

**What do
parents
want from a
health visiting
service?**



Results from a Channel Mum survey

January 2020

Foreword

“What do parents want from a health visiting service? What does good look like? The Institute of Health Visiting has been seeking answers to these questions by asking the people who know best – those who the service is intended to reach.

We are delighted that Public Health England will be refreshing the 4-5-6 health visiting model for England and the Healthy Child Programme in 2020. To support this work, the Institute of Health Visiting is pleased to publish this first survey of 1000 mothers of children aged 0-23 months completed on our behalf by Channel Mum, in 2019.

I would like to thank all the parents who generously shared their time and experiences with us. They are the true experts on what a good health visiting service needs to look like. Listening to parents played an integral part in the development of the Institute of Health Visiting’s Vision for health visiting which was published in October 2019. Our Vision is built on this “voice from experience” and the best available evidence of “what works”. It sets out a blueprint to improve outcomes for children and families and reduce inequalities through strengthened health visiting services.

There are many treasures within this resource and we hope that you will deliberate on them and build the key elements into your services and the way you practice – the loudest message is that parents value being “met as a person” and the trusted relationship with a named health visitor, which is provided through continuity of carer.

I note many parents shared very positive experiences of the support that they had received and the difference that it had made. Sadly, this was not the experience of all parents, with some describing the service as rushed and impersonal – this is not the service that parents deserve, or health visitors want to provide.

We hope that the experiences of these parents will be valued for the gift that it is – if we are willing to hear, we can learn from both positive and negative experiences. The findings present a mixed picture of health visiting nationally and insight on what it is really like to be on the receiving end of the care that health visitors provide. I hope that policy makers, commissioners, providers and health visitors will hear the voice of these parents. The real test will be whether these parents feel that they have been “listened to and heard” by those that are able to make the difference and ensure every child has the best start in life.

My thanks to Channel Mum for conducting the survey on our behalf and 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**



Acknowledgements

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Listening to parents to identify the key elements of an effective health visiting service

In October 2019, the Institute of Health Visiting published, "[Health Visiting in England: a Vision for the Future](#)" which was developed in response to Public Health England's call for collaboration in its refresh of the health visiting 4-5-6 model and the Healthy Child Programme. This supplementary paper outlines the integral part that listening to parents played in the development of our Vision which sets out a blueprint to improve outcomes for children and families and reduce inequalities through strengthened health visiting services.

By working collaboratively with parents, we sought to answer the question, "What do parents want from a health visiting service?" which should form the starting place for any policy for health visiting. Our engagement included a survey of 1000 mothers of children aged 0-23 months completed on our behalf by Channel Mum, in April 2019.

The findings are set out in the eight key elements of an effective health visiting service which are centred on relationships and the needs of families. These key elements also reflect and draw upon common themes identified in published research on service user engagement in health visiting and further insight gained from the numerous co-production groups that are integral to the work at the Institute.

Figure 1: The eight key elements of an effective health visiting service



Co-production is an integral part of healthcare

Co-production - doing with and not for, or to, people; not just sometimes, but all the time - is widely accepted as integral to quality improvement in healthcare.

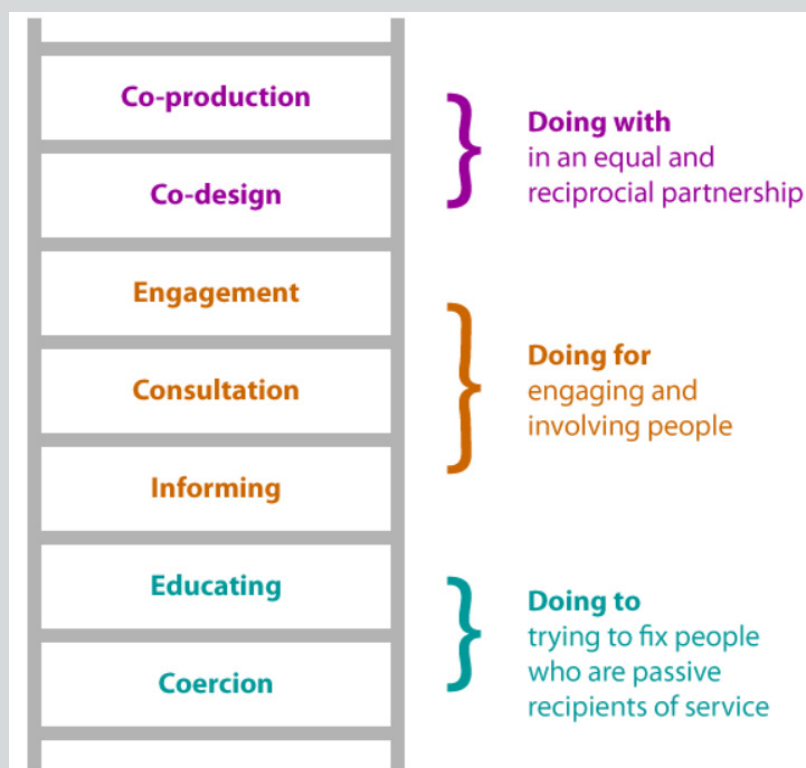
Co-production is defined as “a way of working that enables people who use health and care services, carers and communities to come together in equal partnership. Ideally, it engages groups of people at the earliest stages of service design, development and evaluation”.

