Health Visitor Implementation Plan 2011–15

A Call to Action

February 2011

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Contents

A) Purpose

This Health Visitor Implementation Plan sets out a call to action to expand and strengthen health visiting services.

The start of life is a crucial time for children and parents. Good, well resourced health visiting services can help ensure that families have a positive start, working in partnership with GPs, maternity and other health services, Sure Start Children's Centres and other early years services. That is why the Coalition Government has made the challenging commitment to an extra 4,200 health visitors by 2015.

This Plan sets out what implementing that commitment will mean for families, for health visitors, and for all who have a part to play. It covers:

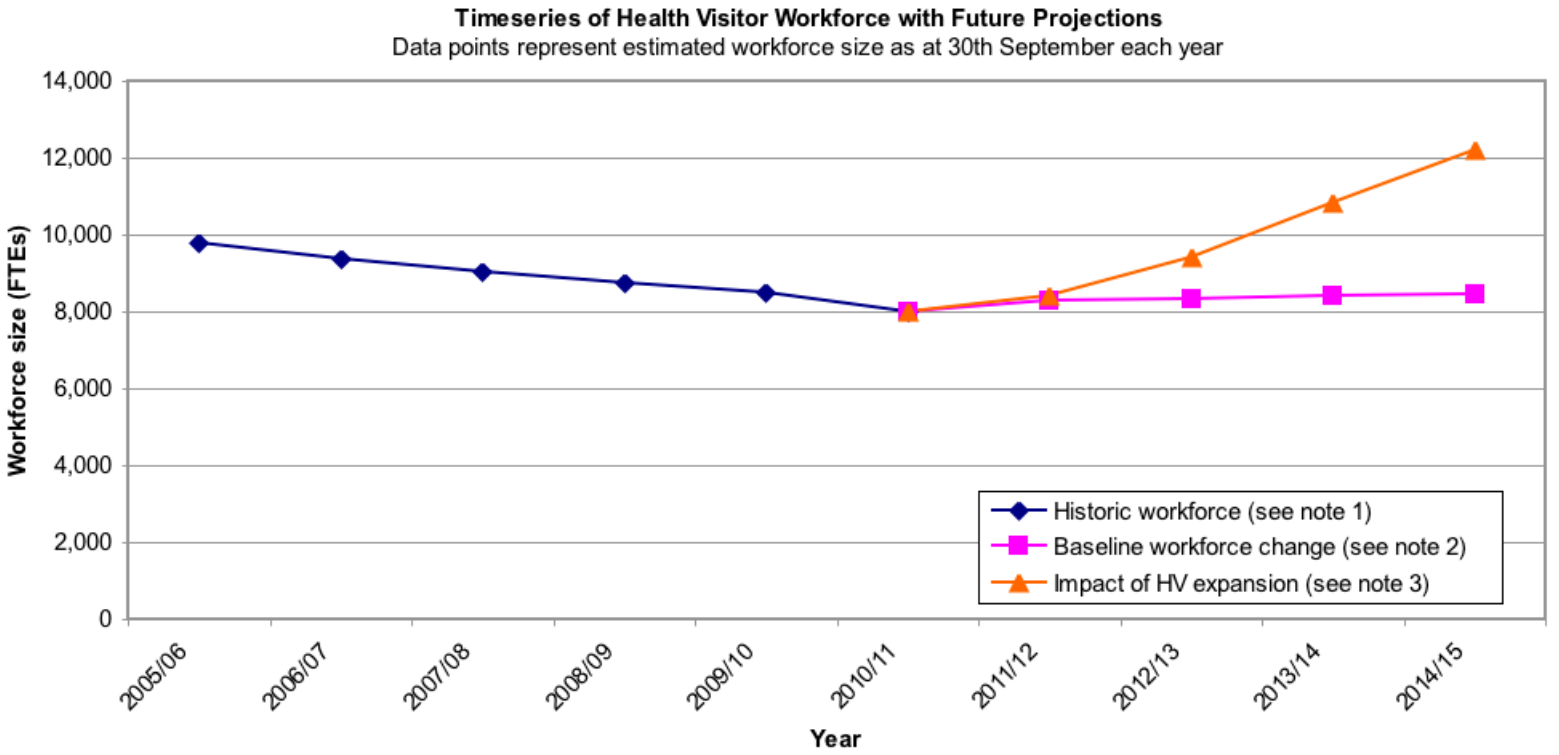
- the vision – why health visiting matters – and the new health visiting service
- the call to action: to professionals, to service commissioners and providers, to higher education institutions, professional bodies, and local partners
- the pathway to 2015
- the supporting work programmes:
  – growing the workforce
  – professional mobilisation
  – aligning delivery systems to ensure rapid progress.

The Plan sets an ambitious pace. It will require innovative approaches to training and development, and rapid spread of learning. Some elements need national planning, such as managing the transition from the existing NHS structure to the new one. But change will ultimately be delivered locally by commissioners and providers of service, and above all by health visitors and their partners working with families and their communities.

So the Plan is a living document that the profession and its partners will help shape. For 2011/12, it will be backed by further detail in the NHS Operating Framework and associated management guidance. In future it will be revisited annually and revised as necessary.

The chart below shows historical numbers and the projected path for improvement.

Health visitor (HV) numbers – actual to 2009/10; proposed from 2010/11



1. Historic data from IC annual workforce census for 2005/06 to 2009/10 and IC monthly workforce publication for 2010/11: baseline May 2010: 8,092 FTE. Goal for 2015: 12,292 FTE
2. Baseline workforce change includes the impact of current training plans plus reductions from attrition and retirements
3. HV expansion includes additional training expansion and return to practice initiatives on top of the baseline estimate

The Plan will put in place across the country a new health visiting service that all families can expect to access.

The new health visiting service: what it means for families

Your community 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.

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.

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.

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.

The service will be available in convenient local settings, including Sure Start Children's Centres, and health centres, as well as through home visits.

B) Vision

Why health visiting matters

The Government believes that strong and stable families are the bedrock of a strong and stable society.

The start of life is especially important in laying the foundations of good health and wellbeing in later years. The period from prenatal development to age 3 is associated with rapid cognitive language, social, emotional and motor development. A child's early experience and environment influence their brain development during these early years, when warm, positive parenting helps create a strong foundation for the future. New evidence about neurological development and child development highlights just how important prenatal development and the first months and years of life are for every child's future.

