



HEALTH VISITING; DELIVERING THE FUTURE

Case Studies



Dear Colleague

On 21st October 2010 the Department of Health (DH) announced that they would deliver 4,200 new Health Visitors by April 2015 to improve young children's and families' health and wellbeing across England.

Since 2010, we have all been working hard across NHS Midlands and East to increase the numbers of health visitors in post by training, retention and supporting returners. This programme is not just about numbers; so we have also been focused on delivery of the service offer to children and families, so that health outcomes can be improved.

This compilation of case studies begins to capture some examples of the excellent progress that has been made. Case studies are important because they describe examples of best practice, innovation and clinical leadership. They are also important because they can provide inspiration for all of us; as individuals and teams, to implement on-going improvements to the service and outcomes to the clients we serve.

This is our next challenge; first we had to grow the workforce and now we have to demonstrate that this increased investment can really make a difference to children, families and communities.



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EARLY START CHARNWOOD - THE INTENSIVE EARLY INTERVENTION PROGRAMME FOR FIRST TIME PARENTS



This programme is designed for first time parents who are experiencing a number of vulnerabilities. The programme provides intensive support from early in the ante-natal period until the child's second birthday.

One of the first people who agreed to be part of the Early Intervention programme was K a 17 year old woman, who identified that she had a number of vulnerabilities.

The intensity of the programmes visiting meant that a good working relationship was established to address the issues responsible for her

vulnerabilities. Good multi-agency working has been achieved involving her Health Visitor, support worker at her accommodation, social worker and midwife.

As a new mother K will continue to receive intensive support. The benefits this level of support provides means the likelihood of change is made more possible. If K were on a universal caseload there would not have been the capacity to work at this intensive level.

For a Health Visitor this way of working is extremely satisfying to work in such an innovative way and

is very rewarding when the changes happen. Challenges will arise when her baby arrives and will depend on the relationship with her partner. K will remain on the programme for 2 years and during this time she will be encouraged to become less dependent on professionals. The programme will continue to develop and the areas covered and the team are likely to grow.

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What started out as a considered management response to a change in the way health visiting services were delivered in the Shropshire locality of Shrewsbury and Atcham, soon turned into a service development that has seen both staff and clients benefiting from a range of important service improvements.

Health visiting services in Shropshire went from having individual health visitors attached to specific GP practices in the county, to being centralised with all local health visitors working across one of the three Shropshire County locality areas. Health visitors based in GP practices in the Shrewsbury and Atcham area were brought into a single centralised team in the North of the town and this relocation led to the introduction of a Health Visiting Advice Line.

One of the technical problems with the centralisation of local health visitors meant that where previously each health visitor had access to a single, personal telephone with answer-phone facility, the provision of 24 plus individual direct dial phone lines into one office seemed both costly and impractical.

A decision was then made that the health visiting team for Shrewsbury and Atcham would change to a system of a single Advice Line, which would be staffed by a qualified health visitor at all times, Monday - Friday from 9am till 5pm. Concurrently clinic sessions were changed from walk-in sessions to 'appointment only' - which needed to be booked through the Advice Line.

This service covered the Universal offer of rapid access to health advice via telephone or text and allowing for booking appointments for clinic attendances or review contacts. Also the Universal Plus offer of rapid access to support for specific programmes or interventions.

Since introducing the Advice Line, the team have received an increase in the volume of enquiries, they have also seen an increase in the actual range of topics being enquired about - it seems that clients often feel more comfortable asking someone on the phone about something, rather than face-to-face. Though, those families that need and want a face-to-face appointment are still able to get one - without the long waiting time

Other NHS services and GPs are starting to refer more and more to the Advice Line. It's quick and easy for them and their patients to get the help they need.

Other partner agencies that visit hard-to-reach groups are also making use of the Advice Line whilst they are with the client - helping to show that it is easy to use and encouraging good behaviour change in these groups, who would normally not engage with the service

The introduction of the Advice Line was not just about giving families in Shrewsbury and Atcham a single, easy number to remember to get in touch with the health visiting team, it also allows the team to provide a much faster, triaged, relevant and localised service to new mums and dads -

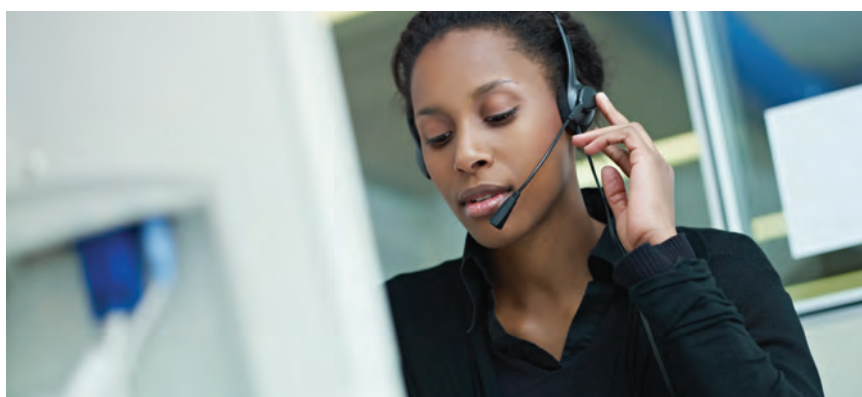
meaning that a whole host of benefits are obvious to local families with young children and babies, including:

- Instant advice and support to families through the Advice Line being staffed by a qualified health visitor - this means that often people get the advice they need straight away.
- Families getting access to quicker health visiting advice means that they don't have to make use of another NHS service - such as GP consultations or treatment and care from Emergency Departments as frequently.
- Through triaging of family concerns, those that need access to a face-to-face consultation with a health visitor can be booked into a clinic straight away, or, if appropriate can be booked in for a home visit or provided with advice to access other NHS services as relevant.
- Through appointment-only clinics, families do not have long waiting times, unlike the old system of drop-in clinics.

The Shrewsbury and Atcham team has already begun to share its learning and success with the other locality teams across the county, who in turn have developed a single Advice Line approach.

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Making it easy for first time mums to get the right support at the right time for them.

For new mums, getting the right support can be an uncertain and sometimes daunting process. That is why a network of community-based teams made up of health visitors and nursery nurses offer flexible advice and support through clinics, activities and home visits throughout Birmingham during the crucial early months in a child's development. The service has had very positive outcomes for new mums and links in well with the universal service offer for all families building robust contacts with families early in the child's life.

Feedback from first time mums:

"The support she received since the birth of her son Joshua through Birmingham Community Healthcare's health visiting service has proved invaluable, both in terms of providing practical help but also the opportunity to share experiences with other mums.

"I really don't know how I would have got through my first year as a mum without the brilliant help and support of the health visiting team.

"Being a mum is a wonderful, rewarding experience but also harder than anything else I could imagine. I am so grateful for all the countless hours the team spent helping me through tough weaning times and for all the practical help with things like medications or different types of formula milk.

"As much as anything, the health visiting service has provided opportunities for mums to support one another - navigating that unfamiliar world is one of the hardest parts at first. I'm sure that the friendships I've met through the post-natal group will be lifelong."

Feedback from staff:

Community nursery nurse Sue Bearcroft, of the Poplar Road health visiting team, explained that the service provides a flexible range of assessments, advice and activities to

promote family wellbeing and the health of both mum and child.

"The main strength is that we have the range of skills, experience and facilities to be responsive to the specific needs and concerns of each mum and child close to, or actually in, their homes," she said.

"Becoming a mum for the first time is a wonderful experience but is different for every individual mother and their child. It can also be a very daunting time; for some, it can be quite isolating. And although there is plenty of support out there from professionals and other mums, it's not always obvious at first how to tap into that network. So as well as clinical assessment and advice, we provide opportunities to forge those links."

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The health visiting service within Sandwell and West Birmingham Hospitals NHS Trust (SWBH) is committed to offering newly qualified health visitors and those returning to practice or changing practice area, a period of preceptorship in the first six months of practice within the organisation. The organisation acknowledges the value of its staff and seeks to make the transition from novice to expert as smooth as possible. Whilst it is recognised that newly qualified staff and return to practice staff are accountable, competent practitioners an additional period of support in the form of preceptorship demonstrates an understanding of the stress associated with embarking on a new role.

Preceptorship will support the policy drive to place quality at the heart of everything we do in healthcare (Darzi 2008). Guidance and training will be provided by experienced and supportive preceptors and practice teachers. As a newly qualified health visitor many people find the transition from being a student to an accountable individual practitioner a daunting prospect. Although they are competent and knowledgeable they may feel they need the support and guidance of more experienced professional colleagues as they find their feet in professional practice.

The same may apply to those who have returned to practice after a break of five years or more and those who enter a different area of practice. It may also apply to those who enter a different area of practice by virtue of a new registerable qualification, for example a registered nurse who subsequently qualifies as a Health Visitor. The preceptorship process has been designed to assist the new practitioner to consolidate their skills and to assist them with recording evidence of their development towards their KSF outline.

The evidence is recorded in the practitioner's development portfolio and forms part of the practitioners continuing professional development. This period should help identify the support and development needed to commence working towards fully developed status of their KSF outline after their preceptorship period is complete.

Benefits for Preceptees

- The preceptee feels supported by having a recognised process with time allowed for support in the first few months.
- Any concerns the preceptee may have are more easily identified and addressed.
- The stress of coping alone is removed.
- The preceptee is able to explore professional and personal issues away from the workplace and their colleagues who provide day to day support.
- Takes responsibility for self-directed learning.

Benefits for Employing Organisation

- Stress in the workplace may be reduced resulting in less absence and sickness.
- A period of preceptorship can settle in new staff, helping to improve morale.
- The organisation can plan training/education needs of staff, responding more appropriately to client needs.
- A forward thinking preceptorship programme will attract staff from other areas who will benefit from the scheme, as it highlights the organisations commitment to lifelong learning.
- Provide quality assurance.
- KSF framework embedded at the start of employment.

