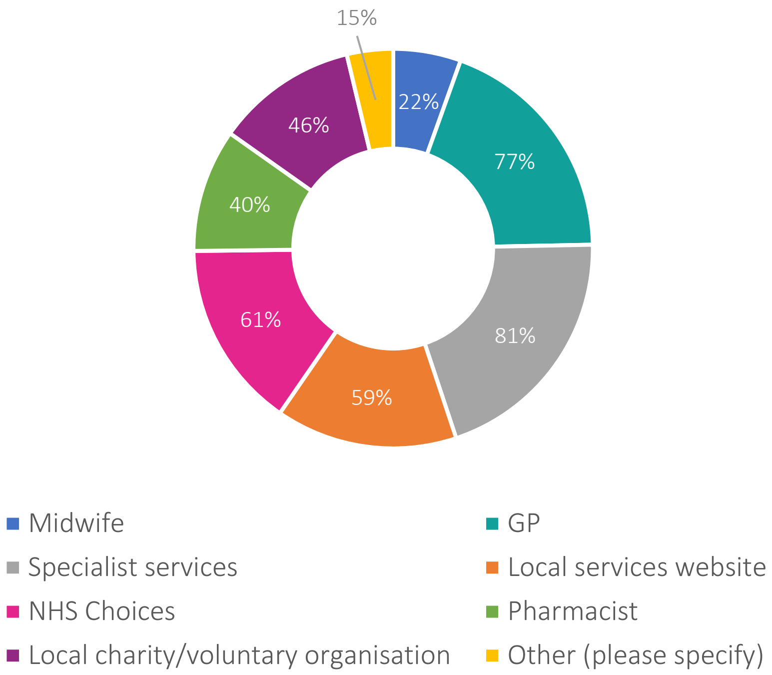
Similar responses were given when asked about referring families to an intervention or specialist support outside of the health visitor service. This is illustrated in Figure 9. Fewer respondents knew where they could refer families to for intervention or specialist support with physical activity, 31% agreed they knew where to refer, compared with 57% for smoking.

Figure 9: I know where to connect/refer families to when they require an intervention or specialist support outside the health visiting service



When families are signposted or referred for onward support, respondents were most likely to refer to specialist services (81%) which included local wellbeing services, leisure centres and gyms, and local and national charities. This is illustrated in Figure 10.

Figure 10: Where families are signposted to or referred for onward support



In the free text box comments, respondents reported that their decision making on treatment planning and onward support referrals were influenced by a number of factors. This included continually changing or inconsistent services, closed waiting lists and restrictive referral criteria which limited their ability to refer families, and up-to- date knowledge of local services, including where to refer and signpost to.

> *Demand way outstrips availability of services.*

> *Some local services available but [they are] inconsistent and many professional services have closed waiting lists or reduced criteria for referral.*

> *Services that used to be available, particularly for healthy weight, have now gone.*

Concerns were raised about having conversations with families but being unable to refer on to other services which may have been decommissioned.

> *We used to have lots of services run out of children’s centres and leisure centres, but these have now all gone leaving families few resources to support them with healthy weight and physical activity.*

When asked if they were aware of how to refer to their local specialist support services for behaviour change or healthy lifestyle support, 54% of respondents said yes, they were aware, 19% said no and 27% reported being unsure.

When asked to detail which resources they currently recommend or use, 71% of respondents do not currently use or recommend any resources to facilitate family engagement in conversations about the main contributing risk factors for CVD. The remaining 29% who do recommend resources, cited the following:

- NHS websites
- HENRY website and resources
- Making a change – alcohol
- NHS Start4Life resources
- Local and voluntary services
- First Steps Nutrition Trust website and resources

Finally, the survey asked respondents to share any other information about their experiences of having conversations with families. The responses indicated that practitioners are concerned about their capacity to take on additional work, suggesting that the intervention needs to be incorporated into their current practices.

> *Limitations/capacity with staffing does not enable workforce to take on any additional work, even fitting training in is currently difficult. As public health specialists we should be addressing all of these areas.*

Although practitioner respondents stated that they would welcome training in this area and felt it was central to the health visitor's role, some also raised the importance of utilising the skills within the skill mix team as part of a 'whole team' approach to CVD risk reduction and early intervention.

