Department of Health

Public Health England

NHS

Health Visitor Implementation Plan:

Quarterly Progress Report: April 2014 – September 2014

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Health Visitor Implementation Plan:

Prepared by: Policy Team, Health Visitor Programme, Department of Health

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1. Introduction

Purpose of the report

In its 2010 Coalition Agreement, the Government committed to increasing the number of health visitors by an extra 4,200 FTE above the May 2010 baseline by April 2015. Ministers wanted the extra capacity to bring with it the ability for local teams to improve public health outcomes for the under-fives, with health visitors having the time to provide parents with critical health and development advice, and to connect families to the array of health and wider community resources that help them to give their children the best start in life. *The Health Visitor Implementation Plan: A Call to Action*, published in February 2011, set out how this would be achieved through a 4-tiered model of health visitor delivery of the Healthy Child Programme (HCP) to all, with support for all parents and early help when needed. The 4-tier model aims to:

- improve access to evidence-based interventions;
- improve the experience of children and families;
- improve health and wellbeing outcomes for under-fives; and
- ultimately reduce health inequalities.

The Implementation Plan also committed to publishing quarterly reports explaining the programme's progress.

This report summarises the progress of the Health Visitor Programme (HVP) from April 2014 to September 2014 (Quarters 1 and 2, 2014/15). It has been co-produced by the Department of Health (DH), NHS England, Health Education England (HEE) and Public Health England (PHE).

Previous quarterly reports, can be found at: https://www.gov.uk/government/publications/health-visitor-plan-quarterly-reports-2013-to-2014

2. Key achievements in quarter one and quarter two

Workforce Growth - see further detail in section 4

At the end of Q1 (June 2014) there were 10,350 health visitors in post, whilst at the end of Q2 (September 2014) there were 10,800 health visitors in post. The end of Q2 figure represents a total growth in the health visitor workforce since May 2010 of 2,708 FTE (+33%).

A total of 1,445 health visitors were reported to have completed training in the first half of 2014/15, an over performance of 147, (from the September 2013 full-time cohort and the September 2012 part-time cohort).

At the end of Q2, the reported number of those starting training in 2014/15 to become a health visitor totalled 867 – 91 less than target.

Transforming service and revitalising the profession – see further detail in section 5

The programme's activity has continued to focus on sustainable service transformation and has successfully provided funding to support local transformation projects. The focus has been on delivery of the 4-tiered progressive model of health visiting including the universal elements of the Healthy Child Programme.

Professional leadership and mobilisation - see further detail in section 5

A range of professional leadership initiatives have been undertaken to support transformation within the service, these include:

- the development of the Education Initiative by HEE to support the transformation and enhance the skills and knowledge within the workforce, including the creation of a core Continuing Professional Development menu;
- integrated workshops between early years staff and health visitors to enhance joint working;
- interactive events with students to increase understanding of the expectations of new service model and facilitate the raising of queries/concerns;
- the development of new national induction and preceptorship frameworks; and
- training programmes and support materials that enhance the skills and knowledge of all health visitors.

Preparing for new commissioning arrangements on 1 October 2015 – see further detail in section 7

Substantial progress has been made in Q1 and Q2 towards delivery of a safe transfer of 0-5s public health services commissioning to local authorities on 1 October 2015, and achieving sustainability of the new health visitor service model beyond that date. Progress includes:

- national data and information workshops to test the assumptions about future commissioners (local authorities) information needs;
- continued joint working with key stakeholders from local government, central government and the NHS to agree the way forward and develop draft Regulations on mandation;
- regional LGA-led events to ensure key messages about the transfer were understood within the local government sector and to ensure concerns and questions were captured for response;
- NHS England's extensive work with area teams and local authorities to build a detailed national picture of current 0-5 commissioning in 2014/15 and expected 0-5 commissioning in 2015/16;
- finance principles for the transfer agreed and published by key stakeholders. These clarified that a 'lift and shift' arrangement would be used; and
- a communications strategy spanning the whole of health visiting and the 0-5 transfer was developed and a library of factsheets begun.

3. Organisational responsibilities and programme governance

A summary of the changes to the health and care system that came into effect in April 2013 was set out in the earlier Q1 2013/14 report (page 9) published at the time of changes and available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/265261/3_LOGOED_template_to_capture_final_agreed_version_pre_publication_final_v4.pdf

From April 2014 onwards, services were commissioned using the *NHS England 2014-15 Core Service Specification*. This was updated from the 2013-14 specification, with a strengthened emphasis on delivery of high impact outcomes and integrated working. The update included extensive consultation with existing and future commissioners, health visitor provider organisations, PHE, DH, LGA and others.

To reflect the need to deliver a safe and effective transfer of commissioning arrangements on 1 October 2015 that sees local authorities take over commissioning responsibility from NHS England for public health services (including health visiting) for children aged 0-5, a national task and finish group was established to develop a comprehensive transfer plan. In September 2014, the group was superseded by the 0-5 Public Health Commissioning Transfer Programme Board.

The 0-5 Public Health Commissioning Transfer Programme Board has representatives from the Local Government Association (LGA), NHS England, PHE, DH, SOLACE (Society of Local Authority Chief Executives), ADPH (Association of Directors of Public Health), ADCS (Association of Directors of Children's Services) and the Department for Communities and Local Government (DCLG). The Board's stated function is to support service stability, build on and support continuing service transformation and integration, and ensure that local authorities have the funding, capability and capacity to commission effectively. A smooth transfer to the new commissioning arrangements is the desired outcome.

The diagram below illustrates the programme's development over time, capturing four key phases from its foundation, through to the main focus to ensure sustainability.

4. Workforce expansion

Workforce trajectories

Workforce trajectories have continued to form the key basis for assessing and monitoring progress on delivering the programme's commitment to increase workforce capacity.

During the first half of the year (Q1 and Q2), programme partners, including NHS England's regional offices/local commissioners (area teams), with HEE, local education and training boards (LETBs) and DH, continued to work very closely to continue to deliver to agreed workforce plans.

In response to the need for more timely data to support effective monitoring and timely actions, the Indicative Health Visitor Collection (IHVC) was developed by NHS England in April 2014. The IHVC has since been collected on a monthly basis, alongside the Health Visiting Minimum Data Set (MDS). The IHVC supports more timely monitoring and reporting, but is collected as management information. The Health Visiting MDS remains the *official* dataset which is published by the Health and Social Care Information Centre (HSCIC).

Workforce growth

At the end of Q1 (June 2014), there were 10,350 health visitors in post, whilst at the end of Q2 (September 2014) there were 10,800 health visitors in post. The end of Q2 figure represents a total growth in the health visitor workforce since May 2010 of 2,708 FTE (+33%).

At the end of Q2, the reported number of those starting training in 2014/15 to become a health visitor totalled 867 – 91 less than target.

