The Health Visitor and School Nurse Development Programme

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Foreword

Successive government policies have recognised the vital role that health visitors and school nurses play in improving health and tackling inequalities. The need to strengthen their public health role and work in new ways was highlighted in *Saving Lives: Our Healthier Nation* and *Making a Difference: the nursing, midwifery and health visiting strategy*. Health visitors and school nurses are already making great strides in developing their family- and child-centred public health roles and this pack draws on the numerous examples of innovation that are taking place. We need to build on these developments.

Changing the way we work is a complex process which will only succeed if frontline practitioners are actively engaged and leading the changes. The Health Visitor and School Nurse Development Programme was set up to support practitioners to work in these new ways. This resource pack is one element of that programme produced to help you develop your public health role.

I am sure that this pack will prove to be a useful resource to practitioners and their teams to strengthen their professional contribution to the public health agenda.

Sarah Mullally
Chief Nursing Officer
Department of Health
London, 2001
1. Welcome to the resource pack

This health visitor resource pack has been written to help you develop your family-centred public health role. It offers a framework for practice and guidance for practitioners, their colleagues and managers on the public health aspect of the health visitor role.

This pack:

• provides information about the family-centred public health role and new Government policies

• summarises the principles of public health practice

• suggests activities to help you work in new ways.

Using this resource pack

We hope that you will find this resource pack useful as you consider changes to the way you work and engage colleagues, Primary Care Trusts (PCTs) and others. Although it is possible to make change in isolation, this is difficult as successful public health action involves working closely with others. We therefore suggest you use this pack to agree and plan changes with your primary care colleagues, the PCT, public health specialists, users of services and partners in the Local Authority and voluntary sector.

This pack assumes that the reader already knows the theory and practice of health visiting. It describes the new family-centred public health role and what it means in practice rather than being a core text on health visiting.

Although we have referred to policy documents, research and current initiatives, the pack does not provide an exhaustive list of references. As you develop projects locally you may like to add other materials to the resource pack so that it becomes a dynamic working tool to support your practice.
As far as possible the pack draws on examples from practice with case studies provided by practitioners who are working in innovative ways. For more information on the various innovations which health visitors and school nurses across the country are currently involved in, or to register your own work for others to read about, please visit the innovation website. Until the end of December 2001 access the innovation website at http://www.innovate.org.uk
From 1 January 2002 at http://www.innovate.hda-online.org.uk
2. Why is change needed?

There are pressing health challenges facing people in this country. Unacceptable inequalities in health persist and large numbers of people continue to die prematurely from major killers such as coronary heart disease and cancer. The growing population of older people experience high rates of limiting long-standing illness. Mental health problems affect the quality of life for many people. Too often opportunities for good health are limited by lack of available resources or support for families with young children.

These issues have to be tackled. The **NHS Plan** (2000) has set out a blueprint for action, emphasising the need to strengthen the role of the NHS in health improvement and prevention and to develop services that are accessible, convenient and delivered to a consistently high standard.

As key public health and primary care practitioners, health visitors have an important part to play in achieving these goals. The significance of their contribution was underlined in **Saving Lives: Our Healthier Nation** (1999), which set out a family-centred public health role for health visitors, working with individuals, families and communities to improve health and tackle inequality.

As a result of this modern role:

- parents will receive improved support including parenting education, health advice and information
- individuals and families will be able to have a tailored family health plan agreed in partnership with the health visitor to address their parenting and health needs
- the health needs of families and communities will be met by a team led by a health visitor including nurses, nursery nurses, and community workers
- health visitors will initiate and develop programmes for peer support, based on the experience of organisations such as Homestart, Newpin and ‘community mothers’, where local parents use their experience to support others
- neighbourhoods or special groups such as homeless people within a practice or Primary Care Trust will have their health needs identified by health visitors, who will lead public health practice and agree local health plans
- local communities will be helped to identify and address their own health needs, for example accident prevention for older people.

See **Saving Lives: Our Healthier Nation** para 11.17 for further details

‘Health visitors will lead public health practice and agree local health plans’
A family-centred public health role for health visitors

We expect health visitors to lead teams to include nurses, nursery nurses and other community workers that will:

- deliver child health programmes and work in partnership with families to develop and agree tailored health plans to address their parenting and health needs
- run parenting groups and provide home visits to help improve support, advice and information to parents – and especially to vulnerable children and their families – supporting initiatives such as Sure Start
- work through Primary Care Trusts to identify the health needs of neighbourhoods and special groups such as the homeless, and agree local health plans
- work with local communities to help them identify and tackle their own health needs, such as measures to combat the social isolation of elderly people or the development of local accident prevention schemes
- provide health improvement programmes to target accidents, cancer, mental health, coronary heart disease and stroke.

See *Making a Difference* para 10.8 for further details.

How far is this a new role for health visitors?

The new role described in this pack aims to strengthen the community based, population approach of public health and integrate this with individual and family work. Health visiting has always been based on public health principles with a strong preventive emphasis. But the ways in which services have been organised have not always supported practitioners to work flexibly to tackle local health problems or to work with others in teams to address the causes of ill health.

The development of Health Improvement Programmes (HImps), Primary Care Trusts and new models of service delivery, such as Sure Start and Healthy Living Centres, give health visitors new opportunities to focus on the most important issues affecting people’s health and on population groups in greatest need. A family-centred public health approach enables health visitors to reclaim their public health roots whilst providing a framework in which to maximise the impact of their family-based work.
What is being done to support the development of the family-centred public health role?

This pack is one element of the Health Visitor and School Nurse Development Programme. Funded by the Department of Health this programme aims ‘to make significant demonstrable progress towards a family-centred public health role for health visitors by April 2002’. It consists of a range of activities and projects to help health visitors and school nurses to change their practice.

31 leadership posts who are delivering public health activities in their local communities and supporting their colleagues in developing their public health role.

Funding for over 100 projects to support practitioners in delivering parenting support and health improvement programmes locally.

Establishing 4 PCT-based, whole system change sites where health visitors and school nurses are implementing changes across the whole system and addressing the barriers to change i.e. practice, professional, managerial, organisational and educational.

The Innovation Network - a Health Visitor and School Nursing Innovation Network has been established. This provides an on-line resource to disseminate new ways of working, enabling practitioners to learn from each other. Until the end of December 2001 access the innovation website at http://www.innovate.org.uk
From 1 January 2002 at http://www.innovate.hda-online.org.uk

Award schemes - health visiting and school nursing awards have been funded for the past two years to support innovation in the new public health role.

Work with educationalists to ensure that training supports the new role and to provide continuing professional development opportunities for health visitors and school nurses. This has included a public health skills audit undertaken by the Health Development Agency to identify the gaps in public health skills and knowledge amongst practitioners.

Regional events have been held to describe the new role and to hear from practitioners what it looks like in practice.

Workforce planning - the health visiting workforce has been reviewed in the light of the demands of the current health and social care agenda. 100 extra health visiting commissions were funded between 1999 and 2001. Work is continuing to ensure that the workforce is in place to meet future needs.

A review of Family Health Plans was undertaken and the findings of this work have been incorporated into this pack.
Summary

This section has given the reasons why the change to a family-centred public health role is necessary. Section 3 describes the role in more detail. You may find it useful to read the following key policy documents which will provide you with more information on why change is needed.

References and key policy documents

Department of Health (2000) 

Department of Health (1999) 
*Saving Lives: Our healthier nation*,

Department of Health (1999) 
3. What is a family-centred public health role?

A public health approach
‘better population health is the sum of better health of individuals, but needs more than individuals’ action to achieve it’
(CMO Report, 2001)

‘the art and science of preventing disease, promoting health and prolonging life through the organised efforts of society’
(Acheson, 1998)

Public health is a way of looking at health that takes the population as the starting point. By taking an overview of the population we can see what the key health issues are for that population be it the practice population, neighbourhood, PCT or region. We can also see what needs to be done to improve their health and tackle inequalities. With a population perspective it is possible to identify and address the wider determinants of health such as poverty, unemployment, social exclusion, transport, education and the environment.

Public health is made up of a wide range of activities including health promotion, protection and prevention as well as healthy public policy and individual and community empowerment.

The key elements of public health are:
• assessing the health needs of a population

• planning and implementing programmes that promote and protect health, such as: immunisation and screening programmes, health promotion campaigns and planning and delivering integrated services across agencies

• working with other sectors to address the wider threats to health e.g. housing, transport, social exclusion

• identifying health inequalities and taking action to address these
• working with local people to identify needs and using a community development approach to deliver health improvement e.g. women’s health groups, food co-ops, community awareness raising on domestic violence and child protection.

What does a public health approach mean for your practice?

A public health approach means:

• tackling the causes of ill health, not just responding to the consequences
• looking at health needs across the whole population rather than only responding to the needs of an individual
• planning work on the basis of local need, evidence and national health priorities rather than custom and practice
• working within the framework of the local HImP and considering what your team can do with others to achieve HImP goals
• using the live information you have about local community needs and strengths into the HImP development process
• working with other agencies and sectors to plan services and promote well-being
• finding out which population groups have significant health needs and targeting resources to address these
• taking action to make healthy choices easy choices
• leading or joining a multidisciplinary team rather than working alone or in a unidisciplinary team
• influencing policies that affect health locally and nationally
• finding meaningful ways to evaluate the impact of your work.

The continuum for public health practice in health visiting

Health visitors have a strong tradition of working with individuals, families and communities to promote health. The family-centred public health role recognises the relationship between these different elements of health visiting practice, acknowledging their interdependence. You may find it helpful to see the individual and population approaches on a continuum rather than as opposites. The diagram opposite illustrates this point.
Working with individuals

An assumption is sometimes made that public health work means working with groups rather than individuals, but as the above continuum illustrates one-to-one work is an essential part of an overall public health approach. However, this individual work does need to be set in a wider population context. The wider population view can help you and your team decide how to use your skills and resources more effectively in order to determine:

- which individuals to seek out and prioritise because they are likely to experience greatest health threats and poorest access to services (refugees, young people leaving care, socially-isolated older people may be some examples)
• the most effective ways of working with individuals identified around priority health needs
• what community resources can be mobilised to help address these needs and reduce inequalities
• what other agencies are doing and how you can work together to improve health.

**Working with families**

The family in all its diverse forms is the basic unit of our society and the place where the majority of health care and preventive work takes place. The Acheson report (1998) on health inequalities and *The NHS Plan* recognise the importance of working with families with young children to improve the lifetime health chances of those in the poorest sections of the population. The Government consultation document, *Supporting Families* (The Ministerial Group on the Family, 1998) also spelt out the importance of health visitors’ support role in improving child and family health and well-being.

Health visitors have always played a vital role in promoting family health and supporting parents. This remains important in the new role. The family health plan (see Section 4) supports this work and provides a tool to assess family health needs and plan services to meet these needs. A family-centred role means also working with men, older people, carers and others who may have been excluded by the service’s emphasis on young children.

**Working with communities**

A public health approach means looking at health needs across a community or population group and having a responsibility for improving the health of a local community or practice population. Health visitors who lead or form part of a multidisciplinary team can focus on a local neighbourhood within a practice or PCT area and target their individual and family work.

• Community development work can be particularly effective in building the health capacity of local communities. It involves working alongside local people to enable them to find ways of addressing the issues that they see as affecting their health by generating local partnerships and action. (See Section 5)

• Community development can also be a powerful way to narrow the health gap, increasing social support in deprived communities and getting resources into areas that need them most. Initiatives such as Sure Start and New Deal for Communities are bringing much needed resources into the most deprived communities.
Working to common priorities

A public health approach involves working with others on common priorities using methods that are known to be effective. Health visitors will increasingly work to local and national priorities such as preventing coronary heart disease, providing smoking cessation support, reducing teenage pregnancies and promoting mental health. Whilst this may feel more of a top-down way of working, it is vital to work to common priorities if we are to make a difference to the health of the population. If we all work on different priorities using a variety of methods we will not improve health at population level. National Service Frameworks (NSFs) provide us all with common frameworks for addressing the major causes of mortality and morbidity. The contribution practitioners can make is in implementing these programmes locally and determining how best they can be adapted to meet local needs.

Universal or targeted?

The services provided by health visitors are greatly valued for their non-stigmatising universality. But ‘universal’ does not mean ‘uniform’ and ‘targeted’ is not the same as ‘selective’. The skills that health visitors have can make a real difference to health priorities such as coronary heart disease. Giving time and attention to other health priorities and to those groups most at risk is an essential part of a public health approach. But health visitors cannot be expected to do everything and resources need to be targeted to areas where health needs are greatest. Families that are well supported and have access to information and resources will clearly require less input that those who don’t. A universal health visiting service means all families having access to a range of services provided by a team of people not all families getting the same service from the same person.

Conclusion

Health visitors have always been trained as public health workers, using a partnership and empowerment approach with individuals, families and communities. However, in recent years many health visitors have been encouraged to give priority to individual and family work, with an emphasis on routine assessments of child development. The family-centred public health role means a change of emphasis to increase community based and targeted public health activities that have long been advocated by the profession. However, the process of change is never simple. Current service agreements, the expectations of others, custom and practice, workloads or skill shortfalls may all be local barriers to change. You will probably find you make better progress by working in collaboration with colleagues, managers and other local stakeholders to agree a plan for change. Local health needs assessment should help to indicate work that is no longer a priority, or could be
delegated to others in a multidisciplinary team. A systematic assessment of community needs will also help to identify where services should be focused.

Summary

This section has set out the family-centred public health role. Section 4 describes the community and family health needs assessment process which underpins this role.

References


4. Identifying health needs and planning your work

The starting point of a family-centred public health role is identifying health needs then planning and delivering a variety of programmes to meet these needs.

Health needs assessment is not just about looking for health problems and threats to health. All individuals, families and communities have strengths and assets that promote health and well-being (knowledge, resources, self-care, friends, family, community facilities). If these resources are not acknowledged they could be undermined.