The Government wants to ensure that all parents and children have access to the support they need to get off to the best possible start, with early intervention to ensure additional support for those who need it, including the most vulnerable families. Intervening early, working with families to build on strengths and improve parenting confidence and, where required, referring early for more specialist help, including specialist mental health services, is the most effective way of dealing with health, developmental and other problems within the family. Health visitors, working in partnership with GPs, midwives, Sure Start Children's Centres and other local organisations, have a crucial role in ensuring that this happens. Getting this right can affect the child's physical and mental health and wellbeing, their readiness to learn, and their ability to thrive later in life. This matters for the child, their family, local communities, and our wider economy.

Health visitors are trained nurses or midwives with specialist training in family and community health and are key to meeting the needs of families. They are skilled at spotting early issues, which may develop into problems or risks to the family if not addressed, for example a parent struggling to cope or a child health issue which needs special attention. They are public health nurses trained to work at community, family and individual level. They lead and deliver the Healthy Child Programme (HCP),[1] which is designed to offer a core, evidence based programme of support, starting in pregnancy, through the early weeks of life and throughout childhood. At the same time they provide or are the gateway to other services which families may need.

[1] Department of Health (2009) *Healthy Child Programme: Pregnancy and the first five years of life.* Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107563

However, numbers of health visitors have been in decline. In too many areas, there are just not enough health visitors to offer all families the support they need. Opportunities are missed to provide a clinically effective intervention to a depressed mother struggling with a new baby; to identify during a developmental check a child with speech and language problems who would benefit from early help; to help families access other local services, like parenting or relationship support through their local Sure Start Children's Centre, at the right time for them. We are failing too many children and families. The lack of capacity means that health visitors are too often unable to perform the wider public health role that they have trained for, working with communities to improve health outcomes. Health visitors are frustrated by the gap between the role they have trained for and the amount they can do in practice.

This programme commits to investment in workforce expansion – an extra 4,200 health visitors (full-time equivalent) – to put this right. It calls on the profession, those who commission health visiting services, and those who provide them to promote a revitalised service, one which ensures that all families are offered a core programme of evidence based preventative health care with additional care and support for those who need it. As well as bringing in new recruits, the programme will offer existing health visitors the opportunity to refresh and develop their skills. For example, we will make sure that the learning from the Family Nurse Partnership (FNP) and other evidence based programmes and methods aimed at helping families with complex needs is available to all, alongside a new programme to update knowledge and skills in community health.

Health visitors have been central to developing **their** new service vision, and are positive about embracing the opportunity of increased capacity to energise and transform services, to re-establish the profession as a vital part of family and community health and to use their skills to work with others to improve health outcomes and life chances.

The new health visiting service maximises the contribution of health visiting teams at community, family and individual level. In doing this, existing and new health visitors will work closely with Sure Start Children's Centres, FNP teams, other early years services, GPs, midwives, specialist services and, where appropriate, social care services.

Frank Field's Independent Review on Poverty and Life Chances and Graham Allen's Independent Review on Early Intervention highlight the importance of good, joined-up support for children and families at the start of life.

The new health visiting service will be a key part of the response to the challenges they pose. Developments will also take acount of Dame Claire Tickell's Review of the Early Years Foundation Stage and Professor Eileen Munro's Review of Child Protection.

We have already set out that local partnership working will entail a strong relationship between health visitors and Sure Start Children's Centres and that commissioners will need to ensure the best fit between all local services for early years, including children's centres – but what does that involve?

HEALTH VISITORS IN SURE START CHILDREN'S CENTRES

Sure Start Children's Centres are accessible to all families with young children, and have an important role in identifying and supporting families in greatest need. Local authorities have statutory duties under the Childcare Act 2006 to secure sufficient provision of children's centres to meet local need, as far as is reasonably practicable. Every children's centre should have access to a named health visitor. Health visitors have unique, professional expertise to:

- deliver universal child and family health services through children's centres (the Healthy Child Programme)
- lead health improvement through children's centres, on subjects such as healthy eating, accident prevention and emotional wellbeing
- help families stay in touch with wider sources of support through children's centres, including from the community and other parents
- be leaders of child health locally, including fostering partnerships between GPs, midwives and children's centres.

Many health visitors already work closely with their local children's centre, using it as a base; work with their local children's centre leader and are members of the management team; share information appropriately; review local cases; and share skills and experience.

The new health visiting service: what it means for commissioners, providers and the profession

Interactions at community level: building capacity and using that capacity to improve health outcomes and **leading the Healthy Child Programme for a population**.

Universal services for all families: working with midwives, building strong relationships in pregnancy and early weeks and planning future contacts with families. Leading the Healthy Child Programme for families with children under the age of 5.

Additional services that **any family may need some of the time**, for example care packages for maternal mental health, parenting support and baby/toddler sleep problems – where the health visitor may provide, delegate or refer. Intervening early to prevent problems developing or worsening.

Additional services for **vulnerable families requiring ongoing additional support** for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health problems or substance misuse.

Making sure the appropriate health visiting services form part of the high intensity multi-agency services for families where there are **safeguarding and child protection concerns**.

C) The Call to Action

This plan represents a call to action to all with a part to play in delivering the new service.

Partnership working, locally and nationally

Improving support for children and families at the start of life calls for strong partnership working at all levels:

- Health visitors working across health and early years services and at community level will build and strengthen partnerships, including with general practice and Sure Start Children's Centres.
- Locally, the new Health and Wellbeing Boards will bring together local authority, health, early years and other partners and will have an important potential role in ensuring the best fit between health visiting and other local services, in ways that best meet the local needs identified in the Joint Strategic Needs Assessment.
- Nationally, the professions, regulating bodies, higher education institutions and many others will lead and shape action.

Commissioners will need to have in place:

A reviewed and revised commissioning specification that:

- includes the Healthy Child Programme (HCP) as set out in the HCP national model specification
- includes all five levels of the service model set out for health visiting services, ensuring that families are offered the full universal offer, with an early focus on improving coverage of the 2–2½ year health and development check
- gives consideration to the national currency and pricing guidance for the HCP
- utilises the national model contract for community services where appropriate
- ensures best fit with wider local services for children and families in the early years, including Sure Start Children's Centres, primary care and maternity services.

