Health Visiting – Project 4

Supporting Commissioning Tools, Framework and Guidance

Department of Health

Final Project Report

23rd March 2012

Produced for:

Health Visitor Programme
Department of Health

Contents

1 – Introduction

The Health Visitor Implementation Plan 2011-15 published in February 2011 set out the full range of services that families will be able to expect from health visitors and their teams, depending on their needs. It will create a bigger, rejuvenated workforce with an extra 4,200 health visitors by 2015 and an improvement in the quality of the health visiting service for children and families.

The rejuvenated service will:

- Develop, support and promote the services set up by families and communities themselves as part of the 'Your Community' service;
- Deliver the Healthy Child Programme - ensuring all children get the essential immunisation, health and development checks - as part of the 'Universal Services';
- Ensure a rapid response with expert help for problems like postnatal depression or a sleepless baby - as part of the 'Universal Plus Services'; and
- Provide on-going support as part of a range of local services working together and with disadvantaged families, to deal with more complex issues over a period of time – under the 'Universal Partnership Plus' service.

On the 23rd August 2011 the Department of Health (DH) emailed Strategic Health Authorities inviting expressions of interest to deliver Projects that would provide key additional support elements of the Health Visitor programme.

One of these was Project 4 – Supporting commissioning tools, framework and guidance.

NHS East of England were keen to take the lead on this project and had expressed an interest to the DH via Kathy Branson (HV lead for NHS East of England).

Having previously worked with Sustain on a project within the multi-professional deanery and having had first-hand knowledge of the level of expertise Sustain have in developing and delivering such projects, Kathy Branson approached Sustain for our views on Project 4.

Through Sustain's recent work on the development and implementation of Mental Health PbR they could jointly see some immediate parallels between this work and an approach to the deliverables of Project 4.

Both Sustain and Kathy Branson were keen to influence delivery from the start of the project and to seize the opportunity of providing a multidisciplinary approach to the development and delivery of project 4.

Through initial discussions a very clear vision specifically tailored to the HV program was developed.

2 – The Vision

In constructing the proposal and approach for the delivery of Project 4 Sustain had a clear vision of what was required to ensure the output was one that provided an innovative and complete approach to a commissioning framework.

The key elements are:

- Ensuring we seized the opportunity to develop, with clinical staff and commissioners, best practice pathways that identified the specific clinical outcomes necessary to measure the impact of Health Visiting Interventions.
- For the professionals to be at the heart of developing objective assessment and decision tools which encapsulate the daily judgement calls that they make when faced with children and families.
- At the same time to ensure that all involved in the project understood the importance of, and were able to define within the pathways, all the necessary information required for successful commissioning, service delivery and service management.
- To ensure that both commissioners and providers worked on the developments together and were able to develop the depth of understanding of priorities and viewpoints through objective conversations that would remove tensions and change some of the stereotypical behaviours that often prevail.
- To ensure pricing and capacity evaluations are developed from the necessary detail, within the pathways, that will allow objective commissioning discussions as services and demand develop. In addition for service management to understand the impacts of demand, seasonality, staff impacts upon the service and the key drivers for utilisation and caseload.
- To engage and involve all necessary skill sets, not just clinicians, throughout all elements of the process involved in the development of the package – bringing to the table their valued thoughts and requirements throughout and ensuring they are committed and engaged with the project plans

3 – The Deliverables

The Department of Health agreed 5 key deliverables within the scope of Project 4, these were:

- Develop appropriate Best Practice Pathways
- Produce initial thoughts/key considerations on pricing model/methodology
- Develop a Capacity model for providers
- Identify Key Performance Indicators for Commissioners and providers
- Complete a review of relevant data systems

4 – The Plan (What we have done)

At the start of the project it was agreed that two pilot sites would be identified to develop and deliver the required outputs. These were:

- Suffolk (NHS Suffolk and Suffolk CC)
- Peterborough (NHS Cambridgeshire and Cambridgeshire & Peterborough NHS Foundation Trust)

The overall project was divided into three key phases each with a set of clear deliverables, the phases were:

- Planning & Development Phase — 1st November 2011 to 9th December 2011
- Intermediate Phase — 12th December 2011 to 6th January 2012
- Delivery Phase — 9th January 2012 to 31st March 2012

Planning & Development Phase

The purpose of this phase was to:

- Enable all involved to develop a cohesive understanding of what was required to deliver the overall project objectives.
- Work with the two pilot sites to co-create the project plan for the delivery phase.

Intermediate Phase

The purpose of this phase was to:

- Develop and ensure required meeting structure was in place for commencement of delivery phase.
- Ensure all necessary documentation/materials were available to key clinical, finance and commissioning staff within the pilot sites.