Co-production changes the power relationship between policy makers, commissioners and members of the public, valuing and acknowledging that people are experts by experience and should have an equal role in the process of understanding local need and developing innovative solutions to address them.

The benefits of working together and really listening to those who use our services are obvious and integral to designing services and systems that can improve quality of care and outcomes. If we do not work collaboratively, we risk developing programmes that are irrelevant, unhelpful, not feasible, ineffective, or even harmful. In recent years there have been some excellent examples of how co-production through meaningful, collaborative partnerships have created the means to rethink how healthcare is delivered. Health visiting has much to learn from Maternity Voices Partnerships – these multidisciplinary groups have brought together commissioners, providers and the women and families using the services, to positively shape the Better Births² programme in maternity services.

We are delighted that Public Health England will be refreshing the 4-5-6 health visiting model for England and the Healthy Child Programme. Much of the success of this programme will rest on whether the voices of families are listened to and heard as an integral part of this refresh. By listening to the stories of those who have experienced health visiting services as they really are, we can move into more meaningful and effective “patient engagement”³ (Figure 2 – Ladder of Co-Production) - because when it comes down to it, it is only the people who use our services who can actually tell us how they really are.

Figure 2: Ladder of Co-Production*⁴



*This graphic has been reproduced with permission from Think Local Act Personal: <http://bit.ly/2NiQgHR>

Effective co-production relies on us being ready to “hear”, but also to ensure that everyone feels “listened to and heard” as part of an equal reciprocal relationship - feedback will include both positive and negative experiences which may represent a challenge to us as professionals. There are many reasons why it can be difficult to actively seek feedback and welcome ideas and challenges. We may feel a need to insulate ourselves from perceived criticism to “stay positive” during tough times. Perhaps there is an element of power and prestige that comes from being the professional “expert”. Yet most of us came into health visiting wanting to make a positive difference to children and families. If that’s the case, then we need to actively seek to engage with the people who use our services – currently too many of their experiences, advice and ideas are unheard and their valuable insight is lost.

What do parents want from a health visiting service?

To help us answer this question, a survey of 1000 mothers of children aged 0-23 months was completed on our behalf by Channel Mum in April 2019, alongside insight gained from the numerous co-production groups that support our programmes of work at the Institute, and published research on service user engagement in health visiting. The survey achieved good geographical reach with a proportionate sample from all geographical regions in England and the devolved nations of Scotland, Wales and Northern Ireland (Appendix 1).

The findings were reviewed using the principles of Experience Based Co-Design⁵ which aims to provide insight of parents’ experiences of services. The aim was to identify key touchpoints - these are described as emotionally significant points, which represent positive or negative feelings and experiences of care along the parent’s journey that may have promoted or hindered outcomes. These touchpoints provided useful insight and learning that represent two sides of the same coin, with parents providing accounts of positive treatment in some areas, whilst other parents reported negative experiences when faced with similar situations. These experiences of care were sorted into themes which informed our “Eight Key Elements of an effective health visiting service”.

Key Findings

This survey has highlighted a mixed picture of health visiting nationally with many mothers valuing the service that they received; however, some reported a poor experience. The service that families receive is largely dependent on where they live, rather than their level of need, captured in these representative responses to the question, “How can the health visiting service be improved?”

“More standardised care - A friend lives 1.5 miles from me and had a baby within 2 weeks of me yet had a very different experience of health visitors. She had a home visit prior to birth and was given useful advice. I didn’t receive this”.