> *Health visitors offer 5 mandated contacts - last 45-60 minutes, include many topics and assessments. Health visitors do not complete all contacts as we work in skill mix.*

2.6. Summary

In summary, it can be seen from the survey respondents that CVD prevention is seen as part of the health visitor's role and that health visitors want to fulfil this. However, health visitors perceive many barriers to embedding these conversations into their contacts with families. These barriers are further impacted by the lack of training and resources. Therefore, it is important that the blended online learning programme not only aims to upskill health visitors in having effective and sensitive conversations with families, but it also does so in a way that addresses the perceived barriers and can be easily incorporated as part of their routine work with families. The 'Let's talk heart health' programme described in the next section aims to support practitioners to use their time most effectively and work in partnership with families to reduce CVD risk.

3. CO-DESIGN AND INSIGHT WORKSHOPS

3.1. Co-design Workshop

To support the translation of the survey findings into the development of a bespoke training programme aimed at health visiting practitioners, a co-design workshop was held to provide one element of co-production for this project (see Insight groups for other elements). Invitations to join the co-design workshop were shared via the iHV networks, as well as to those who had expressed an interest in being involved from the survey.

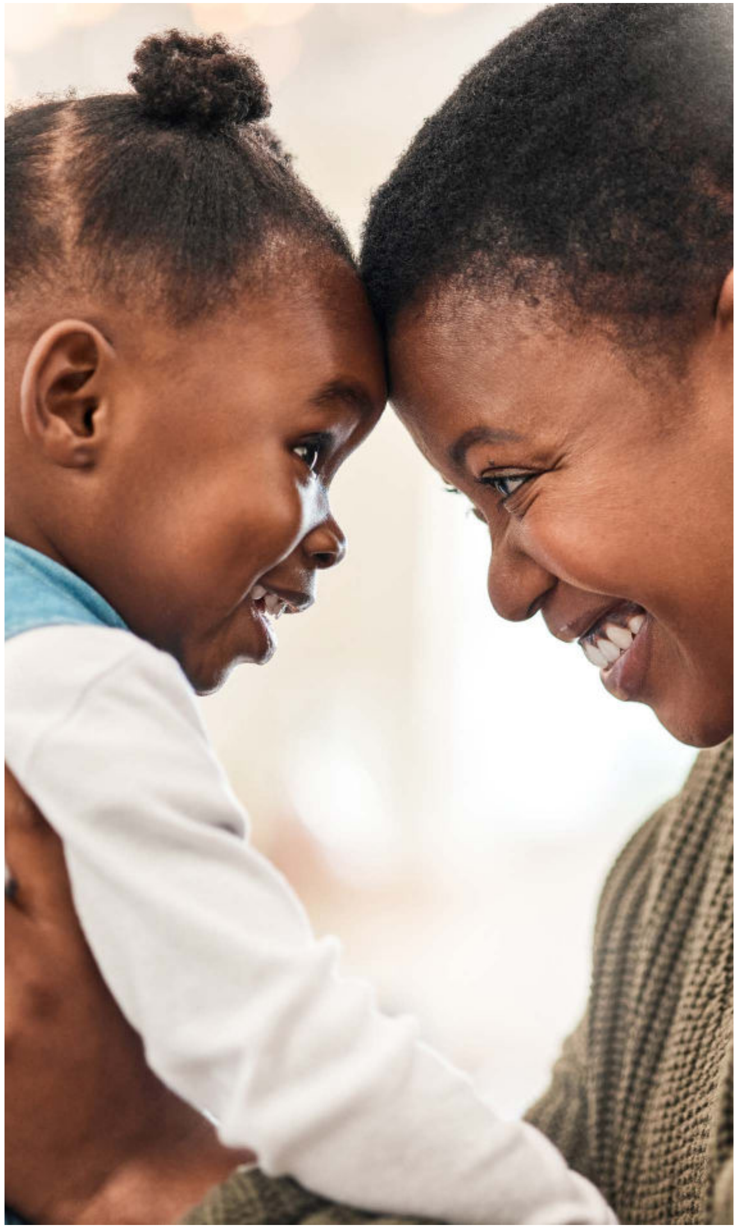
The half-day co-design workshop was arranged to be face-to-face in London to suit the preferences of the ten participants who had initially expressed an interest in attending.

The session was led by the iHV project team and also attended by Professor Crispin Day and the e-learning and film designers Eggu (formally Onclick). This enabled all members of the team to understand the needs of the practitioners first-hand and allow opportunity for further exploration of specific aspects of the feedback or resources as needed. The outline of the workshop can be seen in Figure 11.

