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Title: What makes health visiting successful – or not? 1. Universality

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Abstract

The altered landscape surrounding commissioning of public health provision has affected the nature and range of health visitor services across England. This is the first of two papers reporting evidence from a programme of research that focused on how health visiting works, also reporting service user and workforce perspectives. Evidence for a service model is offered, based on universal principles and maximising the capacity of the health visiting resource. Where service specifications fail to give careful attention to this evidence, the reshaped services for children and families may miss core ingredients that enable health visitors to make a difference, delivering a proportionate and successful child health programme for the early years.

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Key points

1. Universal health visiting services directed at improved parent and child wellbeing have the potential to secure important public health goals, included reduced health inequalities.
2. A growing evidence base indicates specific interventions and programmes that are effective in preventing and reducing barriers to good health and development in the early years.
3. The way in which health visiting services are organised and delivered affects how likely they are to succeed in their public health goals
4. Universal services provide a non-stigmatising service and safety net for all eligible families
5. Proportionate universalism ensures delivery to all, which enables identification and support of families who need more than the minimum.

What makes health visiting successful – or not? 1. Universality

Background

There is increasing recognition that an infant's future health and well-being are significantly influenced by experiences in pregnancy and the first years of life (Center on the Developing Child at Harvard University, 2016). In response to this new science, universal home visiting services directed at improved parent and child well-being, such as those delivered by the United Kingdom health visiting services are being implemented in many countries around the world (Whittaker and Brown 2014). This is the first of two papers reporting evidence from a programme of research that focused on how health visiting works, also reporting service user and workforce perspectives in England. Here we consider the concept of universality and health visiting, explaining first the premise of health visiting and thereby home visiting, before discussing the existing service model and evidence from the health visitor research programme.

Health visiting began in the Victorian philanthropic public health movement, gradually moving from the voluntary sector into local government by the end of the nineteenth century and becoming established as a state-sponsored profession and service following the Notification of Births Acts of 1907 and 1915. This nationwide service developed in local government through much of the twentieth century, before moving (with other community and public health colleagues) into the NHS in 1974. Since then, devolution has led to increasing variation in service provision across the four countries of the United Kingdom, although the principle of universality is common throughout (Hoskins 2009; Appleton and Whittaker, in press).

Targeted home visiting programmes have a long history in the USA, but provision of a universal service is relatively new. A randomised controlled trial (RCT) in North Carolina

demonstrated the preventive impact of universal nurse home visiting, specifically reducing the amount of emergency medical care through early assessment, identifying individual family needs, intervening briefly or connecting the family with targeted community resources (Dodge et al 2013). Studies of home visiting programmes have shown that the effectiveness of provision is influenced by a number of organizational factors, such as the frequency of home visits (Grindal et al 2016) and the qualifications of practitioners (Olds et al 2002). These studies give information about elements that contribute to the success of health visiting services and which, taken together with professional and organizational expertise, can show how likely it is that the overall provision will succeed in its particular public health aims. However, evaluating the impact of an entire service, particularly one that is as variable and long-established as health visiting, is inevitably fraught with difficulties. Day-to-day practice includes a wealth of activities, including but not limited to the implementation of evidence-based interventions and programmes. Service leaders require 'clarification and insight' along with 'interpretation and critique' of the wealth of research-based and other forms of knowledge (Greenhalgh et al 2018) to help guide their plans. Managers and commissioners commonly use Key Performance Indicators (KPIs) or audit points, such as the 'markers of success' cited by Cowley (2007), or the key elements and milestones along the 'pathway to success' proposed by (Wheatley 2006) for evaluating new services. These, in turn, are translated by policy makers as impact indicators and are presented to the public as a means to assess government policy success (Freeguard et al., 2015). Pragmatically, therefore, we have chosen to describe the achievement of overall aims or purpose as being 'successful,' rather than using the term 'effective,' which is closely implicated with specific forms of research.