Delivery Phase

The purpose of this phase was to:

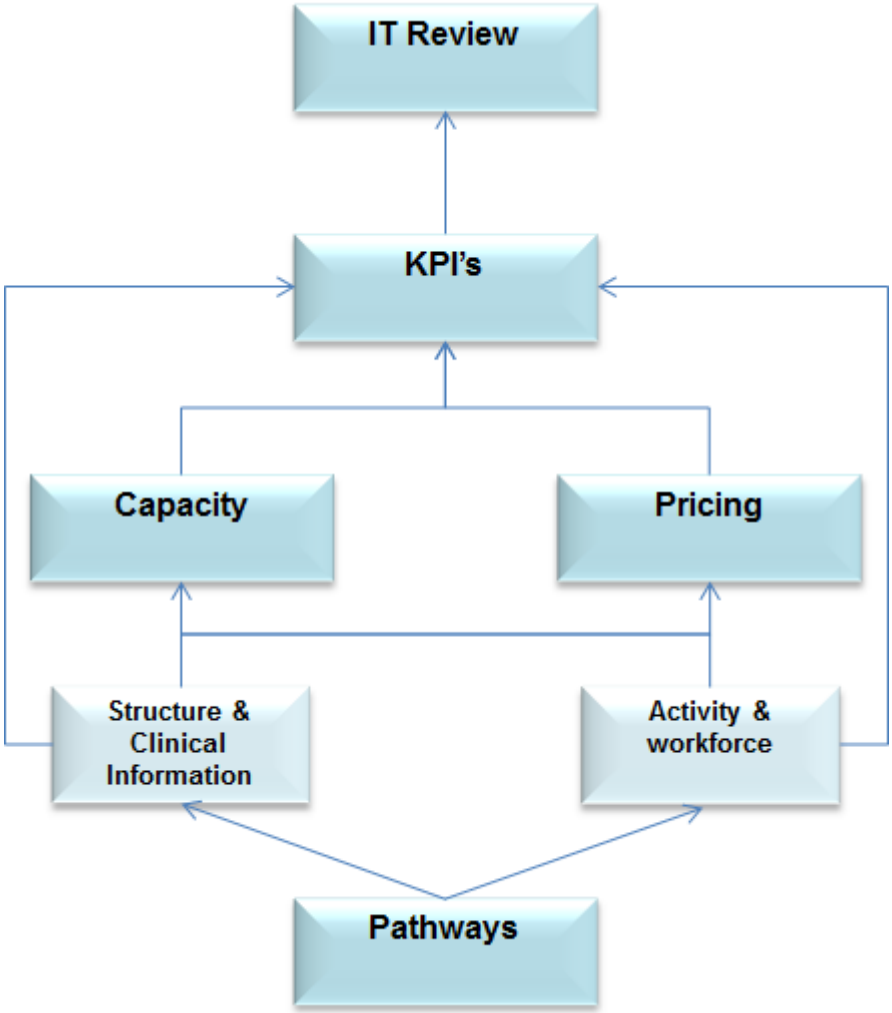
- Ensure the effective delivery of the project plan and overall project output requirements.

Delivery Plan

Following the completion of the Planning & Development phase the following delivery plan was produced.

The delivery plan consisted of five interrelated components; figure 1 below, provides a diagrammatic representation of the interdependencies of these components.

Figure 1



The five components were:

Best Practice Pathways

Drawing on the content and structure of the Healthy Child Programme, the best practice pathways needed to identify and describe the evidence based interventions necessary from pregnancy to 5 years in Universal, Universal Plus, Universal Partnership Plus and Building Community Capacity.

The pathway work also had to develop a range of key criteria (or pathway allocation tool) that can be used to underpin the clinical decision making process when identifying children/family needs and clinical rational for allocating children/families to a particular

pathway. In addition the pathway work needed to identify and develop any transition protocols e.g. transition from midwifery to Health Visiting services.

In addition to identifying the required clinical interventions, the best practice pathways needed to identify a range of additional information that was necessary to develop a provider capacity model and initial thoughts/key considerations on pricing model/methodology. This included:

- Frequency, duration and intensity of contacts
- Mode of service delivery (Groups, Clinic, Domiciliary)
- Skill level of staff delivering interventions

Pricing Model/Methodology – Initial Thoughts/key considerations

This component would utilise the information provided as part of the pathway development, which when combined with an array of accounting assumptions would enable the production of a model/methodology for pricing individual best practice pathways.