For NHS provider trusts and other provider organisations the task, in line with the requirements of their commissioners, will be to:

- develop the local service offers for families for *Community, Universal, Universal plus* and *Universal partnership plus* services, and contribute to safeguarding and child protection arrangements, working with Sure Start Children's Centres and other local partners
- come to an agreement with commissioners to implement the new service, and where this cannot be achieved within one commissioning year, commissioners and providers will need to agree a staged implementation of the new service evidenced by a delivery plan towards full implementation
- plan for the new health visitor workforce they need to deliver the new service, including support for training and development, and leadership development plans for the current and future workforce.

For local delivery partners in maternity services, primary care, Sure Start Children's Centres and other early years services, growing numbers of health visitors will mean opportunities to review and strengthen local joint working arrangements to provide the best support to families, helping them find the right support at the right time.

For health visitors this is an opportunity to reclaim the role which brought many into the profession, and to refresh and develop their public health skills in working with children, families and communities. It brings new leadership challenges, with opportunities to lead health visiting and wider skill-mix teams across early years settings, working with Sure Start Children's Centres and others. This will also mean important development opportunities.

Development opportunities

Health visitors in practice and in leadership roles have worked with the Department of Health to develop the key roles for health visitors, the new service vision and the family offer, and the profession has been welcoming and enthusiastic of the proposed approaches. The Public Health White Paper sets health visitors centre stage in providing high quality preventative services to children, families and communities. It thus:

- reaffirms health visitors as key professionals in public health delivery
- **enables health visitors to regain professional autonomy** in working with families and communities in determining local approaches to health and wellbeing.

This Implementation Plan sets out the service vision and family offer, and the delivery plans to increase capacity. As capacity grows, health visitors will have the opportunity to:

- work directly with families and lead teams to provide services across the full range of preventative health care for children and families for which they have trained, including to:
  - provide effective links between midwifery, primary health care and family services
  - deliver the HCP in full (*Universal*) and ensure that all children receive the health development check at 2–2½ years old
  - provide responsive care when families have problems or need support, and undertake new training to extend this range using new evidence in neuroscience and early intervention (*Universal plus*)
- work with partners, especially in Sure Start and with social workers where families have ongoing needs requiring multi-agency support (*Universal partnership plus*)
- promote community capacity building to enable families and communities to build on their strengths to develop new ways for providing services as part of the Big Society
- be able to access a nationally sponsored programme to refresh public and community health skills and approaches and learn new ones.

In some areas, services are close to providing the service model and health visitors will have the opportunity to be part of supported pathfinder sites and/or sites which showcase key aspects of the new model and offer.

Health visiting services are already responding with enthusiasm to showcasing work and 40 sites have come forward with good practice approaches.

Health visitors are also clear that the implementation plan is a call to action and that real energy and commitment are required at all levels to deliver the implementation plan. Health visitors have responsibilities in promoting the profession, welcoming Return to Practice practitioners, taking part in new approaches to educating students, and working with providers and commissioners to embed the new service for families locally.

D) The Pathway to 2015

The period to 2015 will see:

- **more health visitors in training and returning to practice**
- **growing numbers of health visitors in post**
- **a more comprehensive health visiting service locally.**

Plans for 2011/12 will set out the first phase of development. During 2011/12, full plans and trajectories through to 2015 will be developed.

Planning assumptions: workforce and training

This Plan sets out key assumptions in the modelling work that supports the commitments to 4,200 extra full-time equivalent health visitors by 2015. These will be refined with national and local partners and adjusted as necessary in the light of experience. For example, success with Return to Practice schemes and in retaining the current workforce will affect the number of new trainees required. The development of flexible training routes may influence training timetables. But it is important that everyone understands the overall scale and pace of change that the modelling work demonstrates.

The NHS Operating Framework for 2011/12 and supporting guidance set clear expectations for workforce and training growth for 2011/12. These will be tested and confirmed through primary care trust (PCT) and strategic health authority (SHA) plans. The Department of Health will work with SHAs to monitor progress. A key task during 2011/12 will be to develop plans and trajectories for 2012/13 and 2014/15.

It is estimated that some 6,000 additional health visitors will need to be trained over the period to 2015 to allow for retirements and other loss from the workforce and achieve 4,200 extra health visitors. Broad planning assumptions are that the current level of commissions for training places will be maintained and will further increase as follows:

- 2011/12: 25%
- 2012/13: 37.5%
- 2013/14: 37.5%.

This is a minimum aspiration and the work programme will explore the scope to move more quickly if possible, while maintaining training quality.

On workforce numbers, the immediate task is to halt the decline and begin growth. In line with training plans, growth will be concentrated towards the latter part of the planning period (see diagram on page 5). For 2011/12, all areas will be expected to plan workforce and training growth. Further work will be done on relating the health visitor workforce to local need and to explore new ways of attracting and supporting health visitors to work in the areas of greatest need, and this will be available to inform planning for later years.

Rolling out the new health visiting service

Every area will need to assess how far they are from delivering the full new health visiting service and develop timetabled plans for putting the full service in place as their workforce increases.

- **Pathfinder/early implementation sites**
  The first communities to start the new health visitor service are being identified as pathfinder/early implementation sites. It is expected that the pathfinder/early implementation sites will be ready to start a full implementation of the new health visitor service (*Community*, *Universal*, *Universal plus* and *Universal partnership plus*) by the end of 2011/12.

- **Component exemplar sites**
  Those communities with examples of good practice for specific components of the health visitor service (e.g. examples of sustainable community capacity building and a good practice method of delivering a *Universal partnership plus* service) are being identified as component exemplar sites. It is anticipated that the component exemplar sites will be ready to start a partial implementation, leading with their exemplar component, by the end of 2011/12.

- **All sites**
  All other communities will deliver through a staged approach signed off between commissioners and providers, with a delivery plan in place by March 2012 and with full implementation to be achieved as workforce capacity increases towards 2015.

The new health visiting service for each area will start when:

- commissioning specifications for evidence based services for children and families that include the HCP and the new health visitor service are in place. This includes all five levels of the model (shown on page 6) – i.e. the full family offer and the health visiting service contribution to multi-agency safeguarding services
- provider delivery plans for a full or staged implementation of the new health visitor service are in place
- the new health visiting service is developed and the four offers – *Community*, *Universal*, *Universal plus* and *Universal partnership plus* – are either fully or partially in place (if a staged implementation) and are ready to be delivered to families
- families understand the offer and are involved in local development and, where appropriate, delivery.