After 40 years of being wholly based in the NHS, English health visiting services have been commissioned by local authorities since October 2015 – a move that is not mirrored elsewhere in the UK. This shift in funding coincided with significant funding

constraints across local government as a whole, including an in-year reduction of 6.2% of the public health budget for 2015-16 followed by further annual cost savings of 3.9% each year until 2020 (Public Health Policy and Strategy Unit Department of Health, 2015). Therefore, some local authority commissioners are asking searching questions about how health visitors achieve public health gains for pre-school children and whether alternatives might offer better value for money. Others aim to economise by reconfiguring health visiting services in well-intentioned ways that may, nevertheless, harm the effectiveness of the provision. This paper is the first of two that draw upon a programme of research commissioned as part of the English Health Visitor Implementation Plan (HVIP) (Department of Health 2011). The research was funded for and set within England, but findings apply nationwide. The paper aims to remedy the gap in evidence about service models for achieving universal service provision. It highlights the importance of universality as a fundamental base for the health visiting service and explains the skills and requirements for the successful implementation of 'proportionate universalism' in practice. The second paper (Cowley et al under review) details other important features that need to be borne in mind when planning changes to the structure and delivery of health visiting services.

Existing Service Framework

The English health visiting service, since the period of the HVIP, has been organized through a system described as the '4-5-6' model, shown in Figure 1. There are four different levels of service provision, delivered simultaneously by generic health visitors and their teams, managing caseloads and covering geographic areas. The intention is to embed the principles of proportionate universalism through service design and make explicit the opportunity for service delivery to be tailored to need. Thus ensuring, that a minimum service reaches everyone through community support and five mandated health reviews at the Universal level, with additional provision to target families with specific needs as they arise.

(place Figure 1 near here)

The Universal Plus level of service is about indicative prevention, where action follows early identified needs or risks such as a short term feeding difficulty or relatively long-term challenges, such as post-natal depression or other illness. Universal Partnership Plus generally refers to work with families facing more complex and long-term concerns where other health and/or social care services may be involved, for example, if a child or parent has an identified disability or illness. If a risk or vulnerability can be predicted ahead of time, then well-targeted, evidence-based programmes can provide selective prevention. Two examples are the Family Nurse Partnership (FNP) programme (Robling et al 2016) offered to teenage mothers and the Maternal and Early Childhood Sustained Home Visiting (MECSH) programme adopted by some areas for parents experiencing a wide range of needs, such as psycho-social distress in pregnancy (Kemp et al 2011, 2017, Goldfeld et al 2018). Finally, the community level is concerned with collaboration across the local area and the five health checks offered to all families. It involves capacity-building and embedding health action across a geographical area to help ensure the correct level of provision is available for families.

The service summarized by the 4-5-6 model, aims to improve children's health and wellbeing and to reduce health inequalities. It describes how the Healthy Child Programme (Department of Health 2009), which is informed by a regularly reviewed evidence base (Barlow et al 2008, Axford et al 2015), is to be delivered and how the mandated provision can be enhanced according to need. Thus, it illustrates how to achieve 'proportionate universalism,' the principle recommended by Marmot et al (2010) as essential for reducing health inequalities. This requires health visitors to work in ways consistent with those required to 'flatten the social gradient' (Carey et al 2015:4). The 4-5-6 model also highlights six high impact areas, as shown in Figure 1. These were selected as important public health concerns and auditable fields on which

the overall success of the health visiting service will be judged. It is not always clear, however, what these models mean in terms of how services should be organized to maximize the potential from health visiting provision and gain the best outcomes. These two papers aim to provide some clarity in these areas.

The programme of research

The programme of health visiting research encompassed three studies, summarised in Box 1. First, a scoping study and narrative review of the literature focused specifically on practice, to try and understand the craft of health visiting and what health visitors bring to the 'table' of early years provision (Cowley et al 2013; 2015).

Place Box 1 near here

We identified some trials and information about outcomes, but that was not the primary focus, because effective programmes had been recently reviewed (Barlow et al 2008) to inform development of the HCP (Department of Health 2009). There is a plethora of relevant guidelines for practice, developed by National Institute of Health and Care Excellence, as well (see Box 2). The programme of research focused primarily on identifying evidence about particular skills, knowledge and forms of practice that health visitors use to help improve the health of parents and their pre-school children.