Capacity Model

The capacity model would also draw on information provided by the pathway work along with other information such as organisational establishment information, demographic data and seasonal/other demand variations to provide a model by which providers can:

- Assist providers in matching the demand for services against available resources in a planned manner.
- Model the impact of demographic changes on resource requirements.
- Review such things as staff utilisation and skill mix.

Key Performance Indicators

This work would combine the anticipated clinical outcomes developed through the best practice pathways along with a range of additional provider and commissioner KPI's to develop a comprehensive suite of KPI's. These can be used to:

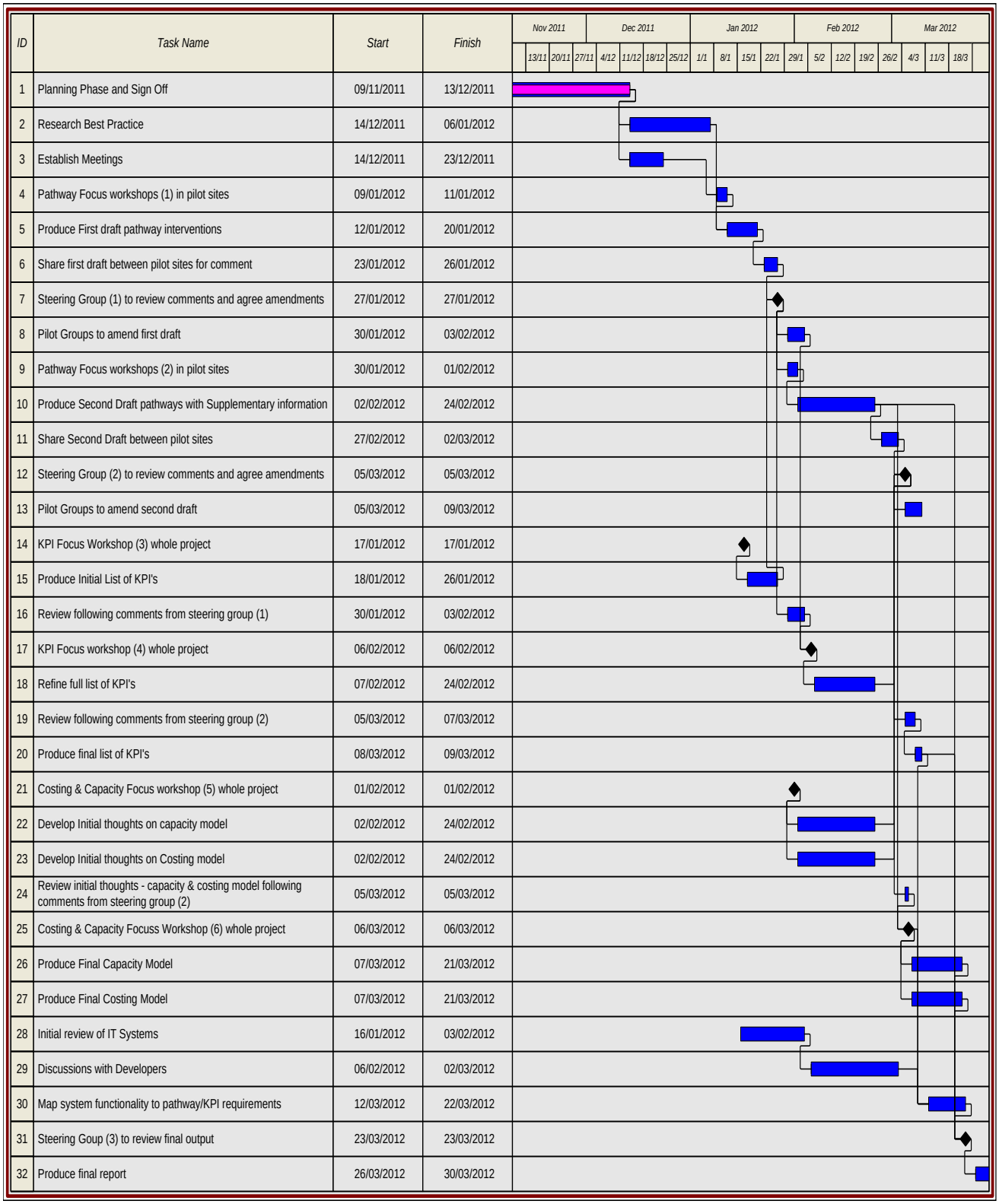
- Monitor the clinical effectiveness of individual or component parts of pathways.
- Identify key areas of development.
- Monitor the efficiency of Health Visitor service delivery.

