NHS Rotherham’s Plan for investing in a further 24 Health Visitors by 2015

Introduction

In line with the government’s commitment to strengthen the health visiting workforce by 4,200 in 2015, NHS Rotherham have developed an implementation plan to deliver the 24 FTE required for Rotherham (based on the 35.66 FTE May 2010). This figure is determined by GMS weighted population.

Needs assessment

The health visiting service currently has a skill mix comprised of 36.00 FTE Health Visitors, 11.00 FTE Staff Nurses, 14.00 FTE Nursery nurses and 1.80 FTE Support Workers. Workforce planning is in place to ensure that we can anticipate movement in and out of the service for example student placements leading to qualification or retirements. The skill mix ensures delivery against the Healthy Child Programme and provision of targeted and responsive work by having the right person in the right place at the right time. The increase in health visiting staff will support continued outcomes.

Table 1 below demonstrates how Rotherham currently matches against ‘The Health Visitor implementation plan’

<table>
<thead>
<tr>
<th>Your community</th>
<th>has a range of services including some Sure Start services and the services families and communities provide for themselves. Health visitors work to develop these and make sure you know about them.</th>
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</thead>
<tbody>
<tr>
<td>● Rotherham Health Visitors (HVs) work in partnership with local Children’s Centres to provide comprehensive universal services to children and families e.g. ante natal fairs encourage engagement with both services pre birth and beyond</td>
<td><strong>Challenge</strong> - A lack of resource is affecting the ability to make a significant shift from targeted and responsive work to prevention and early intervention. Additional Health Visitors will enable Rotherham to ‘turn the curve’</td>
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<td>● Each Children’s Centre has a named HV who co-ordinates a joint approach to the delivery of the Healthy Child Programme (HCP) e.g. Children’s Centres promote immunisation uptake; identify children displaying developmental delay</td>
<td><strong>Challenge</strong> - Provision in Children’s Centres is limited and not all Children’s Centres have facilities for service delivery. Further work could be developed and the use of some alternative facilities explored. Increasing the work in Children’s Centres has unfortunately been at the expense of pulling resource away from GP Practices which has affected the Health Visitor/GP interface/communication. Ideally we would like to offer a range of services in a range of settings and be visible again to GPs</td>
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<td>● Pathways exist between Midwifery Services and Children Centres. Midwives deliver ante-natal care in the Centres and work jointly on initiatives such as cessation of smoking in pregnancy and following birth; preparation for parenthood; breastfeeding workshops</td>
<td><strong>Challenge</strong> - Local Midwives are GP attached and Health Visitors work geographically which affects the Midwife/Health Visitor interface/communications e.g. limited capacity of Midwives affects their ability to notify pregnancies to the Health Visitor. Increased Health Visitor capacity would enable more proactive work and better information flows with Midwives and allow them to be more visible in the ante-natal period.</td>
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<td>● HVs support Children Centre registration of new families and have incorporated the registration form into the ‘Red Book’</td>
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<td>● HVs are arranged in communities; they work geographically and are co-located with partners. Information sharing with partners has enhanced joint working and reduced the risk of children and families ‘slipping through the net’</td>
<td><strong>Challenge</strong> - A focus on building partnerships and joint working with ‘non health’ providers has been at the expense of sustaining pre-existing arrangements with GPs, Midwives and other community health workers.</td>
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<td>● Staff are invited to and receive information from Area Assembly Meetings which enhances their local knowledge</td>
<td><strong>Challenge</strong> - Whilst staff receive information from Area Assemblies, they do not have the capacity to attend meetings and to be more proactive in the community</td>
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<td>● A joint Prevention and Early Intervention Strategy has been produced with input from front line services; there is a ‘Team Around the Child’ model of working and families are invited and engage in meetings</td>
<td><strong>Challenge</strong> - Whilst staff are engaged in a ‘Team Around the Child’ model of working, they have difficulty delivering comprehensive interventions that would prevent escalation</td>
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**Universal services** from your health visitor and team provide the Healthy Child Programme to ensure a healthy start for your children and family (for example immunisations, health and development checks), support for parents and access to a range of community services/resources.