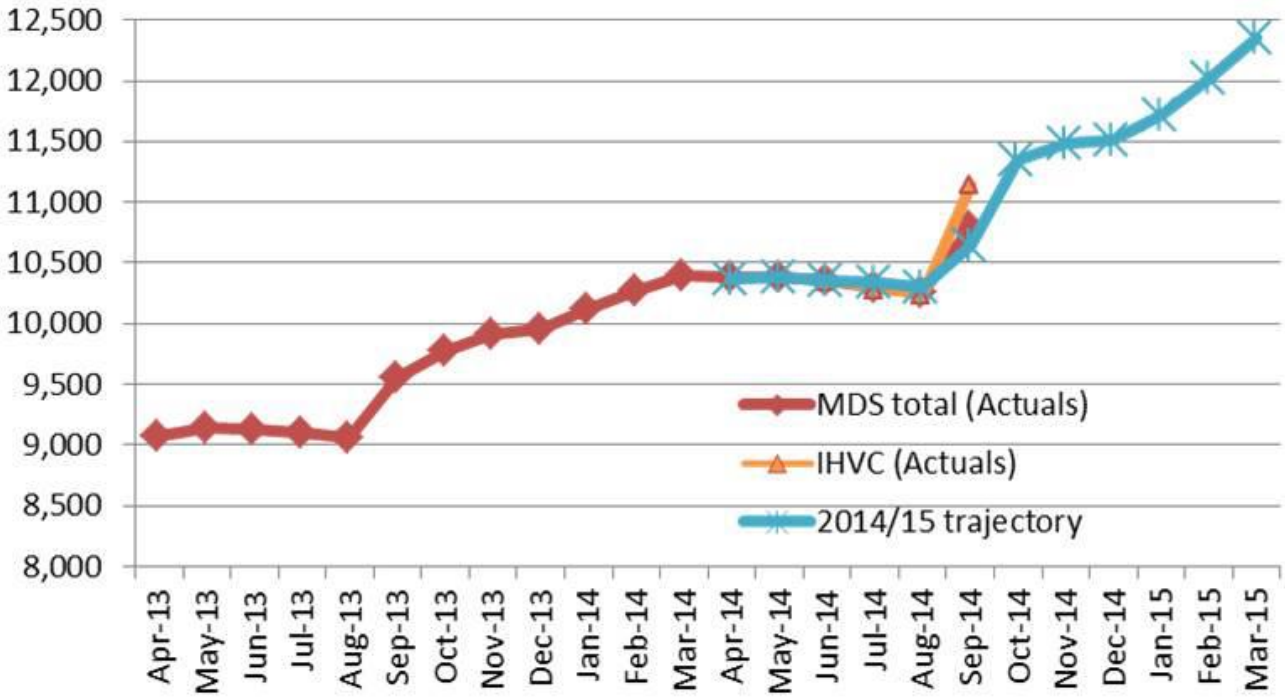
A total of 1,445 health visitors were reported to have completed training in the first half of 2014/15, an over performance of 147, (comprising the September 2013 full-time cohort and the September 2012 part-time cohort).

Throughout Q1 and Q2, discussions at regional meetings, (at which NHS England's national team participated), continued to focus on both the delivery of the additional health visitor numbers and on service transformation.

Regions, local commissioners (area teams) and HEE LETB colleagues also continued to work jointly to understand and address the challenges of students moving from training into the workforce, so as to ensure that the impact of the additional students was maximised.

Both LETB and regional representatives continue to attend the NHS England and HEE *Health Visiting Joint Governance Group.* This continues to ensure both organisations work together and remain focused on delivery and the sharing of good practice.

Growth in Health Visitor Numbers: April 2013 onwards



NOTES

1. The graph above shows growth of the health visitor workforce in England from April 2013 (when NHS England took on operational responsibility for delivering workforce growth) until the end of September (Q2) 2014.

2. The blue line shows the re-baselined 2014-15 national growth trajectory. The red line shows the official Minimum Data Set (MDS) performance as reported by the HSCIC, and the orange line shows the actual workforce FTE as indicated by management information collected from health visitor provider organisations (IHVC)

3. Data related to the graph is available at Annex A, page 35.

Health Visitor training

Numbers starting health visitor training have grown from under 500 in 2009/10 to 967 in the September 2014 cohort. These students will be able to join the health visitor workforce at some point in the twelve months from April 2015 onwards. The programme is ensuring that there are sufficient health visitor training places across the country, supporting workforce expansion by ensuring health visitor trainees are available in the right place at the right time. Through HEE, it has responsibility for:

- planning investment in health visitor training;
- commissioning health visitor training (university and clinical placements);
- supporting recruitment to those programmes;
- monitoring and, where appropriate, managing attrition from programmes; and
- supporting universities, employers and students to apply for and secure first posts in health visiting.

In the first half of the year, joint working between HEE and NHS England focused on retention of students and tracking them to first employment.

In the first half of 2014/15, there were 1,445 health visitorS who had completed training, 147 ahead of the trajectory for the end of September 2014 of 1308. Those who had completed training were predominately from the September 2013 full time cohort and the September 2012 part time cohort.

In the first half of 2014/15, there were 967 new starters on training programmes recruited from the September 2014 cohort.

Looking ahead, the target for qualified completers in 2014/15 is 2,542 (assuming an attrition rate of 8.7%), compared with 2,706 students still capable of completing by March 2015, as at the end of September 2014.

The LETBs are closely monitoring attrition across the three 2014/15 cohorts and providing support through universities for students who required it. There are monthly data collections of leavers and monitoring of placement providers and programmes as part of the overall monitoring dashboard.

Reducing service turnover and improving retention: key activity in Q1 and Q2 2014/15

NHS Employers were commissioned to undertake two elements of work:

(i) provide support to providers of health visiting services as they worked towards implementing 'A Call to Action' – including the facilitation of Share and Learn network meetings and the publication of a **guide** on the use of Recruitment and Retention Premia (RRP); and
(ii) undertake a **recruitment and retention project**.

RRP - publication of the guide

The guide provides an overview of the some of the mechanisms that exist for NHS organisations to help the recruitment and retention of health visitors, focussing on:

- RRP and where its use may help aid recruitment and retention;
- how existing pension flexibilities can help to retain experienced health visitors within the workforce; and
- how the new NHS Pension Scheme in 2015 might or might not affect the workforce.

Whilst the guidance was primarily aimed at the providers of health visiting services, it may also be useful to NHS England Area Teams and other organisations. It is available on the NHS Employers website: http://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/recruitment-and-retention-premia

Health visitor recruitment and retention project with provider organisations

Work to support 30 health visitor provider organisations to implement evidence-based strategies to retain their health visitor workforce was completed in July 2014, with a final event to share learning from the project. The project identified two provider groups (London and outside London) who were offered bespoke support suited to their own timetable.

The project team worked with the 30 provider organisations who received six days of allocated support. They all developed action plans with support from NHS Employers, aimed at improving overall satisfaction of the team and therefore the retention of health visitors.

Providers also had access to the existing NHS Employers Health Visiting Share and Learn Network, as well as the workforce related resources freely available via the NHS Employers website.

As part of the project, NHS Employers launched the *Health Visitor Workforce hub* – making available a range of health visitor recruitment and retention materials to employers at a single location. This incorporates learning from the 30 providers involved in the project.

NHS England began work on a specification of a second phase of the retention project delivered by NHS Employers in 2013/14, with the tender process beginning in September 2014. This second project is based on taking forward the work undertaken during the 2013/14 project and recommendations contained in the end of project report. It will focus on taking forward 15 of the original group of 30 providers identified again with support from regions that are in particular need of this additional level of support.

The aim is to not only support retention of the workforce for these providers, but support them in preparation for the transfer of commissioning to local authorities. In addition, it is also hoped this project will, through sharing the outputs of the project more widely, enable health visitors and providers alike to see opportunity in this transfer and how they can position themselves as public health leaders in the wider local authority team. This project is due to end in Q2 of 2015/16.

Liaison with NHS Employers and its networks

NHS Employers ran five *share and learn* meetings during quarters 1 and 2 for health visiting service provider organisations. Three were held in the north (Leeds) and two in the south (London). The meetings provided a forum to discuss and solve local workforce issues, learn about available supportive resources, including for recruitment and retention, and share learning. The events were attended by over 30 health visiting service and workforce managers with attendees reporting excellent satisfaction, with many saying they ‘would do something different’ as a result of attending.

