Title: Organising health visiting services in the UK: Frontline perspectives

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Conflict of Interest

None declared.

Ethical Approval

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Title: Organising Health Visiting – UK Frontline Perspectives

Abstract

The organisation of health visitor work is an important part of service design that can impact on when and where services are provided and who gains access. The paper reports a 2018 survey of UK health visitors conducted to provide an overview of the range of ways that health visitor cases and workloads are organised. The 584 respondents confirm the operation of three broad types of health visitor service delivery models. Namely the: individual case, corporate case or combination model. Themes that emerge from practitioner experiences of working with different models reflect concerns about: continuity and staffing; accommodating different needs; different services in different places. Overall these data indicate a lack of consistency in health visitor service across the UK. The advantages and disadvantages of each workload model is also detailed and are considered with respect to markers of a quality service, including achieving relationships with clients and sufficient communication within and across teams.

Key words: caseload models; workload model; corporate caseloads; continuity of care

Abstract = 154 words

Main text = 3853 words excluding references

4 – 6 Key points

- Health visitors across the UK work to different service delivery models. This demonstrates a lack of consistency in health visitor service across the UK
- There appear to be three broad types of service delivery model; individual; corporate; combined
- Poor staffing can have an influence on the type of model frontline practitioners are required to adopt
- There appear to be a number of advantages and disadvantages for each type of service delivery model, with no clear best model.

Introduction

The organisation of health visiting services impacts on the nature and availability of access to early assessment, advice and help for babies, mothers and families. A point reinforced by recent practitioner case studies (iHV 2020a) and evidence of workforce changes (Conti and Dow, 2020) introduced as part of the health service Covid-19 prioritization programme in England (NHS England and NHS Improvement, 2020).

The focus of this paper is the organisation of health visitor work and specifically service delivery models, appreciating that getting the service delivery model right is a crucial part of effective care provision to meet responsibilities for communities of people (whole caseloads), whilst attending to individual need (children in families). The nature of service provision has been evolving for some time with changes in staff ratios and the introduction of skill mix (see Craig and Adams, 2007). In recent years, developments to how health visiting provision is commissioned and the continuing pressures on Local Authorities due to austerity (prior to the coronavirus pandemic), have created conditions for the emergence of different models of health visiting design and delivery. This has meant a shift from the traditional model of one health visitor to one caseload towards the allocation of teams sharing responsibility for larger (corporate) caseloads, often incorporating skill mix (Institute of Health Visiting (iHV), 2020b). Unfortunately, the comparative benefits of different models of service provision is unknown as noted by the most recent and comprehensive examination of evidence for health visiting (Cowley et al. 2013; 2015). The key critique of the team or corporate approach is that it threatens continuity of care, a feature of service provision that parent surveys have repeatedly identified as important for service satisfaction (Russell, 2008; iHV, 2020c). Whereas a service delivery model that allows personalized care provided by the same health visitor supports investment in a parent-health visitor relationship that yields trust and family service engagement (Cowley and Bidmead, 2021).

In this year of the nurse, midwife and health visitor (2020) and that which marks the bicentenary and celebration of Florence Nightingale's birth (Florence Nightingale Foundation, 2020; WHO, 2020), it is particularly pertinent to return to debates about the organization of health visiting services. Nightingale was a statistician, social reformer and nurse who connected the dots between infection, hygiene, morale (mental wellbeing), physical health and recovery, making an enormous contribution to early public health knowledge. The actions of Nightingale, including, stimulating an awareness and influencing policy on health, illustrate how her work was seminal to modern health visiting and a feature of this early knowledge concerns the organisation of work to attend to group and individual health needs. Thus, here we turn to the issue of the organization of health visitor work, reporting on findings from a 2018 survey of iHV members who responded to an invitation to comment on how their services were organised. The discussion of the findings from the survey, including health visitor experience of the emerging service delivery models, adds to debates about the organization and accessibility of health visiting services.