- HV work within the framework of a skilled mixed team which ensures flexibility in the delivery of the HCP  
  **Challenge** - Rotherham needs to maintain a good level of skill mix and not convert all its resource to Health Visitors; this would be an inefficient use of resource  
- The HCP is delivered in partnership with Children’s Centres and therefore within ‘pram pushing’ distance  
  **Challenge** - Some Children’s Centres do not have the facilities to deliver services. Working in Children’s Centres has impacted on the interface with GPs  
- In response to an identified need by staff, an EU Migrant Team was established to ensure the HCP is appropriately extended to this transient population; any unmet needs are addressed. The team includes a Roma/Czech'/Slovakian speaking practitioner  
  **Challenge** - This team was established from mainstream Health Visiting resource (HVs counted in the numbers). Need to develop this service further in order to provide a full range of services to EU migrants, asylum seekers and refugees  
- A Primary Care Mental Health Practitioner is located within each multi-agency locality team to advise, train and support staff as well as deliver CAMHS closer to home  
  **Challenge** - Additional Health Visitor capacity would enable more CAMHS intervention work to be undertaken at Tier 1 by the Health Visiting Team and prevent referrals into CAMHS  
- 2 posts in universal services have been converted to work across the borough to deliver preventative parenting programmes e.g. general parenting skills; management of sleep, feeding and behaviour  
  **Challenge** - This service has been established from mainstream Health Visiting resource and is evaluating well. The team consists of only 0.64 WTE working term time only. There is scope to expand this service to provide equity of delivery across the borough 52 weeks per year  
- Nursery Nurses provide packages of support to parents e.g. breastfeeding and link families to Children’s Centres  
  **Challenge** - Nursery Nurses need to provide concentrated levels of support to families. Additional Health Visitors would enable more identification of problems, robust and detailed care planning and better evaluation  
- A corporate approach to managing caseloads has improved the quality of care, maximised the appropriate use of skill mix, has avoided gaps in service provision and created a more equitable distribution of resources  
  **Challenge** - A gap in corporate working is protected time for case discussions, feedback on progress against care plans and frequent review of care packages  
**Universal plus** gives you a rapid response from your HV team when you need specific expert help, for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting.

- There is a single point of contact in each locality to enable timely access HV Services  
- A ‘Duty HV’ is available on each day in each locality to respond to calls for advice or intervention  
  **Challenge** - Whilst having a ‘duty HV’ is good practice and beneficial for families requiring a timely response. This takes capacity away from daily activities  
- A weekly allocation meeting takes place in each locality to ensure case management issues are addressed and interventions monitored  
  **Challenge** - Allocation meetings can be time consuming which limits the capacity for detailed case management discussions, feedback on progress against care plans and review of care packages. This needs attention  
- HVs receive monthly casework supervision to ensure families of concern are discussed and action plans agreed  
  **Challenge** - Health Visitors are often overwhelmed by the number of actions and interventions required when managing large and complex caseloads. Additional capacity would reduce caseloads  
- A Primary Care Mental Health Practitioner is located within each multi-agency locality team and is responsive to families requiring a timely response. This team was established from mainstream Health Visiting resource (HVs counted in the numbers).  
  **Challenge** - Additional capacity would enable Health Visitors to be more responsive in dealing with maternal mental health issues and prevent an escalation of problems  
- A Post Natal Pathway will be launched following staff training  
- Nursery Nurses provide targeted packages of support, following a HV assessment, to avoid families going into ‘crisis’  
  **Challenge** - Nursery Nurses need time to provide concentrated levels of support to families. Additional Health Visitors would enable more robust and detailed care planning and better evaluation  
- HV Teams work with Children’s Centres to provide targeted support e.g. weaning parties, cook and eat sessions, parenting groups
Challenge - Capacity limits the amount of work that can be undertaken in Children’s Centres. Some Children’s Centres do not have the facilities to deliver services and working in Children’s Centres has impacted on the interface with GPs.

- Responsive parenting programmes are provided to families needing help e.g. sleep, feeding and behaviour management
- Multi agency ‘Family First’ meetings plan targeted support to those in need

Capacity limits the amount of work that can be undertaken with families

Universal partnership plus provides ongoing support from your HV team plus a range of local services working together and with you, to deal with more complex issues over a period of time. These include services from Sure Start Children’s Centres, other community services including charities and, where appropriate, the Family Nurse Partnership.