The meetings included presentations on different aspects of workforce recruitment and retention aimed at helping providers work towards their workforce trajectories, as well as key practitioner topics linked to the new health visitor service model. These included:

- total reward strategies;
- staff engagement;
- preceptorships;
- health visitor career pathways;
- Ages & Stages Questionnaires (ASQ-3™) and the Integrated Review;
- Building Community Capacity; and
- the use of social media as a recruitment and retention tool.

In addition, the role descriptions for practice teachers and mentors were shared for comment with the network, and a number of issues raised with resolutions designed and taken forward, such as on health visitor prescribing and consistency in job descriptions.

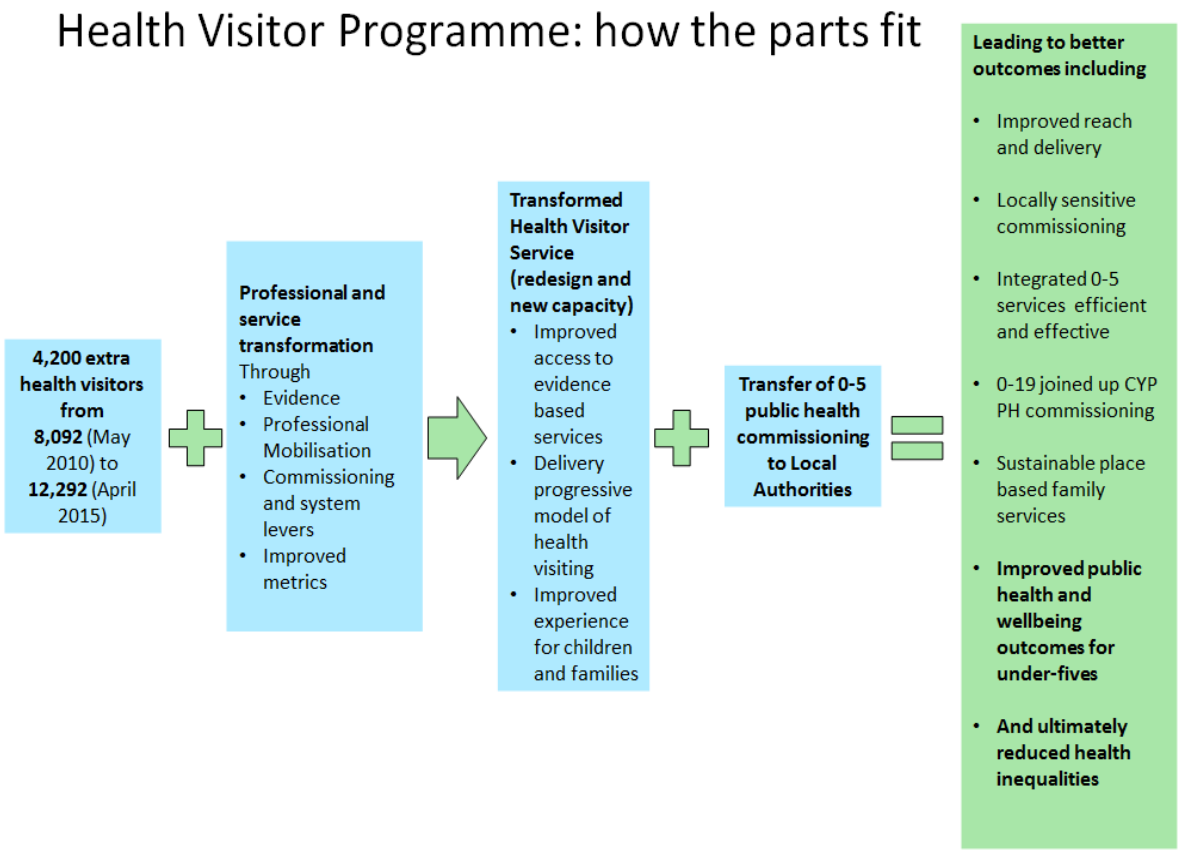
During both quarters, NHS Employers communicated key workforce messages to health visitor provider organisations via the NHS Employers website and other communication channels including social media. Employers were able to freely access resources on recruitment and retention strategies, including using Total Reward and pension flexibilities in recruitment and retention.

5. Transforming the service and revitalising the profession

Service transformation is intrinsically linked with revitalising the profession and is being driven on three fronts:

- development of system and commissioning levers;
- service improvement programmes that are evidence-based and measurable; and
- professional leadership and mobilisation.

In the first 6 months of 2014/15, DH, NHS England, LGA, HEE and PHE continued to work together to ensure that the success of the transformed service can be demonstrated, as well as enabling continuity and building sustainability. The partner organisations continued to build on an integrated approach to embedding health visitor service transformation, as shown in the diagram below - which identifies the system levers and how component parts fit together.



System levers: Commissioner-led activity/local level support

In Q3 of 2013/14, NHS England invited bids from Area Teams (ie local commissioners) for funding to support systematic delivery of the new model of health visiting and demonstration of service transformation[1], in particular to support provider and commissioner development.

For this first phase of funding, Area Teams put forward a variety of projects which reflected local needs. The funding enabled them to set up the projects and start initial development.

A second round of funding was made available for 2014/15. Area Teams were again asked to submit bids during Q1 to gain additional funding to build on these projects and continue to develop projects to match local requirements and facilitate further development of health visiting, particularly outcomes and health visiting within the context of the 0-5 commissioning model.

While formal evaluations of these projects will be described in Q3 and Q4, some early reports from Area Teams demonstrated the following outputs:

- increased morale in staff leaving the training session
- incorporating an information sharing event into training was a successful way of agencies becoming more aware of one another
- recognition of the need to bring together practice teachers into the communities of practice
- challenges in the provision of some nurseries for the delivery of the assessment - some did not have suitable rooms, limited number of children were able to be seen
- increased HV awareness of commissioner requirements and decisions about how resources should be allocated
- all boroughs will now routinely receive performance data in order to begin detailed planning for future commissioning; this was not an intended outcome but has been beneficial to the system. There has also been marked improvement in understanding among both current and future commissioners of the goals of each side and how best to work together to achieve share outcomes. This is likely to pay significant dividends going forward.

Two examples of projects that show the breadth of work being delivered are shown below – with a focus on the HIAs.

Parent Infant Health Model

The Greater Manchester Area Team project is developing a parent infant health model to support embedding parent infant attachment in service delivery. This model is based on the

1 http://www.local.gov.uk/documents/10180/11493/Letter+to+area+teams+writing+expressions+of+interest+for+health+visiting+transformation+funding/d21ffd36-4728-416b-a915-d23cfc832db5

Tameside and Glossop Parent Infant Mental Health Pathway and Early Attachment Service model[2] as it is comprehensive, cost-effective, sustainable and effective.

This project supports the delivery of the 4 tiers of service delivery, delivery of all of the mandated services and improved outcomes for maternal mental health.

Increasing prevalence of breastfeeding in Kent and Medway
Building on the first round of work on transformation of the health visiting service, local stakeholders identified a need to improve and develop the prevalence of breastfeeding and integration with local authority public health services.