While the detail of the service offer is for local determination, there will be an expectation that the following are in place for full implementation of the new service:

- *Community* – based on the Joint Strategic Needs Assessment, the needs of local communities are understood and a directory of services to meet those needs is in place/being constructed. Health visiting professionals in the local area are supported in community development work and have undertaken/are undertaking the new 'building community capacity' training module.
- *Universal* – all elements of the HCP are being delivered. Contacts with families are increased, especially for first time parents.
- *Universal plus* – evidence based care packages offered as part of *Universal plus* are clearly defined. Provider continuing professional development plans demonstrate that health visitors can access any specialist training required.
- *Universal partnership plus* – as a minimum there is a named health visitor on the management board of the local Sure Start Children's Centre and there are services/drop-in sessions provided by health visitors through the centre.

Ultimately, the new health visiting service will be in place when the local community knows that it exists and knows how to ask for it.

E) The Work Programmes

A summary of each workstream and its deliverables follows; further detail is at Annex 1.

1. **Growing the workforce** – planning and delivering the growth required in workforce capacity, and identifying and quantifying the high impact workforce changes required, including levers and routes for implementation education, substantial increases in Return to Practice, improved career opportunities and improved retention.

Numbers of health visitors employed in NHS posts have fallen from 10,137 in 2004 to 8,017 in 2010. The demographic profile of the health visitor workforce suggests that many will be due to retire. In order to achieve an increase of 4,200, it may be that up to 6,000 new entrants will be needed over the period to 2015. All health visitors are qualified nurses or midwives (a three year period of training) who have undertaken further post qualification training in health visiting (usually a further year).

Expansion on the scale required calls for a comprehensive programme of action to increase entry and retention, scaling up current training plans and capacity, and looking rapidly at scope for more flexible training routes to achieve health visitor qualification as well as promoting as many health visitors to return to practice as possible. Constructive discussions have begun with the Nursing Midwifery Council (NMC) and others to develop plans to improve retention, increase the number of training places and provide flexible training options. The NMC will ensure that registrants, higher education institutions and employers are clear about current flexibilities in training health visitors to support rapid expansion of health visitor training. Plans will be fine-tuned in the light of experience, identifying the most promising and cost-effective combinations of recruitment, retention and training approaches – which may vary from area to area. We will identify exemplar and pathfinder sites for new approaches to education and training to ensure that good practice and learning are shared.

The key deliverables for growing the workforce are:

- confirmation of the **baseline number of health visitors**
- **demographic and geographical analysis** to establish location and population need and match with trainees and training places
- robust **data collection system** for health visitor numbers, in order to measure progress towards an increased workforce across the NHS and local authorities
- delivery of **retention initiatives** to retain the current health visitor workforce
- delivery of **recruitment initiatives** to drive the increase in the number of health visitors, including return to practice
- increased **training places** and **flexible training options**.

2. **Professional mobilisation** – using a range of expertise to develop leadership in the community; identifying and developing champions to support SHAs, commissioners, community service providers, higher education institutions and members of the health visiting profession to drive the increase in the number of health visitors and deliver the new service using innovative and evidence based transformational approaches (e.g. mass mobilisation and social movement thinking).

   This workstream aims to promote and share the new service vision and family offer with all those who will be essential to its delivery; to promote the profile of health visiting as a career; and to strengthen development opportunities for existing staff to restore professional autonomy and decision making. It will improve opportunities to use the full range of health visitor skills and re-emphasise health visitors as key public health professionals, and will create a sense of excitement and energy around future opportunities. Additionally, this workstream will include the use of information technology and of information to improve quality and productivity within services. It will also review information technology and information to support knowledge access and choice for families.

The key deliverables for professional mobilisation are:

- **partner analysis** of all groups that are interested in and/or will be impacted by the programme
- design and delivery of the **communications and engagement strategy** and plan
- design and delivery of a **recruitment campaign**
- promotion of **learning, development and spreading of good practice**
- design and delivery of **professional development** training, specifically focused on **building community capacity**, and specific training in new care packages such as cognitive behavioural therapy and new approaches such as motivational interviewing
- supporting high quality professional practice, including the model of practice for effective health visiting and clinical supervision
- **leadership development** to support health visitor leaders to manage and support existing health visiting teams and the new workforce and to promote all health visitors to be seen as leaders in local communities
- work on **joint training** between health visitors and other Sure Start Children's Centre staff, including outreach and family support
- understanding the opportunities of **information technology and improved information** in supporting the new service model.

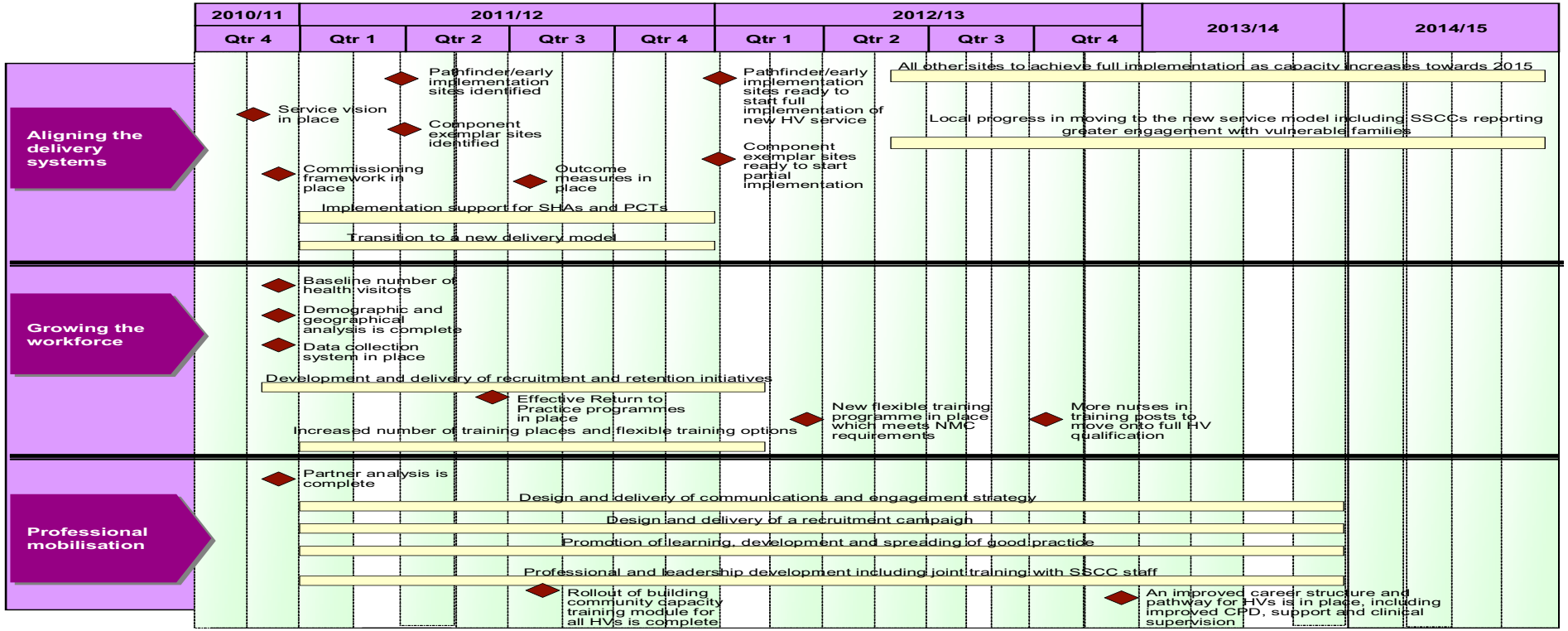
3. **Aligning the delivery systems** – this workstream will design and oversee the systems needed to ensure that the new service is commissioned, that the programme is delivered at pace, that drivers and incentives ensure a strong focus on responding to differential needs and improving outcomes, and that systems promote effective join-up between services in ways that best meet local needs. It will develop approaches in line with developments in the NHS and the opportunities offered by the development of the new public health service, adapting to the process of transition and building for a sustainable future model.