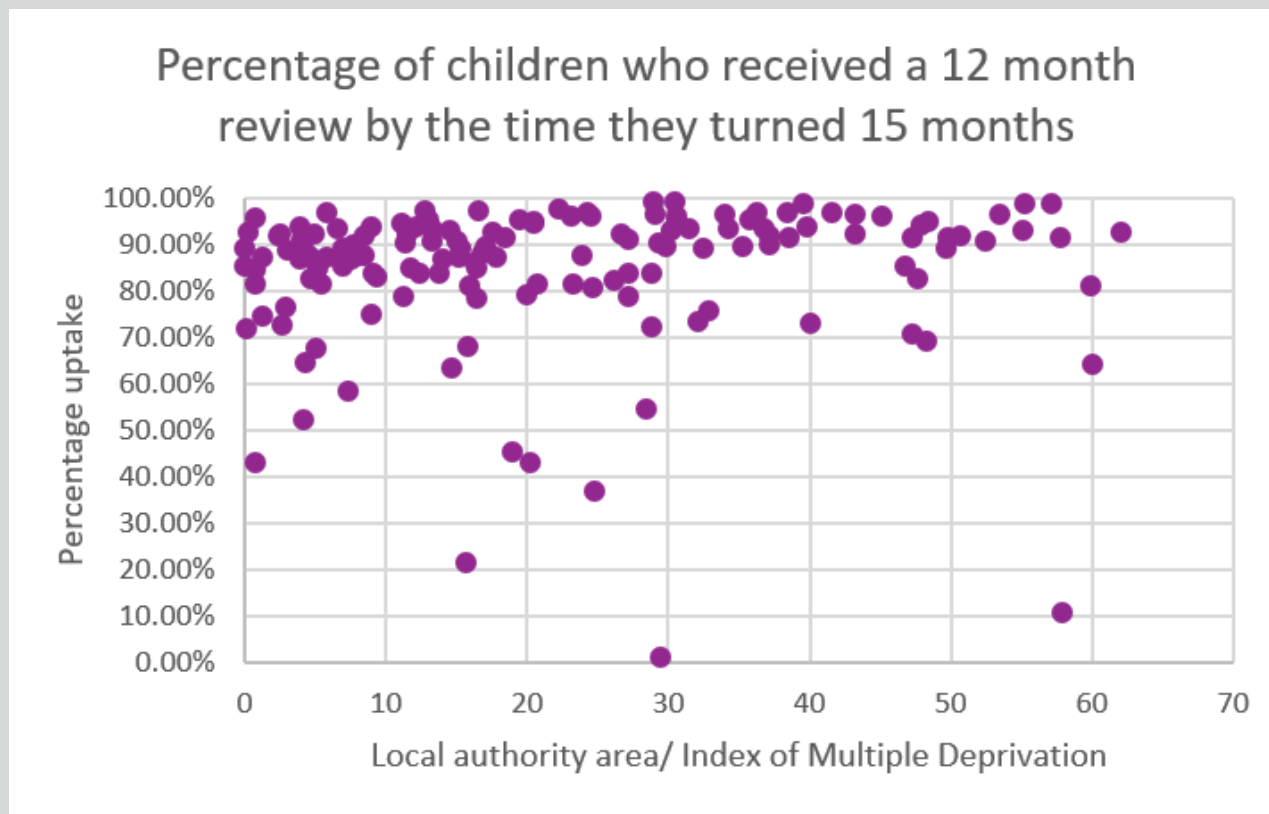
(response 885)

“Be consistent - If I have a friend who has a child the same age as mine (a week apart) and she has had a health visitor appointment as routine, then so should I”.

(response 931)

Regional variation in provision in England is starkly demonstrated by the graph below which depicts health visiting activity (in this case the published national data on uptake of the 12-month health review (PHE, November 2019)) by area of deprivation. The graph depicts no correlation between deprivation, as a proxy for level of need, and service uptake – rather a postcode lottery of health visiting activity, with very poor provision in some areas.

Figure 3: Uptake of the 12-month health visiting health review by local authority area Index of Multiple Deprivation



Eight Key Elements

1. Personalised – to be met as a person

The provision of continuity of practitioner which enabled the development of a health visitor-client relationship was found to be an important factor in parents’ satisfaction with the health visiting service.

Mothers valued being treated as an individual, with a personalised service that was responsive to their individual circumstances and needs, rather than a “one-size fits all” approach. Positive experiences were linked to continuity of health visitor and a non-judgemental strengths-based approach that was based on client-led goals and a shared understanding of their priorities:

“[I experienced] Excellent support through the health difficulties of my eldest as a baby and with my own postnatal depression second time round. Very individualised support and help. Given advice per person, not grouped advice, as every baby/parent are different”.

(response 68)

“My health visitor knows me and addressed my emotional needs when no one else understood. She supported me, gave me advice and pointed me in the right direction, boosting my confidence as a first-time parent. I felt completely comfortable knowing she had my interests and my baby’s interest as a priority”.