Benefits for The Client

Preceptorship is part of the clinical governance framework. Through preceptorship, preceptee's should feel well supported and confident in their practice. Clients can expect:

- Safe, accountable practitioners who demonstrate evidence based practice.
- Appropriate, focused interventions.
- Confidence in their Health Visitor.

In conclusion, by involving the HV's in the preceptor programme from the initial stages of the framework and as this was a unique service offered by Sandwell and West Birmingham Trusts the majority of HV's were signed up to this programme. At interview many HV's would ask what support was available to them upon qualifying or if they were RTP. The knowledge that there was a preceptor framework was well received.

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AUDIT REVIEW OF HEALTH VISITING CARE PLANS AND RECORD KEEPING IN SANDWELL.

Sandwell is a challenging area to work in, it is the 14th most deprived town nationally and 4th most deprived outside of London. Following a poor Ofsted inspection in Sandwell Children's Services, it was seen as an ideal opportunity by health visiting supervision leads to review their own systems and processes within health visiting too. The initial audit was completed in April 2011 and reviewed care plans and recording keeping within the health visiting services. The audit was small scale and reviewed 20 health records with the following points identified:

- Care plans were out of date or a care plan was not identified in the notes.
- Staff acknowledging difficulties in writing care plans.
- Poor record keeping.

To address the above points a training programme was developed and delivered for all staff within health visiting services. All health visitors have access to supervision had been in place for 18 months which supports staff in managing some of their most complex and vulnerable families and this training would ensure robust recording keeping.

A re- audit was undertaken 12 months on to reassess the quality of care plans and record keeping within the health visiting service. This audit showed a marked improvement in records containing a completed care plan.

The following table demonstrates the improvements in terms of record keeping and care planning following the training delivered and regular supervision.

Criteria	2011	2012
Care Plans Completed	89%	94%
Care plans reflected the most up to date care delivered at the last contact	77%	85%
Health Care Needs Analysis (HCNA) on the child reference card corresponded with the care plan	66%	72%
Children had been seen within the last six months	70%	84%

The record keeping audit was an excellent opportunity to examine record keeping and highlight training needs.

The record keeping training was delivered to all health visitors and encouraged staff to discuss care planning at length.

Benefits to health visitors were:

- They felt supported in their practice, whilst delivering a high standard of health visiting.
- The audit training was followed up in supervision
- Enables planning and delivery of preventative services, rather than reactive services for children and their families.

The overall project has:

- Promoted critical thinking.
- Enhanced record keeping.
- Met training needs.
- Improved and standardised filing systems within the trust.
- Ensured that the audit and supervision process are embedded within the health visiting service.

It is very important that health visitors are supported in their practice; and that record keeping standards are maintained. The record keeping audit has addressed this by identifying a learning need; and successfully delivering training. The audit then measured the success of the training, by revisiting records and documenting the improvement.

Lord Laming (2009) states that '..' work requires not only knowledge and skill but determination and courage... this must be recognised in training'. The record keeping audit has clearly achieved this and will continue annually, to maintain the standards that have been achieved.

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PROMOTION OF CHILD SAFETY BY STUDENT HEALTH VISITORS

According to Boekle (2011) children need to be cared for in a safe and healthy environment starting at home. Every day lots of babies are rushed to hospital because they have been hurt in accidents. Most of the accidents happen at home because that's where babies spend most of time (Child Accident Prevention Trust 2012, CAPT) Mulvaney, Watson and Errington (2011) confirm that childhood accidental injuries are a major public health problem, also serious accidents can cause injuries to children that take months to heal. Irving (2000) believes that health visitors are in a unique position to undertake accident preventative work. This promotion activity would relate to Community and Universal parts of the HV service vision.

As a team of student health visitors we were approached by our practice teachers to organise a health promotion activity during child safety week 2012. The objective for this exercise was to organise a range of health promotion activities on child safety to raise awareness and focus this in geographical areas where the incidences of accidents were high.

The group decided that they would concentrate on several aspects of home safety and do a range of

activities. Road shows were planned in various local children's centres and health centres promoting home safety aspects e.g: burns and scalds, fires, choking and suffocation, sleeping, strangulation, drowning and poisoning.

The student group organised meetings with children centre staff and their health visitor colleagues to ensure everyone was engaged with and aware of the campaign. The student group met regularly themselves to develop and identify resources needed for the road shows and develop a poster resource which promoted the key safety messages.

These road shows were planned at times when there would be activities happening such as baby clinics or parenting classes to ensure we targeted the parents and carers of children. Advertising this campaign was also important and this was done through the Trust intranet, giving information out to health visitor colleagues and children centre staff. Posters were also used to raise the campaign with those visiting the children and health centres.

The benefits of this campaign were two fold: firstly to promote the issue of child safety with parents

and make them aware of the risks within the home and what role they play in ensuring their environment is safe for their children. Secondly, for us as a team of students we gain excellent experience in working in multidisciplinary teams, planning and organisational skills, developing proposals and getting buy in from key stake holders and colleagues, and finally utilising our public health skills to improve community health.

According to Avery and Jackson (1998) in order to address the problems of accident prevention we must educate children, parents and health professionals with whom they come in contact with and have responsibility of designing the environment in which the children are brought up both inside and outside the home. This was achieved by the road shows which were held during baby clinics so we were reaching as many of the families within our areas.

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INTEGRATED WORKING LED BY HEALTH VISITORS IN SANDWELL

This case study aims to highlight the benefits of integrated working within the community. At Friar Park, health visitors are co-located within the Children's Centre and as such have a close working relationship with the different professionals working from the same location.

The health visiting team first became involved with the family at the new birth visit for child two. At this initial assessment it was decided that a Common Assessment Framework was needed to help support the family and try to meet the needs identified.

At the Children's Centre we also held our own 'Team Around the Family (TATF) meeting' so as a team we could discuss the relevant issues and put together a multi-disciplinary action plan.

The initial issues that prompted the TATF meeting were:

- Domestic abuse.
- Support for depression.
- Support with housing and benefits.
- Child safety and wellbeing.
- Child health needs.

The referral to Children's Services was made because there were obvious safeguarding issues. The intention was that mother should get support because she was extremely

isolated without her partner and found it difficult to cope. A 'Child in Need Plan' was to be put in place which would mean mother and family would have the extra support needed.

In working together as an integrated team, the members from the different teams were able to identify a range of support such as: Respite care for the middle two children so that the mother would only have the baby to look after for several times a week. This gave her time to get up to date with cleaning, shopping and other household chores.

The eldest boy was referred to specialist mental health services and counselling service to manage his behaviour which had been deteriorating because he had many issues to deal with within the family.

Regular check ups were organised for the children to ensure their growth was monitored, and for one child anaemia was identified requiring medication. Children's Centre transport took the family to their hospital appointments to ensure that the children kept their appointments and treatment was monitored.

In getting the additional support for the family working as an integrated

team, the health visitors were able to demonstrate the reduction in:

- Domestic abuse as partner received anger management support and no further incidents of domestic abuse were reported.
- Health issues for family were addressed, children growth demonstrated good nutritional intake. Development milestones for language were being achieved.
- Mother was able to restart her anti depressant medication and with further support from the health visitor was able to take control on issues and take action.
- Safety in the home was improved as parents took on board advice and were able to articulate the actions they need to take to reduce accidents in the home.
- Engagement of housing and benefits services enabled the family to sort out their finances and have plans in place to pay back any debts.

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The importance of Health Visitor intervention within maintaining good mental health for mothers in both the antenatal and postnatal period is evident within the National Service Framework for Mental Health (1999) and the Healthy Child programme (DOH 2009).

The Time 4 Mum postnatal support group delivers an effective initiative within the Health Visitor Implementation Plan, by addressing an identified need to promote community development, as well as linking into universal plus and universal partnership service delivery.

It is estimated that approx 75,000 women within the UK are affected by postnatal depression. (PND) (Hanley 2009).

As Health visitors, together with Family Action Sunflower Children's Centre it was identified that there was a need to address the prevalence of postnatal depression in the area and subsequently to explore what community support was accessible to these mothers.

Following discussion and consultation with other health visitors it became apparent that the numbers of postnatally depressed women on individual caseloads were high. Despite Worcester being fortunate to have an abundance of support for new mothers i.e. several children's centres and local groups, it was felt that there was a gap in supporting mothers within a group situation who feel low in mood and not eligible for specific mental health support. Individual health visitors and mothers themselves reported some apprehension within accessing postnatal groups in the fear of being different to other mothers enhancing feelings of inadequacy and undermining their confidence.

It was decided to set up a postnatal support group for women called 'Time 4 Mum'.

Referral criteria was agreed for women:

- With an EPDS of 12 and above, to discuss if below 12.
- Depression occurring within the first year of babies' birth (child under one year old at time of referral).
- Referrals not accepted for mothers who are suicidal, self-harming or harming their baby.

The pilot group consisted of 7 sessions. The group commenced on 04/11/2011 and ran to 16/12/2011. It was facilitated by two health visitors and a Family Support Worker. There was a crèche facility for babies and children to allow the mothers to be able to focus upon the sessions and have time to focus on themselves.

In preparation for the project the Health visitors were offered a three day programme on post natal depression and the EPDS assessment tool.

Key achievement to date has been that all health visitors within the patch are engaged with the project, this was achieved through consultation and one to one meetings by project team. The project offered the opportunity for the health visitors to develop their professional knowledge, awareness and understanding of post natal depression and the link to mental health outcomes.

From a health visitors perspective, the project offered the opportunity for personal and professional development by enhancing professional knowledge, awareness and understanding of postnatal depression and linked mental health conditions.