Assessing need is just the beginning of the process. Practitioners and their teams have to follow through in planning, delivering and evaluating programmes which address local and national priorities.

There is a variety of tools for assessing family and community health needs and references are given at the end of this section. Here we discuss two approaches: one for a community health needs assessment, and one for a family health plan. Ideally, such tools should be developed and adapted locally to ensure ownership and to reflect local circumstances.

A community health needs assessment

A community health needs assessment (CHNA) involves systematically looking at the needs of the population by using health information and consulting with local people and others who work in the community.

A CHNA enables you to:

- learn more about the resources, needs and priorities of the local population
- identify inequalities in health
- prioritise client groups in greatest need and plan and deliver the most effective care
- tailor health service resources in the most efficient way to benefit and improve the health of the population
• apply the principles of equity and social justice in practice  
• work collaboratively with the community and other professionals  
• measure your impact on people’s health  
• influence policy and priorities  
• develop local partnerships  
• demonstrate the reasons for deciding what to do.

Before carrying out your CHNA it may be helpful to think about:

• **The willingness to reflect and make change:** Everyone involved should be aware that a CHNA can be a challenging process. It can confront you with difficult issues, such as, which model of health to use, who defines need, how to decide on priorities, how to ensure equity and how effective is current practice? You must all be willing to reflect on current practice and be willing to change in response to priorities.

• **Community involvement:** A CHNA involves members of the community so that their views are included when identifying priorities and they become involved in planning and implementing health programmes. This is a complex process, requiring time and expertise. Be prepared to work with others and spend time ensuring that the process is acceptable locally.

• **Team approach:** The CHNA should be undertaken jointly by those who will be responsible for delivering the health care programmes. This will ensure their commitment to the outcome. This may be a primary care team, a neighbourhood team, an inter-agency team, or a health visiting team for a particular area.

• **Use of family health plans:** Some of the information from your family health plans could be incorporated into a CHNA. However careful attention has to be paid to confidentiality and the Data Protection Act. It is advisable not to use information about individual health status but rather to use what families are saying in general about their local community.

**Steps to success**

CHNA consists of five stages, however all too often it gets stuck at the profiling stage without moving into action!
**Stage One: Profiling** i.e. describing the health of the population you have selected.

1. Agree the scope and purpose of the CHNA with relevant colleagues before you begin.
2. Define the focus of your CHNA and be realistic about what you can achieve: this may be a geographical area, a particular population group or a health issue already identified by the HImP.
3. Use a range of information to prepare your profile, being aware of their strengths and limitations, and try to use existing data rather than collecting new information – useful links might be made to school health plans compiled by school nursing teams.
4. Find out what has already been done in relation to the population.
5. Ensure that the relevant people are involved in the process from the outset.
6. Involve the local community in the process.
7. Obtain comparative local or national data to enable you to interpret your information.
8. Make links with those who have specialist skills, for example, public health specialists and health promotion colleagues.
9. Beware of drawing conclusions from small numbers of cases – seek help from someone with expertise, for example a public health specialist.
10. Ensure that you include information on minority vulnerable groups.

**Stage Two: Deciding on priorities for action**

Not every need can be met. The following questions will assist you to decide what issue is most important.

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<th>Question</th>
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<td>What is the size of population affected?</td>
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<td>What is the impact on health of the population affected?</td>
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<td>What is the effectiveness of possible interventions?</td>
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<tr>
<td>How adequate are the existing services?</td>
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<tr>
<td>Which priority will help meet national and PCT priorities?</td>
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<tr>
<td>Do we have the expertise to address this problem and is training available?</td>
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Stage Three: Planning public health programmes

Preparation

- What is already being done to address this need?
- What effective actions can be taken to address this issue? (NSFs will provide you with evidence-based interventions)
- Do you have sufficient resources and time to do this?
- If not what will you stop doing to address this priority?

Agreement of aims

- If you are successful what will have happened? What are you trying to achieve?

Description of objectives

- What do you need to do to achieve your aim?
- What specific outcomes are you trying to achieve?

Activities needed to meet these objectives

This should be a detailed plan of the actions to be taken:

- **What** is to be done?
- **Who** will do it?
- **When** will it be done?

<table>
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<tr>
<th>Health problem to be addressed</th>
<th>Objectives</th>
<th>Action to be taken</th>
<th>Who will do it?</th>
<th>Timescale</th>
<th>Evaluation measures</th>
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</table>
Stage Four: Implementation
Carry out your action plan, record what you have done and meet regularly to review your progress.

Stage Five: Evaluation of the health outcomes

Who is the evaluation for?
Different people will want to know different things.

What do you really need to know from the evaluation?
There are three types of evaluation with different functions.

1. **Process evaluation** – this gives you information on the progress of the work as it proceeds allowing you to amend plans in accordance with its findings. It is undertaken whilst the programme is in progress.

2. **Impact evaluation** – this measures whether the objectives of the programme have been achieved. It is undertaken at the end of the work but planned from the start.

3. **Outcome evaluation** – How are you going to measure it? This uses measures to indicate progress or success. These may be quantitative measures (such as numbers receiving treatment, giving up smoking or attending groups), or qualitative (such as the views of those attending new services). Information from records, diaries, notes of meetings can also provide evidence for evaluation. Consider whether you need to record baseline data before you begin your work in order to measure change.

A family health plan
A family health plan is a core tool for enabling a family to think about their health and parenting needs. The plan should identify:
- the family’s needs as they see them
- how they wish to address these needs
- an action plan for the family, including support to be provided the health visitor and others
- what has been achieved.

Working in partnership with a family to assess needs challenges aspects of professional practice and requires a high level of communication skills. The tool itself may look deceptively simple but the process is complex. Open-ended questions, headings or illustrations are more useful than a checklist in helping the family to determine which issues they would like to discuss.

Health visitors have found the following ‘triggers’ useful when introducing the family health plan to families:
- vulnerable or priority groups identified by the community health needs assessment
- life change events, for example, birth of a child, bereavement, illness
- people who may have difficulty accessing services.
Any family health plan should aim to:

- put the family’s agenda at the centre of the process and enable individuals to express their needs and choices and decide what service they want to receive
- engage disadvantaged groups such as: families living in poverty, young fathers, refugees, travellers, homeless people
- avoid stigmatising families
- provide, as far as possible, robust health information
- combine the public health and family support elements of the health visitor’s work
- ensure confidentiality and observe the data protection act.

What should the family health plan include?

Parents who have been involved in designing family health plans have chosen the following topics and language:

- **Family health**
  - Work (or lack of it)
  - Relationships (partner, children, others)
  - Stress/relaxing
  - Diet/smoking/alcohol
  - Illness
  - Money
  - Contraception
  - Disability
  - Depression
  - Caring for others
  - Domestic violence/abuse

- **Community issues**
  - Housing
  - Public transport/traffic
  - Parks and play areas
  - Noise/crime/drugs
  - Racism
  - Neighbours
  - Childcare/school
  - Isolation/loneliness

- **Bringing up children**
  - Bullying
  - Sleeping
  - Behaviour
  - Feeling alone
  - Children’s fears and anxieties
  - Child growth and development
  - Parenthood
  - Feeding
  - Play/shared activities
  - Safety
  - Preparation for school
  - Your own childhood experience
  - What to do when your child is unwell.
The family health plan belongs to the family. The health visitor can use tear-off summary sheets to remind them what they have agreed with the family and to identify community health issues.

**What should be in place to support health visitors to develop family health plans?**

- a group of practitioners who want to do it and have time to get involved
- local parents and other agencies who can bring a different view
- a skilled facilitator to support the process
- local support from the PCT
- senior managers who are prepared to support practitioners wishing to change their practice and to manage the risk that this may involve.

**Summary**

This section has discussed community health needs assessment and family health plans. Both approaches are central to the successful adoption of a family-centred public health approach. Section 5 will discuss the various ways in which health visitors can respond to need.
Further reading


Norfolk Public Health Nurses Forum (2001) Norfolk Needs Assessment Toolbox available from peter.brambleby@norfolk.nhs.uk


5. Responding to health needs

This section looks at the type of activities health visitors can carry out within a family-centred public health framework. It is designed to balance individual and population based work that is central to the new role. It sets out the three elements that are required within a public health programme to ensure comprehensive family-centred public health provision. These are:

- individual and family health programmes
- providing and promoting access to information and other services
- community development.

These three elements are not mutually exclusive and they inevitably overlap but you may find that this framework helps you to plan your work across all three aspects of the role. This is best illustrated in the diagram below.

---

**What are our priorities?**

- Health needs assessment
  - Community health needs
  - Family health plans
- Local community

**What public health programmes are needed?**

- Planning, co-ordinating and implementing public health programmes
  - e.g. Immunisation programmes
  - Child health promotion
  - CHD prevention
  - Accident prevention amongst older people

**What do we need to do?**

- Access to and provision of individual and family health programmes
- Information and access to local services
- Community development initiatives to address health determinants, meet local needs and promote community participation

**What services will people receive?**

- **Examples**
  - Parenting support
  - Smoking cessation support
  - Child protection
  - Mental health programme
  - Breast feeding support
  - Postnatal depression
  - Expert patients programme

- **Examples**
  - NHS Direct
  - Health Living Centres
  - Walk-in centres
  - Smoking cessation services
  - Child health clinics
  - Benefits advice
  - Parentline
  - Sure Start programmes

- **Examples**
  - Community safety
  - Intergenerational support
  - Food co-ops
  - Community exercise
  - Peer health counselling
  - Community mothers scheme
At the end of this section we have included a brief comment on current aspects of health visitors’ family work that occupy much of their time to illustrate a family-centred public health approach:

- protecting children
- immunisation programmes
- child health surveillance.

Individual and family health programmes

At different times families and individuals may need more support from health services. For health visitors and their teams examples may be postnatal depression, child behaviour, bereavement or post-myocardial infarction support. Some structured support programmes will already be available and community and individual family health assessments will help to identify priority areas for development.

**Case study**

A family (mother, father, 11 and 7-year-old boys and a new baby) identified in their family health plan how low the mother felt after a recent bereavement. The family discussed this with the health visitor and they agreed to offer the mother more practical support and opportunities to express her feelings. The family asked the health visitor to visit again in a month’s time to see if her low mood had resolved itself.

When discussing community issues the family complained of the motorbikes going up and down the local alleys. This complaint echoed those expressed by other local families. The health visitor raised the issue at the local community forum and police investigations established that these motorbikes were being used for delivery runs for heroin dealers.

**Case study**

As part of the practice’s coronary heart disease programme the nursing team are providing a post-myocardial infarction (MI) follow up service. When the health visitor sees Mr Forrest she discovers that he is very anxious about resuming physical activity as he suffered an MI after running for a bus. The health visitor explains that some exercise will help protect the heart and introduces him to the graduated exercise programme at the local leisure centre. A health visiting colleague had worked with the local authority to set up this programme which has now received HAZ funding to enable it to provide free places to local people.
Promoting access to health information and services

Developments such as NHS Direct, Walk-in Centres, Healthy Living Centres, Sure Start and Parentline, and health-related websites are rapidly expanding the sources of information and support available to people and parents in particular. People will rely less on health professionals as the only source of expertise. This will have an impact on the health visitor’s role providing one-to-one advice and information, particularly to those who are well able to use other information sources. They will continue to have an important role in making sure that people are aware of the services available and in helping people make sense of the information.

Case study

A group of parents involved with Sure Start wish to increase their knowledge of child development. Health visitors work with them and an IT skills development worker to produce a child development website. This includes discussion of some of the key issues identified by the parents, a chat room and directory of local resources. The site is advertised in the library, adult education centre, school and other community venues for local parents to use.

Community development

Community development work is an effective way of tackling issues that restrict people’s health choices and regenerating and empowering communities to influence local health policy and service development. Working alongside local people on issues that they know to be important in their lives can help reduce inequalities in health. Examples of public health work using community development methods are:

• community based health support groups e.g. smoking cessation groups, women’s health groups
• peer education projects, e.g. local people trained and employed as smoking cessation workers or breast feeding counsellors
• working with excluded and ‘hard-to-reach’ groups such as the homeless, refugees and young unemployed men
• local people becoming involved in planning and evaluating services
• increasing access to resources that promote health e.g. food co-
• addressing the wider determinants through economic regeneration and employment e.g. creating jobs through lay employment health projects, Sure Start, Single Regeneration Budget, New Deal for Communities, Education Action Zones, Health Action Zones

• Improving social support and self-esteem within the community through developing local support and self-help groups, increasing access and uptake of educational opportunities and peer education projects.

**Community development work involves a number of key principles:**

- **participation:** everyone having a say in what is right for them in their community
- **collaboration and partnership:** recognising the interdependence of local community structures to improve community health
- **equality and equity:** the belief that people have the right to equal access to resources for the maintenance and promotion of health, and where none exist that they be provided
- **collective action:** bringing people together to deal with issues and needs, which they have defined as problematic
- **empowerment:** by which people, organisations and communities gain control over their lives.

**How to strengthen your involvement in community development initiatives:**

1. Find out if the local authority and local voluntary organisations employ community development workers, and arrange to spend time working with them.
2. Find out about local networks and community initiatives such as Local Exchange Trading Schemes (LETS) and how you might contribute.
3. Get involved in local initiatives e.g. Sure Start programmes, local Health Improvement Programmes, domestic violence forums, crime and disorder partnerships and regeneration initiatives such as New Deal for Communities.
4. Get involved in local Health Action Zones or Education Action Zones.
5. Undertake training and professional development to increase your confidence and skills in community development work.

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**Further reading on community development**

Dalziel, Y. (1999) *Community Development in Primary Care*, Lothian Health Promotion, contact yvonne.dalziel@lpcct.scot.nhs.uk for further details/training opportunities.


6. Look at creative ways of responding to an unmet need, for example healthy eating projects with community dieticians, food co-operatives, growing food projects.