(response 216)

The main drivers for dissatisfaction were lack of continuity of health visitor, the appointments feeling rushed and too little time spent on emotional transition to parenthood. When asked how the service could be improved, parents suggested:

"A more one to one service, every family has their own HV for all their children".

(response 4)

"Having the same health visitor right throughout pregnancy and after birth".

(response 79)

"Keeping to one health visitor - in the past 2 years I've had 5 different health visitors".

(response 114)

"More funding so they can spend more time with parents so that the parent and health visitor can form a bond so that there is complete trust on both sides".

(response 944)

2. Effective

The current national outcome measures for health visiting are largely process measures designed to prove compliance to external bodies. They have been criticised for only measuring a very small proportion of the scope of the health visitor's role and workload, and for incentivising a positive reporting culture which downplays or explains away negative findings. As a result, opportunities for organisational learning from successes as well as failures are missed. They also provide very limited information on service quality and information on the breadth of the health visitors' contribution across numerous clinical pathways, nor details of children and families who have not accessed the service.

From a parent's perspective, an effective health visiting service is one that supports them with the things that matter to them. Having sufficient time and not feeling rushed was a common element of effective practice identified by respondents:

"I felt she was very patient and understanding when I admitted I had been feeling low. She had a lot of time for me and I didn't feel rushed. I felt that none of my questions were silly and she made me feel comfortable and more confident".

(response 143)

"My health visitor is very supportive kind and professional. Understands my concerns and gives me the best help and support to suit my needs".

(response 226)

"My health visitor helped us with our living conditions and my child has additional needs. She always has time and listens and is on our side".

(response 942)

Respondents also provided their perspective on being at the receiving end of a service that was overly focused on the completion of performance management “tick boxes” and how this hampered the personalised support that they found so beneficial:

“In almost every way, they need to stop ticking boxes and start listening to parents in what their children need, tick boxes don’t know children, parents do”.

(response 104)

“Longer visit, more relationship between mother and HV. Show care and take time to listen and ask about how the mother feels. Don’t make it feel like it’s a task to tick off”

(response 124)

“Seemed to be just following procedure, box ticking, stressed, unfriendly and quite unapproachable”.

(response 881)

“Don’t make people feel rushed and create a rapport so that they feel comfortable to be honest”.

(response 51)

“They seem to be too busy. They have no time to get to know you, it makes me understand why the role has such a high turnover. Also, how assessing your mood is a very standard question which makes lots of mothers feel like they have to give the standard answer. It is difficult to speak about your mood when the HV asks you that after they have started packing up their bits and are getting ready to leave. It should be a real focus point”.

(response 907)

Health visitor workload and caseload size will directly influence how much time a family will have with a health visitor. The Institute of Health Visiting’s annual survey in November 2019 highlighted that 28% of health visitors in England have caseloads of more than 500 families (the optimum recommended number is 250). We can presume that those parents reporting less rushed services live where there is a lower ratio of children to health visitor, this is the case outside England in the rest of the UK.

3. Evidence-driven

Respondents valued access to expert, up to date advice for a range of child and parental physical, emotional and social needs. They also valued a partnership approach that recognised and built on their expertise and strengths:

“Very helpful, listened to my views and opinions. Never came across judgemental”.

(response 910)

“Right advice was given and the HV was very kind and had a very good approach that made me feel very easy to talk with”.

(response 826)

“Very knowledgeable about so many different topics - Sorted out breastfeeding support as my support never showed. Then supported with weaning - encouraged me to make use of Surestart centre which I didn’t know about. Made me aware of things to do which in turn helped me recover from postnatal depression which they identified. Encouraged me to seek help with PND. Just general information given throughout which was up to date, relevant to current situation”.

(response 850)

Conversely negative experiences were linked to conflicting/ inaccurate advice or feeling that the health visitor's approach was judgemental:

"Had different health visitors and each one had a different answer to my questions, making it hard to know what I should be doing. Also felt rushed and no one asked about my feelings after birth".

(response 45)

"I have 2 children and I have never had one set worker it's always a different worker with different advice and different opinions - some were excellent and some need more training".

(response 71)

"They shouldn't rush meetings - Take time and also give us a chance to show, as well, what we're capable of too".

(response 911)

"Try not to be judgemental or condescending and it's more likely parents will honestly use the service".

(response 918)

4. Accessible

Respondents valued easy access to the right support when it was needed. Service entry points need to be widely accessible to the local population. Over three quarters (78%) of mothers polled say that they know who their health visitor is and how to contact the health visiting team if needed (Scotland had the highest rating at 90%). Less than half of the respondents (41%) said that they were given a clear explanation of the health visiting service available to them.