Methods

A survey was developed to collect information about the variety of ways in which teams and caseloads are configured for provision of health visiting services. As health visitor academics and researchers, we were aware from anecdotal evidence of differences in caseload and team organisation. This includes health visitors working within integrated teams with early years providers and with various caseload models, reflecting the team/caseload arrangements described by Cowley et al. (2018). What is more, this appears to be a rapidly changing picture.

The survey

The advantage of undertaking a member survey of a nursing organization is that it provides a valuable picture about service developments (at a point in time) from the front line. Having a clearer

insight into the existing situation is important for establishing the service potential and to learn more about the 'best' models for designing services. Furthermore, the survey was an opportunity to provide a snapshot across the country of the context for service provision to meet the universal health needs of young children and their families. The short e-survey, delivered using the SurveyMonkey® package, had an opening statement explaining that the Institute of Health Visiting was working with its Trustees and Health Visitor academics to understand the current practice arena. It was stated that the anonymous survey information would be used to:

- understand if there are different ways of working across the country.
- inform publication, bid and resource material development for guiding health visitor practice.

The survey itself was designed by the researchers following consultation with local practitioners. It included five close-ended questions asking respondents about: the county located; whether employed as a health visitor; the employer type; the team model and caseload model. The items concerning team and caseload required the respondent to select an option from a drop-down menu.

- For 'team' the options included: Health visitor only; Skill mix with community staff nurse and/or nursery nurse; integrated team between health and children's centre services; other.
- For 'caseload model' the options included: individually managed; corporate (shared with health visitor colleagues); caseload determined by GP attachment; caseload determined by client specialist needs; combined individual and corporate caseload; several types of caseload model in operation in my area; other.

A final open question was included in the survey to encourage respondents to expand on answers provided to the closed questions (O'Cathain and Thomas, 2004) and invited anonymous comments on the organisation of the model health visitors were working with.

Data Analysis

Simple descriptive statistics were used to analyse e-survey closed questions and where appropriate results from data analysis are displayed using graphs and charts. The final e-survey open question was analysed for content and cross referenced with the type of model in operation. This enabled the research team to categorise the ways in which the different models were operating and to note any highlighted advantages or disadvantages for each model. Free text Comments pro

Respondents

The e-survey was promoted to iHV members via a membership electronic mailshot and was open for a month during April 2018. Social media was also used to promote member awareness of the survey and a single reminder message was sent during the period that the survey was open.

Ethics

Permission to proceed with the survey was granted by the iHV chief executive and ethical review was completed by the UCLan ethics committee, which granted approval (STEMH-929).

Participation by iHV members was entirely voluntary and anonymous responses where submitted online. The iHV were unable to identify which members completed the questionnaire as no names of people, organisations, or contact details were included in responses and so, to ascertain whether the audit had UK wide reach, respondents were invited to specify the county where they worked.

Survey results

Replies were received from 584 people working in each of the four UK nations (Figure 1.) In the main responses came from those working in England (n=531). Thirty-two respondents worked in Scotland, 12 in Wales and 4 in Northern Ireland. Five respondents either did not specify where they worked or listed their place of work as the UK.