Short, medium and long term actions were scoped and implemented – these focused on improving the recording of activity surrounding the 6-8 week checks on the Child Health Information Service and working with GP practices. These actions also utilised current work streams and governance arrangements

Health Visitor User Experience Survey

In Q4 of 2013/14, NHS England started a tender process for the delivery of a Health Visiting Service User Experience Survey toolkit and guidance. The Picker Institute was commissioned in Q1 of 2014/15 to take this work forward, and work on the development of the specification began in Q2. This toolkit will enable providers of health visiting services to robustly collect parents' views on the health visiting service. It is anticipated this project will be completed in Q1 of 2015/16.

Ensuring the service is using the latest evidence

The Healthy Child Programme 0 – 5 years: evidence review

In Q4 2013/14, PHE commissioned a rapid review of the evidence base underpinning the *Healthy Child Programme (HCP): Pregnancy and the first five years of life*. The evidence base for the HCP, which was last updated in 2008, is continually evolving as new research is published, so it is essential that the new health visiting service is based the latest evidence. The topics included within the scope of the review include:

- parenting skills;
- parent/infant attachment;
- nutrition including breastfeeding, weaning guidelines and healthy diet/reducing obesity, latest evidence/best practice on growth monitoring;
- speech, language and communication;
- parental emotional and mental health (notably impact on outcomes for the child);
- perinatal mental health – assessment and management;
- smoking/alcohol/drug misuse;
- domestic violence;

[2] See http://www.c4eo.org.uk/themes/earlyyears/vlpdetails.aspx?lpeid=436 for further information on the Tameside and Glossop Early Attachment Service

- unintentional injury in the home;
- dealing with neglect; and
- new research in relation to identifying families in need of additional support (including implications for delivery of the programme, for example, the number and timing of universal assessments, locality of visits, early identification/use of multiple or single risks, resilience and protective factors).

The evidence base informs the delivery of the HCP in a number of critical ways, including:

- clarifying the importance of the universal programme;
- informing the balance between universal and more targeted approaches;
- informing transitions in the delivery of the HCP between midwives and health visitors (including when to start the transition/how many antenatal visits) and between health visitors and school nurses;
- assessment and delivery of specific interventions including motivational interviewing, brief interventions and behavioural insight;
- how the HCP could be delivered in a more consistent manner;
- learning points from the research examining the science of implementation in general, and in relation to this specific programme;
- implications and recommendations for workforce skills and training;
- implications for practice recommendations; and
- clarifying the wider economic, health, and social benefits the HCP can deliver.

The contract to deliver the review was awarded to a consortium of academics led by Dartington Social Research Unit, with Warwick and Coventry Universities. A draft report was received in April. The advisory group met to review the findings and provide expert feedback, after which the report was revised accordingly. Three subgroups of the advisory group were established to consider the implications for policy, practice and commissioning. The subgroups were asked to report back to the advisory group in July 2014.

Towards the end of Q2, the advisory group identified some key areas that were not covered by the systematic review and commissioned further work to include these areas in the report. The final report was published in Q4 and will be discussed in more detail in the Q3/Q4 report.

Assessing progress & measuring impact of a transformed service

The 6 early years High Impact Area (HIAs) documents were developed to support the transition of commissioning to local authorities and to help inform decisions around the commissioning of the health visiting service and integrated children's early years services. They articulate the contribution of health visitors to the 0-5 agenda. **It is possible to take each one of the six HIAs as a conduit through which progress can be assessed via themes of: access, experience, outcomes, and (over time) the impact on inequalities**.

The Health Visitor Service Delivery metrics measure whether visits occurred and as such represent health visitor activity. Whilst activity figures are presented for England and the regions (see Annex B), these are based on the incomplete figures provided and as such may not be representative of the whole population where coverage is lower. Therefore, they should be interpreted with caution and alongside coverage figures giving the percentage of health visitor provider organisations who have returned data passing the validation checks for each indicator (see Annex B).

Data coverage, which helps illustrate the impact of a transformed service, has increased significantly since the earlier data collections – in Q1 2014/15 the average coverage for the seven service delivery metrics was 90% at national level. In Q2 2014/15, this rose to 92%.

HIA 1: Transition to Parenthood and the Early Weeks

A significant body of evidence demonstrates the importance of sensitive, attuned parenting.

● Access: as illustrated by the metrics data which shows:

- ***'Number of mothers who received a first face-to-face antenatal contact with a health visitor at 28 weeks or above'*** was collected as a number, rather than as a percentage, because of the difficulty in defining the population of women who should receive this contact in each area in each quarter. In Q2, the reported number of contacts in England was 45,232 (based on returns from 95% of provider organisations), an increase from 38,804 in Q1.

- ***Percentage of New Birth Visits (NBV) completed.*** The percentage of NBVs undertaken within 14 days in England was reported to be 75% in Q1 2014/15, and 79% in quarter two 2014/15. The percentage of NBVs undertaken *after* 14 days in England was 22% in quarter one 2014/15 and 17% in quarter two 2014/15. Overall, delivery of NBV has shown a small increase from 95% in Q1 2014/15 to 96% in Q2 2014/15.

● Experience: Feedback can be attained from service user experience questionnaires on satisfaction with antenatal and new birth review contacts via local commissioner and provider data.

● Outcomes: Generally, there are better outcomes when parenting programmes start in pregnancy. These will be demonstrated over time in development of the Public Health Outcomes Framework (PHOF), and through use of the *Ages and Stages Questionnaire 3* (with its 5 areas of development).

● Inequalities: Preventative approaches and early intervention will over time, impact resilience, and physical, mental and sociological outcomes in later life.

HIA 2: Maternal Mental Health (Perinatal Depression)

Perinatal mental health is a key Government focus following robust evidence on the impact of maternal mental health during pregnancy and the first 2 years of life. Effective delivery is likely to be via the development and implementation of local multi-agency pathways that set out evidence based assessments, identification and interventions for perinatal depression etc.

● Access: an indicator is in development which is related to the proportion of women who are asked about their mental health at three key points.

● Experience: indicators are in development, eg *'did you feel comfortable speaking to your health professional..?*'

● Outcomes: indicator in development, e.g centred around 'whilst you were pregnant/first year after child's birth, did you experience any problems with your mental health….*?'*

● Inequalities: the impact can be demonstrated over time, e.g on the lack of recognition and awareness of mental health per se and how this manifests itself in some black and ethnic minority groups.

HIA 3: Breastfeeding (Initiation and Duration)

● Access: Implementation of evidence-based infant feeding policies. Up to date, evidence-based multi-agency infant feeding policies set out best practice in relation to breastfeeding support.

● Experience: feedback from health visitor service user experience questionnaires on satisfaction with breast feeding support etc.

● Outcomes and links to impacting inequality: PHOF 2.2(ii) – breastfeeding prevalence at 6 – 8 weeks.

● Inequalities: Over time, the PHOF is likely to be able to demonstrate increased duration of breastfeeding among those otherwise least likely to breastfeed e.g those living in areas of deprivation.

HIA 4: Healthy Weight, Healthy Nutrition (to include Physical Activity)

● Access: use of up to date evidence-based multi-agency infant feeding policies including healthy weaning and nutrition in early years settings.

Metrics data below refers to activity likely to include focus on healthy weight and as such, act as a proxy to indicate progress with access.

- ***Percentage of 12 month development reviews completed.*** The percentage of children in England who received a 12 month development review by the time they turned 12 months is reported to be 67% in Q2 2014/15, with validated returns from 97% of providers. The percentage of children receiving this review was 65% in quarter one 2014/15 with coverage for this indicator at 95%.