The respondents' experiences highlight the important role that the health visitor has to broker engagement by all groups, particularly those who do not currently experience easy access to services. From a service perspective, this will also require identifying barriers to service uptake and solutions to reduce the number of "invisible" children who are not known to the health visiting service or families who have disengaged. Positive experiences that improved service uptake included:

"She was so supportive and understanding of our unique family quirks. Non-judgemental. Didn't try and take over or control anything".

(response 842)

"They made u feel comfortable".

(response 957)

"They came to my home and therefore understood my needs better".

(response 886)

Many parents requested increased levels of support and "more health visitors". They also requested better information on the role of health visitors and how they can help families:

"Need more knowledge about what health visitors do and how they can help, more information given to parents".

(response 182)

"Need more health visitors – not enough of them – and need more time".

(response 240)

"More staff and longer appointments to talk".

(response 949)

"More information on where they are and more easily accessible".

(response 209)

"Need access to drop-in clinic so I don't have to make a special appointment - I would probably be more likely to seek extra help and advice".

(response 6)

Interpersonal skills were important – poor interpersonal skills were a barrier to service uptake:

“Understand people’s culture and background more to understand why we do things the way we do and help balance the western and eastern way of doing things”.

(response 919)

“Staff training including people skills! No good having a health visitor if they don’t have people skills. Communication is key alongside listening skills- this can be more relatable to life experiences instead of knowledge out of a book”.

(response 878)

“Be more considerate when people are less knowledgeable”.

(response 15)

5. Responsive

Health visiting services need to be responsive to changing needs over time, providing a continuum of support for a continuum of need. Movement between levels of support should be fluid in recognition of the dynamic changes that occur in many families between pregnancy and the time that children start school. Respondents valued timely face to face support and home visiting, alongside telephone and support augmented with personalised technologies like text-based services and email.

68% of mothers in the survey (UK data) access the health visiting service when needed through face to face appointments in their home; 58% attend drop-in clinics or groups and 49% via telephone contact.

When asked how they would like to access the health visiting service, face to face contacts were the highest rated options. In addition, 41% of mothers would also like a health visiting app (only 7% currently have access to a HV app); and 27% of mothers would like a texting service (15% currently have access to a texting service).

Being able to have access to increased support when it was needed, and without “labelling” or stigma, was an important part of respondents’ satisfaction with the service:

“My health visitor is amazing and helped me through so much without having the usual “insecure, are they testing me?” feeling”.

(response 220)

“She provided lots of information which was great because this was my first child and I felt I had no clue on a lot of things. She talked me through any questions, made sure I was ok without feeling like I was judged and made sure I knew I would always have help if needed for a wide variety of things”.

(response 832)

“I always felt I could ask for help - Helped me a lot with breastfeeding issues and weaning and then later with development issues”.

(response 110)

“They were easy to contact - amazing when I was tired and felt I was not managing well. Really reassuring and friendly just when I needed it”.

(response 898)

“Very quick call back home, within hours. I was quickly passed to my local HV who called me and made an appointment with me ASAP. She was kind, open, complimentary and not in the least judgemental”.

(response 913)

“It provided an opportunity to raise any queries that felt too trivial for a GP appointment but really helped put my mind at rest”.

(response 170)

28% of respondents had received additional support from the health visiting service (more than the universal mandated contacts - UK data). The most common reasons for additional support were:

- 31% - breastfeeding/ infant feeding
- 29% - adjustment to parenthood/ support for perinatal mental health problems
- 25% - introducing solid food/ wider feeding issues
- 18% - concerns about child development
- 18% - behaviour/ sleep management
- 13% - complex health needs/ disability
- 12% - wider support e.g. support with housing problems/ claiming benefits
- 10% - managing minor illnesses

Negative experiences were linked to poor access to timely support when needs arose:

“Need to be available when children have minor health concerns instead of visiting a GP”.

(response 11)

“Need to create more time for visits. You used to be able to have a one on one sit down at the weigh in clinic with a HV but due to money cuts that has gone and you have to stand around trying to catch a minute with a HV now. Terrible for new mums”.

(response 46)

“Didn’t answer the phone the whole day”.

(response 24)

“Need to be easier to get hold of someone by phone / email etc. More contact options for phone-shy parents. More at home appointments”.