In addition, project participants received additional support from colleagues within the recently formed Worcester Postnatal Depression Health Visitor Forum.

For the client group there was increased recognition they were not alone and their increased knowledge of mental health as an illness. The participants were able to build personal networks with other mums for outside the group, and one lady has set up a electronic social networking page. Confidence building as been key for the participants and one participant now represents the group at our internal management group to share the positive outcomes for her.

Implications for this project for the future is to ensure collaboration with other children's centres and colleagues to disseminate the project across the Trust and offer an equitable service to all our clients. Utilising the childrens centre as a venue has been very positive as it reduced the stigma for clients as the reason for attending this venue could be for a variety of reasons.

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The HCP focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. There is a strong evidence base for the HCP, as set out in Health for All Children (Hall and Elliman, 2006) and adopts the recommendations of Health for All Children as the underpinning universal programme.

Furthermore, the HCP also aims to explore opportunities for Health Visiting (HV) teams to work closely with Sure Start Children's Centres (CC) and General Practitioners to meet the eclectic needs of children and families in Coventry.

This project aimed to achieve:

- Improved co-ordination of services and intervention so as to offer greater control and choice for the families.
- Improve public expenditure savings by working in partnership and identifying problems early.
- Improve customer experience.
- Improve health and social outcomes.

By working together in partnership to integrate services in a more efficient and effective way thus, work collaboratively. In addition, we aim to have clearer lines of accountability and transparency of roles through rationalizing functions. A great deal of successful partnership work has taken place within three pilot sites in Coventry to enhance joint working with Children's Centres.

Service improvements to date are as follows:

- Jointly agreed health action plans which are in line with strict timing plans and are being adhered to.
- All HV led clinics have moved across to the CC in the pilot areas i.e. six week developmental assessments, eight to one year assessments, two and a half year assessments and open baby clinics.
- Early qualitative evidence suggests parents are extremely happy with the move to CCs as they can access all services under one roof.
- Quantitative evidence has demonstrated a significant increase in attendance. Furthermore, fathers, who are a particularly challenging group to engage and sustain are increasing in number(footfall).

Other key outcomes from this project are:

- Tracking systems are being developed in order to monitor the services accessed by families entering the CC. For example, if a mother presents at the six week check, is she then signposted into a baby group/health promotion session? If she accesses the baby group does she then go on to access another service? The impact of each intervention is being evaluated.
- Ante natal baby fairs have commenced whereby all pregnant mothers in the areas are invited into a one stop shop. Multiple agencies are represented to address issues such as smoking cessation, fuel poverty, cooking on a budget and breastfeeding. The parents are encouraged to attend

a further programme of post natal health promotion sessions concentrating on the identified, jointly agreed health priorities.

- A named HV is having regular liaison meetings with the local midwife in order to instigate early intervention and prevention strategies as evidence clearly indicates the antenatal period is an opportune time regarding learning and development and receptiveness to behaviour change.
- Liaison with the maternity services at UHCW is underway and we are endeavouring to obtain all ante natal notifications directly from source.
- A HV is on the Parents Advisory Board at each of the CCs in the pilot sites.
- All HV contacts with the general public are now being registered with the local CC so that all parents can be contacted and offered support early.
- Consent to share information with the CC is being obtained from parents.

In conclusion - this is very much work in progress, however, the learning from the three pilot sites will support the ongoing development of services in the future.

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BUILDING COMMUNITY CAPACITY IN THE EAST OF ENGLAND:

APPRENTICESHIPS LINKED TO CHILDREN'S CENTRES AND HEALTH VISITORS

This project sets out to equip young people with the skills, knowledge and experience needed to help them contribute to their own communities and bring about positive changes they want to see.

Two apprentices will be employed by Norfolk Community Health and Care NHS Trust (NCH&C) and work with the staff and newly qualified health visitors, at their respective children's centres supervised by the centre manager.

NCH&C runs seven Sure Start Children's Centres in Norfolk. One of these centres, the Bowthorpe and West Earlham Sure Start Children's Centre, in Norwich, is within the 15% most deprived wards in the country. Another is based in Thetford, which is a town which has been described as an 'island of deprivation'.

Linking with The Prince's Trusts' 'Get Into the NHS' employment programme, funded by NHS Midland and East, disadvantaged unemployed young people will undergo pre-employment training, including The Royal Society for Public Health Level 2 Award in Understanding Health Improvement. Suitable candidates will take part in four weeks' work experience at NCH&C's children's centres and two candidates will be selected for the apprenticeships, starting in the first quarter of 2013.

The apprentices will meet local residents and groups to establish the needs of their local communities and develop health improvement activities, with support from a health visitor and children's centre staff.

The children's centre manager and nominated health visitor will supervise their respective apprentice to establish a project that helps them to build community capacity.

They will then support the apprentice to work in the community to deliver a project that helps address identified needs, as well as take part in the daily life of the children's centre. The project will last for up to 12 months and will be within the timescale of the apprenticeship.

Apprentices will also develop relationships with local support organisations which will help signpost families to further support.

Apprentices will gain real work experience, coupled with training, which should provide them with excellent career prospects for their future.

The Apprenticeship Framework will be a Level 2 Certificate in 'Children and Young People's Workforce', which is ideally suited to someone who wishes to have a career working with children aged 0-19, primarily within Early Learning and Childcare;

Children's Social Care Learning and Development and Support Services. The children's centres will benefit from an additional member of the workforce, who can be developed to provide additional resource. They also gain the different perspectives offered by their apprentices who will also provide the voice of the community.

Meanwhile, health visitors will have the opportunity to work with a local young person, who can help to communicate with the local community and deliver a practical project that will achieve aspects of Building Community Capacity.

The Building Community Capacity project will be led by a partnership between the NHS Midland and East and NCH&C and will be monitored by a project manager. The two apprentices will keep a daily log of their activities, which will be used as evidence and regular meetings will be held with the centre manager, the health visitor, the apprentice and the project manager to record progress.

Overall, this project aims to bring about further improvements to the services on offer to families within the local communities.

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Evidence shows that breastfeeding has a major role to play in public health, as it promotes health and prevents disease in both the short and long term for both infant and mother. The evidence shows that as well as providing complete nutrition for development of healthy infants and protects against gastroenteritis and respiratory infections to name a few, evidence also demonstrates that breastfeeding is beneficial for mothers and those women who do not breastfeed are significantly more likely to develop ovarian and breast cancer.

To address the low breastfeeding activity in Solihull, the Council and Solihull PCT/ Public Health who together form the Solihull Partnership, implemented a Local Area Agreement with a performance reward stretched target. The objective was to develop a breastfeeding strategy that would become self sustaining, improved monitoring and addressing health inequalities, grounded in the principles and recommendations from the Unicef UK Baby Friendly Initiative.

An evidence-based model was required to address the low breastfeeding activity and inequality issues in Solihull, the range of activities included using:

- The Unicef UK BFI programme for the community as this provides a recognised and accredited framework for routine breastfeeding practice across the NHS community to increase breastfeeding rates.
- Education and support for pregnant women providing a combination of education and support programmes delivered by health professionals and peer supporters providing information on breastfeeding technique are now implemented.

- A breastfeeding policy for clinical care in the community was developed encouraging unrestricted baby led breastfeeding.
- An education curriculum for professionals was developed and ratified by BFI.
- Complementary Peer support service was introduced utilising volunteer face to face support. The volunteers are mothers who had used the breastfeeding service in Solihull and have followed the Solihull peer support training programme which was developed by a team of health visitors and midwives and is in the accreditation process.
- Media programmes have been introduced and a successful social marketing project was designed with the target audience being the under 25 age group from areas of deprivation.
- Breastfeeding cafes were opened across the borough offering breastfeeding support in a relaxed environment with mother to mother support and expert help. The health visitors refer into the cafes and provide support.
- This innovative project is unique as it incorporates several initiatives including a successful social marketing campaign which was designed with mothers and health visitors working together to address the breastfeeding issues specific to the community of Solihull. The mothers themselves now have a voice and their needs and ideas are listened to and acted upon as a result of a multifaceted approach from relevant agencies.
- The health visitors are key professionals when providing postnatal breast feeding support. They give encouragement, support and information to mothers to

help them continue their chosen method of feeding for as long as they wish too.

- The achievements in developing this breastfeeding support programme have been recognised and greatly appreciated by the women of our community in Solihull.
- The participation of the health visitors in its development was significant as a team approach was essential when working towards the achievement of UNICEF UK Baby Friendly Stage 2.

The uniqueness of this project in using PEER breastfeeding supporters and venues which were relaxed and inviting contributed to the success of this project. The pregnant and breastfeeding women of Solihull benefited greatly from the impact of the project however the women from the deprived area of the borough probably benefited the most from this initiative as it was very much aimed at the disadvantaged communities in Solihull.

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LOOK WHO'S TALKING NOW!

Until recently, neither of Abigail Sibanda's two-year-old twins could say a single word, only communicating with each other through their own language made up of different sounds that only they understood.

Whilst other toddlers their age were starting to develop their vocabulary, Abigail was becoming increasingly worried about her son and daughter, Cyril and Constance Mapika, who had developed their own language that no one else could decipher.

Due to their close relationship, the twins were able to interact with each other and understand the other's thoughts and feelings through simple sounds and gestures. However, this meant that interaction with other children or adults became a difficult for them and an increasing frustration for their parents.

Abigail took the twins to a health visitor drop-in clinic at her local health centre where Satnam Lgah was able to support the family with some early intervention speech development techniques, while they waited to see a speech and language specialist for an assessment.

Abigail said, "It has only been a few weeks since we first went to the health visitor service, but already we are starting to see a real improvement through applying the techniques that Satnam recommended.

"Their father and I were encouraged to read to them separately which they love and have started to recognise words in the books.