7. Work with existing groups to identify and meet their expressed needs.

8. Develop social support networks between families.

9. Try to secure managerial support for this work.

10. Document your community development work by having a project plan with clear objectives and recording what you do.

11. Discuss with public health specialists on the PCT and seek their support in developing proposals, securing funding, and evaluating initiatives.

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**Case Study**

Epidemiological data identified coronary heart disease as a local priority. Through community health needs profiling the health visiting team determines a number of local risk factors. These include:

- lack of accessible exercise and recreational facilities across a range of age groups
- poor access to affordable fresh fruit and vegetables
- widespread lack of confidence in preparation of fresh foodstuffs.

The health visiting team works with local community activists and a range of agencies to develop a programme of community initiatives. These include working with GPs and local authority leisure services to help local people run a series of community health walks which are graded for a range of fitness levels. Health visitors also join forces with the local authority Agenda 21 sustainable development co-ordinator to generate support for a food co-op. The health visitor forms a local taskforce to look at the feasibility of diverting unused open space to develop community vegetable gardens.

With the support of local mothers, health visitors initiate a weekly cook and eat club within the mother and toddler group. The group concentrates on cheap, quick to prepare, healthy meals and ways of encouraging children to sample different tastes. A snapshot food diary completed by participants at the beginning of the project and after six months indicates an increase in the variety of family food intake and the quantity of fresh food consumed. The mothers wish to develop a booklet of recipes from the programme and the health visitor links them with a local further education college which is able to provide them with skills training to make this possible.

A review conducted by community volunteers, with support and funding from a university research programme, identified a reported increase in social support networks and greater sense of involvement in their community among participating local residents. The evaluation will consider the impact of the programme on levels of fitness and obesity.
Protecting children

Health visitor teams provide a widely accessible and non-stigmatising service. Coupled with their knowledge of children and families and expertise in child health and development, they are able to identify children in need of protection and to work with vulnerable families. Guidance for such work is issued through local procedures, Area Child Protection Committee (ACPC) guidelines and policy documents (see below). This pack assumes that you are familiar with these. All health visitors should be aware of child protection procedures and where to go for advice. They should also ensure that procedures are followed and children are referred promptly wherever they are concerned about the safety or welfare of a child. The family-centred public health role should enable health visitors to play a more proactive role in promoting the welfare of children using a public health approach.

What is a public health approach to child protection?

A public health approach means looking at health needs across a population, targeting inequalities, working in partnership with others and tackling the causes of ill health. In the context of child protection this means:

• looking at risk patterns in a community to identify children and families potentially in need of support

• using best available evidence to find effective ways to work with those who are most vulnerable

• monitoring risk factors and trends and highlighting these to the PCT and the Area Child Protection Committee

• identifying contributing factors such as poor social support networks and lack of affordable childcare provision and working with others to address these

• establishing parenting support groups to develop parents’ capacity to respond to children’s needs

• raising awareness of the needs and rights of children within the community and among other health professionals, teachers, community workers, police, housing workers etc.

• providing support and information about what people can do if they are concerned about a child or finding difficulties coping with their own

• working with local people and other agencies to ensure that support is available to families and children such as advice lines, safe play areas, employment and education opportunities

• working in partnership with other agencies when contributing to the Assessment Framework for children in need.

Further reading


Issues to think about

For practitioners, reconciling traditional child protection responsibilities with the development of a family-centred public health role has been particularly problematic. It may help to think about the following issues.

- Protecting children is a shared community and professional responsibility.

- Health visitors need to be clear why they are working with families and the aims of their planned interventions. It may be necessary to consider whether their needs can better be met in other ways, for example, through Sure Start or community mothers programmes.

- Multidisciplinary teams of health visitors, social workers and other parenting support workers offer one model in which practitioners might work more effectively. Within health visiting teams some practitioners may have particular skills and interest in working with vulnerable children. Other health visitors may prefer to work at community level developing support networks and improving conditions for parents and children.

- Family health plans and community health needs assessment will help to determine the range of individual and community support programmes needed. (See Section 4)

- Many people work with children and have a responsibility for their well-being. As more children move into early years services at a younger age the range of people with opportunity and responsibility to identify and protect those at risk is increasing. Good communication between agencies becomes even more important.

- Access to professional advice and help is important. Undoubtedly some families benefit from individual health visiting interventions. However this is not sufficient to justify services which concentrate 100% on individual work with mothers of children under five.

- Other primary care professionals also have a responsibility to identify children in need and at risk. Ensuring that these professionals access local training may defuse the feeling that this is solely a health visitor concern.

- As you develop services to meet the new parenting and public health agenda you will need to involve managers and child protection support staff in any proposed changes and work with them to re-examine traditional ways of working on child protection issues. The goal must be to develop services which proactively promote the well-being of children and families at community level whilst providing, in partnership with others, effective support programmes for those in need.
Immunisation programmes

Protecting the population against infectious diseases has always been a cornerstone of the public health work of health visitors and the rest of the primary health care team. In general good progress is being maintained towards a target of 95% uptake for childhood vaccines. However, negative publicity has reversed the increases seen previously in MMR uptake. Nevertheless immunisation has led to the incidence of childhood disease being at their lowest ever levels. Health visitors play an essential role in ensuring that children are protected by giving parents evidence-based advice. Parents look to health visitors as their primary source of professional knowledge.

As the number of immunisation programmes increase and the public and professionals are faced with new and sometimes contradictory information, the need for local leadership and co-ordination becomes more important. Practice nurses are playing a vital role in immunisation programmes and a reluctance by some health visitors to inject babies has led to confusion about the health visiting role.

A strengthened public health role for health visitors provides an opportunity to improve the overall provision of immunisation services.

The key elements of a successful programme include:

- The provision of understandable, accurate and up-to-date information for the public and support with decision making.
- A flexible, convenient, high quality immunisation service that is able to deliver immunisations in a variety of settings to ensure access to disadvantaged groups.
- Well informed and trained staff (both clinical and administrative).
- Systems to monitor uptake at Primary Health Care Team (PHCT), PCT and Health Authority levels with regular feedback to the Public Health Department, the PHCT and the public.
- Flexibility and a commitment amongst the workforce to respond to local outbreaks and deliver new programmes.
- Regular auditing of standards.
- A team approach within the PHCT with a lead person to co-ordinate the programme and ensure that these elements are in place.

Health visitors have a key role to play in leading and co-ordinating immunisation programmes by taking on a public health leadership role in the community and the primary health care team. Who provides the programme, how it is provided and where will depend on local circumstances but the delivery of the programme will always need to be a team responsibility.
Child health surveillance

Child health surveillance checks by health visitors were viewed in the past as the only way of recognising children's health and development problems and have accounted for a substantial proportion of health visiting time. The development of a family-centred public health role supports a more proactive approach to promoting child health and a reduced emphasis on surveillance. This shift reflects the Hall Report's (1996) increasing emphasis on child health promotion as opposed to child health surveillance and a reduction in the number of routine contacts. It is recognised that child development cannot be viewed in isolation and that more can be achieved by adopting a holistic family and community approach. At the same time, however, it is vital that any screening tests are carried out to a high standard and regularly audited to assess uptake and quality.

It is increasingly recognised that child health promotion should be a team activity that will include others who see children frequently and regularly. This includes members of the PHCT, school nurses, early years workers in nurseries and schools, child minders and, of course, parents and family members. This means that the health visiting role will become more one of co-ordination, liaison, review and monitoring of the overall programme.

Many health visitors have developed creative ways of providing child health promotion services which are more positive and empowering for parents. These include:

- drawing on the special skills of nursery nurses and play workers to help parents maximise their child's potential
- offering parenting support groups which include a child development focus
- using quizzes, questionnaires, cartoon sequences and IT materials to help parents from a range of backgrounds understand more about their child's health and development and identify any concerns
- developing child health promotion provision in accessible community venues such as libraries and community centres.

Summary

This section has described a framework for the family-centred public health role of health visitors. We have considered the various ways in which health visiting teams can use a family-centred public health approach to work with individuals, families and communities to address priority health needs. The next section summarises some of the evidence that you may wish to use when planning how to respond to health needs.

Further reading

6. Working towards evidence-based practice

The overwhelming majority of health care practitioners strive to work in ways that are effective and which will result in the best outcomes for their patients/clients, communities and populations. More is known about ‘what works’ in family-centred public health practice than ever before, but for many the sheer volume of knowledge now available, particularly via the Internet, can feel quite overwhelming. However, it is reassuring to note that the principles and policies underpinning modern public health practice, including health visiting, are increasingly evidence-based. We are also fortunate to have publications such as the Hall Report (Hall, 1996) on child health surveillance and National Service Frameworks that have done the work for us by providing evidence-based recommendations for practice.

In this section we have summarised the evidence for key areas of practice within the family-centred public health role of health visitors. However, evidence of what works is continually changing and is frequently contested as people will always have different views on what counts as evidence and which aspects of health visiting are most important. Furthermore, it is not always easy to generalise findings to health visiting practice. This section cannot therefore be considered a definitive guide and readers are urged to read widely, keep up-to-date and engage in debates about what does and doesn’t work.

But what is meant by ‘evidence’? It might be information derived from:

- well-conducted research studies e.g. randomised controlled trials, critical ethnography, particularly where these have been combined into systematic reviews of a large number of individual studies
- systematic analysis of individual practitioner’s health care activities e.g. via critical incident analysis, in-depth reflection in clinical supervision
- rigorously conducted focus groups or other methods of engaging members of distinct communities to elicit views and experiences.

Evidence based on such systematic data collection methods underpins much of the content of this resource pack. Further examples of evidence in key areas of health visiting practice are considered below. You may find it helpful to reflect on your current approaches, preferably with one or more colleagues, and consider whether you might change your practice in line with the best available evidence of ‘what works’.
**Effective parenting interventions**

Recent studies, many of which are included in systematic reviews, provide the following key messages for health visitors.

**Parenting interventions**: well-designed and effectively delivered interventions by a range of professionals, including health visitors, are effective in improving key outcomes in young children (e.g. behaviour problems, intellectual development, immunisation rates, frequency of unintentional injury), mothers (e.g. anxiety, depression, self-esteem) and parents (e.g. parental confidence, partner relationships and parent-infant relationships), (Ciliska, et al., 1996; Elkan, et al., 2000; Thomas, et al., 1999; Barlow, 1999; Barlow and Coren, 2001).

**Home visiting**: visiting programmes delivered by health visitors and other public health nurses can be effective in improving a range of maternal and child psycho-social and health outcomes (e.g. improving breast-feeding rates, detecting and managing depression, improving difficult childhood behaviour) (Elkan, et al., 2000). Factors associated with effective home visiting programmes include: empathic, trusting and respectful relationship between home visitor and parent(s) using empowerment strategies (Barlow, et al., in press). In addition, programmes aimed at reducing the risk of child abuse and enhancing maternal and child well-being amongst vulnerable populations are most effective if there is: early identification of families 'at risk' via a universal service identified during the antenatal period, initiation of supportive services during pregnancy, case management support, frequent visits over an extended time (i.e. > 6 months) and programme delivery by trained professionals (Cox, 1998).

**Group-based parent education programmes**: Evidence suggests that group, as opposed to individual, methods of supporting parents through critical transitions (e.g. in the peri-natal period and at the toddler stage) are more effective, both for children and parents. Many parents obtain benefit from support provided by other parents in the group (Barlow, 1999). Programmes based on parental empowerment, which include role play and which are facilitated by empathic, skilful and professionally trained workers can be particularly effective (Thomas, et al., 1999). The UK-based PIPPIN programme embodies many of these critical features and an early evaluation indicated significant benefits (e.g. improved relationships between parents and their infants, increased parental confidence, child-centeredness, coping-skills and reduced anxiety and vulnerability to depression) (Parr, 1998).

**Effective health promotion strategies**

A recently published review of systematic reviews of a wide range of health promotion interventions undertaken by health visitors and
other public health practitioners (Elliott, et al., 2001) reflects many of the findings of effective interventions. The review indicates that sustainable, health promoting behaviour change is more likely when:

• education or counselling is combined with modification of the local environment e.g. where safety equipment is provided to prevent accidents

• behaviour change strategies are multidisciplinary, based on theoretical models from psychology and sociology and interventions that include skills training

• interventions are long term in order to achieve and sustain health gains

• interventions are targeted at high-risk groups rather than general populations to ensure maximum relevancy and motivation.

However, the same review showed that such positive behaviour change is much less likely when interventions involve:

• the passive transfer of information which seldom leads to behaviour change

• the provision of general support which lacks clearly stated and achievable aims

• brief unfocused activities which are unsupported by theory

• complete prohibition rather than encouraging safe practices or skills development.

Effective approaches to reducing health inequalities

A systematic review of interventions aimed at reducing health inequalities (Arblaster, et al., 1996) indicates that work in this area should include:

• continuous monitoring of local people’s use of and access to health services

• frequent prompting to encourage people to use available services

• positive action to improve access where it is found to be poor

• interventions should target not just the ‘worst off’ in society but also the ‘least well off’

• prioritising activities which are based on expressed needs of specific target populations

• wherever possible a multi-agency/multidisciplinary approach to service delivery
• peer involvement e.g. community mothers programmes

• education, which plays an important part in reducing inequalities in health, in particular pre-school education.

Community participation and user involvement

Not all research needs to be large scale to convey important messages. Consider the following messages from four well-designed, qualitative studies of community participation in four deprived neighbourhoods (Anastacio, et al., 2000). In these studies, local people:

• wanted to be consulted on service developments if this would impact on decision-making. However, many were sceptical as to whether it would

• often felt their suggestions were not acted upon, their queries not answered and their problems were taken over by professionals resulting in feelings of exploitation

• were dissatisfied with representative arrangements, sceptical about the ability of projects to tackle service providers, ill-informed about initiatives and were not permitted to exercise control over local budgets.