Figure 11: Outline of the co-design workshop

Outline of the session

- Explanation of the project
- Current insights
- Developing the training
- Group work
- Next steps



Due to an unexpected high rate of attrition, only three practitioners were able to attend the face-to-face workshop on the day. The group comprised two participants who were leads in their service and able to share insights from health visitors in their services, and an experienced recently retired heath visitor and public health academic, all of whom were able to provide valuable insight into the survey findings and the development of the resources.

There was much discussion around the survey findings. All in attendance agreed that CVD prevention conversations were part of the health visitor's role and welcomed the blended learning on how to have these conversations using the FPM. However, there were concerns raised about "buy-in" and how health visitors, Service Leads and Commissioners could be engaged – it was felt that CVD may be perceived as a topic that is more relevant for services focused on older adults than health visiting, as the impact of interventions for babies, young children and their families would not be seen immediately. Tackling this perception requires a shift away from selecting interventions in childhood based on quick 'cashable savings', to also include investment in long-term outcomes, including the absence of disease in adulthood. Evidence-driven interventions should include proximal outcome measures linked to reductions in the four main risk factors for CVD of smoking, unhealthy diets, physical inactivity and alcohol consumption.

Participants felt that the following features of the planned training were important:

- Ensure that the FPM principles are understood by attendees.
- Training delivery needs to be flexible, allowing practitioners to complete the programme on their own, or a service to deliver it to their workforce as a whole.
- Supports skills development and reflection. It was agreed by all that the training programme needs to be completed in pairs to allow health visitors to discuss the implementation of the FPM into their practice.
- Short 'bite-sized' learning to support scaffolding of knowledge and skills development. Participants felt that the e-learning element should be completed in sections, with health visitors using the skills in practice and then returning to the e-learning to complete the next step and reflect with their "buddy".
- Open-access to all members of the health visiting team to ensure that conversations with families are consistent and effective. Consideration was given to expanding the training to the Early Years workforce and School Health Nursing, but following wider discussion it was agreed that this is outside of the scope of the project and the remit of the iHV.

The final part of the workshop considered the blended online training content and specific aspects of the look and feel of it. The participants were asked to comment on how different aspects of the interactive learning would look and an outline of the different models and length of time to complete, as can be seen in Table 5:

Table 5: Suggested module outline for the interactive learning

MODULE	TITLE	LENGTH
1	Why is CVD a Public Health Priority?	20mins
2	Partnership and the Helping Process	30mins
3a	Conversations to Support your Practice around Tobacco Use	10mins
3b	Conversations to Support your Practice around Family Activities	10mins
3c	Conversations to Support your Practice around Alcohol Use	10mins
3d	Conversations to Support your Practice around Meals, Snacks and Family Foods	10mins

The attendees liked the layout and the interactive aspects of the e-learning, they especially liked that it was not a case of reading PowerPoint slides and then answering questions. The issue of practitioner unconscious bias and preconceptions of their own health were discussed. There were concerns that some practitioners may shy away from discussing these risk factors, as they partake in these unhealthy habits themselves and may feel they are being hypocritical, or families will not take them seriously. It was felt this needed to be addressed in the blended online programme and practitioners would be signposted to where they can get support for themselves.

Finally, the group were shown the logos in Figure 12, of the potential training imagery. All attendees agreed that they preferred Logo 1 and the associated imagery, this reinforced the findings from the Expert Advisory Group who also preferred Logo 1.

Figure 12: Potential blended online learning imagery 1 and 2

Logo 1	Logo 2
	

Other aspects of the blended online learning that the group liked were topic cards and a parent-held record to facilitate and guide conversations with families.

Following the insights and decisions from the workshop, there were a number of steps agreed to move discussion points on:

i. Two virtual focus groups to take place, one for health visitors to gain the insights from those who were unable to attend the face-to-face workshop, and one for parents to ensure that the findings resonated with them and that the blended online learning contains information that parents wish to know, in a way that they find accessible.

ii. Recruitment advertising needs to consider how organisations are approached to obtain interest and engagement. May need to consider targeted advertisement of those already involved in the project and universities where students will have more capacity to attend.

iii. A guide to be created to support local facilitation by pairs of practitioners or services as a whole.

iv. Build in activities/reflection on practitioner bias to encourage practitioners to stop and reflect on their own bias and views, and how this may differ from others' perspectives. This will also include signposting to where they can get support for their own health behaviours.