IT Review

The IT review would draw on information from all of the other components of the delivery plan to produce a comprehensive data set for Health Visiting Services. Having identified the data requirements a review of current system functionality would be conducted to identify any technical/system barriers to information collection and reporting

The Full Project delivery plan and timescales are provided in Figure 2

Figure 2

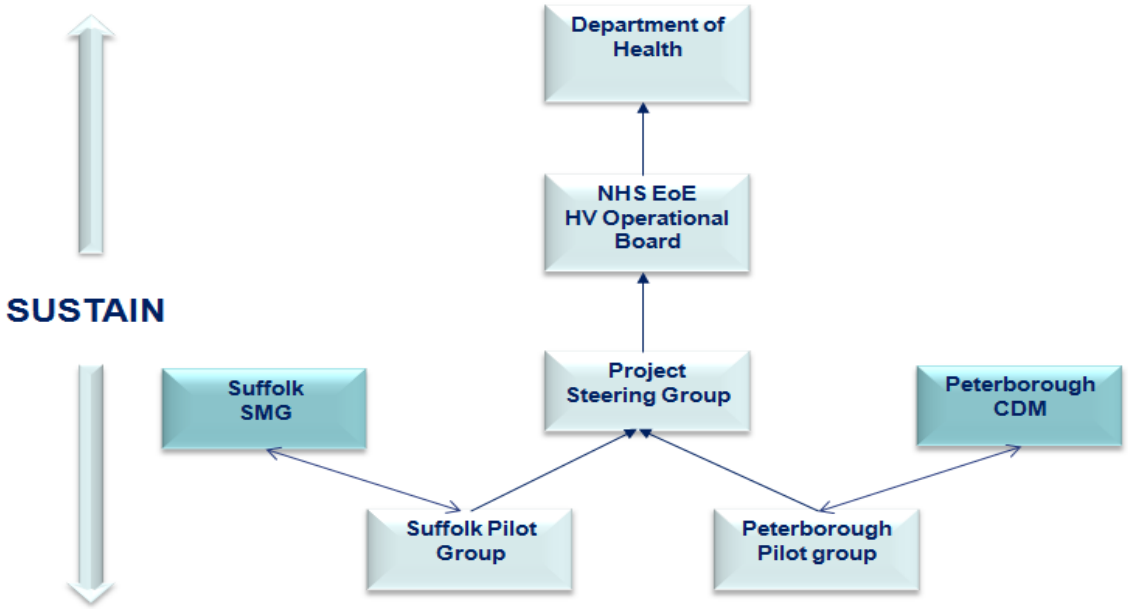


ID	Task Name	Start	Finish
1	Planning Phase and Sign Off	09/11/2011	13/12/2011
2	Research Best Practice	14/12/2011	06/01/2012
3	Establish Meetings	14/12/2011	23/12/2011
4	Pathway Focus workshops (1) in pilot sites	09/01/2012	11/01/2012
5	Produce First draft pathway interventions	12/01/2012	20/01/2012
6	Share first draft between pilot sites for comment	23/01/2012	26/01/2012
7	Steering Group (1) to review comments and agree amendments	27/01/2012	27/01/2012
8	Pilot Groups to amend first draft	30/01/2012	03/02/2012
9	Pathway Focus workshops (2) in pilot sites	30/01/2012	01/02/2012
10	Produce Second Draft pathways with Supplementary information	02/02/2012	24/02/2012
11	Share Second Draft between pilot sites	27/02/2012	02/03/2012
12	Steering Group (2) to review comments and agree amendments	05/03/2012	05/03/2012
13	Pilot Groups to amend second draft	05/03/2012	09/03/2012
14	KPI Focus Workshop (3) whole project	17/01/2012	17/01/2012
15	Produce Initial List of KPI's	18/01/2012	26/01/2012
16	Review following comments from steering group (1)	30/01/2012	03/02/2012
17	KPI Focus workshop (4) whole project	06/02/2012	06/02/2012
18	Refine full list of KPI's	07/02/2012	24/02/2012
19	Review following comments from steering group (2)	05/03/2012	07/03/2012
20	Produce final list of KPI's	08/03/2012	09/03/2012
21	Costing & Capacity Focus workshop (5) whole project	01/02/2012	01/02/2012
22	Develop Initial thoughts on capacity model	02/02/2012	24/02/2012
23	Develop Initial thoughts on Costing model	02/02/2012	24/02/2012
24	Review initial thoughts - capacity & costing model following comments from steering group (2)	05/03/2012	05/03/2012
25	Costing & Capacity Focuss Workshop (6) whole project	06/03/2012	06/03/2012
26	Produce Final Capacity Model	07/03/2012	21/03/2012
27	Produce Final Costing Model	07/03/2012	21/03/2012
28	Initial review of IT Systems	16/01/2012	03/02/2012
29	Discussions with Developers	06/02/2012	02/03/2012
30	Map system functionality to pathway/KPI requirements	12/03/2012	22/03/2012
31	Steering Goup (3) to review final output	23/03/2012	23/03/2012
32	Produce final report	26/03/2012	30/03/2012