The key deliverables for aligning the delivery systems are:

- a **service vision and model** and **service offer to families** for health visiting services that deliver the Healthy Child Programme and are aligned with Sure Start Children's Centres, the FNP, early years, early intervention services and the new Mental Health Strategy
- a **commissioning framework** on which to develop local commissioning specifications
- **outcome measures**, in order to measure the impact of the increase in health visitor capacity
- **delivery plans for 2011/12**, developed with SHAs and PCTs
- **implementation support** for SHAs and PCTs in 2011/12 to support the achievement of the commitment at regional and local levels
- design of and **transition to a new delivery model** to align with the emerging system architecture and responsibilities for commissioning.

Progress towards delivering the Health Visiting Programme will be monitored using clear milestones.

The number of health visitors in post will be used as an ongoing guide to progress. In addition, the following milestones will be monitored.



Evaluation and learning

The programme includes work to monitor progress on key deliverables and outcomes, and to evaluate effectiveness of key interventions, with an emphasis on rapid learning to shape further development. The programme will also work through equalities implications as part of this.

On workforce expansion, we will monitor workforce trends and assess the impact of workforce initiatives in order to measure success and cost-effectiveness. This will include work with the Centre for Workforce Intelligence (CfWI).

The Department also intends to commission research through the National Nursing Research Unit at King's College London, to inform and help shape ongoing work on health visitor expansion. This will include:

- work on effectiveness and outcomes
- outcome measurement
- work on skill-mix
- work on user experience.

It will also be essential to review progress through the Public Health Outcomes Framework, in the light of consultation.

Implementation plans will be adapted and fine-tuned in the light of emerging evidence to maximise effectiveness.

F) Governance and Accountability

Leading delivery of the Health Visiting Programme

Overview – the Government intends, under the proposals set out in *Healthy Lives, Healthy People* and in related consultations, that responsibility for this major public health initiative should pass to the new Public Health England and that health visiting should be funded through the Public Health England budget. In due course, the Government sees health visiting being commissioned locally as part of the health improvement responsibilities that will pass to local authorities. The local Health and Wellbeing Board, led by the local authority with membership including GP consortia, will be well placed to promote the joining up of all public health, NHS and social care services that support children and families in the early years, taking account of local needs.

However, special arrangements will be needed initially given the scale of the challenge: an extra 4,200 health visitors and a re-energised workforce by 2015. This will require concerted action by NHS service and education commissioners, community service providers and higher education institutions and others, at a time of transition for both the NHS and the public health service.

The Department of Health and the NHS Commissioning Board (NHS CB) will be charged with leading the commissioning of this programme in the first instance, on behalf of Public Health England, subject to consultation on the new public health structures and budgets proposed in *Healthy Lives, Healthy People*.

Arrangements for 2011/12 are set out in the NHS Operating Framework, working within existing NHS funding and accountability arrangements. SHAs will be responsible for working with PCTs to ensure that workforce, education commissioning and service plans are in place for the first stage of workforce expansion. PCTs will need to reflect plans for health visitor expansion in their service commissioning plans, and SHAs will need to ensure that training plans and commissions support local requirements. Funding will be included in allocations to PCTs and in the Multi-Professional Education and Training budget, managed by SHAs. Further detail is in the Operating Framework 2011/12 and supporting materials. Accountability will run from PCTs through SHAs to the Department of Health.

In 2012/13 PCTs will be responsible for delivering the additional health visitors and will be accountable to the NHS CB.

Plans for 2013/14 and beyond will be developed over the coming year, taking account of progress on NHS reform, the proposals set out in *Healthy Lives, Healthy People*, and the consultations on future funding and commissioning arrangements for Public Health England. As the proposed new Health and Wellbeing Boards develop, they will be well placed to promote joint working locally across health visiting, Sure Start Children's Centres, primary care, maternity services and the FNP, to help families access the right blend of support to meet their needs at the right time. Accountability for delivering the additional workforce numbers will remain with the NHS CB until a decision is made to transfer responsibility to local commissioning.

Over time, accountability arrangements will be developed to focus not just on the expansion and development of the health visiting workforce, but on services for children and families to achieve improved outcomes. Progress measures will include numbers of health visitors in post and in training, while local plans will cover rollout of the service offer. The proposals for the Public Health Outcomes Framework will offer scope to track progress on children's health and development. Work is also proposed to assess families' and health visitors' experience of the new service.