- ***Percentage of 12 months development reviews completed by the time the child turned 15 months*.** This indicator measures the percentage of children in England who received a 12 month review by the time they turned 15 months and adds to the percentage of children who received the 12-month review in the previous quarter. There was a small increase in the reported percentage of children in England who received a 12 month review by the time they turned 15 months from 76% quarter one 2014/15 to 77% in quarter 2, with validated returns from 88% and 84% of providers respectively.

● Experience: feedback from service user experience questionnaire on satisfaction with weaning etc.

● Outcomes: PHOF 2.06i - percentage of children aged 4 – 5 classified as overweight or obese (4.02), mean severity of tooth decay in children aged five years (2.02ii), breast feeding prevalence at 6-8 weeks after birth – number of infants who are totally or partially breastfed at 6-8 week check via early years profiles.

● Inequalities: Addressing childhood obesity will impact a significant health inequality factor - with higher rates amongst children in disadvantaged areas and some ethnic groups.

HIA 5: Managing Minor Illness and Reducing Accidents (reducing hospital attendance/admissions)

● Access: coverage of universal elements of the HCP, as all visits include accident prevention, e.g note metrics data above from 12 month review/completed by 15 months.

● Experience: feedback from the health visitor service user experience questionnaire on satisfaction with delivery of the HCP via local commissioner/provider data.

● Outcomes: health episode statistics data on non-elective admissions for 0-4s. Indications too via NHS England's metrics data (for example the 12 month development review latest data above).

● Inequalities: there is a strong link between unintentional injury and inequality, with the most disadvantaged families more likely to suffer injuries. Death rates and poisoning have fallen for all social groups except the poorest – where children are more likely to die.

HIA 6: Health, Wellbeing and Development of the Child Age 2 – Two year old review (integrated review) and support to be 'ready for school'.

● Access:

***Percentage of 2-2.5 year reviews completed*.** The percentage of children in England who received a 2-2.5 year review by the time they turned 2.5 years is estimated to be 68% in quarter two 2014/15, a 5 percentage points decrease since quarter one 2014/15. This is based on returns from 96% of providers in quarter two 2014/15, up from 89% coverage in quarter one 2014/15.

***Percentage of Sure Start Advisory Boards with a health visitor present*.** This is measured as the number of sure start advisory board meeting in the quarter with a health visitor present as a percentage of all meetings. In England the percentage of sure start advisory boards with a health visitor presence is estimated to be 97% in quarter two 2014/15, slightly higher than 95% in quarter one 2014/15. This is based on returns from 81% of providers in quarter two 2014/15 and 86% of providers in quarter 1.

● Experience: Parents will be able to actively participate in their child's development/reviews through use of the *Ages and Stages questionnaire* and other assessment tools.

● Outcomes: The PHOF includes (in development), 2.5i – proportion of children aged 2-2 and a half receiving a HCP assessment or an integrated review. Sub-indicators are based on use of the ASQ tool and include areas of development such as communication, gross/fine point motor skills and problem solving.

● Inequalities: As with the other HIAs, the programme will continue to evidence progress through existing measures of outcome, access, effective delivery and experience. In this case, intervention offered by way of the review will inform discussions with parents about their child's progress. Facilitation of early intervention and support for families will help deliver a reduction in inequalities in children's outcomes.

Professional development and mobilisation

A range of professional leadership initiatives have been undertaken to support transformation within the service, including:

● **Integrated workshops between early years staff and health visitors** continued in Q1 and Q2 to enhance joint working and to increase understanding of each other's professional roles. These enabled teams to consider how they could improve outcomes through innovative service delivery, integrated working and increased partnership approaches. They have also provided an opportunity to discuss what hinders and what improves partnership working and have provided an opportunity to explore solutions.

● The series of **question time events with student health visitors** to increase their understanding of the expectations of the new health visiting service, and to enable students to raise concerns and queries directly with national leaders continued into the first half of 2014/15, with the final event taking place in September. These events have also informed national bodies of potential problems or issues, enabling a rapid response and support approach to be possible at a local level.

● **Engagements via conferences, regional events and national forums** have been helpful both for continuing to raise the profile of health visiting and for highlighting case studies and best practice.

● The programme has continued to contribute to a **cross-Government focus on families** under the over-arching commitment to strong and stable relationships. The aim is that through the breadth of support available to families, maximum effort is placed in support of sustainable and healthy parental relationships, and in helping parents give their children the best start. DH has (under the Department for Work and Pension's (DWP) lead), undertaken to contribute towards:

- piloting relationship support as part of antenatal classes in six areas across the country;
- underpinning recognition of health visitors' important role as trusted professionals in supporting new parents. Here the programme's professional leads have engaged in dialogue with DWP about guidance and training products that will best support health visitors' role at the interface with families - in recognising responding to the signs of relationship difficulties. The programme's progress towards delivering the 4,200 additional health visitors will leave the workforce better positioned to maximise the benefits of guidance and training.

- Building on the enhanced entitlement to **free early education for all 3 and 4 year olds**, by the end of Q2, the national entitlement of 570 free hours of early education for 2 year olds was extended further to reach around 260,000 children from low income families in England. The programme has facilitated links to the local authority leadership of this initiative, with the aim of health visitors being in an informed position to highlight to families as appropriate, their potential access to this extended free education offer.

● Work has taken place with a wide range of **stakeholders** to ensure partners are able to contribute the professional voice to documents and interlinked policy areas, e.g. work with *4Children* strategic partners, the armed forces, SEND partners and Department for Education. There has been ongoing dialogue with the NMC to ensure that newly qualified health visitors are registered with the NMC in a timely manner and to clarify issues relating to return to practice and other registration issues.

● Professional leadership is being maintained with **health education institutions** – this has been helpful in shifting agendas and adapting programmes to meet the needs of the current and future service.

● **Professional advice and support** has been maintained through a range of media and contacts, including webinars, for information sharing and debate purposes.

● Work has continued on the ***Education Initiative*** to support the transformation and enhance the skills and knowledge within the workforce. In particular:

- Development of a core standardised Continuing Professional Development (CPD) menu;
- A review of current CPD availability, and the development and introduction of elements across the country to ensure access for all practitioners;
- Introduction of evidence-based programmes to enable staff to deliver the 6 High Impact Areas;
- A programme of support developed and delivered nationally on reflective practice and leadership.

● The Department of Health has developed an **outcome measure of child development at age 2 – 2½ years**, the data for which will be collected via the Child Health Information System (CHIS) and published in the PHOF from 2015. The Ages & Stages Questionnaires (ASQ-3™) public health outcomes measure was launched in November 2014. From April 2015 all health visitors will be required to use it as part of two year health reviews. E-learning materials are accessible on the e-LfH website and DH has funded one set of ASQ-3™ materials on CD-ROM per health visiting provider in England which was distributed by the end of 2014. The e-learning is an interactive tool that incorporates video clips from actual 2-2½ year reviews and covers the practicalities of using the ASQ-3™.