3.2. Insight Groups

To explore the themes generated from the survey and the co-design workshop, two focus groups were held, one for health visitors and one for parents. The participants were identified as follows:

i. Parents – One of the partners on the project, University College London (UCL), has an active group of parents who are part of their focus groups. UCL sent the information about the insight group to those parents to ask if they would like to attend. All parents who attended were given a £25 Love2Shop voucher as a thank you for their time and sharing their experiences - this is in line with NHS Patient Participation guidance.

ii. Health visitors – Those who completed the survey were asked to share their contact details if they would like to be involved - those who agreed were contacted and invited. An invite was also sent to iHV members who had completed previous iHV training relating to the 4 risk factors and those who were unable to attend the face-to-face workshop.

The aim of the insight groups was to:

- gain a better understanding of what health visitors and parents think about CVD.
- gain a better understanding of what health visitors discuss during contacts with families.
- gain a better understanding of how parents feel about these discussions.
- gather feedback about imagery for the resources.
- gather feedback and ideas on what resources health visitors would like developed.

3.2.1. Parent Insight Group

Following the advertisement of the group through iHV partner organisations and Expert Advisory Group members, 12 parents expressed an interest, they represented a varied demographic which included:

- 2 fathers
- 3 single parents
- 1 who defined themselves as any other White background
- 1 who defined themselves as any other Black/African/Caribbean background
- 1 who didn't want to state their ethnicity and another who did not want to state if they had a disability (all others responded that they had no disability).
- They also varied in age, falling into the following age ranges:
    - 1 aged 16-24 years old
    - 1 aged 25-29 years old
    - 2 aged 30-34 years old
    - 3 aged 35-39 years old
    - 4 aged 40-44 years old
    - 1 aged 50-59 years old

However, on the day 3 mothers attended, all White English/Welsh/Scottish/Northern Irish/British, aged 30-44 and in a relationship.

This insight group followed a similar format as the co-design group. Insights were shared from research of what parents had previously said about conversations with healthcare professionals when discussing the 4 CVD risk factors. The session went on to share the health visitor insights gathered from the survey and co-design group. Finally, the mothers were asked to share their views on the imagery and resources to be developed as part of the blended online learning training.

The mothers' views corresponded with that of the health visitors in their agreement that health visitors should have conversations with families about heart health. As with previous research about conversations on smoking and physical activity, the mothers felt that it is the responsibility of the health visitor to raise awareness of actions which are harmful and can be changed, to allow for better health outcomes. These should be raised without pre-judgement and in a universal manner to avoid stigma.

> *I'm constantly thinking about them being healthy... But you don't think specifically about their heart health. it's just never actually occurred to me to think specifically about that.*

The mothers were clear that before conversations about sensitive topics could take place, they needed to feel comfortable, and that the practitioner was interested in them and their family – not simply the paperwork. The parents felt that if simple precursors to establishing a positive relationship were missed by professionals, such as introducing themselves, smiling and an awareness of their body language during a contact, this would impact on their level of engagement.

> *Ideally [I would like conversations] ..., with someone that I'd seen or spoken to before. Or if someone was asking how I was rather than how the baby is, because I think mum does get forgotten definitely.*

They also felt that the best time to begin having these discussions was in the antenatal period.

> *It should be antenatally... is the best time for it to be brought up... because that's when you're thinking about everything for the future... once the babies arrived you don't always get that time to sit and think about stuff like that.*

The mothers also agreed that framing discussions from a positive angle and introducing topics of conversation with examples of other parents' experiences would make it easier to have open discussions.

> *Not even focusing on the negative elements... I don't know whether you should, you know, to make people feel less uneasy with being attacked in their home about bad habits, whether you can really promote the benefits of the good rather than attacking about the bad.*

The mothers identified similar barriers to CVD conversations as the health visitors, most of the perceived barriers discussed by the mothers related to a lack of connection and individualised support. The parents wanted to feel health visitors had time for them and took an interest in their family and individual circumstances, and avoid tick-box, paperwork-based contacts. Interestingly, none of them mentioned that if the practitioner smoked or was overweight it would have an impact on how they would receive the information. They only stated that believing that their health visitor was knowledgeable and would be able to signpost them to further, local information was important to the parents.