"It's been a huge help so far and the twins are trying harder to say more words. Even their behaviour has improved and I now feel more in control."

This was an unusual case for Satnam Lgah who, despite her three years experience in health visiting, hadn't come across a case quite like this before.

She said: "In some areas of Birmingham it is not uncommon for children to have a speech delay if their parents aren't reading to them or talking to them enough - but this situation was very different.

"When I first met the family both parents were distraught and didn't know where to turn for help. Although the twins appeared happy, they were becoming increasingly distant and badly behaved.

"The family have fully adopted all the techniques I have recommended whilst they wait to see a specialist which have all had a very positive impact.

"It's early days but already the family are much happier and it's so rewarding to see how my role can be pivotal in the health and wellbeing of a family."

Birmingham Community Healthcare is committed to developing a larger, re-energised health visiting profession to lead and deliver improved services to achieve the best possible outcomes for children, families and communities in the city.

If you are interested in a career in health visiting or know someone that would like to return to the profession, now is the time.

Visit: www.healthvisiting.westmidlands.nhs.uk

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Pictured (left) are twins Cyril and Constance Mapika with health visitor Satnam Lgah (left) and their mother Abigail Sibanda.

A significant amount of cases requiring additional support identified at the health visitor new birth assessment could have been addressed antenatally, thus improving the life experience of the mother, child and family.

This led to the implementation of the Antenatal Healthy Child Collaborative (AHCC) within some cluster areas in Suffolk, which has enabled Midwives to refer between 16-24 weeks of pregnancy, those who fall into the partnership plus category of need.

The AHCC meets a maximum once per week or minimum once per month. The lead midwife for the local area, Link HV and Children's Centre worker meet to discuss who can best meet the needs of the family. The client is contacted within 2 weeks and offered an in depth family health needs assessment (in line with CAF) by the HV and CC worker in partnership if appropriate or singular if necessary.

The service change was led by the service manager, HV Locality Clinical Manager, Midwifery leads at West Suffolk Hospital and Ipswich Hospital, Children's centre leads, HV, Midwives.

Regular meetings were held, plus focus groups and training sessions with appropriate staff in localities to inspire and motivate staff.

- Key stakeholders were informed at the outset of this innovation but engagement has been limited.
- Feedback has been monitored along the way.
- Families have been involved and their experience will be audited in 2013.

Benefits include:

- Less duplication with problems highlighted earlier.
- Services working in partnership in a SMARTER way.
- Early intervention and prevention, issues resolved much earlier improving early experience of parenthood.
- Individuals have benefitted by seeing positive outcomes.
- Anecdotal benefits perceived by the mother
- Improved relationships and working patterns between midwifery, HV and CC staff.

A base line audit tool has been developed to highlight the reason for referral and whether the outcome was met, partially met or fully met. Audit is planned for Jan - Feb 2013.

Some of the challenges faced by the Midwifery, Health Visiting and Children's Centres in implementing the Ante Natal Healthy Child Collaborative are:

- The risk of making decisions about what services to provide to families without first consulting the mother.
- Difficulty in releasing staff to attend the meetings due to pressures of work and competing priorities.
- Reduced resources resulting in limited ability to follow up on some referrals.
- Repetitious paperwork.
- Health visitors and midwives working to different organisational and geographical boundaries.

These challenges are being worked through and solutions developed. The ANHCC has demonstrated that it is possible to work collaboratively to improve outcomes if there is a will from all parties, a common goal and an understanding of what each party can offer.

Early feedback suggests that sharing of information in the antenatal period has supported early intervention and improved outcomes for both mother and child from a health and social care perspective. It has also reduced the amount of intervention necessary in the early post natal period.

Resources, pressures of work, service delivery models and concerns regarding sharing information can form barriers to integrated/ collaborative working however these can be overcome with some imagination and effort.

The ANHCC has been rolled out throughout the Suffolk area (excluding Waveney) and interest has been shown by other neighbouring HV and Midwifery teams in adopting this model of early intervention in the antenatal period. This model will be reviewed at regular intervals to ensure continuous improvement and to monitor outcomes ensuring its viability.

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TO PILOT ANTENATAL OFFER AND TEST THE DEVELOPED TOOL - STAFFORDSHIRE

In Stoke on Trent we have continued to offer a high level of coverage for most aspects of the Healthy Child Programme, for example coverage of the 2 year review is currently 91%. However as discussed previously antenatal contacts were ad hoc and coverage poor. To raise the quality of our Healthy Child programme it was necessary to focus on improving antenatal contacts. We were also aware that ante natal contacts would potentially offer us the best opportunity to start improving outcomes. We considered the emerging evidence around neuroscience and the knowledge that early intervention and prevention is key to delivering positive outcomes for parents and babies.

To ensure the quality of our antenatal contact we wanted our practitioners to deliver a standardised evidence based approach to ensure the service is equitable and of a high standard. Promotional interview training was offered to us a part of the Early Implementer plan and we wanted to ensure this training opportunity was taken up by health visitors. We felt that an antenatal pilot would be a good way to embed this in practice and provide feedback on a suitable tool to use.

This project will provide the opportunity to pilot a system to facilitate antenatal contacts and to develop a tool for use at this contact.

This tool will be based on the Pregnancy Birth & beyond model.

Health visitors in Stoke-on-Trent have always offered opportunistic and some targeted antenatal contacts, however these ad hoc contacts were not based on any particular evidence based model and there was no system in place to facilitate consistent up to date information from the midwife.

The pilot involved two midwives linked with two specific GP practices and antenatal women that lived in a specific geographical area. This area was geographically covered by three health visiting teams. The midwives completed a booking communication form with the antenatal women and a copy of this was passed to the health visitors during face to face contact. This form enabled the health visitor to identify risk factors and need. All the women in the pilot were sent a letter - women with identified risk factors or need were sent a letter with details of a pre-arranged home visit and the women without any identified need or risk factors were invited to request a contact by telephone.

There were thirty three women in the pilot and eight were identified as having risk factors. These women were targeted for a pre-arranged home visit by the health visitor. To date five of these women have been visited.

The other women were sent a letter and to date three of these women have been visited. The pilot does not finish until the end of the month so these figures may change. The health visitors used the antenatal promotional interview approach and either completed our newly developed tool or the promotional interview checklist during the contact.

This project specifically influences our Health Visitor Service Vision because it introduces the health visiting service at a much earlier point in a family's journey and transition to parenthood. It also promotes improved partnership working with midwives. This will ultimately enable us to offer an improved core health visiting offer to all families, offering the best possible start and therefore improving outcomes. As the pilot is still completing we only have interim data. The final data will be evaluated along with parent's views before we decide how to take our offer forward and scale this across the new organisation.

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PREDICTING, DETECTING AND TREATING PERINATAL MENTAL ISSUES FOR WOMEN IN THE PERINATAL PERIOD - STAFFORDSHIRE



The aim of this development was to improve the Health Visitor's ability to identify those mothers who are most vulnerable and at risk of perinatal mental health issues. By implementing the recommendations outlined in the NICE guidelines, alongside those in other social policy documentation, we aim to minimise the negative impact of perinatal mental illness on mothers, children and families. This was to be accomplished by providing appropriate, evidenced based assessment, early intervention and quality services that are appropriate and accessible. It aimed to improve communication and co-ordinated care for women across primary, secondary and tertiary services, so reducing the persistent inequalities in health and wellbeing.

The local specialists perinatal mental health team were engaged in the development of guidelines and pathways to support the health visitors to utilise the 'Whooley' questions with clients who were offered the Universal health visiting service and the Edinburgh Postnatal Depression Scale for those that were offered the Universal Plus health visiting service. This also ensure a clear pathway for referrals when issues were identified.

General practices were engaged with the project through regular meetings and highlighting the need to utilise evidence based assessment

tools to reduce inappropriate visits to the surgery and effect and timely referrals to secondary care services.

Health visitors were trained in teams on the assessment tools and referral pathways to ensure tools to ensure standardisation of the process and that they were clear on the referral processes. The training was delivered by the regional perinatal mental health specialist and a designated health visitor with special interest.

Systems were put into place to ensure the copies of the assessment tools were recorded into the GP systems to ensure all key providers of care were aware of the outcomes for the client and the treatment options being offered. Perinatal clinical supervision was introduced for all health visiting teams has been which enables staff to reflect on their practice hence identifying continuing educational practice training needs and provide support as needed.

The outcomes of this work have ensured Health visiting teams are now using evidence-based tools to support the decisions they make regarding the care of women with perinatal mental health issues. This thereby minimises clinical risk within the organisation by the more effective use of professional skills and time, and enhanced communication through sharing and accurate documentation.

Through early detection using the new assessment tool it health visitors are able to minimise the negative consequences of perinatal mental illness on family relationships and the cognitive and emotional development of children. It has also meant there is an improved knowledge and awareness of the role health visitors play in promoting improved education of mothers and their families, resulting in improved health outcomes for children.

There are always challenges with any project when there are competing high profile agendas. For this project the challenge for staff accessing training was overcome by delivering training locally and using local training providers.

To ensure sustainability of this project we have involved all stakeholders in the project from the beginning. For health visiting staff they have been engaged with the development of the training and resource packs for the project which ensures they have ownership of the project.

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IMPROVING HEALTH VISITORS CAPACITY TO THINK - RESTORATIVE CLINICAL SUPERVISION - WEST MIDLANDS

The restorative clinical supervision programme has been delivering supervision for the last 18 months to over 600 Health Visitors within Trusts across the UK. The supervision was considered important given anecdotal evidence both nationally, regionally and locally that within Health Visiting services morale was low, retention remained a real issue for several providers and high levels of long term sickness and stress were resulting in a negative impact on their services. Numerous child death reviews have recognised the need for staff working within challenging clinical environments and caring for increasingly complex families as needing strong leadership and support via supervision.