People Involved in the Project

The formal structure developed to support this project and provide the necessary assurance is identified below (see figure 3)

Figure 3



For each of the pilot groups there were identified project sponsors, project leads and Sustain Leads. These were:

	Suffolk Pilot Group	Peterborough Pilot Group
Sustain Lead	Val Macqueen	Tony Hadley
Project Sponsor	Simon White *Director of Children & Young People Partnership* Lynn Wigens *Director of Patient Safety Clinical Quality*	Janet Gandolfi *Director Of Operations*
Project Lead	Alan Cadzow - Assistant Dir Integrated Service Delivery Eugene Staunton – *Children's Commissioning Lead*	Rowena Harvey - *HV Professional Lead* Helen Geall – *Children's Commissioning Lead*

In addition to the project leads and sponsors the following clinical/managerial staff from each area were actively involved in the complete development of the project outputs.

Suffolk Pilot Site	Peterborough Pilot Site
Steve Kent - Finance Bronwen Whittaker – Lead Nurse Clare Slater-Robins – HV Ops Lead Claire Picavance - HV Christine Wheeler - HV Alison Littler - Midwife Tania Bowes - Midwife Tara Saunders – Locality Clinical Manager Carrie Rayner – HV Anita Farrant - Integrated Service Manager (Health) Geraldine Sewell - Service Manager for Looked After Children and Safeguarding Named Nurse Jayne Appadoo - Health Visitor Susie Mawson - Team Leader for Children with Learning Disabilities Melanie Webster - Health Visitor	Keith Davies - Finance Chris Buzzard – Head of HV & School Nursing Angela Rees - HV Val Carradice - HV Tim Sherley - Performance Derek Mcnally - Finance Sarah Morton - HV & CPT Christina Massey - Team Leader HV Heather Mizen - HV & CPT Fiona Webb - HV & CPT Nicola Ayres - Service Manager for Children's Services Peterborough Karen Smith - HV Denise Franks - HV Sheryl Challis - Community Nursery Nurse Hannah Chambers - Student HV Sam Cannon - Community Nursery Nurse Dawn Warwick - Community Nursery Nurse Katie Slater - Student HV Ann Fortescue - Student HV Amanda Godfrey - Student HV Judy Cockrill - Student HV

As well as the project site specific staff additional support was provided to the project from the EoE SHA in the form of:

- Pamela Agapiou – Health Visitor Lead/Public Health & Operational manager of an EIS
- Emily Steggall – Specialist Registrar in Public Health

As an integral part of the project delivery plan a number of meetings/workshops were convened to provide a wider engagement across a range of groups, these were:

Meeting/Workshop	Attendees
Clinical Reference Group	Janet Clarke *Consultant Community Paediatrician Lead for Child Dev Unit* Ges Gregory *Consultant Community Paediatrician, Designated Doctor for Children in Care* Sarah Pickles *Chief Dietician, Lead for Children.* Ann Goldsmith *Interim AD Safeguarding , Peterborough City Council* Faye Haffenden *Public Health Consultant, NHS Cambs* Karen Moody *Head of Early Intervention Prevention.* Angela Nottingham

	Manager, Early Intervention Prevention Team
EoE Children's Commissioners	Tracy Cogan - Deputy Regional Director Child Health and Wellbeing Helen Jackson – NHS Norfolk Elaine Mash – Great Yarmouth & Waveney Jocelyn Ang – NHS Bedfordshire Maureen Fitzgerald – NHS South West Essex Susan Jalali – NHS Hertfordshire
Clinical Commissioning Group – Childrens Leads meeting (NHS Norfolk)	Lynne Woodall- Project Manager -Child Health commissioning Dr Maggie Carter Dr James Gair Dr Alison Dow Dr Lindsay Spingall Jane Black – Lead Nurse Child Protection

5 – The Products

During the development phase the project team identified the need to utilise the full timeline for the delivery phase (9th January – 31st March) to develop, sign off and publish the output products associated with the project (April 2012).

As a result it is not possible to provide the final output products within this report; however the following section provides an overview of the product detail.