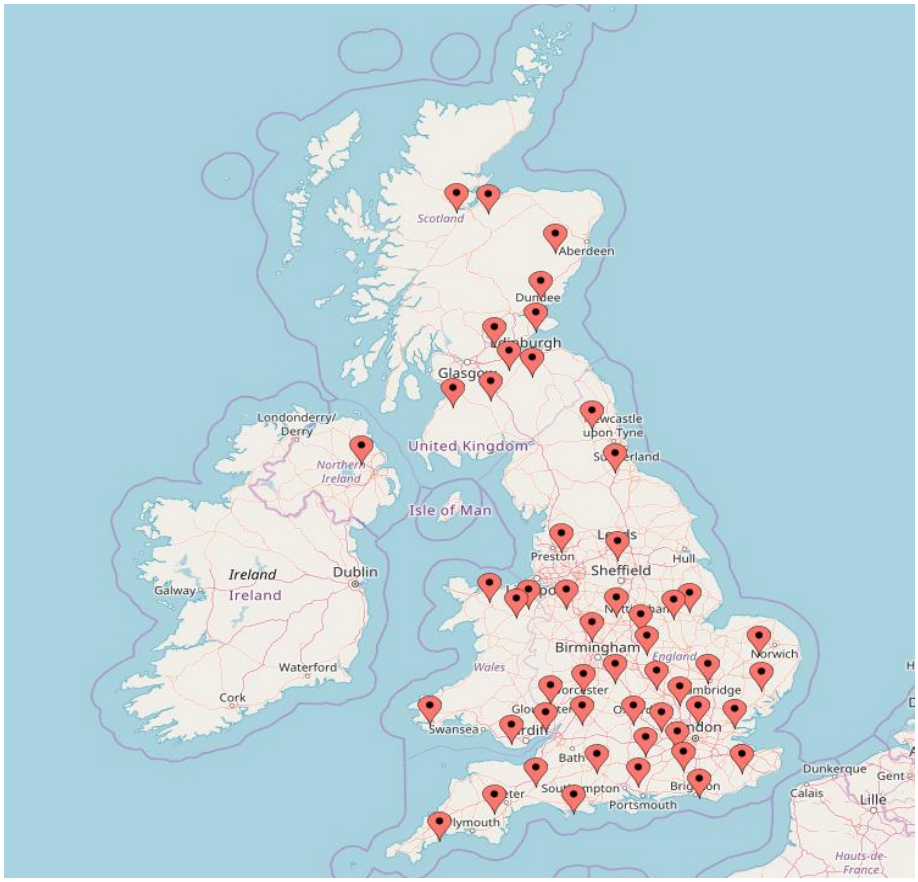

Figure 1. Distribution of respondents

Of the 584 respondents, the majority (n=577), were either health visitor practitioners (n=435; 74%), health visitor team leaders (n=98; 17%) or health visitor team members (n=44; 8%), with the remaining respondents (n=7) holding specialist roles e.g. safeguarding lead, infant feeding lead.

Employer

The NHS was the employer for the majority of survey respondents, whether that be within a Community NHS Trust or Acute Care Trust providing community services (Figure 2). A sizable proportion of respondents (n=128; 22%) were employed by non-health service organisations, such as local authorities, small to medium enterprises (SMEs) or private companies. The latter included a large private provider of publicly funded health and social care services now operating across England as well as health and social care organisations described as SMEs.