Baseline results showed that burnout and stress scores were at clinical levels for the majority of participants and these scores would mean that their capacity to think and make decisions would be detrimental. 76% of respondents have indicated that their psychological wellbeing was poor or ok and only 24% reporting good psychological wellbeing at the time of testing. There is little variation amongst the group suggest this is a common experience for Health Visiting staff.

In context, Health Visitor scores were 33% higher than ambulance workers who were asked to reflect on a recent traumatic episode and 23% higher than soldiers pulling their deceased colleagues from the battlefield.

On the positive side, Compassion Satisfaction (the pleasure one derives from doing the job) was high and at this level should be a protective factor for participants' experience of stress.

The impact for staff experiencing these levels of stress will find emotional engagement in future care episodes difficult. Coping with the emotions of families during critical periods is likely to become more challenging. Long term impact can be sickness, low morale, decreased productivity, poor time-keeping, impaired decision-making, increased conflicts, increased accidents, patient dissatisfaction which means a rise in complaints.

The restorative clinical supervision programme has been given funding to address the burnout and stress issues for all Health Visitors across the West Midlands. The aim of the project is to ensure that the restorative model of clinical supervision is embedded within Health Visiting services across the West Midlands. The supervision has also accompanied the leadership programme as it rolls out nationally and this has meant opportunities to listen and impact the health and wellbeing of Health Visitors across the country.

Each Trust was asked to identify a quarter of their Health Visiting workforce to be trained as restorative supervisors. These participants receive restorative supervision from the external supervision team and

when they are ready they take on the supervision of a further four colleagues. This resulted in one afternoon a month spent supervising.

The long term benefits are of Health Visitors who are effective professionals who understand their boundaries of work importantly where their responsibilities end. The increase in engagement skills means that they are able to engage with other professionals to support the families needs. The reduced mind set of emergency response to families needs and more thinking through of what needs to be done means a more effective service. We know that the impact of staff under the levels of stress is that they will find emotional engagement in future care episodes difficult. Coping with the emotions of families during critical periods is likely to become more challenging. The long-term result can be sickness, low morale, decreased productivity, poor time-keeping, impaired decision making, increased conflicts, increased accidents and patient dissatisfaction, which means a rise in complaints. Reducing stress levels to the extent that the restorative supervision has will mean Health Visitors and their organisations are less likely to see these negative patterns.

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DEVELOPING AN HEALTH VISITOR ANTENATAL WORKSHOP FOR PARENTS

During a team Away Day for one of the 0-19 teams, staff expressed their disappointment and frustration about not meeting the antenatal element of the Universal Healthy Child Programme (HCP). Vulnerable families identified by the Maternity services were the only families who were known to the 0-19 Team. The team were unaware of other pregnant women in their locality. There was limited contact and information sharing with Midwifery Units, a lost opportunity for the team to support and provide health promotion in readiness for parenting and to join midwives and other agencies for holistic care.

The option of group sessions for parents was discussed to overcome the barriers for a cohort of 50 women per month. It was considered impractical to conduct individual assessment but health promotion information delivered in a parent-led way would help to provide what was currently missing. The benefits for making this contact would include:

- An opportunity for enhanced relationships between parents and 0-19 team.
- The provision of improved and timely information.
- Greater support of mothers by the 0-19 team in the early postnatal period.
- Increased parent confidence.

The project approach allowed other partners to be involved, particularly Children's Centre staff and our

breastfeeding buddies. Sharing the delivery of the workshop helped with resources and widened the opportunity for parents to meet agencies involved in the postnatal period. A plan was devised by the team and led by the team leader for those living in a locality. Plans were drawn up to ensure all women in the area were invited, staff had a consistent message, the work was evaluated effectively and parents were able to be kept informed.

A small, skill mixed, sub group from the 0-19 team with an interest, got together with the Children's Centre staff and our breastfeeding buddies, who are new mothers from our locality, to design the style and content of the workshop which they had agreed to co-facilitate.

Information sharing was agreed with Midwives to provide the details of pregnant women from 24 weeks. From this the administrator generates a list of potential participants. Invitations are left for the midwives to deliver when they see every pregnant woman regardless of parity.

The team leader monitored progress at every monthly team meeting with partners. Once the workshop was running progress and later evaluation by parents was discussed and monitored at the locality cluster meetings incorporating the 0-19 team, children's centres and volunteers. To demonstrate success for parents, we adopted a method of evaluation which was short, sharp

and user focused. They gave us their views on:

- What was helpful?
- What was less helpful?
- What were they surprised to learn about?
- Was it worth their time?

The average attendance grew over time as local word spread. From making contact with 3% of the monthly caseload we are now reaching 20% who attend groups. The majority of comments are positive.

On reflection it became clear that many first time pregnant women did not expect Health visitors to be supporting their breastfeeding and were surprised to know that Children's Centre staff were skilled professionals.

More requests for support by parents have been made and the 0-19 team have reshaped early breastfeeding support.

Audit results have shown that parents' knowledge of how to reduce the risk of cot death was improved over 6 months. Families are more familiar with the 0-19 service.

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THE INTRODUCTION OF ANTENATAL CONTACTS USING AN EVIDENCE-BASED TOOL BY HEALTH VISITORS IN NOTTINGHAM CITY - AN INTERIM REPORT



Nottingham CityCare Partnership has developed the introduction of antenatal contacts. There were two key reasons for selecting this as a project:

- To build on the focus on early intervention which is already a key element of work in the city
- In response to staff requests.

It was decided to use an approved evidence based tool, promotional interviewing, to form the basis of the contact. The challenges that followed would be around managing operational issues such as communication links with midwifery colleagues. It was agreed that a pilot would be used to test out these challenges and ensure they were fully resolved before training the full workforce.

A task and delivery group was set up to scope out the pilot and is on going. 18 staff volunteered to take part in the pilot and have been asked to undertake 5 visits using the tool.

Introducing this antenatal contact by the health visiting service means that it can deliver one of the key commissioned elements of the Healthy Child Programme. Benefits felt by health visitors are a feeling of satisfaction at undertaking an important contact, leading to an improved feeling of morale.

A number of challenges were also faced during this pilot. One such challenge was regarding links to midwifery and accessing details of pregnant women in order to plan visits were encountered. This has been addressed in part but still needs some action.

Recommendations during training were given as to optimum time in pregnancy to undertake the visits. However staff found this did not always reflect the reality for the antenatal mother eg if she was still working. Further consideration on this aspect will be needed before roll out as part of the universal service offer.

This project has shown that it is possible to introduce a new activity to a workforce which is already undergoing significant change when it is something they believe in. Training to the full workforce will be completed with the support of the SHA.

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A key part of the new health visiting service offer relies on health visitors being able to utilise their expertise by supporting the community to develop and engage in health enhancing activities. Whilst the existing workforce has the potential to undertake this role, health visitors have been overwhelmed by current workloads, and few have been able to sustain the necessary skills or up to date knowledge. With this in mind in the East of England it was agreed to adopt an innovative approach to ensure this key aspect of the new health visitor offer was not lost.

All newly qualified health visitors in the region would undertake a Building Community Capacity project in their local areas as an integral part of their preceptorship period. This would support the development of the required skill set.

In order to ensure a systematic approach and equity of support for all newly qualified practitioners the following took place:

- Workplace Advisors were selected in each provider organisation to support the programme.
- 3 workshop sessions were delivered to the selected workplace advisors from across the region to upskill them in the Building Community Capacity approach and aid sharing of practice across the region.
- Workplace Advisors are from a range of backgrounds. One area has utilised the skills of community development workers to become the workplace advisors for the health visiting team which has supported further integrated working within a Local Authority setting.

- A further 3 sessions have taken place with in excess of 200 newly qualified health visitors and the Workplace Advisors together to enable early relationships to be formed and to be transparent about what the expectations are of the BCC projects
- Access to the BCC website has been encouraged for all staff to consolidate skills.

The benefits of this approach are wide ranging.

All newly qualified staff will have completed their preceptorship programme and a Building Community Capacity project in their first year of qualification thereby reinforcing the stepped approach to development and creating a supportive environment for learning. Potentially this could also support workforce retention rates in the region.

Sharing of information and skills across communities of practice cannot be underestimated and therefore each individual, organisation and wider partners have benefitted from a joined up approach.

Health visitors have been enthused at being able to do something that in their eyes had been stopped, and to be able to revisit their public health role with the freedom to engage with the community which supports the principles of health visiting.

Families will be encouraged to develop their own skills and resilience which will help them to increase their life skills and also the outcomes for their children. The community have the best ideas about what works for them and this bottom up approach is the key to any sustainable development.

Inevitably a number of challenges have been addressed in developing this approach to Building Community Capacity. These include the capacity of existing staff to support the newly qualified health visitors in addition to large numbers of students.

Another key challenge has been getting staff to think small when planning projects and to ensure they are based on community identified need that also links into strategic health objectives.

Looking ahead further training will be delivered in 2013 for additional Workplace Advisors and the next cohort of newly qualified health visitors. A regional event is planned in summer 2013 to 'showcase' the current projects as part of the communities of practice work.

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Children and families are at the centre of both the health visiting service and general practice.

General Practitioners perception of a communication breakdown became a cause of concern following the health visiting move to geographical working 4 years ago. Health visiting teams were aware of the concerns and worked towards providing solutions to the perceived difficulties. NHS.net secure email was introduced.

A pilot project was undertaken in Derbyshire in 2011. Challenges faced included information governance and

additional IT training required by both GP's and health visitors. An agreed written process was put in place for managing the secure email address. An audit of the pilot has identified safeguarding concerns as the most common concerns from GP's.

Since the pilot began all health visiting teams in Derbyshire now have a generic email account which all team members can access. GP's have reported improved satisfaction regarding communication with the health visiting teams. Health visiting teams are more accessible and this has led to quicker response times.