Best Practice Pathways

Throughout the development of the Best Practice Pathways the project group have been clear that the focus is on 'What should be done' not what is currently being delivered within the individual provider areas. To this end they have focused on:

- What evidence exists to support the delivery of particular interventions, programmes or groups.
- What learning can we take from the Early Implementer Sites operating in the East of England

From this basis the Best Practice pathways section of the product has delivered four key areas, these are:

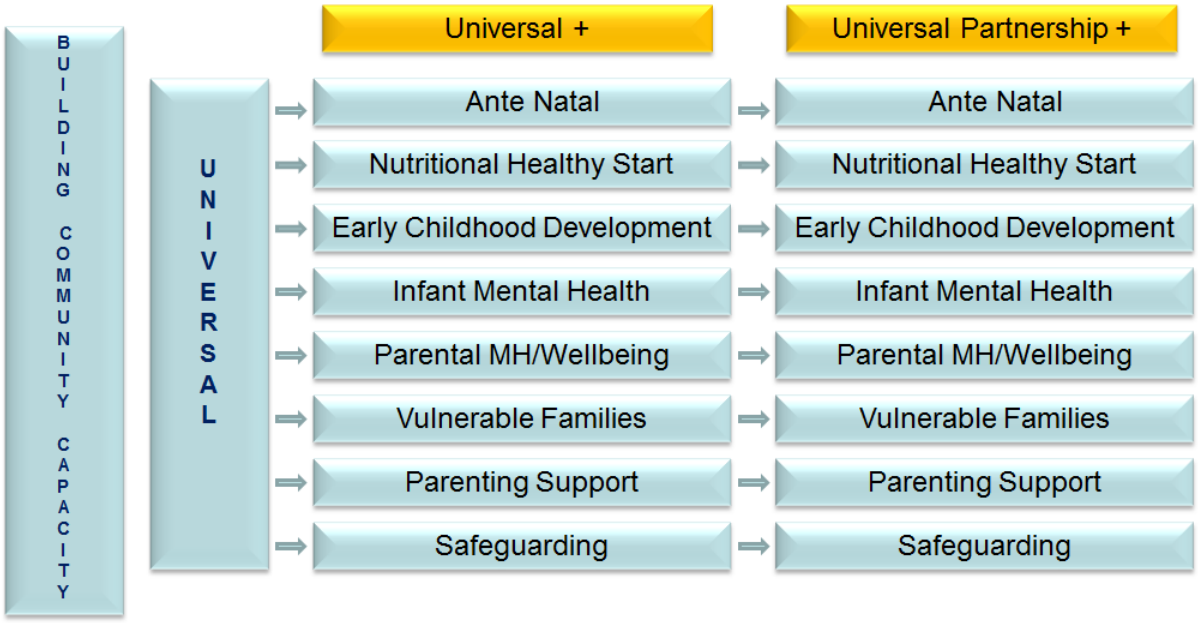
- Identification of the specific pathways required to meet the varying needs of children and families at the levels of universal, universal plus and universal partnership plus. Within this work it is essential that we are able to describe the service offer at universal, universal plus and universal partnership plus at the lowest or most specific level possible to reflect the particular needs of the child/family (see figure 4).

  In order to achieve this, the project group has developed:

  - A single universal Pathway covering antenatal to 5 years of age.
  - Eight Universal Plus Pathways & Universal Partnership Plus Pathways
    Antenatal
    (Covering the period from Notification of pregnancy to New Birth)

    Nutritional Healthy Start
    Parental Mental Health
    Infant Mental Health
    Parenting Support
    Early Childhood Development
    Vulnerable Families
    Safeguarding
    (All covering the period from New Birth to 5 Years old)

Figure 4



- For each of the above pathways, clear descriptions of the individual interventions that occur at the various ages/point in the pathway from Antenatal to 5 years old are described. For each of the interventions the pathways provide a description of what the Health Visitor service is undertaking during the contact with the child/family.
- For each pathway, clear identification of the activity information i.e. average visit length, skill level of staff required, mode of delivery, for all of the identified interventions.
- In addition to the pathway specific information this section of the product also provides a 'Pathway Allocation Tool'. The tool provides a framework by which clinicians can review the particular needs of a child/family within the levels of Universal, Universal Plus and Universal Partnership Plus to aid and make more transparent their clinical decision making.

  This Pathway Allocation Tool is supported by:

  - A HV decision tree which clearly identifies the key milestones and review points across the antenatal to 5 year old age range. These milestones and review points are both formal i.e. development reviews, and less formal maximum review periods necessary to support the implementation of the capacity and pricing methodologies.
  - A comprehensive guidance manual which describes for clinicians the rational for Pathway Allocation and its use in day to day clinical work.