- HEE commissioned the Institute of Health Visiting to strengthen induction and preceptorship in health visiting by producing new **National Induction and Preceptorship Frameworks**. Developed with health visiting leaders and experts from across England and in consultation with students, newly qualified, return to practice, practice teachers and senior managers from the health visiting profession, the new national Health Visiting Induction Framework sets the best practice standards for a high quality induction programme for newly qualified, return to practice and new to area health visitors. The new national *Health Visiting Preceptorship Framework* provides a consistent approach to preceptorship across the country - providing the support for newly qualified/returning to practice health visitors, to fulfil their role as an independent, autonomous and innovative health visitor, meeting the requirements for health visiting in England during their first 2 years of employment.
  http://www.ihv.org.uk/news_events/news/181/New%20Preceptorship%20Framework

- As part of the effort to strengthen inductions and preceptorships, work was taken forward in Q1 and Q2 to ensure that Specialist Community Public Health Nursing (SCPHN) health visitor students experienced an **effective practice placement**. HEE, DH and PHE consulted with a range of stakeholders to gain a collective understanding of the challenges of health visiting practice placements and the quality of the learning experience. Similar themes emerged across the consultation and, as a result, HEE established the Health Visitor Placement Quality Task and Finish Group. The Group developed a report (which was published in Q3) which reviewed the policy and research evidence-base related to effective practice learning. The first ever *National Placement Quality Survey of Practice Teachers, Mentors, Health Visiting Students and Senior Managers/Clinical Leads* informed the findings. As part of the report, national role descriptors and a national competences framework for both Practice Teachers and Specialist Mentors, and a set of National Standards for Assuring Quality in Practice Placements were developed.

- Delivery of a number of commissioned pieces of work to strengthen leadership, including:
  - By the end of Q2, we had through the commission with iHV successfully funded **over 300 perinatal mental health champions** and this total was likely to further increase. It covers the fundamental requirements necessary for health visitors to manage anxiety, mild to moderate depression and other perinatal mental disorder, including knowing how to assess for the presence of these conditions and, if identified, the variety of ways they can support mothers - either by intervening themselves or through referral on to a GP or specialist. The training model enables participants to become local perinatal mental health champions and to disseminate their skills and knowledge to health visitors and other professional colleagues locally. All health visitors also have access to supportive interactive e-learning modules to help them in the detection and management of perinatal depression and other maternal mental health conditions.

  - iHV made good progress in attracting applicants for their new **Fellowships**. The Fellows are health visitors with exceptional leadership qualities delivering excellence in practice. They are known as professionals who push the boundaries, have an entrepreneurial spirit and have made a real difference to the health outcomes of children, families and communities. Fellows can act as the catalysts to communicate and lead messages about local leadership to maintain momentum around service transformation that has been built over the last 4 years.

- **Domestic violence and abuse training** continued.

- ***Start at the beginning*** research and development pilot project, supported by health visitors, commenced to improve pre-conception health in women who are planning a pregnancy, through the use of a pre-conception and pregnancy mHealth device for personalised coaching on nutrition, diet and lifestyle behaviours. The benefits of pre-

conception health positively impacts health life course benefits in maternal, paternal and child health. This project is ongoing – progress will be discussed further in the next report.

- Development of a **Perinatal Mental Health Value Scorecard** to identify patient reported experience and quality indicators aligned to the early-years public health outcomes for perinatal mental health. The aim of the scorecard is to drive up the quality and consistency of services delivered by the health visitor workforce. This project is ongoing – progress will be discussed further in the next report.

- Development of a **pilot DIY health training programme and toolkit** to build parental confidence and empower self-management of minor and self-limiting illness. The pack will support facilitated sessions to build skills, best practice, experience sharing, differentiation and reflection. This project is ongoing – progress will be discussed further in the next report.

Refreshing the pathways guidance documents

- A group made up of key professionals was established to review and refresh the guidance pathways published since the start of the programme. The review focuses on:
    - feedback on pathways;
    - how they are being used;
    - any gaps or key changes; and
    - any new resources, guidance or policy that needs to be reflected.

  The pathways/guidance refreshed during the second part of 2013/14 were:
    - supporting military families;
    - female genital mutilation; and
    - special educational need and disabilities.

6. Health Visitor Taskforce

The Health Visitor Taskforce (HVT), set up in 2011, has continued to champion the vision of the Health Visitor Programme (HVP). It met in both of the first quarters of 2014/15. Chaired by Dame Elizabeth Fradd, the Taskforce provides strategic challenge to the delivery of the Government's commitment to improve services and health outcomes in the early years for children, their families and the community. It acts independently as a critical friend, with membership drawn from the voluntary and community sector, parent representatives groups and professional organisations who sit alongside national and local members from public health and the NHS with strategic direction set by observers from key partners such as the DH, NHS England, PHE and the LGA. Together members provide a wealth of experience and expertise.

The HVT recognises its range of membership and its key role as a a champion, which puts it in a unique position to offer advice and support to the health visiting community. As such, during quarters 1 and 2, it has been invaluable in supporting delivery of the HVP. Members of the HVT undertook five visits during this period, to Guys and St Thomas's NHS Trust, Bromley, Lewisham, Buckinghamshire and Nottinghamshire.

The general role of the HVT has continued to be important as the programme of transformation gathers pace and the transfer of 0-5 children's public health commissioning to local authorities (October 2015) moves closer. Members have continued to show enthusiasm as they undertake visits to those providers that deliver health visiting services offering them help and advice during a period of change, particularly to those sites that may face the biggest challenges. Feedback received confirms the benefits and value placed on these visits, where, in the main, all participants, including students, gain something.

The HVT will continue throughout 2014/15, sitting alongside other groups leading the progression and delivery of change.

7. Transfer of commissioning of 0-5 years children's public health services to local authorities

The Government's aim is to enable local services to be shaped to meet local needs. As set out in the white paper *Healthy Lives, Healthy People: Our strategy for public health in England* (2010), local government is best placed to identify the needs of their populations and to influence many of the wider factors that affect health and wellbeing.

From 1 October 2015, local authorities will take over responsibility for commissioning public health services for children aged 0-5 from NHS England. This includes health visiting services and the Family Nurse Partnership. NHS England will continue to commission 0-5 public health services (universal and targeted) until 30 September 2015. The mid-year transfer supports improved stability of the system before the transfer of services and provides NHS England sufficient time to embed the Government's commitment to increase the number of health visitors and transform the service.

Commissioning of public health services for 5-19 year olds was transferred to local authorities in 2013, so the transfer of commissioning for 0-5s services completes the move of 0-19s public health commissioning to local authorities, thus enabling joined up commissioning from 0-19 years old, with improving continuity for children and their families.

As reported at Q1 2013/14, a dedicated task and finish group co-chaired by DH and SOLACE was convened in June 2014 to co-design a comprehensive transfer plan for children's 0-5 public health commissioning responsibilities. The task and finish group was superseded by a full programme board (the 0-5 Public Health Commissioning Transfer Programme Board) in September 2014 chaired by the Senior Responsible Officer (SRO) for the transfer, Viv Bennett (DH/PHE). The 0-5 Public Health Commissioning Transfer Programme is accountable to the Children's Health and Wellbeing Partnership Group, ensuring the Board has robust and strong decision making powers, with clear escalation routes to resolve specific issues.
In Q1, NHS England's Executive Board agreed that the 0-5s transfer work should be designated a major programme within NHS England (in addition to it being designated a Major Government Project as part of the HVP) and that strengthened governance and additional resource should be put in place. NHS England set up an internal 0-5 Transfer Sender Board following this decision, and appointed a corporate SRO at the first meeting at the end of July 2014.

Four sub-groups were formally set up in September 2014 to underpin the work of the 0-5 Public Health Commissioning Transfer Programme Board. *Preparedness and assurance* - ensuring NHS England is ready to hand over its commissioning responsibilities and that local authorities are ready to receive them; *finance and contracting* – ensuring the right resource is in the right place for 2015/16 commissioning and that provider contracts are in place to ensure continuity of public services; *data and information* – ensuring that local authorities have the information they

need to commission effectively and realise the intended benefit of services being more focussed on local need; and *communications* – making sure that the system has a shared understanding of the transfer and continues to focus on the benefits that the HVP and Family Nurse Partnership Programme are delivering. Representatives from all partners are engaged in the delivery of outcomes from each of these groups.

