# Public Health Briefing

Institute of Health Visiting
Excellence in Practice

## iHV Local Authority briefing (8):
## Commissioning for outcomes through skill-mix in Health Visiting and Early Years Teams

**Local authorities are charged with commissioning children's public health services as part of a wider remit for children's services. This briefing provides an overview of the changed context of early years' service design and skill-mix; best practice; challenges and opportunities for skill-mix; and indicators of quality that are likely to provide the best return on investment for outcomes in the early years and beyond.**

### The changing context of early years' service design and skill-mix

From the launch in 2011 of the Health Visitor Implementation Plan (DH, 2011), not only has the health visiting profession undergone a period of expansion and rejuvenation, but the landscape of children's services and public health has also changed. Health visiting has rebased its service model from GP attachment to be population/community based, better aligned with Children's Centre services that include a wide range of skills and qualifications. The transfer of commissioning from the NHS to Local Authorities in 2015 now builds on these changes to focus on integrated services. The imperatives of public sector funding reduction AND the urgency of prevention and early intervention require optimising the composition of the workforce to deliver outcomes.

### Best practice in skill-mix

Skill-mix refers to the appropriate blend of knowledge, skills or competencies required to address the needs of a client group or population. A range of skills is required in order to meet the diverse and sometimes specialist needs in an integrated manner. This diversity may include but need not be limited to the level of training or seniority and reward attached to grades for post-holders – this is grade-mix, which concerns cost containment. Workforce design needs to align service design with the skill and grade-mix to deliver the best possible outcomes within the resources available.

### Best practice in skill-mix is indicated by:

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| **A planned process** | Severe cost constraints leave little scope for a considered approach, but matching needs to assets through a planned process maximises the potential benefits of skill-mix review to deliver the desired outcomes. |
| **Staff and community engagement** | This builds legitimacy and the likelihood of tailoring the service to the needs of the local community; it is consistent with principles of 'place-based systems of care' (King's Fund, 2015). |
| **On-going evaluation** | This provides feedback to gain intelligence on unintended consequences and further opportunities to shape the service. |
| **Retaining valued assets within the workforce** | An assets or strengths-based approach enables the benefits of recent investment in rebuilding the health visiting workforce to be retained and built upon to add value to the wider children's workforce and outcomes for children and families. |

(Adapted from Fisher, 2009)

## Challenges to best practice in skill-mix

Achieving best practice in skill-mix is challenging under conditions of highly constrained budgets that drive urgency and short time scales that militate against staff and service user engagement and the culture change required to achieve integrated services.

Other challenges include:

- An existing loss of skill-mix within health visitor teams as an unintended consequence of the Health Visiting Implementation Plan.
- Health visitor workforce attrition due to disproportionate representation in the workforce of recently qualified AND pre-retirement practitioners (hour-glass age-profile).
- The impact of immature shared language and data collection/sharing linked to outcomes.

## Opportunities for Skill-Mix

- The health visiting service has the asset of a highly trained professional workforce with substantially enhanced knowledge and skills levels following the Health Visiting Implementation Plan.
- The first '1001 critical days' from conception to age two, is the 'age of opportunity' when the impact of social and other adversity can become biologically embedded in brain development as manifested in social, emotional, cognitive and physical developmental outcomes. '1001-days' strategies (WAVE Trust, 2015) provide a common agenda for integrated working.
- The Healthy Child Programme (DH, 2009; PHE, 2015) is an evidence-based programme that provides opportunities to deliver an enriched 'offer' through integrated service development.
- Skill and grade-mix, including administrative staff, can ensure that the most complex work is undertaken by the best prepared workforce (avoidance of removal of most expert practitioners from client-facing work).
- Focus on organisation and management of work to support relationship-focused health visiting with the continuity that parents value (National Nursing Research Unit, 2013), including a shift (back) to named health visitors with caseloads and away from corporate caseloads.
- Training Needs Analysis for integrated service delivery and workforce development.
- Health visitors with specialist areas of clinical leadership (such as Champions for Perinatal & Infant Mental Health) disseminate advanced knowledge and influence service development and improvement across professional and organisational boundaries.

Children's Centre services offer many opportunities to innovate with skill-mix to deploy knowledge and skills to the greatest effect. Health visitor membership of Children Centre Advisory Boards enables health visitors to contribute to the local strategic planning through data sharing, public health skills to analyse data from Early Years Profiles and to shape data collection to focus on 'Measuring What Matters' (Roberts, Donkin and Pillas, 2014).