References for all the above studies and reviews are in the reference list at the end of this section.

Key resources for evidence-based practice

In spite of the continuing problems many practitioners face in accessing the Internet at work, there can be no doubt that this is by far the most useful source of information about evidence-based public health practice. The resources listed below are all web-based and collectively provide an excellent starting point for gathering the most up-to-date evidence on ‘what works’. Please also remember that there are services available to carry out searches on your behalf and many libraries and local initiatives offer training in such skills. Even if you personally have no Internet access, it is likely that there is a facility nearby at work. Working in groups can be particularly useful in this respect. Believe it or not, searching for evidence via the Internet can be fun and you are bound to come across lots of absolutely fascinating information you always wanted to know but never dared ask!

Enjoy…
Useful websites

Department of Health for policy documents and National Service Frameworks:
http://www.doh.gov.uk

NHS Centre for Reviews and Dissemination:
http://www.york.ac.uk/inst/crd/em51.htm

School Nurse and Health Visitor Innovation Projects at:
http://www.innovate.org.uk
until 31 December 2001.
From 1 January 2002 at
http://www.innovate.hda-online.org.uk

WISDOM resource database on evidence based practice (UK):
http://www.shef.ac.uk/uni/projects/wrp/seminar.html#EBP

Our Healthier Nation in Practice Database:

Health Development Agency (HDA) website:
http://www.hda-online.org.uk/

Health Technology Assessment website (for the systematic review of domiciliary health visiting):
http://www.hta.nhsweb.nhs.uk/htapubs.htm

Public Health Research, Education and Development Programme:
http://www.health.hamilton-went.on.ca/CSARB/ephpp/ephpp.htm

References and other resources


7. Developing skills to respond to health needs

The new family-centred public health role means that health visitors and their teams will inevitably find themselves working with a wider range of health issues and population groups. Responding to local health needs and addressing national priorities is likely to demand new knowledge, skills and different ways of working for health visitors and their colleagues. The previous two sections of this resource pack have looked at how you might assess health needs and possible public health responses to these. This section looks at how the team can prepare itself to undertake this work.

We know that health visitors already have many of the skills needed, either individually or in their teams. However, there are likely to be areas where you need to acquire new skills and knowledge. This can be done by going to other disciplines and agencies for the skills needed to meet local needs, for example, bilingual skills or early years workers, and building your team accordingly. Assessing skills and knowledge can be done by:

- drawing on personal professional portfolios and the skills identified through clinical supervision and appraisal
- using the public health skills audit tool in Section 10 that has been developed with the support of the Health Development Agency
- informally asking colleagues
- thinking about the skills you use within and outside the work setting.

The most effective way of filling any gaps in skills and knowledge is to learn by doing. This means that most learning about the new role and how to undertake a health needs assessment or community development will largely happen by ‘having a go’. The process and structures you may need to think about in order to ‘have a go’ and try out new public health approaches are discussed in Section 5.
We would recommend that you build in a range of activities to your learning, such as:

- shadowing others
- regular discussion group to explore critical incidents and share experiences of new ways of working
- reading
- visiting other projects
- using informal contacts with colleagues to talk through ideas
- running workshops
- journal clubs
- learning sets
- attending courses.

We know from audits of public health skills that there are key skills that practitioners have said they need for changing practice:

- working in partnership (team working and with other sectors)
- leadership
- project management
- evaluation.

**Working in partnership**

**Working in teams**

Health visitors will increasingly find themselves leading mixed teams of people. These teams may be made up of nursery nurses, community development workers, and other nursing and support staff. Moreover, as power is devolved to front-line staff health visitors will be making key decisions and leading public health programmes.

Alternatively teams may come together to improve the health of a specific community or client group such as asylum seekers, or around a health issue e.g. coronary heart disease. These teams may consist of people from the same or different organisations e.g. Sure Start, or include local people. This is a challenging agenda, both for the employing organisations, in supporting the development of these teams, and for practitioners who will need to work flexibly within a number of teams.
Building an effective team

Teamwork is a complex process, requiring thought and attention if it is to succeed. Some of the things that have been shown to be helpful are:

- having clear objectives
- assigning different roles and responsibilities to create a flexible whole
- assessing the quality of its work
- managing change effectively
- sharing expertise
- making the most of what team members have to offer and developing further skills
- frequently answering the question ‘what difference are we making?’
- keeping up-to-date with clinical and professional developments
- having clear lines of accountability
- developing networks with other service providers
- sharing their knowledge and expertise with others
- learning through experience.

Multi-sectoral/agency partnerships

Partnership working is the sharing of information, skills and resources to work together towards agreed objectives. As professional boundaries are becoming more fluid it is important to ensure that the whole team receives the support they need. This is a challenging agenda for all involved as collaborative working is not always straightforward. The differing organisations in any multi-agency work are likely to have a range of potentially competing priorities which need to be taken into account and it takes time for different professionals and lay people to get to know and trust each other sufficiently for effective joint working. However, the impact of work undertaken in partnership with others is likely to be far greater than that which can be achieved alone. Special consideration should be given to helping local people to participate equally with others. Do they need additional training, resources (such as crèches, translation facilities, payment) or other action in order to feel able to participate fully in planned activities? Developing the skills to work in this way will be key to the progress of a family-centred public health role.

Potential partners are set out here:

- Healthy schools
- Local people
- Programme co-ordinators
- Job centres
- Community activists
- Playgroup nursery nurses and youth organisations
- Lay PCT board
- Public health specialists members
- Self-help groups
- Community development workers
- School nurses
- Local businesses
- Midwives
- Social workers
- Practice nurses
- Spiritual leaders
- Teachers
- Police
- Dentists
- Drugs workers
- Youth clubs
- Clients
- Probation
- Community children’s nurses
- PCT Board
- Youth offending teams
- Women’s refuge workers
- Domestic violence workers
- Voluntary organisations
- General practitioners
- Physiotherapists
- Nurses with other specialist skills
- Counsellors
- Housing
- Regeneration initiatives
- Environmental health
- Pharmacists
- District nurses
- Occupational health
- Hospitals
- Community arts groups
Leading change

Leadership is key to both changing health visiting practice and to planning and delivering public health programmes. Both dimensions require similar qualities. Good leaders are needed at every level of the service but particularly to develop team working and improve practice and to work with PCTs and local people. All health visitors should see themselves as leaders and develop the qualities needed to fulfil this role locally.

What makes a good leader?

The key skills and attributes which are likely to be needed by health visitors are:

• a commitment to improving services, involving users, and improving the health of those with greatest need

• an ability to demonstrate the reality of the new way of working in their own practice

• to enable others to recognise the need for change

• a clear vision of the journey ahead, establishing common and realistic goals, direction and purpose

• to be facilitative, enabling others to be fully involved and to own the agreed changes

• to be able to mobilise the energy and enthusiasm of others

• to help others to learn from what they do, see and feel about the new ways of working

• to work well across organisational and professional boundaries to achieve the goals

• to ensure that external pressures are addressed and solutions found to obstacles that can so easily get in the way of change.

This may seem a daunting list but there are many similarities between being an effective health visitor and being a good leader. It is also important to realise that one person does not have to lead on everything. For example, one health visitor may lead a public health programme on teenage pregnancy whilst another may lead a multi-agency group undertaking the community health needs assessment.

As part of the programme to implement The NHS Plan a wide range of training and development programmes are being made available nationally and locally to support health visitors and others to develop leadership skills. Further information can be obtained from the Nurse Leadership website: www.nursingleadership.co.uk
Project management

Project management is a skill we all use. It is about deciding what you want to achieve, how to achieve it and how to recognise you have achieved it. Good project managers share many of the same characteristics as good leaders. Project management is an essential skill for good public health practice. As you and your team initiate public health programmes you will require project plans to ensure that your intended objectives are met. Each project will take you through a number of stages from initial definition to final evaluation and the celebration of successes. These stages are outlined below.

- **Assess the current situation and define the project**: be clear about what you are setting out to achieve and agree the desired outcomes with all those involved in the project.

- **Plan the project**: identify the stages of work or major tasks that need to be accomplished. Use a chart, for example a Gantt chart, to plan the sequence of these activities, to show how long each activity will take, when the key events must take place and who is responsible for each task. Identify project milestones and how they can be achieved.

- **Implement**: the team of people working on a project may not have worked together before. It is important that they establish good working relationships and have clear areas of responsibility and agreed communication networks. If mistakes happen, use them as learning opportunities and ensure a supportive environment.

- **Monitor/adjust**: project activities will need to be monitored against the project plan. You will inevitably have to problem-solve by modifying plans and co-ordinating the progress of the parts of the project.

- **Evaluate**: review your successes as you make progress towards the goals and evaluate how successful you have been in achieving them.

- **Celebrate your achievements**: celebrate at various stages during the life of the project to boost morale and reinforce the team’s sense of identity.

Evaluation

Evaluation is generally considered to be of three types. Each performs a different function and which one you chose depends on your objectives. They are outlined below with evaluative questions which you may like to adapt.

- **Process/formative** – the collection and analysis of information during a piece of work, to inform progress and so improve the way things are done.
  
  *e.g. Are we doing what we said we would do? If not, why not? What*
else of significance was going on? What did participants think of the programme components? To what extent are the community involved in the programme? What needs to be changed?

- **Impact/summative/output** - this measures the overall impact (effectiveness) of the programme, or a component part, on the target group(s).
  
  e.g. What happened as a result of what we did? Are there changes in the knowledge base of participants? How many and which people attended? Do local people feel or act differently?

- **Outcome** - this assesses whether the changes created by the programme had a long term health effect.
  
  e.g. Has there been a decrease in teenage pregnancies? Are fewer people being diagnosed with CHD?

This last area is particularly difficult to evaluate due to the need to establish a causal link between the inputs and the effect.

In addition an evaluation framework might also consider:

- **cost efficiency** - a consideration of the benefits in relation to the costs incurred

- **relevancy** - is there a need for this programme? This is usually used to investigate existing programmes and can be a very useful question to investigate as it will potentially release resources for other work.

This may all sound quite daunting and if this is the case it might help to think of evaluation as an extended form of reflective practice. Indeed, reflecting on practice is an important form of ‘on the job’ evaluation, often using the same sorts of questions. Seeing it like this can help with confidence, as can working with local researchers when necessary.

**Finding the evidence**

- A variety of methods can be used for data generation including questionnaires, focus groups, minutes of meetings, interviews and records of those who have attended services.

- If you are able to collect information to use for your evaluation from a number of different sources this will enhance its validity.

- When evaluating a specific piece of work you will need to establish a plan for action at the outset, against which progress can be measured. In addition, the approach taken in an evaluation should mirror that used in the programme itself. Thus a community development programme would aim to involve local people in decisions regarding the expected outcomes, the nature of the evaluation, the types of measures to be used and the collection of evidence.
• Evaluation can seem time consuming and difficult to those already stretched to provide services, and for this reason is often neglected. However, evaluation is the key to improving our services and ensuring that they are accessible and acceptable to local people.

Summary

This section has considered the skills needed to implement the family-centred public health role. Having considered the ways in which health needs can be assessed, public health approaches to meeting these needs and the skills needed to make this possible, Section 8 considers the mechanisms you could use to bring about this change of focus in your area.

Further resources

8. Changing practice: steps to success

Getting from here to there: the process of change

Everyone has the potential to lead and make change. But we do need to understand how change affects us and how to make change effective and long-lasting. Practice evolves as we reflect and learn from our work and respond to new knowledge. Changes in society, the NHS and the family-centred public health approach challenge traditional practice. The degree and type of change will depend on where you are starting from. Whatever the degree of change required, it will help if you treat developing the family-centred public health role as a change project that needs to be planned for and managed. Change is often achieved at a price, in terms of time and effort, and the benefits must be seen to outweigh this cost. A robust project plan will help you to manage this change effectively.

There are a number of key elements in any change process (see below). Try to incorporate these into your plans. You can work through the change process as an individual or as a team, but it would be better to work on this issue as a PCT project, especially if you feel large scale changes such as changing professional practice will be required. You may need to involve a senior organisational manager as a ‘sponsor’ for the change process. They will be able to ensure that the plans are accepted and acted upon across the organisation and assist you to find the resources and skills you need to implement your plans.

Key stages in implementing change

Agreeing what needs to change and why

Questions you could ask…

• What are the needs of our community and how are they currently being met?

• Why do we need to change? This resource pack discusses the reasons but it may be useful to do further reading or discuss the changes with others (not necessarily your immediate colleagues).
• What do we want to change about our current work? Is what we do still needed? Does everyone need it or should our work be more targeted? Is everyone accessing our service?

• Do we currently make best use of all our skills and knowledge?

• What other changes have there been in the NHS and outside that impact on what we service?

**Developing a clear and attractive ‘vision’ of the future - what could/should be happening**

*Questions you could ask…*

• What would our service look like if we focused on improving the health of the local population and reducing inequalities in health?

• How will the health of the local population improve as a result of this change?

• How will the change meet the needs of the PCT? Health Authority?

**Managing the change process - clarifying how changes will be made and implementing plans**

*Questions you could ask…*

• What will get in the way of implementing this vision and what will help it? What plans do we need to make to minimise the obstacles and strengthen the enabling factors?

• How can we involve all practitioners in the change process?

• How and when can we involve local people in the change process?

• What do we need to do first to get to where we want to be?

• How can we stop providing services which are no longer needed?

• What will the impact of our proposed changes be on:
  – the local community?
  – our existing clients?
  – ourselves?
  – our colleagues?
  – the rest of the PCT?
  – other agencies?
  – managers?
  – the PCT?
  – public health departments?
  – anyone else?

• Are there any risks associated with this change? How can we minimise these?
• How can we ensure a ‘win-win’ solution that will benefit all those involved?