Place Box 2 near here

We wanted to learn from service users, as well; particularly what they felt about the proposed service envisaged by the HVIP, so in the first of two empirical studies, we interviewed parents using services in two different Early Implementation Sites (EIS) (Donetto et al 2013; Donetto and Maben 2015). The second empirical study was about recruitment and retention of health visitors, gathering information from qualified health visitors and students (Whittaker et al 2013; 2017). This used appreciative inquiry to

identify what is working, to add to an understanding of health visiting practice and service organisation.

Orientation and themes

Analysis of the literature (Cowley et al 2013; 2015) revealed that health visiting practice is characterized by a particular approach that we called an 'orientation to practice.' This embodies the values, skills and attitudes needed to deliver health visiting services through salutogenesis (health creation), person-centredness (human valuing) and viewing the person in situation (human ecology). Through the scoping review, we also identified research about health visiting actions focused on three core forms of practice: home visiting; needs assessment and parent-health visitor relationships. The 'user voices' study also pointed to the significance of health visiting outside the home – the practice that occurs in children's centres, well baby clinics, delivery of support groups and so on, which were deemed very important by parents (Donetto et al 2013; Donetto and Maben 2015). Such activities were relatively under-researched, so they did not feature strongly in the literature review. However, they are sufficiently important to be considered a fourth core practice for health visitors.

Each of the three studies incorporated recommendations for service, education, policy and research, based upon the findings. There were 13 detailed recommendations from the literature review and 12 from each of the empirical studies about service users and recruitment and retention of health visitors, giving 37 in total. An examination of these recommendations revealed some themes that recurred across all three studies, demonstrating key elements that help to make health visiting more or less effective in enabling health gains for pregnant women, pre-school children and their families. These themes form the basis for inter-connected, recommended principles that should underpin the organisation of health visiting services, in summary:

1. Universality is the fundamental basis for all health visiting services.
2. Relationships are at the core of all health visiting provision.
3. Continuity and co-ordination are essential elements of team working.
4. Professional knowledge and autonomy are necessary requirements, which enable health visitors to provide a flexible service, tailored to individual need.

This first paper will draw explicitly on the programme of research to explain how universality works in health visiting practice, and the second paper will explain the remaining three key principles. Using these principles to underpin the organisation of evidence-based health visiting provision can help ensure positive practice and success in achieving the public health aims of the service.

Universality

The 'Why Health Visiting' review (Cowley et al 2013; 2015) showed that universal provision is the fundamental base upon which the rest of the health visiting service is built. The study revealed an empirical literature that was widely dispersed and, to a great extent, consisted of single studies rather than larger programmes of research. Even so, the analysis demonstrated a number of consistent themes, including the extent to which the work of health visitors is integrated, with each element incorporating, or dependent upon, others. Accordingly, universality appeared integral to the whole service, being ubiquitous and threaded throughout the health visiting literature. At times, it appeared so embedded that its presence was simply assumed – possibly as the default position for 'usual care' control groups in trials of specific aspects of health visiting practice (e.g., Morrell et al 2009, Wiggins et al 2005), or as a means through which to identify families requiring particular early interventions (e.g., for parenting support programmes, (Whittaker and Cowley 2012), or help with breastfeeding, (Tappin et al 2006).

Whole population

In health visiting, 'universality' takes a specific form. It means that all eligible families (that is, expectant parents and those with children under five years) receive at least a minimum service, regardless of their situation or needs – a single contact is not enough. In England, five contacts are mandated (Public Health England 2016). In Scotland (The Scottish Government, 2015) 11 home visits are prescribed over the same (0-5 years) period, whilst Wales and Northern Ireland each specify between eight and ten (Department of Health Social Services and Public Safety, 2010; Welsh Government, 2016). This universal provision is described as an 'offer,' because families are at liberty to take up or reject the service, but health visitors are required to provide it where accepted. It is unusual for families to want a reduced service, partly because of the health visiting skills deployed to gain access to families, whether or not they have asked for a service (Luker and Chalmers 1990).