The increased accessibility has led to more work in the universal plus part of the core programme.

Benefits to the pilot project have been that GP's feel more confident with the health visiting team. The health visiting team are more responsive to families, and families who are new to the area are contacted quickly

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IMPLEMENTING PARTNERSHIP PLUS IN ESSEX

The expectation in "A Call to Action" is that health visitors will work differently.

The revised health visiting offer clearly defines four levels of delivery. Community, Universal, Universal Plus and Partnership Plus. This final level provides intensive support to families with complex and challenging needs. The Family Nurse Partnership provides this type of support to a differentiated population of young first time mothers. However as was recognised in the now infamous case of 'Baby P' it is not just first time mothers who need this level of support.

There is extensive literature which shows the positive outcomes of delivering sustained home visiting to vulnerable families. Essex is currently implementing a model developed in Sydney Australia (initially with aboriginal families); known as Maternal Early Childhood Sustained Home Visiting (MECSH).

- MECSH is underpinned by the Family Partnership Model (Davis, H & Day, C. 2009), all health visitors in Essex have had an introductory training day which will be followed by 5 further days training in family partnership, Helping Families and Ante and Post Natal Motivational Interviewing. They all have access to the Programme Manual, E learning package and the 'Learning to Communicate' tool. It is planned that MECSH training will become embedded in the SCPHN training at the partner HEI.

- Families and partner agencies including Public Health Consultants have been engaged in the development of the model.
- 78 clinical champions have been identified to drive MECSH forward across the five organisations, they will be trained as clinical supervisors to ensure sustainability post 2015.

There are a number of benefits in the MECSH approach.

Families who are identified as potentially benefitting from sustained home visiting will be identified in the ante-natal period. They will be encouraged to develop their own skills and resilience which will support them with increasing their life skills and also the outcomes for their children. Parents' aspirations for their children will be raised and through sustained home visiting parents will be helped to 'parent effectively' in spite of the circumstances they find themselves in.

The Healthy Child Programme will be delivered to all MECSH parents, as every month one of the home visits will focus on developmental review of the child and anticipatory guidance based on the child's age and development.

Health Visitors have been enthused as MECSH builds on the principles of health visiting. It is also able to measure outcomes of the health visiting offer.

Some health visitors have struggled with the concept of working

intensively with some families and also delivering the other levels of the offer. Previous practice meant that health visitors would undertake around twenty visits to complex families, which tended to be reactive and in response to crisis. MECSH enables these families to be identified early and a structured programme of intervention to be implemented instead which, in addition to working in partnership with others frees capacity. MECSH will also work effectively alongside FNP.

There was concern that data collection for MECSH would be excessive and significant time would be spent collecting data to feed different needs. The establishment of a data group consisting of clinicians and data experts will support the development of a system for streamlining data collection. The initial outcomes data will be available by September 2013. MECSH provides a means to impact on public health outcomes in a structured sustainable way. The model provides a population wide basis for intervention and by 2015, 7640 families will have benefitted from a programme of a minimum of 20 sustained home visits in the first two years of the child's life.

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Within the health visiting service in Nottinghamshire we have developed a health needs assessment tool to complete in partnership with a family to determine the level of need.

The delivery of the Healthy Child Programme requires the Health Visitors having a good knowledge of the local area, its communities and the individual needs of children and families. Promotion of health and well being of children is key as is the need to offer services that fit need. This is dependent on having highly skilled, professional and dedicated staff to carry out assessments of families. To aid this we have developed a health needs assessment which is used at ante natal contact/primary birth visits/ transfer in contact or any other time in a child's life as required.

This tool has been used across the organisation since 2000. It has developed over time and ensures that all aspects of a child and their families life are addressed.

Assessments are carried out in partnership with families and are revisited as required. It allows

discussion around pregnancy and parenting, the family, emotional health and well being, healthy lifestyles, environmental and economic factors and family health history. Topics such as breastfeeding, shaken baby syndrome and immunisations along with others are also discussed.

After completion the health professional makes an analysis and in partnership with the family and agree the level of need at that time. A task and finish group has been established county wide and their remit is to ensure assessments are reviewed and updated. Any new techniques such as motivational interviewing will be included once they are introduced locally.

The Health Needs Assessment tool is now an integral part of service delivery within our area. It is recorded within Systmone and has raised client awareness of the services health visitors offer.

Use of the Health Needs Assessment tool has standardised practice and it provides evidence that the health visiting team are raising awareness

about the service and working in partnership with clients and fits with the ethos of the Health Child Programme.

The main challenges faced with the introduction of the tool were around change management, training and recording and reporting procedures.

Engagement with health visiting teams from the outset was important to promote a feeling of ownership. All members of the team were offered a chance to be involved or make comments. There were large numbers of staff to be trained in the use of the tool. This was staggered to allow training to be coordinated.

Since the introduction of the tool in 2000 there have been many different versions. It is a constantly evolving document.

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Health visiting teams across the East Midlands have introduced skill mix to increase the effectiveness of the service. They have included Specialist Community Public Health nurses (SCPHN), Registered nurses and Nursery nurses. Registered nurses and Nursery nurses do not have a competency framework to work to. Some have been developed locally, but in an effort to stop a variation in practice NHS East Midlands have developed a framework for Band 5 staff to consolidate practice across the region. Health Visitor Clinical Associates produced a tool that supports a more consistent approach to service improvement across the region.

Specific achievements of the framework include:

- Ability to quickly assess learning needs and development

- Framework works well alongside induction, particularly for staff who may not have previous experience in health visiting or working with children
- Supports the development of a sustainable workforce with common transferrable skills which may eventually contribute to skill mix across the region.

The framework has been very well received by Band 5 staff and mentors.

Benefits have included:

- Improved confidence
- Provides planned and structured approach to development
- Consistent approach for assessing competencies
- Supports registered staff who want to work towards becoming a Health Visitor

Challenges encountered whilst developing and rolling out the framework included:

- Rolling out across the whole region was difficult
- Mentorship and supervision
- Clear guidance on maximum and minimum timescales for the completion of the framework.

Learning from the project has included:

- Ensuring organisation champions were in place to support the implementation.

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DEVELOPING AND DELIVERING POLISH CLINICS IN NORTH FENLAND

North Fenland, particularly Wisbech area has historically experienced extreme challenges in relation to attracting and retaining Health Visitors and therefore it has been consistently difficult to deliver the Health Visiting offer as described within the Healthy Child Programme.

Existing staff have rarely had the opportunity to be creative and respond to any identified need differently than what is described within the care pathways. As a result staff morale has consistently been low and service user engagement levels have not improved over the last 5 years.

Local data provided evidence that a large percentage of Polish families residing in North Fenland were not engaging with the service, particularly for the 2.5 year development assessment.

Service user feedback suggested that effective translation support was a real barrier to engagement and the existing model for delivering this intervention was not flexible in terms of meeting the needs of this specific population. Therefore, not recognising or supporting some of the cultural differences within the community. The Health Visiting resource growth

has enabled the North Fenland team to make time to scope, develop and implement a joint project delivered in conjunction with Children's Centres. The project aims were to provide specific Polish Clinics that would encourage peer support and build resilience within the community as well as assisting the service in obtaining a greater understanding of the population needs to assist with further service improvements.

The change was scoped, developed and implemented in partnership with the local Children's Centre using a joint steering group with decision making authority. The work was led by a team manager who had only been in post for six weeks who was able to engage with local GP's throughout the project.

Funding for translation devices were obtained via a 'Dragon's Lair' presentation at a NHS Cluster conference in November 2012. These devices will be used to help staff to provide an instant translation service to the Polish community, reducing the reliance on and the cost of local translation services.

Additional funding was provided by the Children's Centre for a joint link worker to enhance the offer.

As a result of this project, the service has benefitted in the following areas:

- Improved morale and motivation within the North Fenland Team.
- All staff are actively involved with sharing the learning from the pilot.
- Effective partnership working has been established throughout the development and implementation of this project.
- A greater understanding of the specific population needs have been obtained through improved assessment and more effective preventative work.
- Greater peer support within the community.
- A sharing of information and skills across organisations has greatly benefitted both practitioners and families.
- The Polish community are actively engaged with the services available

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NEW INTEGRATED SERVICES MODEL IN SUFFOLK

The development of a new integrated service model was achieved over two phases. Phase one commenced in May 2011 when NHS Suffolk and Suffolk County Council agreed to deliver Universal Children's Health services through a Section 75 agreement.

These services include Health Visiting, School Nursing including Specialist School Nurses, Safeguarding, Looked After Children and Learning Disability Nursing teams. Alongside this agreement and as part of phase two, the Council also reviewed and remodelled their existing service provision for Children and Young People which resulted in the development of a new operating model that supports integrated working.

This operating model supports the integrated teams to share care pathways and outcome measures. Close working with specialist services (e.g. social care) is also integrated into this process.

There are 3 local authorities in the country who have a section 75 agreement so the working model and lines of management for health visitors is innovative. It affects the whole health visiting service and new model of working.

The change was led by senior managers and commissioners and included service provision by the local authority and formation of the integrated services including the following:

- Children's Centre teams.
- HV & SN teams.
- Youth Support Workers.
- Parenting Support Advisors.
- Education Welfare Officers.
- Family Support Practitioners.
- Social Workers.
- Locality Community Development Officer.
- CAF / TAC Coordinator.
- Intensive Support Workers.
- Integrated Team Managers 0-11 and 12+

The approach has promoted partnership working. The teams are still developing across Suffolk with regular reviewing of progress, sharing good practice, undertaking reviews and preparing for CQC inspections.

The success of the model can be demonstrated by reviewing the experience of one family. By 8 weeks concerns had been raised by the health visitor and Children's Centre. The mother had low mood and poor understanding of child development with unrealistic expectations of baby. There were concerns regarding inappropriate handling and housing conditions. The mother's partner was not motivated to support her and did not engage with the health visitor.