**Building the capacity of the organisation and practitioners to deliver the proposed changes and reducing resistance to change**

*Questions you could ask…*

- Do health visitors and managers have the knowledge and skills they need to implement the vision? If not how are we going to provide them with the learning opportunities that they need?
- Why are some people resisting change? How can we help them?
- Do we need to develop any new tools? For example, family health plan, community health needs assessment?
- Do we need to review current policies?
- Do we need to find out what others are doing, visit other places, set up a journal club or learning set?
- Do we have local enthusiasts who can act as role models for change and encourage others?
- How can the organisation recognise and be seen to value those who do change?

**Involving key stakeholders**

This is an important part of the change process. Anyone who will be affected by the changes you are proposing needs to be kept informed and even involved as you go through the process. Make sure you talk to local stakeholders, try to see the change from their point of view and explore potential barriers with them. Going through this exploration will help you:

• find out what is going to get in the way
• enlist others’ expertise in removing these barriers
• simultaneously build a coalition of support for the change.

Remember that getting everybody together in one room is not always the best way of exploring things. Apart from being difficult to arrange, people may not feel free to talk openly in such meetings. One-to-one meetings can be a better way to explore the real barriers in the early stages.

Once you have worked through this process you will be able to develop a change programme that already has significant local support and which you can then go out and sell.
Who should be informed or involved?

Most successful changes are supported by coalitions of key local people. Who do you need to be on board? This might include local people, GPs, paediatricians, midwives, managers, social services, community organisations and public health practitioners – you could ask one of the people who obviously needs to be on board who else it would be useful to talk to. Or ask colleagues – especially those in different professions.

How do we look after each other and ourselves?

Change can be a stressful and difficult process. If it is to be managed successfully the personal needs of those involved will need some attention. Here are some key things you might like to think about:

• How do I feel about all this change? Your reaction may be: 'I can't wait – it's what I always wanted to do' or 'been there before, heard it all before – I just want to keep my head down and get on with home visiting'. Whatever your personal reaction, it is important to recognise that team members may feel differently about the proposed changes.

• What motivates us in our work, how can we keep motivated to do a good job?

• What do I need to help me with all this change? Think about the help you need from colleagues, managers and what you need in terms of new experiences, skills and knowledge?

• How are you going to agree ground rules with your group or team about how you want to implement change, for example about keeping people informed, ensuring people feel safe to share their anxieties, what to do if people lose interest?

Key messages

• Be realistic – take small steps but know where you are trying to get to.

• Keep it focused and practical.

• Have a written plan.

• Do it with others and support each other.

• Own the changes – it is your work, you know the real world of everyday practice.

• Involve local users – link to community groups and community workers wherever possible.
• Get support in the right places from the beginning e.g. the PCT, key GPs, public health, paediatricians.

• Link with other initiatives from the beginning e.g. Sure Start, Health Improvement Programmes, New Deal for Communities, Health Action Zones, Excellence in Schools, Neighbourhood Renewal.

• Meet regularly and talk through the dilemmas, issues, risks, feelings that arise for you.

• Keep checking out why? What are the health benefits for the whole population, what needs are being met? What is the evidence?.

• Get involved and influence planners, managers and policy people in the PCT.

• Record what you do otherwise you won’t know what you’ve done and neither will others!

• Enjoy yourself and see this as a personal development opportunity.

Sustainability: keeping going

How will your work be continued so that the change you envisaged becomes an established part of your role? What else around you still needs to change so that this new way of working is seen as ‘everyday’?

In order to embed the changes into the local culture you could:

• ensure that the support from other key people and groups is maintained

• ensure new initiatives don’t depend on one person

• keep others informed about what you are doing

• disseminate your work through websites, local reports, workshops, articles for publication.

Summary

This section has looked at how to create an environment that supports changing health visiting practice and how to engage in the process. The next section suggests some priority areas for public health practice that you may wish to consider.

Further resources


9. Delivering on health priorities

There are some key areas that need to be addressed if we are to significantly improve the health of the population and narrow the health gap. The following information sheets cover those issues that are central to today’s health agenda. They are intended as summary sheets only and you may need to use them with other resources. Practice examples are provided to illustrate how health visitors can contribute to addressing these issues. The key themes that run through the practice examples are:

• working with other organisations and professional groups
• working at the level of both the individual, family and community
• the importance of linking with PCTs
• working in partnership with local people.
Accidents

The issue

Accidents are responsible for 10,000 deaths a year in England and are the leading cause of death among children and young people. Major causes include:

- **Road traffic accidents**: every year 2,500 adults die in road traffic accidents. Each year there are 215 deaths among children who are passengers and 180 deaths among children who are pedestrians or cyclists. Rural areas are more severely affected.

- **Accidents in the home**: About half of all deaths among children under 5 happen within the home. Fires, burns, drowning, choking, poisoning and cuts are all major causes of injury. Older people are also particularly at risk. More than 3,000 people over 65 are killed each year in falls. Osteoporosis, particularly affecting older women may mean that the consequence of falls is more severe.

- **Accidents at work**: These can be linked to the nature of the work, the work environment or failure to manage risk effectively.

Why should health visitors be involved?

There is a great deal that can be done to contain the risks of accidental injury. Health visitors can help households identify risk, minimise environmental hazards and to influence public policy. Home based social support, such as that provided by health visitors, has been shown to be effective in reducing child injury rates. Community programmes involving local participation and using a broad range of interventions are also effective as are interventions targeted at reducing falls in older people with multiple risk factors.
What can health visitors do?

- Work with public health colleagues to identify patterns of accidents and high-risk groups or locations.
- Work with individuals and families to enable them to identify potential dangers and ways of preventing accidents.
- Influence local planning, for example traffic calming measures, pedestrian crossings and safer routes to schools.
- Work with Local Authority housing, leisure and environmental health services to promote safe accommodation and play areas.
- Target interventions at high-risk environments such as bed and breakfast accommodation.
- Work in partnership with other agencies to provide safety equipment such as smoke detectors and car seats through discount or loan schemes. Support targeted at those most at risk plus free distribution of devices is likely to have greatest impact.
- Work in partnership with groups such as the police, fire brigade, A&E staff and road safety organisations to raise accident awareness, such as cycle safety programmes, first aid training for local community groups.
- Work with occupational health colleagues to promote health in the work place.
- Provide information on how to reduce risk of osteoporosis through diet, exercise and smoking cessation.
- Work with physiotherapists, occupational therapists and other colleagues to establish falls prevention programmes for older people. Consider review of drug regimens, development of appropriate exercise programmes, and provision of home safety advice and equipment.

Practice example

In their community health needs assessment the health visitors identify high rates of hospital admission among older people following falls at home and in residential accommodation.

They hold a meeting with local occupational therapists and physiotherapists, care staff and older people’s pressure groups to determine whether there is any preventive action which can be taken to address this issue. The group considers there is a need for:

- improved risk assessment in relation to falls within nursing and residential care settings
- improved assessment and preventive intervention for frail older people living at home
- opportunities for exercise among frail older people.

The working group presents its action plan to the Primary Care Trust, which agrees to fund increased time for the occupational therapist as long as there is an annual audit of accident rates among the target population.

The group implements the following preventive programme:

- occupational therapists offer support to residential and nursing homes to assess risk and make changes to the home environment
- community nurses and health visitors attend a training day on risk assessment within the home
- an exercise video for older people is sent out to all the supported housing and residential care homes locally
- the physiotherapist runs a training programme for all staff who work with older people on promoting physical activity and reducing the risk of falls
- the district nurse runs a session for the local carers group on preventing falls.

Further reading and resources


The Royal Society for the Prevention of Accidents http://www.rospa.com
The issue

Alcohol is an enjoyable part of many people’s lives. However, the harm caused by excessive drinking is a significant public health issue.

- 1/5 of all hospital beds are occupied by people with alcohol related problems
- 1/6 of attendances at A&E are associated with alcohol
- 65% of suicide attempts are linked with excessive drinking
- Alcohol is also a major threat to social well-being
- Between 60-70% of men who assault their partners do so under the influence of alcohol
- Heavy drinking by parents was identified as a factor in over 50% of child protection case conferences
- In over 40% of contact crime such as assaults and muggings, the offender has been drinking

Particular trends include:

- increasing consumption by children and young people
- consumption of large amounts of alcohol in single sessions
- increasing levels of consumption among some women
- continuing dangerous levels of consumption by some men
- dangerous levels of consumption by some socially excluded groups e.g. street dwellers.

Why should health visitors be involved?

Alcohol is a factor in many of the priority health issues that health visitors need to address, including mental health, coronary heart disease, stroke, accidents and some cancers. Problem drinking can also severely affect the well-being of families through its association with child abuse and neglect and domestic violence. Serious drinking during pregnancy may give rise to foetal alcohol syndrome.

Health visitors can raise the issue of alcohol intake in a non-stigmatising way, particularly as part of a family health plan.
What can health visitors do?

- Be aware of latest guidelines on sensible drinking: these currently advocate no more than 21 units per week for men and no more than 14 units per week for women.
- Make sure you know about local agencies and resources that can help people with alcohol problems.
- If you become aware of gaps in resources find ways to feed this into local planning processes.
- Get yourself trained to use brief intervention and motivational interviewing to help people think about reducing their alcohol intake.
- Work with families where there is a serious drink problem to think about how the impact of problem drinking can be minimised.
- Identify particular groups who may be at risk of alcohol related harm and consider whether there is anything you can do with others to address their needs.
- Contribute to or initiate awareness raising campaigns on alcohol use.
- Ensure programmes of care are in place for expectant women with alcohol problems.
- Get involved with or help to establish local multi-agency alcohol forum.

Practice example

Information collected by the practice suggests there is an increasing number of women drinking more than the recommended level of alcohol. High levels of stress and a need to escape the pressures of family life are among the reasons women give. Health visitors work with the housing and tenants associations to establish a community café and crèche facility on the estate to relieve the social isolation. An appropriately skilled member of the health visiting team uses the venue to offer regular relaxation and exercise sessions whilst a qualified and experienced local woman offers massage and aromatherapy. Uptake is high and a survey among those attending suggests reduced alcohol and tobacco usage and use of a wider range of relaxation strategies.

Further reading and resources

http://www.doh.gov.uk
The issue

Britain is a diverse society made up of many different groups that bring strengths and benefits to all. Members of minority ethnic communities are not a homogenous group for health status, disease patterns or health behaviours. A number of studies have shown that there are significant health inequalities among people from minority ethnic communities. These inequalities relate to differences in disease prevalence, differential access to services and differential delivery of services.


A higher proportion of people from black and minority ethnic groups experience poorer health than the general population, having a higher incidence of illness, disability and poor educational achievement than other population groups. For example within the UK population:

- disproportionately high rates of asthma in minority ethnic communities
- high rates of anaemia among children of Southern Asian parents
- more Afro-Caribbean young people experience or are diagnosed with mental health problems
- black Caribbean men showed higher rates for stroke, but lower rates for angina and heart attacks
- high rates of stroke and coronary heart disease among Southern Asian and Irish communities
- black Caribbean and Pakistani women were more likely to be obese
- higher rates of diabetes were reported by men and women from all the minority ethnic groups
- young women from Somali countries can be at risk of female circumcision
- refugees from war zones will have experienced significant trauma
- boys from some minority ethnic communities such as the Afro-Caribbean community, are six times more likely to be excluded from school than other pupils. They also do less well at school, are implicated in more bullying incidents and have high rates of youth unemployment.

The reasons are complex involving many factors. Social deprivation has been shown to disproportionately affect the health of black and minority ethnic communities. They are also less likely to receive the services they need from the NHS. Services have to become more sensitive to the cultural and health needs of black and minority ethnic communities, provide adequate interpreting services and tackle racism wherever it occurs.

Why should health visitors be involved?

Tackling health inequality is an important public health goal. Working with others, health visitors have a responsibility to ensure equality in access, care, outcome and employment practices in both health and education.

*The NHS Plan* gives commitments to tackling health inequalities for minority ethnic groups. For example by:

- 2003 a free and nationally available translation and interpretation service will be available from every NHS premises via NHS Direct
- 2004 there will be effective and appropriate screening programmes for women and children including a new national linked antenatal and neonatal screening programme for haemoglobinopathies.
What can health visitors do?

• Be aware of your own cultural assumptions and how these may affect your responses to people from different black and minority ethnic groups.
• Understand the importance of factors such as age, geography, generation, life experience, occupation, and education.
• Realise the significant impact of culture on people’s lives, but recognise that it is not the only factor that determines a person’s health.
• Ensure that the ethnic dimension is identified in local policies and protocols.
• Implement the requirements of national policies such as National Service Frameworks, Positively Diverse Report 2000 (NHSE, 2000) and the Race Relations (Amendment) Act 2000 (The Stationery Office, 2000).
• Consider how health visiting services are meeting the NHS Performance Assessment Framework (PAF) which covers the following areas: improving people’s health; fair access to services; delivering effective care; efficiency; the experiences of clients; health outcomes.
• Ask local people about their experiences, and involve them in helping to develop appropriate responses to the health issues faced by black and minority ethnic communities.
• Be prepared to raise the issue of racism and how it impacts on the lives of local people, service users, yourself and your colleagues.
• Ensure that the views and experiences of different groups within black and minority ethnic communities are taken into account to support the planning and development of accessible services.
• Be aware that services may be inaccessible due to communication and language difficulties, culturally insensitivity, inappropriateness, or the complete lack of provision.
• Identify resources available to support people from particularly vulnerable groups such as refugees and asylum seekers.
• Work in partnership with black and minority ethnic communities to provide and advocate for appropriate health services and facilities in public and health services e.g. anti-racist policies, training and development opportunities for black and minority ethnic health workers.
• Undertake ethnic monitoring to inform equitable service provision.
• Actively work to promote diversity and challenge racism.