- Views and approaches to developing the wider community capacity through the Health Visiting service.

Pricing Methodology – Initial Thoughts and Key Considerations

Drawing on the full range of information within the development of the pathways and a more commercial approach to pricing & costing, the pricing methodology – initial thoughts & considerations section delivers:

- Recommendations for a standard approach/methodology for the development of specific pricing for each of the individual pathways.

  This approach/methodology focusses on the need to build the pricing model/methodology from the direct costs associated with delivering a service to an individual child/family across the full pathway and how this can be achieved.

  It also addresses, elaborates on and provides recommendations on the full range of accounting treatments that would be required to cover the allocation of indirect costs to build a robust pricing methodology.

- Recommendations, rational and potential approach for future charging/invoicing for delivery of the HV offer that allows commissioners and providers to move away from the historic 'block contract' arrangements.

  Using the combination of the pricing approach and the age structure inherent within the pathways the recommendations clearly identify an approach that would enable charging/payment on an individual child/family basis by age and by allocated pathway.

  This approach enables a greater degree of transparency between commissioner and provider and in the longer term will enable both to more readily benchmark costs with other providers.

- Considerations of how through this charging/payment approach combined with the interventions identified within pathways, by age band the commissioner is able to develop KPI information to validate that the correct level of service is being delivered.

Capacity Model

In a similar vain to the pricing model/methodology the capacity model draws on a range of information provided through the pathway development to identify the overall capacity required by a provider to deliver each of the individual pathways by age of the child.

It also identifies what range of additional caseload/population data and specific HR/organisational data for the provider is required to start building a robust capacity/planning model.

Having identified the total information requirements the capacity model has been constructed to allow the provider and potentially the commissioner to:

- Identify over a one year period (by week or month) the actual capacity required to deliver the range of pathways based on the current caseload by pathway and predicted new births.

- Identify, when factoring in the HR information, potential pressure/surplus areas in the available capacity for delivery of the service based on current caseload by pathway and predicted new births.

- Predict the potential future capacity requirements based on known areas of population growth, current percentage of the population on each pathway and capacity requirements required for the delivery of each pathway.

Key Performance Indicators (KPI)

The development of this section of the product has been based on a need to identify:

- The KPI's that the commissioners would like to implement to monitor the effective delivery of the HV offer.
- The KPI's that would be used internally by the provider organisation to monitor the efficiency of its operational service delivery.

Commissioning

When developing the commissioner KPI's the project group have been focused on ensuring that they challenge the current prevalence of pure activity indicators. As a result they have developed a broad suite of KPI's that fall into three overarching categories:

- Quality
  The quality KPI's draw on a mix of numeric information and information that is more narrative in nature.

  For Example:
  - Professional Practice – Providers to monitor and ensure consistency of approach between clinicians within interventions.
  - Movers-in - Report on response times for all new children/families moving into the area.
  - Report demonstrating the level of consistency of staff providing antenatal and NBV.
  - An annual audit Programme i.e. A % (to be agreed locally) of 2 ½ year checks and track back to check movement between pathways.

- Outcomes – based on Public Health initiatives and school readiness
  A range of outcome based measures that provide an indication of the effectiveness of the HV interventions.

  For Example:

  - Healthy Weight
    - Maternal BMI (Maternity Services KPI)
    - Breastfeeding prevalence at 6-8 weeks
    - Birth weight
    - 1 yr. weight
    - 2 yr. weight/BMI
    - NCMP at school entry
    - Dental caries age 5

  - School readiness

- Infant and perinatal mental health
- 1yr. ages and stages score
- 2yr ages and stages score
- EYFS at school entry

- Activity
  These KPI's cover a range of areas, some of which are already reported and in the view of the project group are still relevant. Others are new and are derived from the proposed changes to clearly identified pathway allocation for children/families.

  For Example:
  - Routine reporting of the total number of children/families allocated to Universal, Universal Plus and Universal Partnership Plus pathways.
  - Routine reporting of the movement, step up/step down, between the identified pathways.
  - Routine reporting of compliance with antenatal, new birth and developmet reviews.
  - Review of actual interventions/activity against described best practice pathways.

Provider

When developing the provider KPI's the project group have focused on ensuring that they have considered all of the information required for a provider to critically appraise the level of efficiency within their HV service. As a result they have developed a broad suite of KPI's that include:

- Family Experience Measures
  The Family Experience Measures are designed to identify issues which highlight the satisfaction levels of Families which are engaged with the services, and which may provide information to support service changes and improvements in the future.

- Clinical Efficiency Measures
  The Clinical Efficiency Measures are designed to highlight whether resources are being focussed most effectively in key areas. These include indicators on types and settings of services, family contact time with services, and level of compliance of service provision against the planned pathway.