(response 54)

6. Fairer

Reducing health inequalities by improving the health of the poorest fastest is integral to an effective health visiting service. This requires a proactive “upstream” focus to identify and support children and families at risk of poor outcomes to reduce the gap between the most disadvantaged children and their peers. Reducing health inequalities should be regarded as a key test of service effectiveness. Respondents offered suggestions to improve uptake of the health visiting service by those who need it most, captured in the following quotes:

Targeting for specific conditions:

“I feel the health visiting service could be improved if they could offer more services and support for parents who are struggling with mental health issues”.

(response 89)

Recognition that needs occur in all groups and not just those with obvious needs (supporting proportionate universalism):

“More help for new parents. I felt that because I looked ok that it was assumed that I knew everything”.

(response 174)

Enabling identification of need:

"Information on how/ who to contact when not coping".

(response 11)

"I really liked my health visitor I had the same lady for all 4 children so she felt like a friend, she was understanding and offered really helpful advice. I do worry that parents who are struggling could go unnoticed due to there being considerably less appointments now, which I found between my first and last child. I also think that children should have a development review at age 3".

(response 152)

"Knowing who my health visitor is and seeing them more often".

(response 12)

7. Collaborative

Health visiting is part of an integrated health and social system, working with others to improve public health outcomes. This requires relationships, trust and autonomy with effective collaborative working across three domains to ensure vulnerable children and families do not fall in the gaps between services:

- Integration working across the healthcare system - GP, midwifery, speech and language therapy etc.
- Integration across other sectors – education, social care, third sector support etc.
- Integration across the life course – support for transition.

Respondents described how the health visiting service had provided an important part of a “joined-up” response to address a multitude of identified needs for physical, mental and social needs for both children and parents:

"[health visitor] helped me get my son diagnosed with Cow's Milk Protein Allergy after 4 horrendous weeks".

(response 111)

"My baby arrived at 27 weeks, my health visitor often reviews his development and discusses the outcomes with me, she always returns a month or so later to review his progress. She keeps up to date with other professionals so is aware of what else is going on".

(response 209)

"Helped my daughter get referred to nursery when she turns two. My HV did all the paperwork for me".

(response 113)

"My son has a serious heart condition and the health visitor provides lots of support".

(response 229)

"I was suicidal she helped me".

(response 163)

"I got referred for counselling, I wouldn't have had it otherwise".

(response 147)

In our “Vision for the Future”, we set out a clear recommendation to drive improvements in collaborative working, taking a whole system approach which recognises the important contribution of the health visitor within numerous clinical pathways:

"to set out model integrated system pathways for key public health priority areas, with the necessary system support in place to implement these in full".

Pathways with sufficient resources to address each of the 15 High Impact Areas set out in our Vision need to be based on actual need, rather than current workload, to address work “not done” and capture levels of unmet need. Workforce modelling will provide greater transparency of unwarranted regional variation in levels of support available and workforce skills required to inform workforce planning. **This is urgently needed to address the role drift experienced by health visitors from their primary function of preventative public health to the current worrying trend to plug the gaps in under-resourced children’s social care.**

8. Professional Autonomy

We have included a final key element of “professional autonomy” which is essential to enable health visitors to provide a flexible service, tailored to individual need, with the means to adapt and change in response to the dynamic nature of the environment and context in which families live. This will need to be supported through “Safer Staffing” guidance.

Greater acknowledgement of the reality of “work done”, in contrast to “work as imagined”, is needed to ensure that the rhetoric of policy is translated into a reality that provides more than “lip service” to personalised care. This will only be achieved by ensuring that health visitors have manageable workloads and realistic caseload sizes to build relationships, broker engagement in early intervention and really make a difference to outcomes for children and families.

“Allowing people on the frontline a degree of autonomy is essential. Working effectively requires the ability to adapt and change in response to the dynamic nature of the environment, because the context which enables interventions to ‘work’ is constantly changing, so our interventions need to constantly adapt and change. If we want better outcomes, we need to help the people and organisations in these systems to collaborate and coordinate more effectively. In other words, healthy systems produce good outcomes”.

Lowe, 2019⁶

Discussion

This survey provides a helpful snapshot into mothers’ perceptions of the health visiting service in the UK. Whilst the sample is small (n=1000), it is a purposive sample with respondents representing all regions of the UK. The sample also represents twice as many parents as the sample used to inform the National Health Visitor Programme – Benefits Realisation (Public Health England, 2017)⁷ - as such the views of these women should be taken seriously.

This survey has highlighted a mixed picture of health visiting in England and across the UK with many mothers clearly valuing the service that they received. The provision of continuity of practitioner that enabled the development of a health visitor-client relationship was found to be an important factor in their satisfaction with the service. Disappointingly, the survey also highlighted that some mothers had little awareness of the role of health visitors and a poor experience of the service.