Practice example

Local public health specialists raised concerns that Pakistani women in the area had lower attendance for breast screening than other groups, and were likely to present with more advanced stages of breast cancer before they sought treatment. As a result they experienced poorer outcomes from treatment. Working with a health promotion specialist the school nursing team piloted female only breast awareness sessions for young women in school. Activities included exercise promotion, information on breast awareness, screening services and advice on fitting bras. Mothers and female relatives were invited to school to participate. As a result women were more aware of the breast screening programmes and had greater confidence in using the services.

The health visiting team undertook further consultation and community development with local Pakistani and Bengali women’s groups around women’s health services. The women themselves wanted to become more involved in delivering health education within their communities and, with support and training, they were able to contribute to a wider health promotion programme rolled out across all schools in the area. Several women who took part in the programme then went on to further training and education, or paid employment in local health services.

References and further information


Child and adolescent mental health

The issue

- The prevalence of mental health problems amongst children and adolescents is currently estimated as 10 – 20% of the child population
- The incidence of suicide in young men has increased significantly in the last decade
- There are strong links between mental health problems in children and young people and juvenile crime, alcohol and drug misuse, self-harm and eating disorders
- Mental health is one of the four priority areas set out in Saving Lives: Our Healthier Nation
- The NHS Plan made a commitment to improve Child and Adolescent Mental Health Services (CAMHS) to help primary care manage and treat common mental health problems in all age groups, including children.

Why should health visitors be involved?

Promoting mental health is a core component of health visitors’ work. They have an important role to play in supporting parents and children and developing community provision to prevent mental health problems.
What can health visitors do?

- Provide support at vulnerable times, such as birth of a new baby or a bereavement, increasing self-esteem and problem solving skills.
- Use evidence-based approaches in individual and group work with parents and children and ensure that you have the necessary skills.
- Work with others to ensure a co-ordinated approach to the planning and delivery of family support services.
- Work with local communities and other agencies to identify need and put in place a range of family support services.
- Help parents to access community facilities, e.g. parenting groups and child care services.
- Run parenting groups to promote social networks and positive parent-child relationships.
- Run groups for children and young people to develop self-esteem, trusting relationships and social skills.
- Identify the mental health problems of parents including postnatal depression and ensure that they have access to appropriate specialist help.
- Secure extra support for children whose parents have mental health problems.
- Work with CAMHS service providers to provide integrated care for families.

Practice example

The local HlmP identifies adolescent mental health as a priority because of an increased incidence of self-harm among young people. Health visitors and school nurses establish a multi-agency group to plan and implement a preventive programme locally. Their activities include:

- a support group for parents who are experiencing difficulties with their teenage children
- a workshop for health care, social services and teaching staff on preventing self-harm
- confidence building drama workshops in the local youth centre
- producing information leaflets for young people with details about where to go for help.

Further reading and resources

http://www.audit-commission.gov.uk

http://www.doh.gov.uk/nsf/mentalhealth.htm

http://www.doh.gov.uk/nsf/mentalh.htm
The issue

Depending on the definitions used, between 3% and 5% of children in the UK are classified as disabled.

The Government aims to:
- strengthen human rights for disabled people
- promote the inclusion of disabled children in society in order to enable them to achieve their full potential
- reduce health inequalities
- offer more support and greater choice for disabled children and their families
- reduce poverty among families with disabled children.

The Quality Protects programme aims to improve the standards of care offered to the most disadvantaged and vulnerable children in our society including disabled children.

Why should health visitors be involved?

Health visitors have contact with children and their families in a variety of settings and are able to assess the health needs of the child and family. They can recognise when extra support or services to promote health and development are needed and enable parents to find the services they require.

Furthermore the health visitors’ networks with the statutory and voluntary sectors mean that they are able to influence service provision and to promoting an integrated approach to the care of disabled children and their families.
What can health visitors do?

- Assess the needs of the child and family and make timely, appropriate referrals to other professionals and agencies to ensure that children and their families receive the additional support services they require.
- Work in partnership with other health professionals e.g. learning disability services, community children’s nurses to ensure that care is well co-ordinated.
- Ensure parents, children and young people have the information which they need to make informed decisions about health, education and welfare needs.
- Advocate and support children and young people to achieve what they want.
- Be aware of voluntary funds and other local agencies providing support for children and their families.
- Support the setting up of support groups for disabled children and young people and their families that are client-led.

Practice example

The health visitor and community development worker run a regular session at the local leisure centre for children with special needs. Soft play facilities are available, together with an indoor sports court and use of the swimming pool. The health visitor applies for funding from the Lottery to pay for staff and volunteer expenses. The manager of the leisure centre agrees to provide qualified sports workers and lifeguards and young people taking their Duke of Edinburgh Award to work as volunteers to provide a café and crèche facility. After a few months the parents and young children start an organising committee who take over the running of the group. The health visitors and community development worker keep in contact and offer occasional support when requested by the organising committee.

Further reading and resources

http://www.doh.gov.uk/learningdisabilities

Delivering on health priorities

**Domestic violence**

The issue

- Domestic violence ranges from verbal abuse, through threats and intimidation, manipulative behaviour, physical and sexual assault to rape and even homicide
- Those who experience domestic violence often keep it to themselves – shamed and embarrassed by what is happening to them; unsure of where they can go and what help they can get, and fearful of doing anything which might make the situation worse. It is estimated that women experience around 35 episodes of violence before they seek help
- Domestic violence is rarely an isolated event and if a woman is being abused, her children are likely to be at risk
- The British Crime Survey 1998 reveals almost one in four (23%) of women aged 16-59 have been physically assaulted by a current or former partner
- Half of those who had experienced violence from a partner or former partner were living with children under 16
- Emotional distress was reported by 90% of the women experiencing chronic domestic violence
- One in seven men (15%) report being physically assaulted by a current or former partner.

Why should health visitors be involved?

The impact of domestic violence on individuals’ health is substantial and people who are victims of domestic violence will often turn to health professionals for help. It is not easy to ask, or be asked, about domestic violence.
What can health visitors do?

- The safety of the woman (and any dependent children) is the paramount consideration in work in this area.
- Listen, establish empathy and trust.
- Empower people to make informed decisions and choices about their lives, and do not try to make decisions on their behalf.
- Respect confidentiality and privacy, and recognise the potential dangers if this is breached.
- Provide regular support to women’s refuges and their residents.
- Work closely with other agencies.
- Ensure that you do not place yourself or your colleagues in a potentially violent situation.
- Lobby for local services that are responsive to family needs, for example, anger management sessions.
- Work with other agencies to ensure consistency of approach.

Practice example

The practice has been invited to attend an Open Day at the local Women’s Refuge - the invitation ends up on the health visitors’ desk, with a note saying ‘this is the health visitor’s role’. Health visitors are aware that a number of women registered with the practice are the victims of domestic violence and are concerned that this short note reflects the views of colleagues within the practice team. The Women’s Refuge reports that they have had very few replies to the invitation.

Health visitors discuss this issue at the next domestic violence forum which decides to develop a training tool to bring home the realities of the health issues faced by victims of domestic violence. The Women’s Refuge makes a tape recording of women sharing their experiences, highlighting the difficulties they have faced in dealings with health professionals. These include missing appointments because they are afraid of meeting their partner, finding it difficult to tell anyone about how their injuries occurred and not having any child care arrangements so they can talk in confidence to health care professionals without their children being present.

Health visitors arrange a training session for practice colleagues in partnership with the Women’s Refuge, where the specific health issues faced by the women are raised. The final part of the session develops a practice protocol for dealing with domestic violence issues. The Practice Manager agrees to co-ordinate the work with the workers from the Women’s Refuge, a district nurse and one of the partners.

Further reading

Drugs

The issue

• Drug misuse is a serious problem in the UK
• Illegal drugs are more widely available than ever before and children and young people are increasingly exposed to them
• Young people such as those who truant, young offenders, children in care and homeless young people are at particular risk for problem drug use
• Drug misuse is linked with other social problems such as unemployment and homelessness and cannot be seen in isolation
• The health effects of drugs can be wide-ranging and their health impact has a social class gradient: whilst professional and skilled workers are more likely to have taken drugs, poorer unskilled workers are more likely to use dangerous routes of administration
• Within the chronic drug using community rates of hepatitis B and C may be as high as 60-85% among those who inject
• Drug use is a threat to communities because of drug related crime
• The Government has set out its strategy to combat drug and alcohol misuse in Tackling Drugs to Make a Better Britain (Stationery Office, 1998).

Why should health visitors be involved?

Their knowledge of local communities and contacts with other agencies means health visitors are in a good position to prevent drug use and address the broader social issues with which problem drug use is associated. They can also provide non-stigmatising support to pregnant women and parents who use drugs and work to promote the well-being of children and families who are vulnerable to the health consequences of problem drug use.
What can health visitors do?

- Use health promotion strategies with active learning methods which develop self-esteem, knowledge and skills. Research has shown that ‘shock horror’ approaches can excite and glamorise the effects of drug and result in an increase in their use.
- Offer practical choices and information about where to seek help and be non-judgmental and supportive to individuals and families who experience problem drug use.
- Assess the risk to children and families and work within local child protection guidelines.
- Be aware of confidentiality issues and the rights of children and young people.
- Ensure that people from all backgrounds, whatever their culture or gender, have access to services and make sure that socially excluded groups are included.
- Promote services such as ‘walk-in centres’ and ‘drop-in’ sessions which may be more accessible for clients with drug related problems.
- Work in partnership with other agencies and voluntary groups to provide preventive programmes.
- Consider initiatives such as life-skills drugs education sessions for schools and drugs awareness as part of parenting programmes.
- Work with other agencies to build alternative recreational opportunities for children and young people.

Practice example

The Health Improvement Programme identified substance misuse as a priority health need and the PCT wants to implement a programme of awareness raising and primary prevention. Over the next year the health visiting team works with the Drug Action Team on the following:

- participating in a school health programme focusing on drug awareness
- attending training sessions so that everyone is up to date and knows how to work effectively with young people and parents on this issue
- ensuring that information on advice and information and treatment services are displayed and accessible in all the settings in which the team work
- facilitating a critical incident case discussion with the team on the recent handling of a child protection case where the mother is using hard drugs.
- co-facilitating a meeting of local parents concerned about needles in the local playground providing them with accurate information regarding the risks and requesting that the Local Authority cleans up the area.
- responding to parents’ concerns about the lack of treatment services by arranging for them to meet with the DAT co-ordinator and the PCT Public Health Specialist
- inviting a local drugs worker to lead a discussion in the PHCT on issues of race and drugs.

Reference and further information

Department of Health (1998) 

Helping people to stop smoking

The issue

- Smoking is the single greatest cause of preventable illness and premature death in the UK and is responsible for 1 in 5 of all deaths (120,000 deaths in the UK each year).
- Smoking causes coronary heart disease, cancer of the lung, chronic bronchitis and emphysema. In pregnancy it reduces birth weight, and contributes to perinatal mortality.
- Smoking kills 500 out of every 1000 people who continue the habit, so smokers have a one in two chance of dying from a smoking related disease and half those deaths will be premature (aged 35-69 years).

Why should health visitors be involved?

Health visitors have a key role to play in achieving the above targets. Intervention to help an individual give up smoking may be the most important single influence a health visitor can have on their health. Clinical guidelines confirm that a combination of nicotine replacement therapy and support works – even those who are highly addicted can achieve success. Furthermore, stopping works, even in middle age and stopping earlier is even better.

What can health visitors do?

- Work with the local authority to help discourage smoking in public places.
- Monitor any new tobacco marketing strategies locally, for example use of discos to promote brands to young people.
- Encourage the introduction of no-smoking policies in schools.
- Work with the primary care team to:

  Ask
  All patients should have their smoking (or other tobacco use) status established and checked at every visit and the information recorded in their notes. Interest in stopping can be assessed with an open-ended question such as ‘have you ever tried to stop?’ and/or ‘Are you interested in stopping now?’

  Advise
  All smokers should be advised of the value of stopping and the risks to their health of continuing. The advice should be clear, firm and personalised.

  Assist
  If the smoker would like to stop, help should be offered. A few key points can be covered in 5-10 minutes such as:

  - setting a date to stop; stop completely on that day
• reviewing past experience: what helped, what hindered?
• planning ahead: identify likely problems, make a plan to deal with them
• telling family and friends and enlist their support
• planning what they are going to do about alcohol
• trying NRT; use whichever product suits them best.

Arrange
Offer a follow-up visit in about a week, and further visits after that if possible. Most smokers make several attempts to stop before finally succeeding (the average is around 3-4 attempts). If the smoker has made repeated attempts to stop and failed, and/or experienced severe withdrawal, and/or requested more intensive help, consider referral to a specialist cessation service.

Nicotine replacement therapy
• Clinical trials have shown that NRT doubles the chance of success of smokers wishing to stop. While NRT can help smokers stop, even if they have tried it before, it is not a magic cure. NRT usually provides nicotine in a way which is slower and less satisfying, but safer and less addictive than cigarettes. Unlike tobacco smoke, it does not contain tar and carbon monoxide. There is no evidence that nicotine causes cancer.
• Zyban is a non-nicotine based treatment which has been shown to be highly effective in helping smokers to quit. Zyban is an anti-depressant that reduces the smoker’s withdrawal symptoms and the desire to smoke. The contra-indications should always be checked.
• As with NRT, only smokers motivated to stop smoking should be prescribed Zyban and they should be given continual support while taking the medication.

Practice example
The Smoking Cessation co-ordinator has sent the PCT information on local rates of smoking and premature deaths due to smoking. The PCT asks the health visitor to develop a programme to reduce smoking in the locality. The Smoking Cessation co-ordinator provides the team with up-to-date information of local rates and effective interventions. A meeting of local health staff, community workers, interpreters, teachers and youth workers agrees a local programme. As a result:
• the community worker consults with local people who identify the following as their priority issues:
  – local shops selling single cigarettes to children
  – advertising near to schools and playgrounds
  – difficulty in accessing NRT and Zyban
  – wanting support groups to be available at a time that suited them
• a workshop is held in the practice on how to tackle smoking in the course of everyday contacts with clients, this includes a role play on talking to people about smoking
• the team has decided to focus on smoking in pregnancy so the local community midwife helps run the session
• the practice manager provides publicity and information for patients on what is available (NRT, helplines, groups etc)
• funding is obtained to train local people who have given up smoking and to pay them to run their own groups. This project is led by the health promotion worker in the PCT and the health visitor
• the Public Health Specialist on the PCT works with the team on an evaluation plan and ensures that the PCT is kept informed of this work.