> *The first health visitor I ever met, she walked into my house. She didn't even tell me her name. It was just like question, question, question. She would write in her book. There was no eye contact, and it was just really, really cold and kind of upsetting.*

> *The paperwork is a barrier... it's a relationship, not an analysis. When I had the health visitors come to my house. It felt very paperwork, very tick box.*

> *A smile, definitely. An introduction. Just to make you feel comfortable that you can actually speak to someone and it's confidential as well, because sometimes you do have to talk about something that's sensitive, or that you don't want to speak to anyone else about. It's just basic friendliness really.*

Fundamentally, the relationship between health visitor and parent determines whether families will engage in conversations about these topics. They also highlighted that the health visitor would focus on a topic such as smoking and discuss it at length, despite it being a non-smoking family. This left the mother feeling that the contact was not tailored to her family and was a tick-box exercise.

> *It is all about that relationship about trusting someone, and that's about how they approach you.*

> *As I was a non-smoker, I've never been a smoker I felt like it was ... what they spoke about the most.*

The mothers agreed that prompt cards to facilitate a normal universal conversation would be helpful for introducing and discussing these risk factors. They felt that it would help them lead the conversation and bring up topics which may be sensitive, or they feel embarrassed about. Table 6 (page 26) details the suggested imagery and the views of the mothers.

Table 6: Mothers' views on topic card imagery

Image	Comments
Healthy Diets	
	The mothers liked the image of the heart of fruit and veg best. They liked that it was clear and that the heart linked to the project topic. They did not like the cartoon food preferring "real" images of healthy foods. They did not like the scales. Again, not liking a "cartoon" image, they also felt that it was stigmatising and made you think only about weight and body image as opposed to the wider context of healthy diets - this took the focus away from the positive aspects of healthy eating. They highlighted that they wanted the conversations and cards to have a positive focus to them.
	
	
Smoking	
	The mothers did not like this image and said they would not like a "real" image of cigarettes or ashtrays. As they mentioned previously, they wanted a positive image - maybe of clean air or clouds and avoid the negative 'telling off' imagery.
Alcohol	
	As with the smoking imagery, the mothers did not like these pictures for the same reasons as the smoking image. They suggested that an image of smoothies or a similar drink would be better, again focusing on the positive healthy aspects.
	
Physical activity	
	Again, they like this as a "real" image. They liked that it was not focusing on a specific "exercise" or showing any ethnicity or demographic, so it could be anyone out for a walk with their baby/child.

3.2.2. Health Visitor Insight Group

The health visitors were recruited as previously outlined. As with the other groups, there was interest in attending the insight group with five health visitors expressing an interest to attend, but four health visitors actually attended the meeting. Their insights and feedback helped consolidate the findings from the health visitors survey, the co-design group and the parents insight group. As hoped, the virtual format allowed attendance from a wider geographical area, having attendees from the North West and South East, the attendees were a mix of health visitors and a health visitor Matron.

The outline of the session followed the same as the parent insight group, it started with an overview of the project and scoping finds to date. Then it discussed the blended online training and finally, the project's imagery and resources.

As with all the previous scoping and insights, the insight group attendees agreed that discussions about CVD were part of the health visitor's role and are an important part of the public health aspect of their work.

> *I think it should be all the time. I think we are public health nurses, aren't we? So, I think these conversations should be all the time.*

However, they acknowledged the difficulty of the current climate and that, due to COVID recovery and the significant shortage of health visitors, there is little continuity of care and public health conversations have been lost - as the focus on safeguarding, core contacts and KPIs are prioritised. Participants described the negative impacts of the loss of focus on preventative public health:

> *I think the reality is that we don't do universal... I think in general we won't have that relationship, I think we just need to accept that it's not going to be that we have time to develop a relationship before we have those difficult conversations.*

> *Not all our families have an antenatal contact, which is a key time to have these conversations. So we have set up the virtual session so that we can try and offer something to all our antenatal families.*

Participants discussed the wider barriers to having CVD conversations, which again reflected the key themes identified in the previous scoping and insights:

- **Lack of training and knowledge on the risk factors** caused them to avoid discussing them or asking closed tick-box questions.
- **Lack of knowledge on signposting and referring, as well as lack of services to refer to**. This was compounded by a lack of confidence in knowing whether resources and services were evidence-based and provided consistent information.
- **Lack of training on 'how' to have a sensitive, meaningful and effective conversation with families.** They acknowledged that making health changes were difficult for many families and they required practitioners who could help them build resilience with support that took account of their individual context, options and preferences.