## Key points for commissioners of children's public health services (0-5)

Complexity of health visiting: open-access and unsolicited home visiting within an undifferentiated caseload with health visitors literally visiting every family with a new baby, makes health visiting highly unpredictable; the universal-plus level of service engages with families for whom health visitor is often the sole professional; safeguarding and child protection work is extensive and includes families below the threshold of intervention by other agencies; a relationship-based model of working (deemed the most effective) requires high-trust/low control engagement; advanced skills in infant and perinatal mental health are routinely needed; clinical expertise is combined with street-level public health including need assessment and active contribution to Joint Strategic Needs Assessment (JSNA) as well recognition of risk, anticipatory guidance and health promotion.

- The health visiting service model reflects international and UK evidence-based recommendations to shift the curve of demand on public services at population level positively through universal primary prevention in the early years.
- A heavily targeted approach to service priorities guarantees failure to manage demand on public services (for child protection; children in care; child and maternal mental health issues; and lack of readiness for school bit.ly/2bI3vYL) due to the 'prevention paradox' (Rose, 2008): the greatest volume of need within the population is widely distributed within the population accessed through a proactive health visiting service.

- There is strong recent evidence (Early Intervention Foundation, 2015) of a high level of preference by parents for health visiting services as a source of authoritative personalised support and advice, particularly for those least likely to take up other services.
- There is strong evidence (Doi, Jepson, and Hardy (2015) that an enhanced health visiting service improves uptake and effective utilisation of other early years and health services.
- The health visiting workforce is an asset that has been strengthened through recent investment in education, training and service modernisation.
- Health visitors are professionally accountable for any delegated activity undertaken within skill-mix teams.
- There are opportunities to enhance outcomes for children and families through integration of services including the judicious implementation of skill and grade-mix as part of an integrated strategy for system leadership and shared governance for quality and outcomes.
- Decisions about skill and grade-mix should balance local needs with equity and inclusivity.
- When the skill-mix team is led by health visitors they can:
  - ensure effective establishment and continuity of relationships that inspire parental trust and confidence;
  - and delegate selectively according to the complexity of health needs and family situations.

The 'Calderdale Framework' bit.ly/2bwyNma can be used to support reviewing skill-mix, roles and service design.

The Institute of Health Visiting has ddeveloped a prototype evidence-based organisational benchmark tool to facilitate organisations in assessing where they are in terms of creating a positive practice environment to build resilience with compassion in their staff.

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## Quality indicators for skill-mix

- Graduate status being a consistent marker for leadership in practice; and trained specialist nurses achieve measurably better outcomes than non-nurses (Olds *et al.*, 1982).
- The quality of health visitor-client relationships is key to effective outcomes of health visitors promoting the health and social and emotional development of young children in the home by working with parents in the first '1001 critical days' (WAVE, 2013; Cowley *et al.*, 2013).
- High quality programmes depend for their effectiveness on governance and programme fidelity.
- National Standards for the knowledge, skills and attitudes required for effective practice to realise the 6 high impact areas for public health in the early years (Department of Health, 2014; Institute of Health Visiting, 2015) indicate the learning and development required for outcomes at the appropriate level.
- Health visitors need to maintain personal and professional resilience to remain courageous and compassionate as well as proficient in unpredictable and uncontrolled environments. The support and supervision of health visitors, including a restorative function, is key to the quality of professional relationships, judgement and decision-making.
- Co-production of integrated services through involvement of parents and other service users: evidence from the Early Intervention Foundation (2015) and the Growing up in Scotland (2015) study show strong preference of mothers for health visitors as their source of advice and support over centre-based or structured group programmes, especially for the most vulnerable/disadvantaged mothers.
  - Integrated strategy and shared governance for quality and outcomes: Health visiting fulfils its greatest potential when in tune with ecological understanding of what helps children to thrive within their families and communities. 'Flying Start' in Wales embeds enhanced health visiting within a range of other services bit.ly/1GlUM6f; the enhanced health visiting service in Scotland is integral to system leadership for 'Getting it Right for Every Child' (GIRFEC) bit.ly/2bO9dHb; and Family Nurse Partnership licensing requires explicit governance, for example to assure skill development, controlled caseloads, programme fidelity and rigorous clinical supervision bit.ly/2biDfWN

## The role of the Institute of Health Visiting

- The iHV has established National Standards for the knowledge, skills and attitudes required for effective practice to realise the 6 high impact areas for public health in the early years;
- The iHV has developed resources to support practitioners and managers/employers to maintain resilience with compassion, including an organisational benchmarking tool. bit.ly/2ccBOJs
- The iHV produces Child Public Health Briefings for Local Authorities which also support evidence-based commissioning. bit.ly/2bhJeME

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