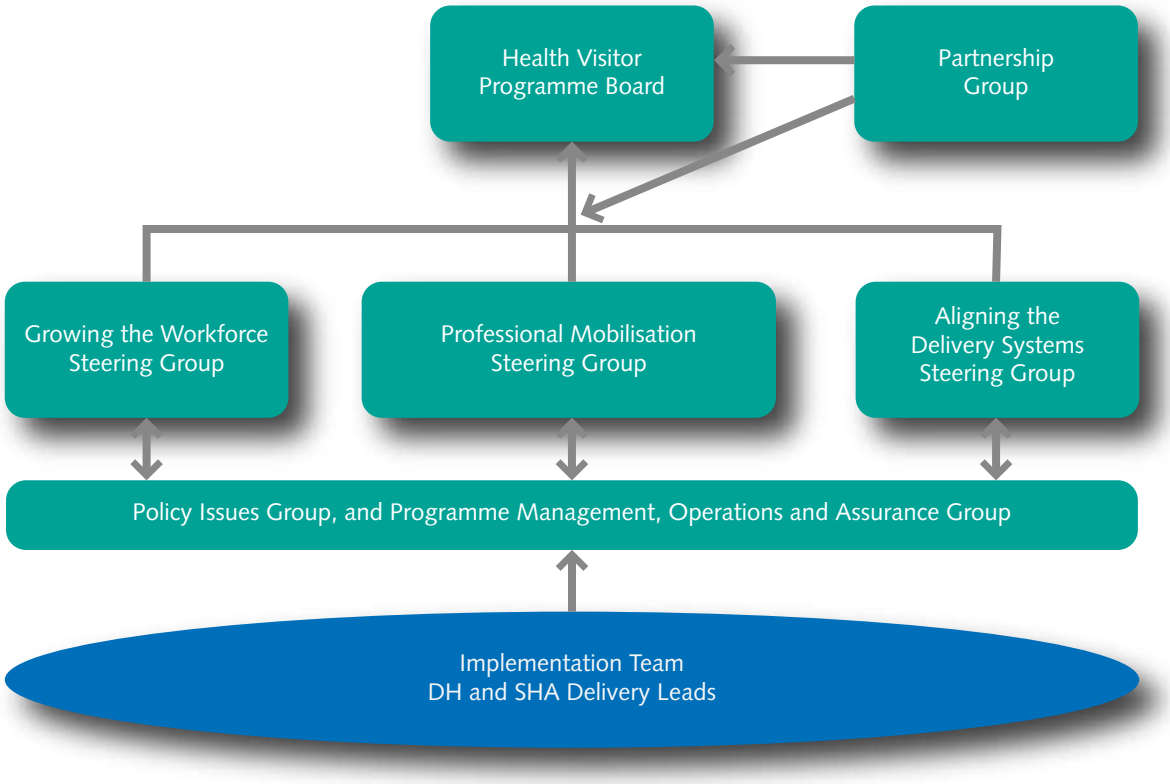
The Health Visitor Programme is included in the Public Health section of the Department of Health's Business Plan. Each month, the Department of Health publishes a report on its progress in meeting these commitments. These reports are available on the departmental website and the Number 10 website.

Figure F.1 shows the proposed national governance arrangements which will oversee the further design work on the programme and ensure that appropriate delivery systems are in place, modifying these over time in line with wider developments.

The programme's success will depend on wide engagement, nationally and locally. Some partners will have specific contributions to make and will be directly engaged in the formal governance of the programme. The programme will also seek the widest possible engagement, in particular through a Partnership Board and partnership network. These arrangements will be developed in more detail through joint work with members. Further detail on delivery partners is at Annex 2.

Governance structure

Figure F.1 illustrates the governance and reporting arrangements for the programme in 2011/12.



Annex 1 Programme Plan

Annex 1 sets out the high level programme plan for the Health Visiting Programme.

The programme plan sets out how, and when, the Department of Health (DH) and its key partners will deliver the activities required to achieve the overall programme objectives.

1. Growing the workforce

Primary delivery partners: DH (Workforce Directorate, Centre for Workforce Intelligence (CfWI)), Department for Education (DfE), strategic health authorities (SHAs), primary care trusts (PCTs), Nursing and Midwifery Council (NMC), higher education institutions (HEIs) – through the Council of Deans and Universities UK (UUK)

Objective:

- *Ensure that workforce planning, training and education, and recruitment and retention initiatives are in place to deliver 4,200 extra full-time equivalent health visitors*

Deliverables:

- Confirmation of the **baseline number of health visitors**
- **Demographic and geographical analysis** to establish location and population need and match with trainees and training places
- Robust **data collection system** for health visitor numbers, in order to measure progress towards an increased workforce across the NHS and local authorities
- Delivery of **retention initiatives** to retain the current health visitor workforce
- Delivery of **recruitment initiatives** to drive the increase in the number of health visitors
- Increased **training places** and **flexible training options**

1. Growing the workforce

Activities	Start	End	Lead Responsibility
1.1 Baseline number of health visitors			
i. Conduct analysis of health visitor workforce (profile, age, location)	Complete		CfWI
ii. Establish baseline number of health visitors from which to chart progress	Started	Feb 2011	CfWI
1.2 Demographic and geographical analysis			
i. Demographic and geographical mapping/audit of health visitors to establish location and population need and match with trainees and training places	Started	Feb 2011	CfWI
1.3 Data collection system			
i. Establish robust data collection for health visitor numbers in NHS, local authorities, and over transitional period to new system architecture	Jan 2011	Mar 2011	CfWI
1.4 Retention initiatives			
i. Investigate flexible retirement packages	Started	Jun 2011	DH
ii. Gather evidence about what health visitors dislike about their role and any productivity measures that may change this, e.g. use of laptops, mobile phones and working practices	Jan 2011	Feb 2011	CfWI
iii. Develop long-term strategies for retention and career progression	Mar 2011	Mar 2012	DH

1. Growing the workforce (continued)

Activities	Start	End	Lead Responsibility
1.5 Recruitment initiatives			
Return to Practice (RtP)			
i. Develop initiatives and incentives to drive RtP	Started	Feb 2011	DH
ii. Determine and initiate RtP pilot sites	Complete		DH
iii. Execute RtP pilot	Started	Mar 2011	PCTs
iv. Evaluate RtP pilot	Mar 2011	Mar 2011	DH
v. Roll out RtP programmes nationally	Mar 2011	Ongoing	DH/SHAs
vi. Explore potential for existing family and staff nurses to support health visiting and encourage health visiting take-up	Jan 2011	Mar 2011	DH
vii. Work with external partners to design a support package which actively encourages health visiting as a career	Started	Jun 2011	DH
1.6 Training places and flexible training options			
i. Parliamentary Under Secretary of State for Public Health (PS (PH)) meeting with NMC to discuss flexible training for health visitors	Complete		
ii. Develop plans to increase health visiting training places	Jan 2011	Mar 2011	SHAs/HEIs
iii. Explore flexible training options with NMC, Council of Deans, HEIs and SHA education commissioners	Jan 2011	Mar 2011	DH/NMC
iv. Engagement with programme providers and dissemination of information on flexible arrangements	Jan 2011	Mar 2011	DH/NMC