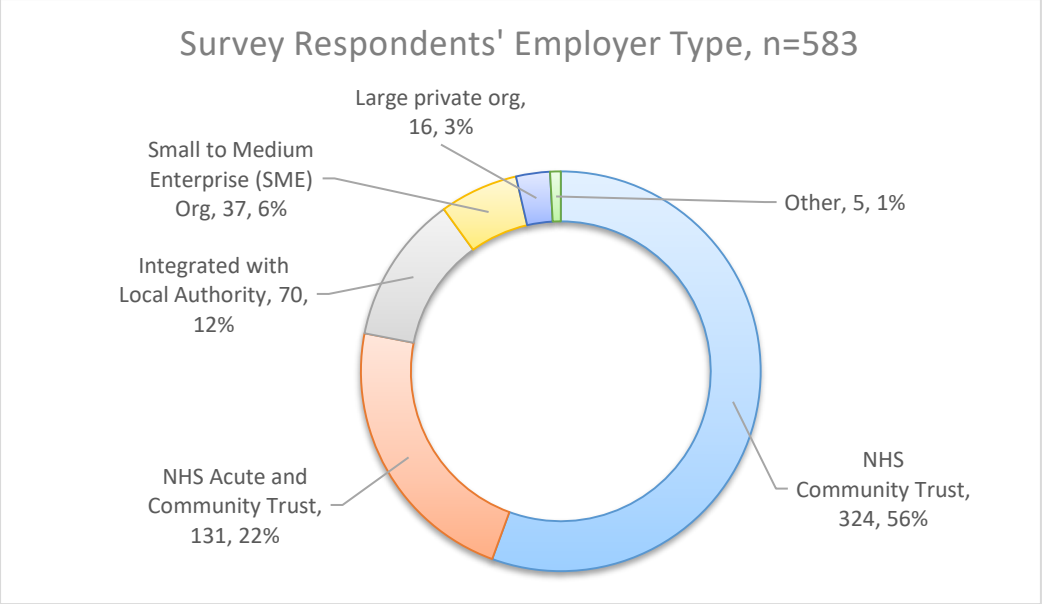

Figure 2. Employer type for survey respondents

Team structure

The survey results indicated that health visiting teams and caseloads were being organised in a variety of ways. A large proportion of respondents said that they worked as part of a skill mixed team involving staff nurses and/or nursery nurses (n=458; 78%), however health visitor only teams, with or without assistance from administrative support workers, were still in operation according to 5% (n=30) of the respondents. Most of the remaining respondents (n=81; 14%) identified as working within a formally integrated team involving health and children's centre workforces (Figure 3).

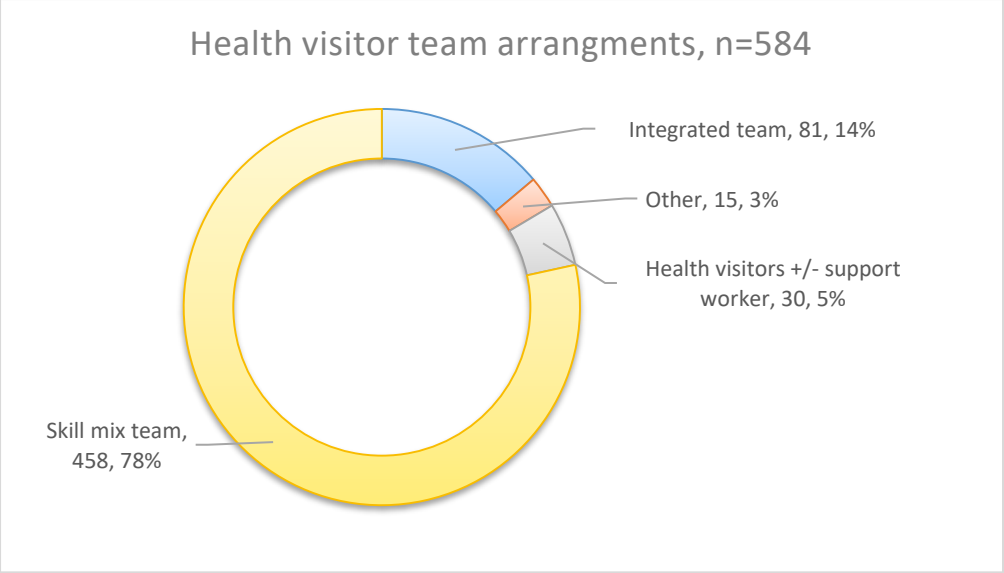

Figure 3. Team structure for survey respondents

Caseload organisation

When asked about how the health visitor caseload was organised, 79% (n=462) of respondents identified one of three broad types of caseload (Figure 4). These are caseloads that are:

- Individually managed (n=172; 29%), where a single health visitor practitioner is responsible for a single group of cases;
- Corporate or shared (n=191; 33%), where a health visiting team (including a skill mixed team) share a single large caseload and families will receive routine services from any available team member;
- Combined (n=99; 17%), where individual cases are allocated to individual health visitors for a period of time, and thereafter cases are pooled and shared by the team to provide service provision.

The remaining respondents (n=122; 21%) noted other features about the caseload such as whether it was General Practitioner (GP) aligned, was targeted at population sub-groups and whether a number of different caseload models operated within their organisation. Unfortunately a limitation

in the survey design means it is not possible to identify whether the GP aligned and targeted caseloads were managed individually, corporately or by a combined approach.