The Institute of Health Visiting is very concerned about the quality of health visiting service that is being provided to some families, particularly those living in England. There are many reasons for this. The challenges facing health visiting have been described as a ‘perfect storm’ driven by significant cuts to public health budgets, reductions in health visiting numbers, unmanageable caseloads and some poor commissioning decisions that have affected the quality of support. Further work is required to understand the key drivers of these positive and negative experiences, and their impact on levels of satisfaction with the health visiting service.

Findings from this survey support the wider evidence that parents want to be treated as an individual by their health visitor and value continuity of practitioner. **Services should aim to provide continuity of practitioner and personalised care in line with the ambitions of the Maternity Transformation Programme⁸ and Select Committee⁹ recommendations.** Yet the same quality standard for continuity of care in health visiting is not experienced by most parents in England - the current norm is that women are discharged from midwifery care at around 10 days after the birth of their child, without continuity of care, when in reality their parenting journey has barely begun. It is widely recognised that the period from conception to age two represents a dynamic period of change and adjustment for many parents, with physical and emotional needs extending beyond the scope of maternity care, and with potentially life-long impact on the health and wellbeing of both infants and parents.

The interrelationship between client trust in the health visiting profession, increased understanding of the purpose of the health visiting service and support seeking behaviours is recognised as most significant when engaging with what are often referred to as “hard to reach”, seldom heard or vulnerable groups. However, the reality is that services are often inaccessible and the problem is ours and not the people we are trying to reach. We are concerned that the drive within the service to achieve even greater efficiencies and workforce pressures have resulted in an untested dilution of the quality of service which will negatively impact on child outcomes.

Health visitors play a crucial role in identifying children at risk and provide a vital “voice” for infants and young children, who often have no voice. The Children’s Commissioner¹⁰ estimates that more than a third of children who are living with risk because of a vulnerable family background are “invisible” (i.e. not known to services) and therefore not getting any support. It is important that these children are not forgotten – a strengthened health visiting service provides an important part of a system-wide approach to address this issue.

However, health visitors should not be regarded as substitute social workers; recent “role drift” in some areas has eroded the primary prevention, early intervention and clinical roles of the health visitor in favour of more reactive “safeguarding” work. This is short-sighted and will ultimately lead to increased costs of intervention at a later date – prevention and early intervention are more effective and more cost-effective in the long run. Equally, cheaper members of the children’s workforce with a very different training and no nursing/midwifery background, whilst enhancing the health visiting service offer in many ways, will have a narrower scope and level of practice and should not be regarded as substitute health visitors

To ensure an effective service, it is important that the health visiting profession does not shift from its evidence base that drives positive outcomes:

1. Health-creating - which involves being proactive, identifying and building strengths and resources (personal and situational) and being solution-focused.
2. Human valuing - focus on client needs, recognising the potential for unmet need, actively seeking out potential strengths, maintaining hope.
3. Recognising the child within the context of their family and community (human ecology) - including assessment and intervention as a continuing process¹¹.

Conclusion:

Co-production - doing with and not for, or to, people; not just sometimes, but all the time.

This paper clearly sets out the things that are important to parents. By listening to the stories of those who have experienced health visiting services as they really are, we can strengthen a learning culture which will be integral to quality improvement.