1. Growing the workforce (continued)

Activities	Start	End	Lead Responsibility
v. Clarify flexible approaches to practice teaching, including additional guidelines for mentors and guidance on practice teacher/mentor ratios	Mar 2011	Jun 2011	NMC
vi. Explore feasibility of conversion courses	Jan 2011	Mar 2011	DH/NMC
vii. Review of the third part of the register	Announce-ment 2011	To be advised	NMC
viii. Provision of additional advice to support the existing standards to illustrate different programme options to enter the Specialist Community Public Health Nurses part of the register	Complete		NMC
1.7 Promoting recruitment into deprived areas			
i. Explore training development and recruitment options to attract and support health visitors to work with communities with the greatest needs	Mar 2011	Aug 2011	DH

2. Professional mobilisation

Primary delivery partners: DH, DfE, SHAs, PCTs, NMC

Objectives:

- *Engage and re-energise the health visiting profession*
- *Promote learning and spread of good practice to drive the increase in the number of health visitors*
- *Update and develop community public health and Big Society competencies*

Deliverables:

- **Partner analysis** of all groups that are interested in and/or will be impacted by the programme
- Design and delivery of the **communications and engagement strategy** and plan
- Design and delivery of a **recruitment campaign**
- Promotion of **learning, development and spreading of good practice**
- Design and delivery of **professional development** training, specifically focused on **building community capacity**, and specific training in new care packages such as cognitive behavioural therapy and new approaches such as motivational interviewing
- Supporting high quality professional practice, including the model of practice for effective health visiting and clinical supervision
- **Leadership development** to support health visitor leaders to manage and support existing health visiting teams and the new workforce and to promote all health visitors to be seen as leaders in local communities
- Work on **joint training** between health visitors and other Sure Start Children's Centre staff, including outreach and family support
- Understanding the opportunities of **information technology and improved information** in supporting the new service model

2. Professional mobilisation

Activities	Start	End	Lead Responsibility
2.1 Partner analysis			
i. Identify partners, i.e. organisations/individuals who are interested in and/or will be impacted by the programme	Started	Mar 2011	DH
2.2 Communications and engagement strategy			
i. Develop narrative around the commitment and the role of the health visitor set within wider early years narrative	Complete		DH
ii. Design an effective communications and engagement strategy and plan	Jan 2011	Mar 2011	DH
iii. Deliver communications and engagement strategy and plan	Apr 2011	Dec 2014	National/local delivery
iv. PS (PH) and Chief Nursing Officer (CNO) to address Unite/ Community Practitioners' and Health Visitors' Association (CPHVA) conference to articulate the service vision for health visiting and announce new 'building community capacity' training module	Complete		
v. PS (PH) keynote speech at the National Child Health Conference for health visitors and Sure Start Children's Centre staff	Mar 2011	Mar 2011	DH
vi. Meetings with SHAs and PCTs via CNO and SHA Directors of Nursing and professional networks, CNO business meetings	Started	Mar 2012	DH

2. Professional mobilisation (continued)

Activities	Start	End	Lead Responsibility
vii. Speaking events to health visitors, commissioners, GPs, Directors of Public Health and professional bodies	Started	Mar 2014	DH
viii. Proactive messaging with partners in professional journals and newsletters	Started	Mar 2014	DH
2.3 Recruitment campaign			
i. Design a recruitment campaign to drive the increase in the number of health visitors	Jan 2011	Jun 2011	DH
ii. Deliver recruitment campaign to drive the increase in the number of health visitors	Jul 2011	Dec 2014	National/local delivery
2.4 Learning, development and spreading of good practice			
i. Work with SHAs to develop plans for mass mobilisation campaigns in 2011/12	Jan 2011	Mar 2011	DH
ii. Identify the tools that will be required locally to support shared learning on how to deliver mass mobilisation	Feb 2011	Mar 2011	DH/SHAs
iii. Create tools and materials that can be used locally to support shared learning on how to deliver mass mobilisation	Apr 2011	Jun 2011	DH/SHAs
iv. SHAs to deliver local mass mobilisation campaigns with DH support	Apr 2011	Mar 2012	SHAs/DH
v. Identify learning from Family Nurse Partnership (FNP) and other evidence based programmes and agree a development and implementation programme	Apr 2011	Mar 2012	DH

2. Professional mobilisation (continued)

Activities	Start	End	Lead Responsibility
vi. Identify learning from research underpinning the Healthy Child Programme (prenatal development and the first five years of life)	Apr 2011	Mar 2012	DH
vii. Deliver the development programme, alongside FNP expansion, to embed evidence based methods and tools within health visitors using effective and sustainable change methodologies	Apr 2012	Apr 2015	SHAs/DH
2.5 Professional development			
i. Share new service vision and develop a module for health visitors in practice and those in education to refresh/provide skills in building and utilising community capacity	Started	Feb 2011	DH
ii. Rollout of access to 'building community capacity' training module for all health visitors	Feb 2011	Sep 2011	
iii. Revisit supervision model	Mar 2011	Sep 2011	DH
2.6 Leadership development			
i. Develop health visitor leaders to help them support and manage new workforce	Apr 2011	Apr 2015	DH
ii. Identify opportunities for joint training between health visitors and Sure Start Children's Centre staff	Mar 2011	Sep 2011	DH/DfE

3. Aligning the delivery systems

Primary delivery partners: DH, DfE, SHAs, PCTs

Objectives:

- *Develop the service vision and new model for health visiting services*
- *Ensure the development of the commissioning framework, outcome measures, health premium and drivers for improvement*
- *Align the service vision and model for health visiting services with Sure Start Children's Centres, early years and early intervention services*
- *Confirm that DH, SHA and PCT capacity is in place for 2011/12 to deliver workforce growth and promote service transformation*
- *Work with and through SHAs to design and execute the delivery approach for 2011/12*
- *Design and support the transition to a new delivery model for 2012/13–2014/15 to align with the emerging system architecture and responsibilities for commissioning*

Deliverables:

- A **service vision and model** and **service offer to families** for health visiting services that deliver the Healthy Child Programme and are aligned with Sure Start Children's Centres, the FNP, early years, early intervention services and the new Mental Health Strategy
- A **commissioning framework** on which to develop local commissioning specifications
- **Outcome measures**, in order to measure the impact of the increase in health visitor capacity
- **Delivery plans for 2011/12**, developed with SHAs and PCTs
- **Implementation support** for SHAs and PCTs in 2011/12 to support the achievement of the commitment at regional and local levels
- Design of and **transition to a new delivery model** to align with the emerging system architecture and responsibilities for commissioning

3. Aligning the delivery systems

Activities	Start	End	Lead Responsibility
3.1 Service vision and model and service offer for families			
i. Design service vision and model for health visiting services in England	Complete		
ii. Launch service vision and model at Community Practitioners' and Health Visitors' Association (CPHVA) conference	Complete		
iii. Set the health visiting vision within wider early years and early intervention strategies	Complete		
3.2 Commissioning framework			
i. Embed health visitor provision in the Operating Framework for 2011/12	Complete		DH
ii. Develop an overarching commissioning framework on which to develop local commissioning specifications	Jan 2011	Mar 2011	DH
iii. Explore how health premium can be used to drive improved commissioning for children and families during transition, and other incentives	Mar 2012	Mar 2013	DH
3.3 Outcome measures			
i. Develop outcome measures in the light of Public Health England Outcomes Framework consultation	Jan 2011	Oct 2011	DH
ii. Develop indicators and outcome measures in respect of early years services	Jan 2011	Oct 2011	DH/DfE

3. Aligning the delivery systems (continued)

Activities	Start	End	Lead Responsibility
3.4 Implementation			
i. Identify delivery leads	Jan 2011	Feb 2011	SHAs
ii. Develop local service and workforce implementation plans	Jan 2011	Feb 2011	PCTs
iii. Ensure that training plans are aligned	Jan 2011	Mar 2011	SHAs
iv. Assurance review of local implementation plans	Mar 2011	Apr/May 2011	DH/SHAs
v. Deliver local implementation plans for year one	Apr 2011	Mar 2012	PCTs
vi. Ensure health visiting is covered by transition planning in 2011/12	Apr 2011	Mar 2012	SHAs
vii. Capture and report robust information, e.g. on attrition and training places	Apr 2011	Mar 2012	SHAs/PCTs
viii. Monitor progress and adapt plans as necessary	Apr 2011	Mar 2012	DH/SHAs/PCTs
ix. Develop national implementation plan for 2012/13	Aug 2011	Mar 2012	DH
3.5 Transition to a new delivery model			
i. Work with NHS delivery, primary care and public health colleagues to determine the most effective future commissioning route	Apr 2011	Mar 2013	DH
ii. Develop a transition plan for 2012/13–2014/15 that aligns with developments in system architecture	Apr 2011	Sep 2011	DH
iii. Ensure positive correlation between workforce growth and population need	Apr 2011	Mar 2013	DH

3. Aligning the delivery systems (continued)

Activities	Start	End	Lead Responsibility
3.6 Future-proofing and sustainability			
i. Implementation and policy review, including risk and impact assessment	Sep 2013	Mar 2014	DH
ii. Development of metrics relating to user and staff experience			
3.7 Contributing to wider early years and family programmes			
i. Contribute to work with the Department for Education and others to respond to the Field, Allen, Tickell and Munro reviews, ensuring that the Health Visitor Programme contributes strongly to wider policy and service development in support of children, families and communities	Jan 2011	Apr 2011	DH

Annex 2 Delivery Partners

Delivery partners – 2011/12

Government departments

- **Department of Health (DH)** – responsible for promoting and ensuring the successful delivery of the programme, working with and through the key delivery partners. Lead responsibilities within DH rest with:
  - **the Chief Nursing Officer Directorate Professional Leadership Team; the Children, Families and Maternity Division; and the Family Nurse Partnership programme**
  - **the Workforce Directorate**
  - **the Finance, Performance and Operations Directorate**.
- **Department for Education (DfE)** – responsibilities include Sure Start Children's Centres, early years services and safeguarding children.

NHS

- **Strategic health authorities (SHAs)** – responsible for regional planning and delivery of the commitment to an additional 4,200 health visitors to improve services for families and children and assurance of local PCT plans to deliver growth in headcount numbers.
- **Primary care trusts (PCTs)** – responsible for commissioning of health visitors to meet the commitment to an additional 4,200 health visitors to improve services for families and children.
- **Community service providers** – responsible for the provision of health visiting services.
- **Shadow NHS Commissioning Board (NHS CB)**.

Local authorities

Responsibilities include commissioning and provision of Sure Start Children's Centres, other early years services and children's social care.

Regulatory body

- **Nursing and Midwifery Council (NMC)** – the regulatory body for nurses and midwives. Practice as a health visitor requires registration as a nurse or midwife and registration on the Specialist Community Public Health Nurse part of the register. As such the NMC sets the standard for entry to the health visitor profession and some educational requirements of the training programme.

Education

- **Higher education institutions (HEIs)** – responsible for the provision of education for health visitors.
- **The Council of Deans** – professional body that represents HEIs.
- **Universities UK (UUK)** – professional body that represents HEIs.

Delivery partners – 2012/13 and beyond

For 2012/13 and beyond, the delivery approach for the programme and partnership arrangements will need to be developed in the light of the emerging system architecture and responsibilities for commissioning.

A plan to support the transition to a new delivery model for 2012/13–2014/15 is a key deliverable for the programme in year one.

Wider partners

In addition to those listed above, there are a number of organisations that have an interest in the programme or may become a future delivery partner, including:

- **Association of Directors of Children's Services**
- **Centre for Workforce Intelligence (CfWI)**
- **Faculty of Public Health**
- **Health Innovation and Education Clusters (HIECs)**
- **Local Government Association**

- **NHS Alliance**
- **NHS Confederation**
- **NHS Employers**
- **Queen's Nursing Institute**
- **Royal College of General Practitioners**
- **Royal College of Midwives**
- **Royal College of Nursing**
- **Royal College of Paediatrics and Child Health**
- **Sure Start Children's Centres partners**
- **UNISON**
- **Unite/Community Practitioners' and Health Visitors' Association (CPHVA)**

We will also seek wider involvement from the voluntary and independent sector and from user organisations over the course of the programme.

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