For further information health visitors can contact the NHS Smoking Helpline on 0800169 0 169 or visit the campaign website on http://www.givingupsmoking.co.uk

Reference
Department of Health (1998)
Smoking Kills, DoH, London.
Nutrition

The issue

• Nutrition is a key area in the Government’s public health strategy as outlined in Saving Lives: Our Healthier Nation. Improving diet and nutrition is crucial in the CHD, stroke and cancer prevention priorities.

• Increasing fruit and vegetable consumption is considered the second most effective way of reducing the risk of cancer after reducing smoking.

• Consumption of 5 portions of fruit and vegetables a day could lead to a 20% reduction in major killers such as coronary heart disease.

• Eating fruit and vegetables also reduces the risk of breast cancer and the more consumed, the greater the protection.

• Poor nutrition leading to low birth weight and poor weight gain in the first year of life, contributes to later health problems, particularly heart disease.

• Serious conditions associated with diets high in fat, salt and sugar also include diabetes, high blood pressure, dental caries and obesity.

• Obesity levels in England have tripled over the last 20 years as reliance on convenience foods has increased and levels of physical activity have dropped.

• 10% of British women and 8% of British men are now categorised as obese.

• The prevalence of obesity increases among lower socio-economic groups.

• Obesity reduces life expectancy on average by 9 years.

Why should health visitors be involved?

Health visitors have an important part to play in promoting health nutrition. Their contact with families and young children may be particularly important during pregnancy, breast-feeding and in promoting healthy weaning. In their public health role in the community health visitors have the opportunity to improve access to healthy eating choices for those who are most disadvantaged.

What can health visitors do?

• Develop local programmes which support people to:
  – eat five portions of fruit and vegetables each day
  – eat less fat
  – eat more fibre-rich starchy foods
  – reduce the amount of salt consumed by a third
  – increase the amount of oily fish eaten to at least two portions each week.

• Working with individuals
  – focus on diet or diet plus physical activity rather than trying to tackle a range of risk factors
  – set clear goals based on theories of behavioural change, rather than relying on the provision of information alone
  – sustain personal contact with individuals or small groups over time
  – give personalised feedback on any changes in behaviour and risk factors.

• Working with communities
  – map access to health foodstuffs as part of the community health assessment
  – work with local people to identify what the issues are and how best to tackle them
  – consider initiatives such as food co-ops, community gardens, cook and eat groups
  – provide nutritional advice that is sensitive to
Practice example

A health visiting team identified that the highest rates of poor health locally, including high rates of heart disease, cancer, diabetes, depression, and anaemia amongst children and young mothers, were concentrated in one particularly run down and isolated housing estate. A high proportion of residents were unemployed or had long term illness or disability, and there was a lack of local facilities and poor transport to shops. Many families on low incomes, those from ethnic minority communities, and older people had inadequate diets. Everyone complained that local shops sold a limited range of foods, which were more expensive than the supermarkets. It was found to be very difficult to buy fresh fruit and vegetables.

Following discussion with other residents, and colleagues, the health visitors and health promotion workers successfully obtained funding from their local Health Action Zone to undertake food availability mapping with the aim of increasing access to affordable healthy food locally. They linked the initiative to the Five a Day fruit and vegetable health promotion campaign, identified priorities in their local HImP, and implementation of the CHD and Cancer National Service Frameworks. They realised that this was a long term initiative and they needed the support of the PCT and involvement of local people to make it work.

Health visitors took on co-ordinating, dissemination and fund- raising roles, and ensured regular progress reports and presentations to the PCT and primary care colleagues.

- Local residents were invited to a meeting, with a free lunch, to plan how to take the work forward. Interested residents formed a working group, to help design the evaluation and to agree how the budget would be spent.
- A group of 10 local people were recruited, trained and employed as community researchers.
- Barriers to accessing fruit and vegetables were found to be cost and difficulty carrying shopping.
- Most popular solution was identified as a local delivery scheme.
- Local food retailers and farmers market involved. Residents co-ordinated local delivery schemes.
- Low cost delivery scheme set up, delivering bulk purchases via community centres to homes, nurseries, adventure playgrounds and youth clubs.
- A wider range of culturally preferred fruit and vegetables are made available.
- Two breakfast clubs set up in local schools, include a piece of fruit with breakfast.

Further reading and resources


http://www.doh.gov.uk/nst/olderpeople
Promoting physical activity

The issue

A physically active lifestyle has important health benefits. Regular physical activity:

• reduces the risk of death from cardiovascular disease
• delays development of high blood pressure and reduces hypertension
• plays a significant part in controlling diabetes, regulating weight, reducing the risk of osteoporosis and reducing the risk of cancer of the colon.

There are declining levels of activity, particularly among children and young people.

Currently only about 37% of women and 25% of men meet the recommended 30 minutes of moderate intensity activity such as brisk walking, cycling, heavy gardening or housework on at least 5 days per week. This is lower among older people and many black and minority ethnic groups.

Why should health visitors be involved?

Health visitors can present the health benefits of regular exercise and suggest forms of exercise which are appropriate and easy to incorporate into everyday life.
Steps to success

- Use family health plans to think about physical activity within the family and to work with families to identify their preferred ways in which this can be increased.
- Work with parents to help them think about how to promote increased activity among children.
- Identify opportunities for physical activity locally and look at patterns of uptake.
- Work with local leisure services and community groups to ensure appropriate exercise provision for at risk groups such as minority ethnic communities and older people.
- Work with the Local Authority and community organisations to ensure provision of safe play areas for young children.
- Look at the knowledge within your team. Is there anyone equipped to advise and lead on physical activity? What training is available to help?
- Work with schools to develop alternative exercise opportunities for those who do not enjoy traditional competitive sports. These might include, for example, dance sessions, pop-agility, roller-skating or cycling.
- Work with partners such as Local Authorities and businesses to create an exercise promoting environment—for example, posting signs to encourage stair climbing or introducing cycling allowances, health walks programmes, walk to work days and virtual school bus routes.

Practice example

As part of the PCT campaign to reduce coronary heart disease the health visitor focuses on promoting physical activity for people who have had a heart attack. The health visitor works with the local authority to set up a graduated exercise programme at the Leisure Centre. He obtains HAZ funding to provide free places to local people. He also liaises with the CHD rehabilitation service and provides support to patients wishing to join the exercise programme.

Further reading and resources

Sexual health

The issue

Sexual health is:

• the capacity to enjoy and express sexuality without guilt or shame in fulfilling emotional relationships
• the capacity to control fertility
• freedom from diseases which compromise health and sexual and reproductive function.

Sexual health is relevant to the majority of the population for the greater part of their lives. There are a number of significant threats to sexual health in this country. These include:

• increasing rates of almost all sexually transmitted diseases. For example, diagnosis of chlamydia virtually doubled in the 1990s
• the continuing threat of HIV and AIDs. There are estimated to be 30,000 people living with HIV. The highest ever number of new HIV infections were diagnosed in 2000
• teenage birth rates which are the highest in Western Europe
• strong correlation between social deprivation and sexual ill health

The Government’s Sexual Health and HIV strategy will:

• ensure that all individuals have better access to knowledge and skills to achieve positive sexual health
• make services and information more available and accessible to all those who require them at all ages.

Why should health visitors be involved?

Health visitors can raise sexual health issues in a non-stigmatising way and ensure that individuals and population groups have access to the information and services they need. They may have a particular role in:

• promoting safer sex among all population groups
• explaining the consequences of sexually transmitted disease and promoting access to appropriate screening and treatment
• supporting families where one or more members are HIV positive
• supporting those affected by infertility or relationship problems
• working collaboratively with other nurses working in sexual health.
What can health visitors do?

• Work with public health colleagues to identify sexual health needs locally and priority groups.
• Promote awareness of local services (contraception, relationship counselling and sexual health clinics), including voluntary sector, local authority provision and helplines.
• Make sure their services are accessible to different population groups e.g. young people, those from black and minority ethnic groups, lesbians and gay men, people with disabilities and men who may find that traditional services do not meet their needs.
• Work with local community groups to influence provision and feed into your local multi-agency commissioning group.
• Look at the skills available within your team to promote sexual health and identify appropriate education and training to meet any deficits.
• Provide confidential, non-judgmental support to individuals and families.
• Promote diversity and address discrimination.
• Think creatively about ways to promote sexual health and reduce stigma among priority groups, for example quizzes and competitions in pubs and clubs or staging events in universities and colleges.

Practice example

Health issues amongst local sex workers are causing concern. Two health visitors are working with family planning services to provide condoms to sex workers and to improve their access to services. The health visitors carried out a survey to find out about the women’s health concerns. The key issues were: sexually transmitted diseases, termination of pregnancy, domestic violence and a reluctance to use mainstream primary care services. As a result a nurse-led, drop-in centre was set up to provide general health advice, counselling and sexual health services.

Reference

Supporting families and parenting

The issue

• The changing face of the family makes parenting in the 21st century a greater challenge:
  – the divorce rate has risen in the post-war years
  – there are more children being brought up in single parent households and in poverty
  – people are more mobile and families are more dispersed
  – far more women work
  – family structures are more complicated for many children.
• Supporting Families (1998) set out a range of Government policies and proposals aimed at strengthening and supporting families. It described an enhanced role for health visitors which would focus on the critical stages of a child’s early development ranging from antenatal classes to sleep clinics, and suggesting more help from health visitors later in the child’s development.
• Sure Start is a radical cross-government strategy to improve services for children under four and their families, in areas of greatest need. Sure Start aims to improve health and well-being of families and children before and from birth, so that children are ready to flourish when they go to school.

Why should health visitors be involved?

Nearly all parents come into contact with health visitors before their first child is born – this puts health visitors in a strong position to recognise when support is needed. Early interventions and support can help reduce family breakdown, strengthen children’s readiness for school and benefit society in the longer term by preventing social exclusion.

In their public health role health visitors work with a wide range of organisations, professionals and community services and can ensure that families are offered a wide range of integrated support services. Health visitors are delivering innovative ways of supporting families, such as community mothers schemes.
What can health visitors do?

- Offering a family health plan can help families to identify and address their health and parenting needs.
- Set up a local, inter-agency, family support group to map need and provision in the local community.
- Use this to provide information for parents and identify the gaps that need to be addressed.
- Find out about new initiatives e.g. Health Action Zones and work with Sure Start and other initiatives that support families.
- Develop a variety of parenting support services which are sensitive to cultural differences and beliefs.
- When working with individual families agree with them what you are both trying to achieve and use planned, focused approaches.
- Consider using recognised, evaluated programmes such as the Webster-Stratton Parenting Programme, which begins with improving the relationship between parent and child through play, moves on to rewarding children for more desirable behaviour and then setting firm limits, communicating clearly and handling misbehaviour.
- Evaluate your interventions.

Practice example

The Primary Health Care Team is concerned at the increasing number of parents who are finding it difficult to cope with their pre-school child’s behaviour. The counsellor, nursery nurse, health visitor and school nurse set up a group who meet with local playgroups and nurseries to agree a programme of work across all services. They secure funding from the PCT Children’s Planning Team to run parents’ groups on coping with their child’s behaviour and produce an information guide for parents on local family support facilities. The parents who attended the groups report that they have a better relationship with their children, feel better about themselves and feel more in control.

Further reading and resources

http://www.doh.gov.uk/quality.htm

http://www.doh.gov.uk/quality.htm


Information about Sure Start:
http://www.surestart.gov.uk
Teenage pregnancy and teenage parenthood

The issue

- Within Western Europe, the UK has the highest rate of teenage conceptions
- In England there are nearly 90,000 conceptions a year to teenagers with 7,700 of these to girls under 16 years and 2,200 to girls aged 14 years and under
- Half of these under 16 year olds and around a third of 16 and 17 year olds opt for a termination of pregnancy
- Teenage parents are more likely than their peers to live in poverty and unemployment and be trapped through lack of education, childcare and encouragement
- The Social Exclusion Unit Report on Teenage Pregnancy (1999) states that there is no single explanation for these high rates in the UK, however three factors stand out:

  **Low expectations**: young people who have been disadvantaged in childhood and have poor expectations of education or the job market are more likely to become pregnant

  **Ignorance**: young people lack accurate knowledge about contraception, sexually transmitted infections (STIs), relationships and what it means to be a parent. They do not know how easy it is to get pregnant or how hard it is to be a parent

  **Mixed messages**: one part of the adult world bombards teenagers with sexually explicit messages and an implicit message that sexual activity is the norm. The other part restricts access to appropriate confidential contraceptive services. The net result is not less sex but less protected sex.

Why should health visitors be involved?

Health visitors can form multi-agency partnerships to develop services/projects, such as partnerships with the local youth service around young women's groups, local healthy schools programme, sexual health education programmes and young men's programmes.

Health visitors can work with school nurses, midwives, family planning nurses, and youth workers to organise and deliver sexual health programmes in a variety of settings.
What can health visitors do?

- Work with others to initiate innovative ways of preventing teenage pregnancy and supporting teenage mothers.
- Participate in joint sexual health training with teaching staff to deliver sex and relationship education (SRE) programmes within the school setting.
- Empower, support and prepare parents in their central role as educators.
- Engage local public health departments to evaluate local strategies and develop research tools.
- Enable young people and teenage parents to participate in planning services.
- Develop a communication strategy which engages the key stakeholders, such as the local teenage pregnancy co-ordinator, parents, and other interested parties in both the statutory and voluntary sector as well as PCTs and acute hospital services.