In addition to the work of the sub-groups, the DH health visitor policy team is developing Regulations to deliver the Government's intention for the commissioning of the universal elements of the 0-5 Healthy Child Programme to be mandated from 1 October 2015. Mandation is intended to apply to five specific checks:

- antenatal health promoting visit;
- new baby review;
- 6-8 week assessment;
- 1 year assessment; and
- 2-2½ review.

Mandation will allow for the health visitor service to be shaped locally while ensuring continued delivery of the assessments in the context of a national, standard format (or specification) for the service and therefore all families can be confident that they will continue to receive universal health visiting support. The five mandated checks will influence six high impact areas where health visitors can make the most difference to a child's early years:

- transition to parenthood and the early weeks;
- maternal mental health (perinatal depression);
- breastfeeding (initiation and duration);
- healthy weight, healthy nutrition (to include physical activity);
- managing minor illness and reducing accidents (reducing hospital attendance/admissions); and
- health, wellbeing and development of the child age 2 – two year old review (integrated review) and support to be 'ready for school'.

The transformed health visiting service is described by the 4-5-6 model. These are the four levels of the health visitor service; the five universal health and development reviews for all children at key stages; and a focus on the six high impact areas which are very important to good child health outcomes and where evidence shows health visitors make a significant difference.

The Government's intention is to put Regulations in place which provide a sunset clause at 18 months. This 18 month period provides a degree of stability for the service post-transfer. DH and PHE will undertake a review of the effectiveness of the Regulations by 1 October 2016 which will inform a decision by Government as to whether mandation should continue.

Local authorities will be expected to take a reasonable approach to continuous improvement and the regulations are not intended to place any additional financial burden outside of the funding agreed for the second half of 2015-16 in the forthcoming financial settlement. We are clear that local authorities will not have to deliver more than the NHS at the point of the transfer and we will ensure that expectations of local authorities to improve performance will not place on them any additional financial burden.

Progress on delivering the Regulations will be discussed further in the next report.

The 0-5 Public Health Commissioning Transfer Programme Board and its subgroups made substantial progress in Q1 and Q2 towards supporting a safe transfer of commissioning on 1 October 2015 and achieving sustainability of the new health visitor service model beyond that date. Some of this progress is described below. Progress made in Q3 and beyond will be discussed in future reports.

- A national data and information workshop was held in **June** to test the assumptions about future commissioners (local authorities) information needs. The feedback from this workshop shaped the design of planned data outputs which were tested further at regional workshops in **September** and October. As a result of this work, a *how to* guide to support a safe transfer of the data and information elements of the transfer was later co-produced by PHE, LGA and NHS England. The guidance was published in Q4.

- A workshop with key stakeholders from local government, central government and the NHS agreed the way forward on mandation in **June**. In **August**, a mandation factsheet was published which set out why and how universal services would be mandated and the benefits of taking this approach.

- Letters were issued by the LGA to local authority Chief Executives, Directors of Children's Services, Directors of Public Health and Directors of Human Resources in **July** to bring them up-to-speed on the plans for the transfer. The letters set out the timetable for the transfer and communicated key information, including the process for agreeing financial allocations, the Government's intention to mandate universal services, the support offer for local authorities, and the hosting in September/October of LGA-led regional events to foster two-way communication between sender, receiver and the policy centre.

- In **July**, the assurance and support framework for local authorities with national oversight by PHE and regional oversight by Regional Oversight Groups was agreed by the Task & Finish Group and the rollout started.

- Three regional LGA-led events were held in **September** in the South East, South West and North East regions to ensure key messages about the transfer were understood within the local government sector and to ensure concerns and questions were captured for response. The events were well-attended and there was positive feedback from delegates. A further six regional events were held in October (Q3).

- Between **June** and **September**, NHS England worked extensively with area teams and local authorities to build a detailed national picture of current 0-5 commissioning in 2014/15 and expected 0-5 commissioning in 2015/16. This picture was instrumental in shaping the Baseline Agreement Exercise launched in Q3 to enable the finalisation of financial allocations in Q4.

- In **August**, the finance principles of the transfer were agreed by key stakeholders and published. These clarified that a 'lift and shift' arrangement would be utilised. The principles also confirmed the scope of the transfer, the assurance and support framework and the approach to contracting.

- NHS England set a baseline in **August** for sender readiness which enabled quarterly reporting to the 0-5 Public Health Commissioning Transfer Programme Board on six key criteria: finance and contracting, legal, communications, workforce, data and information and governance.

- The deliverables for the 2015/16 'NHS public health functions agreement' (which sets out the arrangements under which the Secretary of State for Health delegates responsibility to NHS England for certain public health services) which support the transfer were taken to a final draft stage by the end of **September**. The deliverables were signed off in Q3 with the document being published in December 2014.

- In **Q1**, a communications strategy spanning the whole of health visiting and the 0-5 transfer was developed. As part of this, a library of factsheets was developed, initially containing the mandation and finance factsheets mentioned above, as well as a programme overview document. Further factsheets were published in Q3 and Q4.

- To further strengthen governance and programme management arrangements for the transfer, a formal programme risk register, an interdependency map, articulating the links between workforce expansion, service transformation and the transfer, and a high level programme plan and critical path underpinned by sub-group plans were put in place during **Q1**. These documents were continually updated throughout the first 6 months of 2014/15 (and beyond) and used to inform Board discussions and decision-making.

8. Communications

Communications continues to be an important focus of the programme to reinforce messages to key stakeholders about the impact of service transformation delivered through the National Core Service Specification as well as responding to issues around the forthcoming transfer of 0-5 commissioning role in October 2015. This has included supporting positive messaging to health visitors and providers and links between programme stakeholders.

At the end of Q4 in 2013/14, and in the context of the confirmation of commissioning of 0-5 children's public health services transferring to local authorities on 1 October 2015, it was agreed that the programme would seek more streamlined, consistent messaging and as such, would establish a communications editorial board. The intention is that through 2014/15, this collaborative arrangement would better serve delivery of key messages to the right audiences for both the Health Visitor Programme (HVP) and for the 0-5 Transfer Programme – supporting cohesion across partners. This has met with positive feedback. For example, NHS England's quarterly 'state of readiness' reports monitor progress across the various 0-5 transfer workstreams, including communications, and this has always been scored positively by the regional teams.

Key developments in quarter 1 and quarter 2 of 2014/15 have included development of a plan to better use partners' communications channels (e.g. effective use NHS England Area Teams for onward dissemination of messages to providers of health visiting services, local authority channels, PHE bulletins, local health and wellbeing boards and, in some areas, GPs); further growth of the programme's Webinars, including use as a means of debate, sharing of best practice and dissemination of key messages, development of programme and 0-5 transfer factsheets, core slides and lines to take, and continued growth of the case study database. Through the development of the comms board, it has been possible to include greater and more direct work across the partnership, with messages being adapted to suit the audience. It has also meant high engagement and input from the LGA to inform product development to align to local authorities' priorities and their use of language.

The communications subgroup has supported planning around announcements and the provision of materials that promote greater understanding of health visiting ahead of the transfer of commissioning. This has included setting up a cascade process through partner bulletins and channels to disseminate key information and messaging.