- Staffing Measures
  The Staffing Measures are proposed to monitor whether there are sufficient staff with appropriate skills in the right place, looking after the right mix of families.

- Financial Measures
  The Financial Measures monitor whether service costs and income are in line with planned levels and identify areas for future cost improvement.

- Activity Measures
  The Activity Measures provide an indication of key activities undertaken and whether these are in line with planned levels.

Each of the Performance Indicators will require a target which will be either established as part of the local commissioning discussions and which reflect the level of investment in the service or will be set internally by the provider.

IT Review

The IT review pulls together all of the information requirements from the above outputs to provide a comprehensive list of the data recording elements that will be required within a HV service.

A formal review/audit was then completed to ascertain:

- If the prevailing provider IT systems were capable of recording and reporting the required information.
- What elements could not be recorded with the current IT systems.
- Identify what actions/alternatives recording systems would be necessary to ensure all of the required data could be collected.

The final outcome report will pull together the full information recording requirements along with the conclusions and identification of issues and potential solutions from the audit process.

6 – Links to QIPP

The vision of the original project design, its delivery and development of the final products address's directly the areas of Quality and Innovation.

This has been achieved by ensuring:

- That the component parts were NOT approached within silos but as a single entity with the pathways at the centre.
- That all involved in the project understood the importance of, and were able to define within the pathways, all the necessary information required for successful commissioning, service delivery and service management.
- That both providers and commissioners agreed and were engaged in developing an outcome based commissioning framework.
- That there was transparency and a shared understanding between clinicians and commissioners regarding best practice pathways that identified the specific clinical outcomes necessary to measure the impact of Health Visiting Interventions.
- That the professionals were at the heart of developing objective assessment and decision tools which encapsulate the daily judgement calls that they make when faced with children and families.
- That both commissioners and providers worked on the developments together and were able to develop the depth of understanding of priorities and viewpoints through objective conversations that would remove tensions and change some of the stereotypical behaviours that often prevail.
- That pricing and capacity evaluations were developed from the necessary detail, within the pathways, that will allow objective commissioning discussions as services and demand develop. In addition for service management to understand the impacts of demand, seasonality, staff impacts upon the service and the key drivers for utilisation and caseload.
- That necessary skill sets were engaged and involved, not just clinicians, throughout all elements of the process involved in the development of the package – bringing to

the table their valued thoughts and requirements throughout and ensuring they are committed and engaged with the project plans

7 – Recommendations

The timeframe for the delivery of this project has limited its scope to the development of the 'Supporting Commissioning Tools, framework and guidance'. As a result there has been no opportunity to work with commissioners and providers to test and refine the outputs, which we feel is essential before any consideration can be given to wider implementation.

The project group and SHA sponsor have therefore identified the following recommendations and approach in the short and medium term.

In order to ensure that these recommendations will be taken forward the SHA sponsor has confirmed that the necessary support and resourcing will be made available.

Short term

- Develop and run a formal 'Implementation pilot' with two provider and commissioner organisations within the East of England.
- Provide a formal evaluation and refinement of the tools, framework and guidance in light of the pilot implementation findings.
- Report and deliver findings of the implementation pilot and refined tools, framework and guidance to the Department of Health

The proposed stages/approach to the Implementation Pilot are:

- Publish Project 4 Original Product — 16th April 2012
- Develop Pilot Site Expectations — 27th April 2012
- Identify Pilot Sites & Gain commitment — 25th May 2012
- Preparation & refinement of Pilot Sites understanding and detailed Implementation Plan — 4th June to 27th July 2012
- Commence Implementation Pilot — 30th July 2012
- Produce Interim Report — 26th October 2012
- Complete Implementation Pilot — 31st January 2013
- Produce Final report and refined products — 1st March 2013

Medium Term

- Share the refined tools, framework and guidance across NHS Midlands & East

The proposed timescale for this would be: March 2013 – April 2013

- Plan and deliver a formal 'Rollout' of the refined tools, framework and guidance with all provider and commissioner organisation within the East of England.

The proposed timescale for this would be: March 2013 – March 2014

Long Term

Whilst it is clear, even at this stage that the tools, framework and guidance will be of value to all providers and commissioners of Health Visiting services across England it is not within the gift of the project group or SHA project sponsor to commit to a wider role out without additional support and resource from the Department of Health.

It is therefore recommended that, following the Implementation pilot and roll out across the East of England, the Department of Health and SHA Sponsor consider the approach and resourcing of a National roll out to all Health Visiting providers and commissioners.