Although some of the issues were present at the new birth visit some were not apparent. The challenge was to maintain contact with family and to re-assess their needs continuously, and re-define the desired outcomes.

As a family in the universal pathway there would normally have been routine contacts at the new birth visits and 6 - 8 weeks. However, this family became progressive as more issues were identified and the case was allocated as a progressive case, with more intense visiting.

There was excellent communication from the family support worker at the children centre, who shared her concerns. A CAF was raised by the HV and an action plan agreed. Links were made with the GP and housing issues were addressed. Mother attended baby massage, first time parents baby course and received support from the financial inclusion officer at the children's centre. The father also began to engage with professionals and agreed to do some voluntary work and undertook a Back to Work programme. Positive outcomes included:

- The family moved from feeling criticised to feeling supported.
- The mother's mood lifted, enabling positive engagement.
- The father responded very well and made significant life changes.

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CATEGORIES ON SYSTMONE



In Nottinghamshire we have worked in collaboration with agencies guided by a document called 'Pathway Provision'. This is a multi agency way of working and clearly identifies thresholds for levels of care.

Level 1 - Universal
Level 2 - Early Intervention
Level 3 - Targeted
Level 4 - Child in Need/Child Protection Plan/Child Looked After.

Categories within Systmone have been developed to reflect these areas. After the publication of the Call to Action these categories were reviewed to align with national levels.

Community
Level 1 - Universal
Level 2 - Universal Plus
Level 3 - Universal Partnership Plus
Level 4 - Child in Need/Child Protection Plan/Child Looked After

It was important to ensure practice development in line with these

changes to ensure that health visiting teams adopted the new service offer terminology and that there was full understanding of the levels of care required. This was done via staff briefings and happened in line with the 'Health Visitor Implementation Plan' launch events that happened across the region. Staff engagement and ensuring they were prepared and had full understanding for the reason for change was key. Aligning the levels to the Nottinghamshire Pathway to provision meant that staff very recognised the criteria and identified with them easily.

This piece of work was led by the Health Visitor Implementation Plan Lead, Heads of Service and Health Visitors, along with support from administration staff. It has encouraged and supported multi agency working such as health visiting teams, families, GP's and Children's Centre's.

There have been many benefits from this piece of work such as supporting

the new levels in the service offer, promoting the use of the new terminology with staff and families, reporting to commissioners and helping prioritise caseloads during times of absence.

Challenges have been around understanding of terminology with families, ensuring health visiting teams are moving a child's records to relevant folders, remembering that folders are only seen by health visiting team and school nursing team and not GP's or other professionals.

There are no concerns regarding learning, sharing and sustainability of this piece of work.

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'Tot Talk' commenced in February 2012 following a service user involvement questionnaire, this was given to all parents attending clinics at both Wye Valley Children's Centre's and GP surgeries. Previously the Health Visiting service had provided clinics in both areas with a mixture of booked appointments and drop-in clinics. The service was traditionally provided by both Health Visitors and Community Nursery Nurses.

Across Hereford City, there were approximately 18 clinics running throughout the week, but these were not necessarily spread evenly across the week and as some were run in GP surgeries there were reluctance by both the surgeries, and parents, for attendance if not registered with that practice.

Service user involvement was done through a questionnaire designed to look at what type of clinic the parents wanted, how it was set up and whether or not it should be stand alone or ran alongside a group, taking into consideration the reasons that parents were attending the clinic (for advice, reassurance regarding weight and developmental concerns for example). 125 parents participated in the questionnaire, and of those who responded, 56% wanted a drop-in clinic, and 40% wanted appointment times. 72% of respondents wanted the assurance that it was a health visitor running the clinic and 19% were happy to be seeing a Community Nursery Nurse. 9% did not mind who they saw.

Participants also wanted a group to be running alongside the clinic (87%) during which they requested a health promotion type topic to be discussed such as weaning and sleep problems. 10% of participants requested that clinics be run in the evening or at the weekend.

In order to provide a clinic to parents at the time and in the manner that they wanted, it was decided that a clinic would be provided across the city every day of the week and would be where possible joined to an existing group, or a group set up at the same time.

The branding of the clinic was decided by asking health visitors for suggestions and the 'Tot Talk' name was decided upon, with this then being sat above the West Midlands Health Visiting logo. This is now used across the county to identify a Health Visitor led clinic, alongside 'Early Days' support groups have been set up providing a rolling programme of health promotion such as weaning, sleep, and behaviour, as well as a stay and play, which are led by Community Nursery Nurses from the Health Visiting service and Family Support Workers from Children's Centres.

Both of these services are helping Wye Valley to deliver against the Health Visitor Implementation Plan 2011-2015 by providing fast access to Health Visitors, (GPs are informed of when and where the clinics are held and that they are available every weekday of the week).

Services are held within the local community where the main volume of those attending also reside in the area, which supports building local community capacity by better linking organisations and agencies. Whilst this is a Universal Service offer, it also allows identification of clients who may need more support and benefit from local Universal Plus offerings such as guidance with sleep issues and potentially gives other Services a point to direct clients as a preliminary place of attendance for. For Universal Partnership Plus offers; such as families who may be having issues with certain behaviours, can join in the groups and have immediate involvement, with support from both the Health Visiting service as well as children's centre staff.

Due to the fact that staff are working together and have different skills, abilities and experience they are learning from one another whilst delivering the service. They are also more appreciative of each others roles. For those with less experience, they also have the assurance that they have a more experienced colleague and a qualified health visitor on hand to assist them if they need it.

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The Department of Health recommend that the best age to introduce solids to your baby is 6 months. However many mothers are unsure exactly what foods they can introduce at this age. At routine universal contacts many families request information about what foods they can give their babies. Some mothers also approached the health visiting service to request support as they find introducing solids very stressful. As a response to this Lincolnshire have produced a book of family recipes which was designed to give families ideas of meals which can be eaten by a family and also introduced to babies over six months.

Families and carers were encouraged to share recipes that their baby enjoyed. These recipes were collated by health visiting teams and Children's Centres. The community dietician then checked them to ensure that they were healthy and nutritious.

The recipes were then put into a book and families were very much involved in the process, from asking their views and being involved in the design. A high profile launch followed with the help of a local celebrity chef and the book was very well received.

The book was initially piloted in one area in Lincolnshire but there is now a great deal of interest in it across Lincolnshire and nationally. It has become a business opportunity for Lincolnshire Community Health Services NHS Trust. It has also been supported by Public Health and links into its ambitions to prevent childhood obesity.

One of the challenges faced when working on the book were around promoting it so that it continues to be a success. Posters have been placed in clinics and a further mini launch was held at a different Children's Centre to raise its profile among families in different areas.

Further promotion opportunities are also being sought in the county.

Lessons learnt from this project include stating how many people a recipe feeds, and what a portion size for a baby is. Including more pictures in the book to enhance the design and appeal of the book and securing copyright early on in the project would have been useful, although this is now in place. The idea of featuring some of the recipes on a mobile phone app is also a possibility.

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MATERNAL MENTAL HEALTH - IMPROVING THE QUALITY OF SERVICE FOR MOTHERS, CHILDREN AND FAMILIES - TRAINING HEALTH VISITORS TO DETECT THE LIKELIHOOD OF POSSIBLE PERINATAL ILLNESS

Postnatal depression is a common mental health problem affecting 10/15% of women. The health visitor implementation plan 2011-2015: "A Call to Action" highlighted the value of targeting and supporting families with a range of interventions.

In Lincolnshire the health visiting workforce highlighted their concern at early engagement events about their lack of knowledge and skills in detection of perinatal illness.

The publication of the DH Maternal Mental Health pathway in August 2012 confirmed that a local pathway needed to be developed. It was also acknowledged that training was required to enable the workforce to improve, update their knowledge and management of perinatal illness.

The pathway ensures that Maternal Mental Health is delivered at a Universal level, Universal Plus and Universal Partnership Plus.

Maternal Mental Health training was delivered using the 'Train the Trainer' approach. This method would ensure that the skills of the workforce were sustained. Twelve health visitors were identified as trainers and they made a commitment to train the health visiting workforce.

Evaluations following the training demonstrated an increase in confidence and knowledge of both perinatal illness and the evidence based tools.

The benefits of this training are that the health visiting workforce in

Lincolnshire have a local pathway in place which ensures consistent and seamless support and care for mothers and families. Health Visitors are more confident in their clinical practice and in the detection and management of perinatal illness.

Challenges faced were in giving the workforce access to the 'Train the Trainers' training due to capacity and then subsequently rolling out the training.

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DEVELOPING AND DELIVERING A HEALTH VISITING/CHILDREN'S CENTRE PARTNERSHIP AGREEMENT

The purpose of the partnership agreement is twofold. It outlines the vision and strategic agreement for delivery of an integrated Healthy Child Programme between Health Visiting and Children's Centres in Cambridgeshire. The national context as set out below, describes the drivers for change as well as providing guidelines for service delivery.

Secondly, the agreement describes the operational agreements that have been developed to support frontline practitioners to embed this service change into operational practice.

The Childcare Act 2006 placed a duty on Local Authorities, Jobcentre Plus and NHS service providers to work together to improve the well-being of all children up to the age of five and to provide integrated early childhood services.

The Apprenticeship, Skills, Children and Learning Act 2009 went further and requires these relevant partners to consider providing their services through Children's Centres; guidance stresses that "strong reasons" are needed for a decision not to provide services in this way.

The Government's Child Health strategy also emphasised that health visitors will need to work across GP practices and children's centres when delivering the Healthy Child Programme, a clinical and public health programme

comprising screening, immunisation, developmental reviews, information and guidance to support parenting. Each children's centre will, the strategy promises, have access to a named health visitor to oversee its health programme.