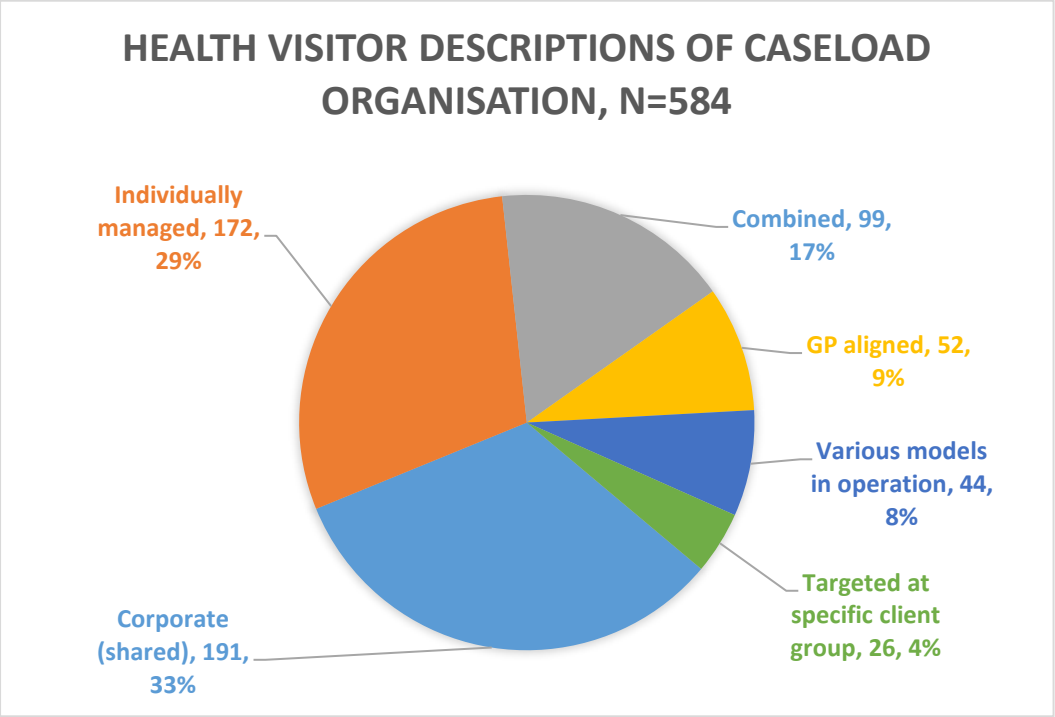

Figure 4. Survey respondents descriptions of caseload organisation

Comments about service delivery models

A few respondents explained that during their careers they had worked with different models and therefore could weigh up the merits of each. Examples included how the individual model provided greater opportunity for relationship building with the multidisciplinary team, however the corporate approach provided greater scope for support from the immediate health visitor team:

> *'In the last 2yrs I have worked within corporate and geographical (individual) caseloading in different organisations. I have found moving to an individual caseload has meant I have much better relationships with the GPs and midwives in my area, which has been invaluable, but I have less support, both practically and emotionally from within my HV team - it's a bigger, wider team and everyone has their own area, so little incentive to work closely*

together and more 'it's not my patch' mentality. There are benefits and costs associated with each model.' (R115).

The data are presented against three emerging themes: continuity and staffing; accommodating different needs; different services in different places.

Continuity and staffing

For those moving to a corporate model from an individual approach, there was an expression of 'worry about the continuity of care for universal families' (R303) and concern about an ability to know the families sufficiently to provide a personalised service:

'Caseload management organisation continues to remain problematic. Families have less continuity with HV due to corporate working. HV don't know families as they did before when having individual caseloads.' (R229)

Staff vacancies was a key issue for several respondents and gave rise to '*very worrying times with high caseloads staff working hard often over hours to provide services and keep up with documentation'* (R439). There were concerns about adequately covering the needs of all families and having to forego some routine visiting, such as antenatal contacts, and new birth visits delegated to a weekend support service. Survey respondents noted that the casualty of insufficient staffing became the ongoing health visitor-client relationship, as the service reduced its ability to deliver health promotion/education work or offered limited continuity.