- HVs work with Barnados staff in Children’s Centres
- Need capacity to identify the full range of partners and explore more opportunities for joint working
- In the absence of an FNP Rotherham has put in place - a Teenage Pregnancy Midwife; Midwife to HV Pathway; Breast Feeding Support Workers; Smoking Cessation Midwives; Link HV and School Nurse for teenage pregnancy and sexual health
- Rotherham requires a dedicated FNP to provide intensive support and interventions and to release capacity in other services
- ‘Team Around the Child’ Meetings are scheduled following the completion of a CAF
- ‘Think Family’ meetings agree multi-agency packages of support for more complex issues
- There is integrated working with the Child Development Centre, CAMHS and LDD Services

Challenge - Capacity would allow this to be expanded

- Joint casework supervision ensures action plans for families of concern are monitored and if necessary amended to reflect the changing needs of families

Challenge - Due to the size of caseloads and number of families with complex needs, Health Visitors are often overwhelmed by the number of actions and interventions required. Additional capacity would reduce caseloads

Table 2, (appendix 1) demonstrates our current self assessment against delivery of the Healthy Child Programme and highlights the joined up approach to delivery across Rotherham between midwifery, health visiting and children centres.

‘Demonstrate a commitment to promote growth of the qualified health visiting workforce, to deliver the PCT economy target, on the basis of achieving 25% of it in each of the next four years.’

Rotherham Health Visitor (HV) establishment is to be increased by 24.00 FTE by 2015

Discussions have taken place between commissioners and providers to establish the most efficient and cost effective way of meeting this target this includes:

1. 4.00 FTE posts will be established from existing resources.
2. 20.00 FTE posts will require additional funding. Y&H have confirmed that funding for the increase in capacity is already in PCTs base budgets
3. Rotherham C&YPS currently have 4 qualified Community Practice Teachers (CPT) and 1 undertaking the course. It is a requirement that each HV student has 1:1 support from a CPT therefore CPTs cannot have more than one student

Of the current compliment of CPTs – 1 has applied for a Specialist Post in Sheffield and 2 are likely to retire in the next 3 years. It was proposed to send a further 2 qualified HVS on the CPT course in September 2011 (2 years Masters Degree Training, students are allocated in the 2nd year). This would enable more students to be trained in the short term and ensure that Rotherham would not be deprived of CPTs if some of the current staff left.

Unfortunately due to the withdrawal of funding from the University, no CPT Courses will be run in 2011
4. We will Promote Rotherham’s Health Visiting Services in nearby universities to encourage recruitment
‘Demonstrate a commitment to prevent further loss of qualified health visiting numbers from the May 2010 baseline’

1. Being mindful that HVs will continue to leave, active recruitment will continue alongside training students. The possibility of ‘Golden Hellos’ will be explored with the Human Resources Department.
2. Staff Nurses will continue to be recruited developed and enabled to access the HV Degree Course i.e. using a ‘grow your own’ method of converting Staff Nurse to Health Visitors. 3 students qualifying in September 2011 were previous Staff Nurses in the service.
3. Attracting qualified HVs back into service. We are in discussion with the University regarding ‘Return to Practice’ modules. 3 ex HVs (1.20 FTE) have already approached us to return to practice.
4. The School Nursing Service will be over established from April 2011 therefore expressions of interest will be sought from Specialist Practitioner School Nurses currently in post who would wish to undertake a 10 week HV Course to be dual qualified and work as a HV.

Below is a projection of the expected increase in the FTE HV workforce as reported to Y&H. This may vary as HVs become available which will require funds to be allocated flexibly. The plan is to achieve the increase of 24.00 FTEs in advance of 2015.

<table>
<thead>
<tr>
<th>Financial year</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
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<tbody>
<tr>
<td>Via CSP Training</td>
<td>3 (plus 3 FNP)</td>
<td>5 (minus 3 FNP)</td>
<td>6</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Currently 4 students who will qualify Sept 2011</td>
<td>Converting 1 x Staff nurse and 1 x Schl nurse</td>
<td>Converting 1 x Staff nurse and 1 x Schl nurse</td>
<td>Recruitment of a further 10 HV</td>
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<tr>
<td>Plus 3 FNP practitioners training from October 2011 to April 2012</td>
<td>Plus the FNP practitioners will be up and running.</td>
<td></td>
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‘Demonstrate how the health visiting service links effectively with key partners, especially children’s centres, primary care and midwives and how these services have been informed of your local development plans’

Children’s community health services have successfully been co-located with Local Authority Children’s teams for the past 2 years. We have a number of joint service centres. Children’s centres are key to our work around prevention and early intervention and Health visitors are/will be working very closely with them as demonstrated in the Self assessment against the 0-5 healthy child programme. The local strategic partnership has also agreed that ‘Giving children the best start in life’ will be one of their 3 main priorities.