Within Cambridgeshire there are 40 Children's centres covering approximately a 35 mile radius.

This work succeeded in:

- Establishing a steering group which enabled appropriate decision making to take place.
- Engaging all 40 Children's Centre Managers and 7 Health Visiting Managers throughout the development and implementation of the partnership agreement.
- Achieving commitment from Health Visiting and Children's Centres to the fundamentals of the Antenatal Care Pathway and the wider CAF processes.
- Establishing integrated training programmes, delivered in Children's Centres.
- Ensuring all first time parents identified as needing additional post natal support are invited to a series of 6 Post Natal Advice sessions.
- Ensuring all 1yr and 2.5yr development checks, where possible, are delivered in the Children's centres and delivered jointly, where appropriate.
- Publishing the new offer with a timeframe aligned to service growth.

The benefits of this work include:

- A greater understanding of specific population needs.
- Greater peer support across services and communities.
- Greater community resilience.
- Sharing of information and skills to the benefit of families and practitioners.
- Reduced duplication, increase efficiency and provided clarity for families.
- Increased staff morale, motivation and active involvement of staff.
- Improved understanding of roles and responsibilities in organisations and more effective service integration across partnerships improving outcomes for families.

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In Nottinghamshire Health Visitors are working in partnership to identify and refer children aged 2 years and under who are in need of support with speech, language and communication.

Research shows that up to 10% of children have a long-term, persistent communication disability and approximately 50% in socially disadvantaged areas have a significant language delay on entry to school.

Some areas within Nottinghamshire County have higher levels of deprivation than the national average. From working with the Speech & Language Therapy and Education settings it was apparent that some children in Nottinghamshire were presenting with language and communication delay.

Children are identified for referral to the Home Talk service by local health visiting teams. The health visiting

service then completes this check between 2-2½ years. The Home Talk service consists of six home visits. The aims of the service are to improve language skills and to provide early identification of children with complex speech, language and communication skills.

This piece of work was led by team managers in both speech and language therapy and health visiting services. It was piloted in Mansfield & Ashfield locality prior to the roll out across the county. It is now a commissioned part of the health visiting service.

Benefits include supporting school readiness at age 5 years, increasing educational attainment, therefore reducing the health inequalities gap.

An increase in referrals to the home talk service has reduced the referrals to speech and language therapists at a later stage, resulting in a cost saving to the organisation. Health visiting teams have also benefitted

by developing their own knowledge and skills.

Health Visitors were involved from the outset of this piece of work to ensure a feeling of ownership. Communication was key and it was publicised widely across the organisation, including Children's Centres and GP's. Large numbers of staff needed to be trained, this was carefully coordinated. Recording and reporting was important and templates within Systmone were changed to allow recording.

The 2 year speech and language check is now embedded within normal practice.

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UP-SKILLING THE ENTIRE HEALTH VISITING WORKFORCE IN ESSEX

The Government made a commitment to increase the number of Health Visitors by 4,200, by March 2015. Their vision is that HVs will support the development of strong and stable families as 'the bedrock of a strong and stable society'.

In Essex there are five Provider organisations and four providers, three Local authorities and two mental health partnership Trusts. When the HV 'Call to Action' was first published, the Providers across Essex all delivered a different health visiting service. It was therefore agreed that across Essex we would look to deliver a single model of Health Visiting Practice. A Health Visitor Implementation Board was established with representatives from commissioning, providers, education, local authorities, public health, county workforce and FNP. MESCH was agreed as the model we would implement, however what was clear was the investment in up-skilling the existing workforce had varied across the County.

The County Workforce Group in response to this agreed to fund a package of five days training for every health visitor in Essex to ensure that all health visitors started from the same baseline and would be competent to deliver the New Offer.

Two Independent Public Health Nursing consultants were appointed to deliver a package of training for every health visitor. Expertise was also brought in from the Brazelton centre and the Local Authority Integrated Training Team.

Sessions were delivered in small groups of 20, to over 300 health visitors ensuring they have all received a core knowledge base related to the HV Offer.

- Every health visitor has received five days of additional training including an introduction to Family Partnership Model, Brazelton Neo-natal Behavioural Assessment, Perinatal mental health, Neuro-science and epigenetics, Leadership and Building Community Capacity, Integrated Working and MESCH.
- Day 5 was an integrated day with invited partner organisations, giving the opportunity to share information on the HV Implementation Plan and the delivery model in Essex.
- All training has been in the workplace, which has ensured staff can attend, and reduced travelling costs.
- Regular contact with the workforce has provided a medium for disseminating information to all staff on developments nationally, regionally and locally for the implementation of the HV Offer.
- Academic staff from ARU attended at least one of each session.

A number of challenges had to be addressed. These included a wide variation in knowledge base, with some protectionism around specialist knowledge.

Delivering training to a workforce made up of significant numbers

of part time workers and across a large geographical area also caused difficulties establishing suitable venues and timetabling, which meant that the timetable was delayed.

Additionally the pace of change and expectations from staff were seen as challenging, staff found it hard to believe that 'investment was happening'. However with the recruitment of new health visitors in September 2012, there was a notable shift in enthusiasm and commitment.

Through the sharing of information and skills across the county each individual, organisation and wider partners have benefitted from a joined up approach to education and training which has provided them with the opportunity to have ownership of developments and an opportunity to showcase examples of the excellent work taking place.

The confidence and knowledge base of the health visitors has increased and feedback has been positive. The days have also improved relationships and communication with the local HEI and shared learning with partner agencies provides a basis for on-going shared learning as MESCH training will be available to key partners.

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IMPLEMENTATION OF SATURDAY WORKING IN HEALTH VISITING

In 2009/2010 Health visitor staffing levels in Luton were extremely low and the service was unable to meet key performance indicators and best practice targets such as completion of development checks and new birth visits.

It was suggested by the team that introducing Saturday working may help cope with demand and was agreed by the health visiting team on a voluntary basis. The project was led by one of the Community Practice Teachers. Key elements of the initial project were to complete new birth visits, followed by development checks. The clinic is located in central Luton very close to the main shopping centre.

Results were extremely positive with backlogs of work being completed, high attendance at clinic and positive feedback from clients and staff. Saturday working then became part of the mainstream health visiting offer with a core group of staff working a Saturday rota, taking time off in lieu.

In the first instance it was only health visitors who worked on the Saturday with a dedicated administrator to book their work. Nursery nurses then joined the project and led development check sessions on the Saturdays aligning with the mainstream health visiting offer.

Developmental checks operate on a 'choose and book' basis during Saturdays and are always fully

booked. Client feedback, data, and a clinic audit by Dr. Foster demonstrated a positive impact and uptake from families. There is notable participation and access from fathers and working families, with school-aged children also attending. The location of the clinic is an essential part of the success as it enables clients to 'pop in' before/during/after Saturday shopping at the main shopping centre in Luton.

The change in offer and working pattern has been achieved without any requirement to increase staffing levels and also at a low cost, overtime is not paid as time is taken off in lieu but there is some increased cost for enhanced hours payment.

The following benefits have been realised as a result of implementation of Saturday working:

- The service is able to be more responsive to need and offers more choice to clients. The 'Did Not Attend' rate for Saturday development checks is much lower than those held on Mondays to Fridays.
- The audiology service now offer a Saturday service from the same building as safety concerns have now been resolved.
- Improvements in some partnership working have been found as pressure on staff on a Saturday is lower. This includes the midwifery service, social care (out of hours), Paediatric Assessment Unit, and Walk in

Centre. Professional relationships have developed as a result.

- From the learning, the Children's Centres have developed fathers' groups.
- Staff have benefitted from greater flexibility in their working hours, particularly for those with caring responsibilities.
- Benefits have been seen with recruitment and retention.
- The benefits will be rolled out to Children's Centres to explore the role of Saturday clinics in other settings.

Home visits on a Saturday offer increased opportunity for contact with the whole family including partners and school aged children.

Social care core working hours are Monday to Friday; a health visitor contact on a Saturday as part of a child in need/safeguarding plan can be extremely beneficial. The clinic is often attended by families from outside Luton.

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GROWING A SUSTAINABLE WORKFORCE: THE HEALTH VISITOR IMPLEMENTATION PLAN:

A CALL TO ACTION - IN ACTION



Nottingham City are looking to recruit approximately 100 new health visitors over the next 3 years. This brings challenges in recruitment, training, support and retention. As an organisation we decided to work closely with colleagues across the region to produce a series of supportive documents. These would be aimed at both informing long arm mentorship and mentoring practices and standardizing a series of band 5 competencies, so that we could facilitate the development of registered nurses and providing an insight into the role of a Specialist Community Public Health Nurse. We worked with the Department of Health looking at preceptorship and the first two years of a health visiting career.

A robust plan was developed for training and retaining students. Suitably qualified staff were asked to mentor students under the 'long arm' supervision of the band 7

practice teacher. A series of in house training sessions were developed and delivered on a rolling programme.

It is hoped that 154 wte will be in practice by 2015. The benefits of this will be that it will lead to service transformation through the delivery of the Healthy Child Programme. Job satisfaction will be enhanced and there will be better outcomes for children and young people aged 0-19 in Nottingham City. A model of practice will be embedded that provides quality training which is developed by practice teachers and utilises the skills and expertise of the current workforce.

Challenges faced have included conflicting role demands and staff shortages which limit the opportunities for teacher and practitioner interaction. Practice teacher numbers are in decline and caseload numbers remain high.

There has been a change in the way that practice teachers supervise students to ensure parity across the organisation. Going forward from January 2013 it is hoped that practice teachers can either significantly reduce or have no attached caseload.

Nottingham City recognise that the increase in health visiting numbers means that long term a change is required in the way we educate and support SCPHN students.

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