> *[It's important to] make sure they're sharing the right information, so that if you signpost them there, if you haven't got time to go into detail, you know that they're going somewhere where they'll still get the same advice.*

> *I still think we should have more training, like the family partnership... to build up our skills.*

- **Making 'best-use' of limited time available** – participants described the pressures of the relatively short time that they have available to work with families. This was compounded by a belief that families know the information already, as is it constantly in the media - there are tv programmes dedicated to healthy eating, and the risk factors for smoking are printed on the packaging. Therefore, they think that the families know it all and there is the requirement to move on to other topics that feel more pressing to the health visitors, such as KPIs. Despite this, it was recognised that these conversations need to be taken in a non-judgemental, non-criticising approach, which takes place as part of a wider discussion with the family.

> *I don't have any problem with actually having the conversations. I'm quite comfortable having those conversations, but I think it's if you're seeing that person for an hour, and there's a whole list of subjects that you have to cover. These things often don't have immediate impact, so there's a tendency to focus on the immediate physical needs.*

> *I know you already know this because it's pushed down people's throats and the media and stuff, isn't it? They know about healthy lifestyles. They know they shouldn't be smoking and drinking. They know that so they don't need it from us as criticism. They need it from us constructively.*

- **Congruence with practitioner's health behaviours:** As with the co-design group, the insights group participants were concerned about how their own health habits reflect on the conversations they have with families and the possibility they undermine the conversations, or make them appear hypocritical.

> *There's also that personal challenge when you're talking about that, and you know you're talking to yourself as much as others.*

> *Sometimes I feel a little embarrassed talking about some of [the CVD risk factors]. I know it's like our profession, and we're there to support the families and the ongoing health for the future, but for me - being that ex-smoker, and being slightly overweight - I do feel like I am patronising the parents sometimes, and sitting there saying, oh, you need to do this, you need to do that. When deep down I'm not doing it.*

As the group discussed these feelings, they reflected that these are professional conversations and that it is not about their own personal choices, but imparting information to parents to allow them to make informed decisions about their own health and the health of their baby/child.

> *Sometimes we struggle if we ourselves are overweight, for example…I think there's such a stigma around it, and we've got to reduce that stigma. We've got to talk more about these things in the same way we do with domestic abuse now.*

> *It's about the human aspect. Isn't it because it's we're not dictating to people. We're not judging them.*

- **Use of topic cards and resources to support guided conversations on CVD risk factors** - The participants agreed with the parents insight group, that the topic cards would be helpful in supporting them to initiate conversations. The health visitors were shown the same images as the parents from Table 6 (see page 24). They also preferred the photographs and real images over cartoons or line drawings, and the images which portrayed a positive message.

> *I don't like the scales… I think it shouldn't be a weight conversation. It should be a health conversation.*

> *I do prefer a real image, because I feel it puts you more in that place of what's actually going on. I think sometimes the black and white images, or the cartoon images are just that, they are cartoons. It doesn't represent real life.*

3.3. Co-design and insights summary

It is evident that both the health visitor and parent participants in the co-design and insights groups reinforced the key themes from the survey findings. That conversations about CVD by health visitors are important and should form a key part of their role. However, lack of training and current service pressures makes it hard to prioritise these conversations. It was interesting to hear that practitioners are concerned about how their own lifestyle choices affect how the information they share with families is received. This is not something that the families considered. Despite the parent insight group being small, this was reflective of wider research findings which also report that families are more concerned about being given information in a sensitive manner and being made aware of the risk to their health of their current actions[9].

The three groups validated the need for training on the four CVD risk factors and, more importantly, that this needs to include 'how' to have effective conversations that broker families' engagement and lead to lasting health changes. The findings also validated the need for resources to support these conversations in practice, to ensure that they are delivered in a universal manner that is personalised to the needs and context of individual families, avoiding stigma and judgement.

4. DISCUSSION

Throughout the scoping and insight work, key themes have been identified. These have been considered in relation to the COM-B model[3] for behaviour change and will be used to support the development of the blended online training programme.

4.1. Capability

Health visitors were less likely to discuss topics they do not feel confident in, and where insufficient training has been received. It is clear from the results of the health visitor survey and feedback from both professionals and parents, that health visitors were more likely to discuss smoking and healthy diet with families than alcohol use, or the importance of physical activity.

The focus on smoking was also identified by the parents. If they were non-smokers, they felt that significant time was taken up discussing this and time could have been focused on a topic more relevant to them and their family.

Reduced practitioner confidence in having discussions about physical activity and alcohol use is reflected in the lack of training to improve their knowledge of alcohol use or physical activity. This is in contrast to the high level of training about smoking, which makes this the CVD risk factor they were most likely to discuss with families, as they felt most informed.