For the 0-5 transfer programme, this has been crucial in enabling discussions around financing and promoting the announcement of the five universal health visiting reviews that will be mandated. This announcement alone received coverage in a range of trade press, and key lines were carried with straight or positive reporting in 60% of targeted media, and through partner communications channels. The related factsheet on Gov.uk had 4,723 views in Q2.

We have also used the first two quarters of the year to support a range of regional workshops for local authorities. Three took place before the end of September 2014 - sharing technical details of the transfer as well as sharing messages on why health visiting and FNP services matter.

At the same time we supported the launch of the six high impact areas of health visiting to support the new service model as set out in the Core Service Specification. These have been widely used and understood, and the page on Gov.uk received 8,029 views between July and September. These documents provide additional context for the service transformation work undertaken by NHS England Regions and health visiting service providers based on the specification and are also crucial in providing a framework for developing case studies that not only showcase a health visitors' role in addressing local need, but provide further evidence of the impact of health visiting on the lives of young children and their families.

In addition, we have been preparing for three separate weeks of action before the end of Q4 (the first of which was in October 2014). It aims to use social media to engage with health visitors, providers, commissioners, stakeholder organisations and service users. These will involve Twitterchats, numerous guest blogs, case studies, pieces in trade media and engaging discussions with service-users via Twitter and Facebook. This will continue the crucial stakeholder engagement needed for the HVP.

9. Conclusion

The programme significantly expanded its focus and governance arrangements in the first half of 2014/15 to ensure safe delivery of the transfer of 0-5s public health services to local authorities on 1 October 2015 as well as delivering its objectives of an expanded workforce and transformed health visitor service by 1 April 2015.

This has involved programme partners liaising closely with a wider range of stakeholders in the NHS and local government to ensure local authorities are ready to receive their new commissioning responsibilities.

The report's four joint authors, hope that its audience will continue to engage actively with the range of information sources and interfaces with which they will become increasingly familiar. This will be a sound platform from which the programme can maintain progress and deliver sustainability in the longer-term.

Annex A

Number of Health Visitors in post (full time equivalents): April 2013 – September 2014 (including 'indicative' data (April 2014 onwards), and planned figures for April 2014/15 (graph page 11 refers)

Month	**Apr-13**	**May-13**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**
Actual health visitors in post (MDS)	9,076	9,149	9,124	9,103	9,066	9,550
Month	**Oct-13**	**Nov-13**	**Dec-13**	**Jan-14**	**Feb-14**	**Mar-14**
Actual health visitors in post (MDS)	9,770	9,920	9,959	10,124	10,267	10,383
Month	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**
Planned health visitors in post	10,365	10,379	10,352	10,344	10,306	10,642
Actual health visitors in post (MDS)	10,389	10,382	10,350	10,298	10,265	10,800
Actual health visitors in post (IHVC)	10,395	10,389	10,345	10,274	10,228	11,138
Month	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**
Planned health visitors in post	11,345	11,482	11,507	11,723	12,028	12,348

NB: **Data coverage**, which helps better illustrate the impact of a transformed service, **has increased significantly** since the earlier data collections – in quarter two 2013/14 the average coverage was 69% at national level; in Q2 2014/15, an average of 92% of providers were able to supply data which was validated for all the indicators.

Coverage (percentage of providers that passed validation checks), England, Quarter 2 2013/14 to Quarter 2 2014/15

Indicators	2013/14 Q2	2013/14 Q3	2013/14 Q4	2014/15 Q1	2014/15 Q2
First antenatal visit at 28 weeks or above	74%	88%	94%	93%	95%
New birth visit within 14 days	77%	91%	96%	93%	94%
New birth visit after 14 days	74%	90%	96%	91%	93%
Development review at 12 months	73%	87%	95%	94%	97%
Development review at 12 months completed by 15 months	54%	74%	84%	84%	88%
Development review at 2-2.5 years	74%	83%	88%	89%	96%
Sure start advisory board with health visitor present	57%	78%	77%	86%	81%

Source: NHS England

Health visitors activity, England, Quarter 1: 2014/15

	First antenatal visit at 28 weeks or above	New birth visit within 14 days	New birth visit after 14 days	Development review at 12 months	Development review at 12 months completed by 15 months	Development review at 2-2.5 years	Sure start advisory board with health visitor present
North	15,666	73%	24%	76%	83%	77%	92%
Midlands & East	8,967	84%	14%	73%	82%	72%	95%
London	1,990	80%	12%	50%	73%	78%	89%
South	12,181	62%	30%	51%	59%	65%	99%
England	**38,804**	**75%**	**20%**	**65%**	**76%**	**73%**	**95%**

Health visitors activity, England, Quarter 2: 2014/15

	First antenatal visit at 28 weeks or above	New birth visit within 14 days	New birth visit after 14 days	Development review at 12 months	Development review at 12 months completed by 15 months	Development review at 2-2.5 years	Sure start advisory board with health visitor present
North	17,193	80%	18%	80%	85%	80%	95%
Midlands & East	11,744	86%	13%	76%	84%	76%	96%
London	2,016	81%	11%	43%	62%	44%	98%
South	14,279	69%	25%	59%	71%	62%	98%
England	**45,232**	**79%**	**17%**	**67%**	**77%**	**68%**	**97%**

Source: NHS England

"HVP: the professional and service transformation journey" (page 9)

In the context of the report's focus on organisational responsibilities and programme governance (p 8, section 3) a chart is included depicting the programme's development over time. It is structured around four key phases showing the journey from: foundation in 2010; its implementation (2011/13); system wide implementation (2013/15); to the current focus on ensuring sustainability beyond 2014. The **key undertakings from each phase are described in the box summary below.**

Foundation 2010	• original commitment and related policy • understanding political context/intention • designing and developing service vision • engagement of profession & related stakeholder
Initial Implementation 2011 to 2013	• 'Call to Action' launched, early implementer sites set up in two phases • professional development • stakeholder building • professional mobilisation and leadership • initial workforce planning and trajectory development
System wide implementation 2013 to 2015	• national core health visitor specification • performance management • early years profiles • DH and HEE commissioned professional development/support for innovative practice. • NHS England's commissioner led service transformation • workforce and training expansion
Sustainable future 2014 onwards	• 6 high impact areas • 2015/16 spec. in partnership with NHS England/LAs • HV fellowships & HV champions • HEE works with LAs to sustain service • CPD programmes

	• ongoing workforce planning via HEE (involves PHE & LGA) • rapid review of evidence for HCP **Transfer to local authorities:** • 0 - 5 transfer agreement • mandation finalised • agreeing funding • programme board constituted

“Health Visitor programme: how the parts fit” (page 15)

This chart illustrates how the programme’s partners work together, building on an integrated approach to embedding health visitor transformations. The chart illustrates the levers’ relationship thus: items at (1) when added to those at (2) deliver the transformed service components at (3). When these are combined with the transfer of commissioning role at (4), they are seen to deliver the ‘better outcomes’ listed at (5).

1) **4,200 extra health visitors** (from 8,092 in May 2010 baseline) to 12,292 (at April 2015)

2) **Professional and service transformation –** through evidence, professional mobilisation, commissioning and system levers and improved metrics.

3) **Transformed HV service (redesign and new capacity)**

- improved access to evidence based services
- progressive models of health visiting
- improved experience for children and families

4) **Transfer of 0 – 5 public health commissioning to local authorities**

5) **Better outcomes**

- Improved reach and delivery
- locally sensitive commissioning
- Integrated 0 – 5 services (efficient and effective)
- 0 – 19 years joined up public health commissioning
- Sustainable place based family services
- Improved public health and wellbeing outcomes for under fives
- Reduction in health inequalities