‘Set out a commitment to sustain and grow existing FNP services and develop new ones in localities where they currently don’t exist, integrating these with the health visiting service’.

A family Nurse Partnership will be developed in Rotherham which should attract interest from HVs out of area. Discussions are currently on going between ourselves and Bassetlaw Provider services to look at a joint model of provision.

The prevention and early intervention strategy is looking at targeting 100 families
- 40 families who are at the extreme end of the spectrum who have multiple persistent problems and where historically positive change has not been achieved.
- 30 families who are likely to have difficulties and have reason for some concern.
- 30 families who might have difficulties in the future including single parents, teenage mums or have a history of involvement with social care.

We would see the two latter groups working closely with the Family Nurse Partnership.
<table>
<thead>
<tr>
<th>Universal</th>
<th>Delivery &amp; gaps in service</th>
<th>Targeted</th>
<th>Delivery &amp; Gaps in service</th>
<th>Progressive</th>
<th>Delivery &amp; gaps in service</th>
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</thead>
<tbody>
<tr>
<td>Health and development reviews</td>
<td>Achieving</td>
<td>Emotional &amp; psychological problems addressed</td>
<td>Delivered in line with the new pathway at Tier 1</td>
<td>High intensity based intervention</td>
<td>Lack of capacity to sustain consistent programmes of care</td>
</tr>
<tr>
<td>Screening and Examinations</td>
<td>Achieving</td>
<td>Promotion and extra support of breastfeeding</td>
<td>Stage 2 of UNICEF Baby Friendly status across Rotherham. Peer Support groups run in children centres, 24 hr breast feeding support number.</td>
<td>Intensive structured home visiting programmes by skilled practitioners</td>
<td>Being developed in partnership with the Local Authority i.e. Prevention and Early Intervention Teams. Could be improved with more health input</td>
</tr>
<tr>
<td>Immunisations</td>
<td>Achieving</td>
<td>Support behaviour change</td>
<td>Referral pathways in place to support behaviour change e.g. – smoking cessation, RIO service, etc.</td>
<td>Referral for specialist input</td>
<td>Referral pathways in place. CAFs utilised as appropriate.</td>
</tr>
<tr>
<td>Promotion of health and well being</td>
<td>Achieving through a mix of HV/MW and children centre delivery</td>
<td>Parenting support programmes including assessment and promotion of parent/baby interaction</td>
<td>Children centres delivering parenting programmes.</td>
<td>Action to safeguard the child</td>
<td>CQC compliant with safeguarding arrangements.</td>
</tr>
<tr>
<td>Promotion of sensitive parenting &amp; child development</td>
<td>Achieving through a partnership approach with Tier 2 CAMHS</td>
<td>Promoting child development, including language</td>
<td>Delivered by a combination of providers e.g. HVs, Children’s Centres, Speech and Language Therapists working in Children’s Centres. Book Start and the Imagination Library support language development and literacy</td>
<td>Contribution to care package led by specialist service</td>
<td>Where possible work in collaboration with specialist services. SystmOne enables information from all community health services involved with a child to be shared; Practitioners are able to view and contribute to care plans</td>
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<tr>
<td>Father engagement</td>
<td>Dads encouraged throughout pregnancy and early years. This is supported by dad sessions within children centres</td>
<td>Additional support and monitoring for infants with health or development problems</td>
<td>Recalls in place to monitor identified problems. Additional support to infants and families could be improved with additional capacity. Referral pathway in place for Community Clinics and Child Development Centre</td>
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<tr>
<td>Mental health needs assessed</td>
<td>New pathway developed and multi-professional training being undertaken in March 2011</td>
<td>CAFs completed</td>
<td>All health professionals have been fully trained in CAFs and utilise as appropriate</td>
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<tr>
<td>Transition to parenthood &amp; family relationships</td>
<td>Delivery by Midwifery, Health visiting and children centres Gaps in service in transition stage</td>
<td>Topic based groups and learning opportunities</td>
<td>Delivered via Children’s Centres</td>
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<tr>
<td>Signposting to info &amp; services</td>
<td>As appropriate</td>
<td>Help with assessing other services and sources of info &amp; advice</td>
<td>Delivered as appropriate</td>
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