During the health visitors insight discussion, they discussed the impact that stigma and personal bias has on their interactions with families. For example, they felt it was challenging to have discussions with families about being a healthy weight, if they themselves were overweight. However, this was not a concern raised by parents whose only focus was to have a professional who was knowledgeable and who tailors the conversation to the family.

4.2. Opportunity

Health visitors were concerned that a lack of capacity and continuity within current health visitor practice limited their opportunity to establish therapeutic relationships with families and influence lasting change. In addition, they felt that where they did discuss factors related to CVD, it was just a small part of a discussion which encompassed information and advice about a plethora of other topics. Health visitors also raised that there was a lack of opportunity to discuss these topics due to the current service pressures of meeting KPI targets and managing safeguarding cases, which they felt left little room for health promotion conversations.

The parents' experiences of varying levels of support, dependent on area and staffing, reflected the pressures described by health visitors to do more, with less capacity.

Priority for the parents was feeling that their lives and current capacity for change was understood by practitioners. The parents felt that developing a relationship founded on trust was essential for them to feel that they could be open about the things that really mattered to them during these discussions. The parents felt that simple gestures such as a smile, and open and welcoming body language, were key in making them feel comfortable discussing issues with health professionals.

4.3. Motivation

The health visitors acknowledged that heart health might not be a priority for some families, but understanding what motivated an individual family could help them to make changes which would have the same long-term outcomes. It was also recognised that how conversations are framed changes how the information may be received, and impacts the motivation to change. Parents agreed that framing discussions from a positive angle and introducing topics of conversation with examples of other parents' experiences would make it easier to want to open up the conversation.

Most of the perceived barriers discussed by parents related to a lack of connection and individualised support. The parents wanted to feel that health visitors had time for them and took an interest in their family and individual circumstances. This was also acknowledged by the health visitors who felt that understanding the family's position and the probability that they are already aware of a lot of health messaging was important, and that personalisation of support is key to improving service uptake and outcomes. Not all aspects will be equally relevant to every family, or for every occasion when health visitors engage with them.

Health visitors highlighted that they were less likely to discuss the CVD risk topics due to the reduction in the services to refer on to. There was also a lack of confidence among health professionals about which organisations families can be signposted to. This was felt by the parents who had limited experience of follow-up from health visitors. Both groups felt that understanding where to signpost families after a discussion was of utmost importance. Health visitors recognised that ensuring any organisations they referred on to were providing consistent information and advice which complemented their initial conversations was critical.

4.4. Behaviour

Both health visitors and parents were in agreement that having a resource to share to initiate conversations in a universal way would be helpful. They felt this gave an opportunity to parents to open up conversations that they feel are appropriate to them and allows health visitors to introduce topics in a non-judgmental way, avoiding stigma.

Working in ways which are inclusive, of diversity in relationships and family formations and including the wider family in discussions about heart health, was important to the parents. They felt that even if the opportunity to discuss a topic in depth was not available, knowing that it was something they could discuss was valuable.

For resources to be supportive and aid conversations about the CVD risk factors, both parents and practitioners overwhelmingly preferred photographs and real images over cartoon or line drawings. They both felt that it was easier to relate to photographic images and there was less ambiguity in the images. The consensus was that using images by way of prompting discussion may support in ensuring the conversation was pitched at a level appropriate for the family at that moment in time.

5. CONCLUSION

Overall, as a nation, we are becoming less healthy. Lives are being cut short and more people are living with CVD and related health inequities that are largely preventable and take root in early childhood. Without a change of direction, the government will need to budget for soaring treatment costs of CVD in adulthood. To change the story, we need to change the beginning of the story with a concerted focus on 'creating health' in the earliest years – prevention is better than cure. However, the findings from this review identified a level of disconnect from this evidence, with efforts to tackle CVD in practice largely focused on interventions for older adults.

It is clear that successful implementation of CVD prevention and early intervention initiatives with families with babies and young children will require 'buy-in' from local Service Leads and Commissioners, alongside national government. Tackling this requires a shift away from selecting interventions in childhood based on quick 'cashable savings', to also include investment in long-term outcomes through interventions that reduce the likelihood of disease in adulthood by tackling the four main risk factors for CVD. The findings from this review highlight the important role that health visitors play in reaching and supporting all families in this area. However, there are also a number of barriers to implementation that need to be addressed.