Practice example

The PCT has identified those communities with a higher than average rate of teenage pregnancy. The health visiting team has been asked by the public health specialist on the PCT to develop and implement a programme to try and reduce the rate. With the support of the Teenage Pregnancy Co-ordinator the health visitor sets up a task group of people who work and live in the community, the group agrees a local action plan which is agreed by the PCT and evaluated with support from the public health specialist. The action plan involves the local health visitor, school nurse and their teams in the following:

- the school nurse runs a programme of sexual health sessions at the youth club with the youth worker
- the health visitor holds a session in the local secondary school at the same time as the parents’ evening on ‘talking to young people, and about sex and contraception’
- the Teenage Pregnancy Co-ordinator runs a lunch time workshop for the PHCT and local community and education staff on talking to young people about sex and how to prevent teenage pregnancy
- the work of the programme is recorded and evaluated and the PH Specialist is given regular updates on the programme
- the health centre manager gathers together all the information on advice and Family Planning services and ensures that all places where young people meet are kept supplied with up-to-date information and leaflets.

Reference

10. Public health skills audit tool and development plan

We have suggested 10 competencies for the health visitors’ family-centred public health role. Each of the competencies is presented as a ‘set’ including a description, a scenario and a series of statements.

**Identifying your current competence**

Use the competencies to compare yourself or your team. For each competency set we suggest you read the description and scenario and then score your current level of competence using the five levels of competence.

<table>
<thead>
<tr>
<th>Level of competence</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novice</td>
<td>1</td>
<td>Little or no previous knowledge/skills/experience of the issue described and would require considerable support/teaching to improve competence</td>
</tr>
<tr>
<td>Advanced beginner</td>
<td>2</td>
<td>Limited previous knowledge/skills/experience of the issue described and would require some support/teaching to improve competence</td>
</tr>
<tr>
<td>Competent</td>
<td>3</td>
<td>Reasonable fluency with the issue described and would seek occasional support/teaching to improve competence</td>
</tr>
<tr>
<td>Proficient</td>
<td>4</td>
<td>Considerable knowledge/skill/experience of the issue and would need little or no additional support/teaching to improve competence</td>
</tr>
<tr>
<td>Expert</td>
<td>5</td>
<td>Has a vast and specialist knowledge/skill/experience of the issue described and may act as an advisor or consultant to others</td>
</tr>
</tbody>
</table>

**Developing your personal development plan**

When you have identified your current level of competence use the personal development proforma to identify the areas where you feel you have most need for further development. Then complete the personal development plan.

**Using the competencies and development plan as a team**

If you are working through the competencies as a team use the development proforma to identify the strengths of team members and to identify areas for development.
1. Health visitor competency: inter-agency working

To be able to work collaboratively with other agencies to maximise their contribution to health improvements in the local community.

**Scenario**

> Although many agencies and groups provide family support locally, currently they are ill co-ordinated and unplanned. The health visitor works with a local social worker to develop an inter-agency family support planning group to map current resources against need, and plan for future co-ordinated action.

<table>
<thead>
<tr>
<th>Competency statements</th>
<th>Novice</th>
<th>Advanced beginner</th>
<th>Competent</th>
<th>Proficient</th>
<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint working with other agencies to support a client/family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Multi-agency strategic planning.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge of the organisational structure and culture of the local social services department where you work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Negotiation and influencing skills to achieve change across organisational/agency boundaries.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Representing your own organisation on a multi-agency steering group or working party.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Experience of multi-agency bid development to gain funds for new services/posts/developments.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
2. Health visitor competency: working with groups

To be able to facilitate groups effectively in a variety of settings.

Scenario

As a result of the work of the Family Support Group the health visitor is aware of a lack of parenting support groups in the area. She has been working intensively with many of her clients who are experiencing difficulties managing their children’s behaviour. Many of these parents have expressed an interest in attending a group to share their experiences and explore a range of behaviour management techniques. The health visitor therefore decides to work with a colleague to establish a group to support local parents.

<table>
<thead>
<tr>
<th>Competency statements</th>
<th>Novice</th>
<th>Advanced beginner</th>
<th>Competent</th>
<th>Proficient</th>
<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of the theory of groups and group dynamics.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Experience as a group facilitator</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Understanding of group work methods</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Ability to effectively manage difficult group members.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
3. Health visitor competency: population health needs assessment

To be able to lead/co-ordinate and/or participate in all types of community health needs assessment including the following elements:

- working with colleagues and the community in identifying, collating and interpreting a wide range of local health information
- critical analysis of qualitative and quantitative data to determine major local health needs
- priority setting within a multidisciplinary forum, engaging the local community and demonstrating the ability to influence and negotiate with others
- action planning within the context of the local HImP audit and evaluation to determine if the HImP has been successfully implemented.

Scenario

*The PCT, as part of its HImP development process, wishes to find out about the needs of local families in order to develop a planned and targeted approach to providing services to this group. The health visitor has the role of co-ordinating the process.*

<table>
<thead>
<tr>
<th>Competency statements</th>
<th>Novice</th>
<th>Advanced beginner</th>
<th>Competent</th>
<th>Proficient</th>
<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gathering data to construct a profile of the local population.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Analysing data to determine the level of health of the local population.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Engaging a wide range of stakeholders, including the general public, to establish local health priorities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Critically appraising research reports.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge of key economic concepts such as cost benefit and cost effectiveness.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Drawing up action plans to deliver services to meet assessed health needs of a local community.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Contributing to the local Health Improvement Plan</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge of a range of methods to evaluate the effectiveness of health programmes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Understanding key research concepts of reliability and validity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
4. Health visitor competency: family health needs assessment

To be able to assess family health needs, drawing on information from individual family members, other professionals and agencies.

Scenario

A local community worker has asked the health visitor to assess the needs of a family who she feels is struggling with multiple health problems. The health visitor uses a family health plan in order to make the assessment in partnership with the family.

<table>
<thead>
<tr>
<th>Competency statements</th>
<th>Novice</th>
<th>Advanced beginner</th>
<th>Competent</th>
<th>Proficient</th>
<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience of using family health plans or other family assessment tools.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge of evidence-based family interventions (e.g. family therapy).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Experience of working with a whole family to improve health/well-being.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Collating family assessment findings for use in local community health needs assessment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Working with families at high risk of violence/abuse.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge of health beliefs of families from a range of cultural/ethnic backgrounds.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
5. Health visitor competency: 
**multidisciplinary team working**

To be able to develop and work as a member of a multidisciplinary team within which the skills and knowledge of each member are harnessed for maximum benefit in achieving health improvement and family support.

**Scenario**

*The health visitor team wishes to extend its focus and undertake an increased amount of community development work. The team agrees that the best way to achieve this would be for the health visitor to delegate aspects of her child health promotion work to the nursery nurse members of the team and hand over much of the clerical work to administrative colleagues, in order to free her time for additional community activity.*

<table>
<thead>
<tr>
<th>Competency statements</th>
<th>Novice</th>
<th>Advanced beginner</th>
<th>Competent</th>
<th>Proficient</th>
<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of the code of professional conduct of at least one non-nursing colleague you work with.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Ability to delegate work to others.</td>
<td>1 2 3 4 5</td>
<td></td>
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</tr>
<tr>
<td>Knowledge of research on primary healthcare team working.</td>
<td>1 2 3 4 5</td>
<td></td>
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</tr>
<tr>
<td>Experience of managerially supervising others in your own professional discipline (i.e. health visitors).</td>
<td>1 2 3 4 5</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Experience of managerially supervising others in at least one discipline other than your own (e.g. nursery nurse).</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of leading a multidisciplinary team.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Ability to formally assess the clinical competence of your health visiting colleagues.</td>
<td>1 2 3 4 5</td>
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</tr>
<tr>
<td>Understanding theories of human motivation in the context of teamwork.</td>
<td>1 2 3 4 5</td>
<td></td>
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</tr>
<tr>
<td>Adaptability to different team roles as required.</td>
<td>1 2 3 4 5</td>
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</tr>
</tbody>
</table>
6. Health visitor competency: addressing health inequalities

To be able to identify health inequalities and to take action with others to promote equity.

Scenario

After discussions with local GPs and examining the findings of a recent audit of emergency hospital admissions for hip fractures amongst elderly people in the district, a group of local health visitors conclude that current services are failing to meet the needs of this vulnerable client group. Consequently, the health visitors decide to work with the local Age Concern office, Social Services and the PCT to develop a falls prevention and well-elderly visiting service for isolated older people.

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of the literature linking poverty and health.</td>
<td>1 2 3 4 5</td>
<td></td>
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</tr>
<tr>
<td>Experience of working with voluntary agencies.</td>
<td>1 2 3 4 5</td>
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</tr>
<tr>
<td>Understanding of the concept of ‘social exclusion’.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Monitoring the uptake of services by disadvantaged families/individuals.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of working with hard to reach groups (e.g. homeless families, asylum seekers, etc).</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understanding of the main determinants of health.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negotiating with others to move resources in order to reduce health service inequality.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health advocacy work for disadvantaged groups/individuals.</td>
<td>1 2 3 4 5</td>
<td></td>
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</tr>
</tbody>
</table>
7. Health visitor competency: health protection programmes

To be able to initiate, co-ordinate and audit programmes for health protection, including national child health screening and immunisation programmes.

Scenario

The public health specialist on the newly established PCT executive committee has brought together a group of health visitors to discuss the uptake of the child health promotion and immunisation programme. They suspect that families in the most deprived parts of the PCT are failing to access these services. The health visitors agree to review the current uptake within their PHCTs and make recommendations to promote equity.

<table>
<thead>
<tr>
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<th>Proficient</th>
<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of the principles of health screening.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Assisting in the planning of immunisation programmes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge of the evidence base about common childhood immunisations, including contra-indications.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Understanding of key immunological concepts such as herd immunity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Ability to communicate effectively the risks and benefits of all main childhood immunisations to parents.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge of current local childhood immunisation rates in the area where you work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
8. Health visitor competency: community involvement and development

To be able to increase the ability of the local community to participate in action to protect and promote their own health.

Scenario

During a series of focus groups of local women undertaken by local health visitors, it emerged that many were concerned about their dependency on anti-depressants. With the help of the health visitor and a local GP, the women set up an anti-depressant withdrawal support group which now offers informal support to a wide range of local women.

<table>
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<th>Proficient</th>
<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience of involving local people in service developments.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Working with community groups to help them identify their own health needs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Experience of running focus groups with local people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Understanding of ways to encourage participation of disadvantaged groups/individuals in health care planning.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge of theory and practice of community development.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
</tbody>
</table>
9. Health visitor competency: 
**priority parent education**

To be able to initiate, co-ordinate and contribute to programmes of parent education, health advice and information targeting vulnerable families and priority health needs.

**Scenario**

*As a result of a research project undertaken by staff at the Accident and Emergency Department within a local children’s hospital, a multidisciplinary team, including several health visitors, meet to develop an action plan to reduce the high numbers of multiple A&E attendances. As a result, the health visitors, in conjunction with the hospital team, set up a new referral service, whereby a nursery nurse, under the supervision of the health visitor, visits families at particular risk to discuss environmental safety issues. Where more in-depth assessment and support is needed, the nursery nurse hands over to a specially trained health visitor.*

<table>
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<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of effective, evidence-based parenting interventions (e.g. to increase parental self-esteem).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Ability to advise parents on effective child behaviour management approaches.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Ability to assess children to identify development outside the norm.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge of local child protection policy and procedures.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge of common adult learning theories.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Developing parenting programmes in partnership with parents.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
10. Health visitor competency: population based health promotion

To be able to plan, undertake and evaluate population based health promotion programmes.

Scenario

The PCT Board has requested that the health visitors in the area work with the local health promotion team to co-ordinate and implement PCT wide health promotion strategies to reduce the risk of coronary heart disease, in line with the local Health Improvement Plan objectives.

<table>
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<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience of developing large scale (e.g. PCT wide) health promotion programmes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Understanding differences between primary, secondary and tertiary prevention.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Experience of facilitating peer education (e.g. community mothers).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Ability to search common electronic databases to gather information about effective health promotion methods.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
<tr>
<td>Experience of managing large scale health promotion programmes.</td>
<td>1</td>
<td>2</td>
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</table>
Personal development plan

Having worked through the 10 competencies, you are now in a position to complete a development plan, see overleaf. Using your responses as a guide, note your most pressing development and/or training needs under each of the headings. You may not feel that all the competency statements are equally relevant to your current or future job. You may not have any pressing needs in certain areas, so don't feel you need to complete each section.
Personal development plan

Part 1  My key public health development and/or training needs

- My most pressing development/training needs in relation to inter-agency working are:

- My most pressing development/training needs in relation to working with groups are:

- My most pressing development/training needs in relation to population health needs assessment are:

- My most pressing development/training needs in relation to family health needs assessment are:

- My most pressing development/training needs in relation multidisciplinary team working are:
My most pressing development/training needs in relation to **addressing health inequalities** are:

My most pressing development/training needs in relation to **health protection programmes** are:

My most pressing development/training needs in relation to **community involvement and development** are:

My most pressing development/training needs in relation to **priority parent education** are:

My most pressing development/training needs in relation to **population based health promotion** are:
Personal development plan

Part 2  My personal public health skills development plan

<table>
<thead>
<tr>
<th>Rank</th>
<th>Bearing in mind my current and possible future health visiting roles over the next 12 months, my top five development/training needs in public health practice are:</th>
<th>I intend to meet these development/training needs by taking the following actions:</th>
<th>I will review my progress in meeting these needs on the following dates:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<tr>
<td>2</td>
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</table>
The Health Visitor and School Nurse Development Programme

Health visitor practice development resource pack

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Fax: 01623 724524
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It is also on our website on:
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