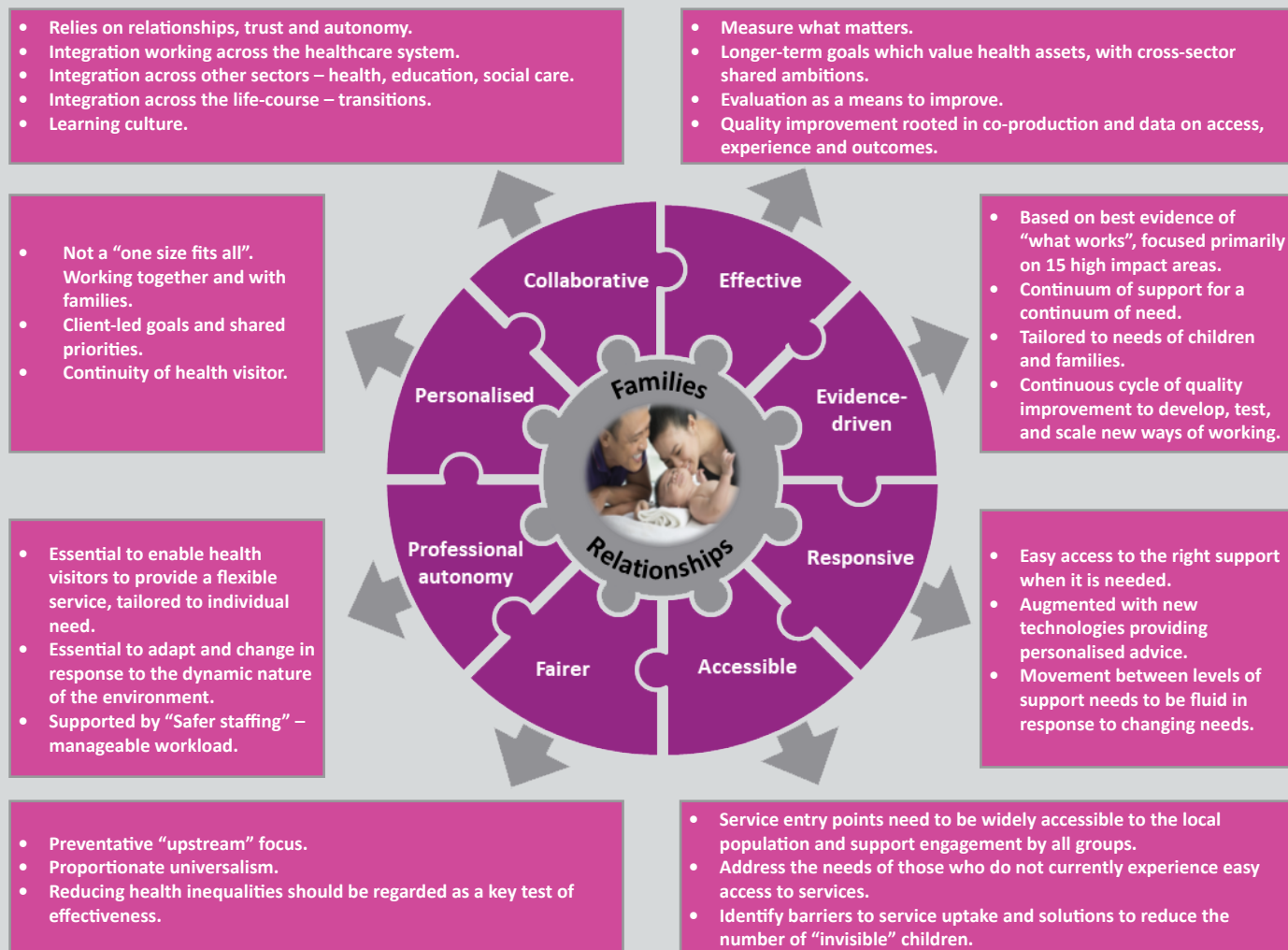
“Every patient has a story. To work alongside patients who have complex and challenging lives we need to understand that story. We need to look beyond the face that sits opposite us in a consulting room and listen with respectful curiosity, understanding that their priorities today and tomorrow may not be ours”

Fair Health, 2019¹²

We hope that the voices of parents that we have amplified in this paper will be listened to and heard by policy makers and the findings will inform the refresh of the health visiting model and the Healthy Child Programme.

Recommendations:

1. Health visiting services should provide continuity of practitioner in line with the ambitions of the Maternity Transformation Programme.
2. An effective health visiting service needs to be centred on relationships and the needs of families and eight key elements which we have set out in our Vision for health visiting. All of these key elements are interrelated and overlapping – collectively they are central to service user satisfaction and improving outcomes – failure to address any one of them will weaken the effectiveness of the health visiting service.



3. We recommend establishment of independent formal multidisciplinary committees, along similar lines to the “Maternity Voices Partnerships”, to influence and share in local decision-making and ensure health visiting services are co-designed with service users and local communities. To ensure that they are sustainable, they should be underpinned by practical support from local commissioners and providers across the breadth of the health visiting clinical pathways (for example, local authority, Primary Care Networks and the NHS), including appropriate financial support.
4. We recommend that all health visiting services incorporate co-production as a way of working that enables people who use health visiting services, carers and communities to come together in equal partnership throughout all stages of service design, development and evaluation.
5. We recommend an annual national survey of parents’ experiences of the health visiting service to benchmark improvements against as part of a continuous cycle of quality improvement and a learning culture.

Appendix 1: Where do you currently live? Respondents breakdown summary

Where do you currently live?	%	Responses
East of England	6.30%	63
East Midlands	8.40%	84
London	12.90%	129
North East	5.40%	54
North West	11.10%	111
Northern Ireland	3.00%	30
Scotland	6.10%	61
South East	16.40%	164
South West	8.50%	85
Wales	5.60%	56
West Midlands	9.00%	90
Yorkshire and the Humber	7.30%	73

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