The insights gathered indicate that health visitors are ideally placed to support CVD prevention and early intervention in childhood. Practitioners' knowledge and skills are essential for effective conversations with families, but are insufficient to support implementation of new ways of working without an organisational commitment to support best practice, continuity of care, and ensure that sufficient time is given to embed these changes as part of routine health visiting. The COM-B model[3] of behaviour change provided a helpful explanatory model for the inter-relationship of these factors, highlighting that practitioner motivation and behaviours in practice are an outcome of the combination of capability (supported by knowledge and skill) and opportunity. When these are well aligned, it supports both practitioners and parents to modify behaviour, supporting CVD conversations, and allowing for professional effectiveness and client satisfaction, enhancing motivation further.

This review has provided a clearer understanding of health visitors' knowledge and training needs relating to the factors impacting heart health. Health visitor and practitioner feedback indicates a lack of knowledge, resulting in a lack of confidence in having conversations with families, particularly in relation to alcohol use and physical activity. These conversations are also more challenging when families are resistant to change, defensive or have differing priorities. And, in these circumstances, practitioners are more likely to avoid having these conversations, or ask closed questions to avoid opening up the conversation further.

There is considerable overlap in the parent experience and the practitioner perspective. The insight will inform the development of bespoke training and resources as part of this project. The Family Partnership Model will be refined and adapted for health visiting and CVD prevention. It is ideally suited to time-poor practitioners as its effectiveness is not dependent upon the time available but the attitude, skills and approach of the practitioner, tailored to the individual parent's needs. This will benefit both parents and families and reinforce the importance of these discussions within health visiting practice.

6. RECOMMENDATIONS

The scoping findings clearly validate the need for training for health visitors, not only on the four CVD risk factors hhighlighted (healthy diets, alcohol, smoking and physical activity) but also how to have conversations in a sensitive way, which is tailored to the specific needs and circumstances of the family.

However, this needs to be considered in balance with the current health visiting context. This is to ensure that over-stretched staff and services do not find the additional training onerous and that they find the information and skills within the blended online training enhance and complement their current practice and service delivery model.

It is recommended that the blended online training programme is developed to be delivered in a flexible way so that different services and organisations can implement the training in a way that suits their staff, service and community.

It is important that imagery and resources created to support the blended learning training are real and promote the positive aspects of the four risk factors and support universal conversations. These need to work for all people, regardless of their backgrounds, ethnicity, socio-economic status, or current lifestyle choices.

Following the scoping and insights work, it is recommended that the blended online training is developed as a training programme comprised of e-learning, webinars and group discussions. The programme, which will be piloted, will be made up of the following components:

- Introduction session – 1-hour online event which will introduce the programme, set-out the expectations of the participants and set the scene of why CVD and why health visiting.
- E-learning – participants to work through 3 modules over the space of 1 month, this is to be undertaken in pairs so that they can discuss aspects of the FPM and reflect on how this has impacted their practice.

The 3 modules will be:

1. Module 1: What is Cardiovascular Disease and why it is important in health visiting
2. Module 2: What is the Family Partnership Model
3. Module 3: Applying the Family Partnership Model to conversations about healthy diets, alcohol, smoking and physical activity

- End of training sessions – 1½ hour virtual session to discuss how the participants found the training and what impact it had on their practice. This is also an opportunity to discuss more complex conversations and situations which e-learning is unable to explore.

It is important that this is developed, so that it is applicable to all practitioners within a health visiting team. Therefore, instead of saying health visitor throughout, it is recommended that the term practitioner is used. It is also recommended that careful consideration is given to the marketing of the training and pilot programme, to help service leads understand the benefits of the training programme for their staff, service and communities. Rather than being an additional burden for services, this training supports practitioners who are ‘time poor’ to make the best use of the limited time that they have. It equips them with the skills to work in partnership with families, in the ‘complex and messy real world’, to make meaningful changes to improve health.

To change the story of CVD, we need to change the beginning of the story. And this needs to start in the earliest years of life.

7. NEXT STEPS

The next steps for the project team are:

1. Develop the e-learning and wider aspects of the training programme.
2. Deliver a launch webinar to raise awareness of the upcoming training and the importance of health visitors discussing CVD.
3. Deliver the pilot training programme to 40 health visitors and their teams.
4. Gather feedback and evaluate the pilot programme, making updates to the training programme as needed.
5. Launch the training programme nationally to 70-100 health visitors and their teams.
6. Complete the project reporting.

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