This universal coverage provides a mechanism for delivering specific health messages to all families, regardless of need, enabling health visitors to reach the whole population of eligible families through the mandated contacts. These are not end points in themselves but auditing their successful delivery can serve as a process measure of family support. These contacts help parents to gain the support they need to see them successfully through the transition to parenthood, which is one of life's major changes (Deave, Johnson & Ingram, 2008) and one of the six designated high impact areas for health visiting (Department of Health and Local Government Association 2014).

Universal prevention aims to prevent difficulties or ill health arising in the first place, so that all children can have the best start in life (Public Health England 2016). Such prevention may be controversial, as parents of healthy infants are asked to take action to prevent something that is a risk, but which may not happen. Health visitors, amongst others, have a key role in providing information about infant immunization, for example.

Their ability to establish trust and convey clinical knowledge is paramount (Bedford and Lansley 2006, Leask et al 2012), especially where parents' wishes and concerns vary from the official recommendations. Any resulting dilemmas require health visitors skilled in negotiating the line between what Brownlie and Howson (2006) call 'the demands of truth and government,' and the need to be seen as knowledgeable but neutral (McMurray et al 2004), in supporting parents to reach decisions.

Parents interviewed for the 'user voice' study indicated that if their choices are not respected, this might impede their relationship with the health visitor, potentially obstructing any opportunities to discuss other aspects of family health. One mother interviewed by Donetto et al (2013) explained how she responded to perceived criticism of her infant feeding choice:

> *"And then I said about [my breastfeeding choices in the past] and I got a really, really negative response with her, with a kind of disgusted face and criticism. It's just not what you do to a woman who's just given birth. So, yeah, that wasn't a good start.[...]. And, yeah, that was kind of the end of the visit because I feel I'd shut her down after that. But, yeah, that wasn't a great start." (Florence, mother of two)*

This example illustrates the importance of skilled communication and relationship formation, as well as commissioner awareness of the need for flexibility when setting Key Performance Indicators (KPIs) for the service.

Safety Net

The mandated visits are central to ensuring parents are aware of the health visiting service. Parents asked about their perception of receiving the universal service explained that early contacts with the health visitor and later attendance at clinics or groups helped to develop their familiarity and confidence in the services and awareness

of how to gain help if needed (Donetto et al 2013). Knowing about this 'safety net' led parents to feel that help would be available should things become difficult or worries arise, as these two mothers explained:

> *" Just kind of having them there if I needed them. It's kind of like reassurance that you're kind of not just left to it, if you like. And if you do need that extra support, like professional extra support, then they are there and you can just call them up or you can just come in, whichever. But I do tell everybody how great they are." (Jennifer, mother of two)*

> *"So we're very lucky, aren't we really, with the level of support that we've had and that we do have? Whether you access it or not it's there; and that's it really, just knowing that they're there, isn't it?" (Cynthia, mother of two)*.

This perceived 'safety net' is important in helping some parents deal with their anxieties and everyday tasks and challenges encountered in looking after their child. This reach enables health visitors to access vulnerable families that might, otherwise, fall through the net of overall service provision.

Non-stigmatising

The universal service enables primary prevention and health promoting messages for all, without stigma. The service does not single out anyone for particular reasons, which reduces stigma and helps to ensure it remains acceptable. Health visitors interviewed for the recruitment and retention study (Whittaker et al 2013; 2017) explained that they felt uniquely privileged to have the opportunity to meet all families with new babies:

> *'Throughout the 26 years of my health visiting career I have valued the unique and privileged opportunity to work with families with young children over a*

period of time. No two families are the same and each and every birth notification and 'movements-in' presents exciting challenge. The first time you knock on the door you are starting a new and exciting journey.' (HV6)

The absence of stigma associated with universality allowed health visitors to use and apply health-promoting knowledge, reaching out to children or parents whose needs might otherwise be overlooked. The health visitors appreciated that their role gave them privileged insights into the lives of others but explained that this was purposeful. Also, being known in the local area, which is a feature of a universal service rooted in a particular community, could mean that concerned neighbours would contact the health visitor, for example:

'Many is the time it was the mothers who came from the maisonettes to tell us about a child that had moved in and how worried they were about that particular mother.' (HV14)

Wiggins et al (2005) demonstrated that only 19% of mothers, randomized to community group support, including drop-in sessions, home visits and telephone, continued to use the service. Some reportedly refused it because they saw it as being for 'problem families.' In contrast, 94% of mothers offered monthly home visiting by health visitors in the same trial, continued to accept the programme for the full year. The mothers who received visits from a health visitor were more relaxed and made less use of GP services than in the community support or control groups. Similarly, new mothers receiving weekly home visits from a health visitor for six weeks in Northern Ireland were less likely to use emergency services (Christie and Bunting 2011). These trials suggest the non-stigmatising nature of the universal service can both enable reach and improve parents' ability to make appropriate use of other, more expensive NHS provision.

Proportionate Universalism

Health visitors use the mandated provision as a base from which to vary the service offer according to the health needs of families. This variation forms the basis of 'proportionate universalism' (Marmot et al 2010) and is explained in detail elsewhere (Cowley et al 2015). Provision of an individually tailored response for each family also helps to improve acceptability of health-related information or evidence-based interventions as a result of the mandated health reviews.

The aim of each health review is to ensure that, in addition to delivering universal prevention, any potential concerns are identified as soon as possible. Appropriate support can be arranged, then, including increased contacts, information-giving, early interventions or referrals as required. This approach has been shown to be successful, particularly when health visitors are trained in the Family Partnership Model and use antenatal and postnatal guides (Davis et al 2005, Puura et al 2005). Health reviews require sensitive assessments of health needs, using finely-honed health visiting skills and knowledge (Appleton and Cowley 2008a, b) and the ability to exercise autonomy and flexibility. This is considered further in the second paper (Cowley et al under review). The proportionate nature of the provision is intended to ensure families who are most in need, or have most difficulty accessing services, will be helped, so the service can contribute to reducing health inequalities and ensuring each child has the best start in life. This may be by health visitors providing additional services themselves or, as these mothers reported in the user study (Donetto et al 2013; Donetto and Maben 2015), by explaining eligibility for benefits or signposting to other provision in the community:

> *She (the health visitor) will still provide me with information of other services that we use or like as I said the DLA and the Carer's Allowance and all of that. She doesn't forget. She brings her notebook and writes down a lot. (Nadine, mother*

of one)

So I went up there for [baby's] 12 week check and it was then that I broke down to [the health visitor] and told her exactly how lonely I was feeling because I didn't have any friends, because I'd only moved up here literally three weeks before he was born. [...] And that's when she helped me, and put me in touch with the [Children's Centre] and got me a [family support worker], and helped me integrate a little bit better. (Denise, mother of one)

Such targeting may be short-term, as in these examples, or may include longer term interventions at the level of the universal plus or universal partnership plus, as indicated above. The multi-faceted nature of health visiting provision requires significant skills, identified in the programme of research and explored in more depth in Malone et al (2016). Our research focused on provision by qualified health visitors. For the literature review, we actively sought evidence about the effectiveness of team work or skill mix, without success, so concluded that implementation of these approaches was running ahead of the evidence.

Conclusions

In the UK, the principle of universality in health visiting is not new. Indeed, when the then Council for the Education and Training of Health Visitors (CETHV) held an investigation into the principles of health visiting, universality was a concept that was considered, but:

- *'A great deal of the material produced at [the two main conferences] and by local groups seem at first sight to have "got lost in the wash". What has happened to the concepts of "availability" and "universality"? If there are principles which have something to do with either of these concepts, then further mind-searching might produce them.'* (CETHV 1977 page 63)

Universal health visiting takes a particular format. It moves beyond 'availability,' in the sense of being there if wanted, into actually delivering a specified service to all families, which enables primary prevention and health promotion. It provides a 'safety net' that is accessible without stigma and whilst the service is universal, it is not uniform. The mandated provision is a base from which to vary the service according to the assessed health needs of families. By using this core service 'offer' to tailor information specific to each family's individual needs, health visitors can draw on particularist principles (Carey and Crammond 2017); provide differentiated help at the level of each family, acknowledging health, cultural and social situations to achieve a service that is proportionate to need (Carey et al. 2015). This enables health visitors to work towards reducing the social gradient of health inequalities by delivering services based on 'proportionate universalism', which is argued to be the key to reducing health inequalities (Marmot 2010).

The programme of research enabled us to describe the mechanism through which health visiting can succeed in meeting the public health aims of the provision, including delivering a proportionately universal service. Evidence from the three studies demonstrated multiple interconnections across different levels, priorities and approaches to practice, indicating that the health visiting service should be planned and organised as a single, holistic form of provision, centred around the universal offer. These interconnections, which were evident in the research, are required in practice to enable health visitors to use their skills to deliver timely and effective services. The research about effective health visiting practice focused on delivery by a qualified health visitor, not by team members. Notably, we found a lack of research exploring the effectiveness or not of team working or skill mix in the literature review. Outcomes-focused research comparing the effect of services delivered by health visitors compared to other team members should be a priority. In practice, different forms of service

organisation are common and will be considered in the second paper (Cowley et al under review).

Acknowledgement

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Dedication

These two papers are dedicated to Christine Bidmead, whose doctoral work on parent-health visitor relationships was a key part of the literature review reported here, and who sadly died whilst these papers were being prepared.

Box 1: Programme of research: Summary of methods

Study 1: Why Health Visiting? A Scoping study and narrative review of the literature (Cowley et al 2012)

Using a three-pronged search strategy, we screened over 3000 papers, seeking UK research that gave details of health visitors' practice. This elicited 348 papers through:

1. Broad initial search of HV literature (yielded 49 papers)
2. Structured and focused search (yielded 218 papers)
    - 15 topics from HCP
    - Search from 2004 – Feb 2012
    - Limited to UK papers
3. Seminal/classic literature and papers deemed essential to study of health visiting; identified by experts who member-checked lists (yielded 81 papers)

Analysis informed by a framework derived from the Health Visitor Implementation Plan (Department of Health 2011). Thematic analysis of older (pre-2004) and more recent papers to assess continued relevance.

Study 2: Health visiting: learning from the voice of service users (Donetto et al 2013)

Aimed to learn from service users' experiences to inform the development of UK health visiting practice and services through:

1. Initial review of the academic literature about service users' experience of health visiting
2. A qualitative empirical study based on interview data gathered at two Early Implementer Sites in England
    - 44 parents (42 mothers, 2 fathers) were interviewed
    - Data were analysed using grounded theory methods.
    - Specific focus on team and collaborative working and health visiting outside the home.

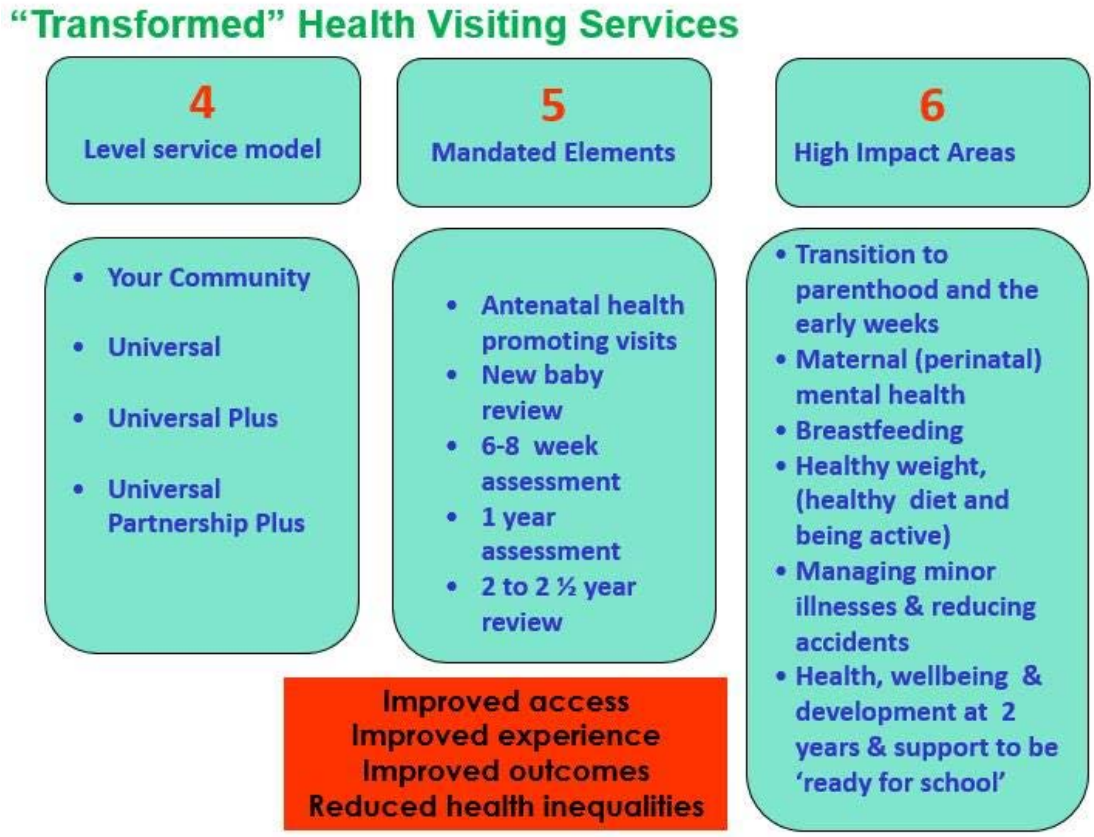
Study 3: Start and Stay: Recruitment and retention of health visitors (Whittaker et al 2013)

A qualitative study of factors impacting upon decisions to join or stay in the health visiting profession in two Early Implementer Sites

1. Data Collection from 53 participants: Students, Health Visitors, Managers, Lecturers, SHA leads
2. Used Appreciative Inquiry exercises, followed by face-to-face and telephone interviews
3. Analysis underpinned by psychological contract theory, to illustrate connections between professional aspirations and work commitment.

Box 2: NICE public health (PH) and clinical guidance (CG): key evidence for health improvement in children under five years of age. https://www.nice.org.uk/			
Guidance	Number	Published	Updated
Antenatal and postnatal mental health : clinical management and service guidance	CG192	Dec 2014	June 2015
Vitamin D : Increasing supplement use in at-risk groups	PH 56	Nov 2014	May 2017
Domestic violence and abuse: multi-agency working	PH 50	Feb 2014	Feb 2014
Weight management : lifestyle services for overweight and obese children and young people	PH 47	Oct 2013	Oct 2013
Social and emotional well-being: early years	PH 40	Oct 2012	Oct 2012
Alcohol-use disorders diagnosis, assessment and management of harmful drinking and alcohol dependence	CG115	Feb 2011	Feb 2011
Unintentional injuries in the home : interventions for under 15s	PH 30	Nov 2010	Nov 2010
Unintentional injuries: prevention strategies for under 15s	PH 29	Nov 2010	Nov 2010
Looked after children and young people	PH 28	Oct 2010	May 2015
Alcohol-use disorders : prevention	PH 24	June 2010	June 2010
Smoking : stopping in pregnancy and after childbirth	PH 26	June 2010	June 2010
Immunisations : reducing the differences in uptake in under 19s	PH 21	Sept 2009	Sept 2009
Child maltreatment: when to suspect maltreatment in under 18s	CG 89	July 2009	July 2009
Physical activity for children and young people	PH 17	Jan 2009	Jan 2009
Maternal and child nutrition	PH 11	March 2008	Nov 2014
Postnatal care up to eight weeks after birth	CG 37	July 2006	Feb 2015
Jaundice in newborn babies under 28 days	CG 98	May 2010	Oct 2016
Oral health: local authorities and partners	PH 55	Oct 2014	Oct 2014

Figure 1: The 4-5-6 model of health visiting



Source: Public Health England (2016)

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