'This team has an uncovered caseload and many child protection families . Unable to do antenatal visits and some primaries being sent to Saturday working HV. Hence relationship with family HV not being established. Feels not good enough - management aware.' (R372)

> *'With the number of health visitors leaving our service, we are finding it difficult to cope. […] I would love to be able to provide regular sessions which focus on accident prevention, healthy eating and introduction of solids because they are the things that would make a huge impact, but we don't honestly have the time and we are being governed by those whose main focus is on the figures.'* (R112)

A particular feature of responses was a belief that corporate working was used as a service solution to improve equity of workload within teams and ensure service cover to manage risk. A critique of this strategy was that it has masked a deeper concern about sufficient staffing levels:

> *'to ensure equity of work between HVs, however, the major disadvantage is that they mask shortages in staff as there is an expectation when there is a vacancy or sickness that other team members will just pick up the additional work despite already having a full caseload and working at capacity.'* (R192)

Alternatively, health visitors described working simultaneously with individual and corporate caseload models in a combined approach (99, 17%), where it was *'corporate for all new clients, individual caseload for cp [child protection] and under 1s.'* (R555). As already noted, difficulties with achieving continuity of care was understood as a feature of a full corporate approach, however a combined model where health visitors were able to build relationships with families in the first year, before moving to a corporate approach, was also seen as a means of resolving the continuity problem:

> *'I feel the corporate model encourages closer teamwork and I believe there are ways of maintaining continuity of care within a corporate model – e.g. by ensuring the same HV who did the antenatal does the new birth and subsequent contacts, checking to see who client was last seen by etc. The continuity of care for the client is of course the most important part of either system.'* (R115)

Accommodating different needs

A small but notable proportion of respondents (44; 8%) noted that there were various models in operation, designed in some instances to cater for different categories of family need. Thus, in one area, the corporate model was used for families identified to have universal needs and the individual model was in operation for those families with greater or more complex needs.

> *'Corporate for universal but UP [universal plus] and UPP [universal partnership plus] go on individual HV caseload.'* (R579)

By contrast another area used corporate working as a means of managing safeguarding cases:

> *'We have 3 large HV teams w NN's [with nursery nurses] attached (but predominantly doing health r/v's [reviews]), each split into 3 sub teams covering geographical areas [with] corporately managed safeguarding due to uneven distribution across borough.' (R581).*

However, the introduction of corporate caseloads to manage safeguarding risks was not without challenge, as sometimes the lines of responsibility were felt to be blurred.

> *'This way of working appears to have lots of duplication of work and no one takes responsibility for anything.'* (R62)

> *'Mixed feelings about corporate working. It's much easier to administrate i.e. central birth book and all notes filed A-Z (we are still using paper) and easier to do caseload counts. However you need to be able to totally trust the team to follow clients up in your absence i.e. when on leave.'* (R317)

These perspectives on the need for clear communication and trust between colleagues also suggest that strong, but democratic, leadership would be an important element of successful service delivery using a corporate model.

Different services in different places

It was evident that several organisations were in the process of changing their caseload/workload organisation altering either where families were drawn from and to whom the cases were allocated, resulting in different services in different places. This included the concerning change that members of the skill mix team, as opposed to the health visitor who would be taking on the role for assessing need in families.

> *'We've moved from being GP attached to a locality model of working.'* (R560)

> *'We are due to move from individual caseload to CNN [nursery nurse] having universal caseload and HVs having levels 2-4 and only 2 stat visits under local authority plans.'* (R35)

Service changes not only included altering how the workload was organised, but also changes to the team composition, distribution, location and practices that were technology enabled.

> *'There are less teams with more HVs and skill mix covering larger geographical areas. Working more agile (to manage space issues). 0-19 services with HV managers managing school nurses and vice versa. HVs and SNs not based together but starting to run joint family clinics.'* (R566)

Whilst different types of models were in operation, there was also evidence that a small proportion of respondents (52; 9%) worked with caseloads that were specifically aligned to a General Practitioner (GP). Unfortunately, due to the way the question was worded, it is not possible to identify whether GP alignment was more commonly associated with any of the three caseload types. However respondent comments indicate an interest in keeping connections with GPs, and that it was less easy to maintain relationships with GPs and the community when working with a corporate approach:

> *Fighting to maintain our GP links whilst supposed to be corporate. The move to corporate working is destroying our knowledge of communities and families which has always been such a strength of the HV model of care.* (R562)

Discussion

How each of these caseload arrangements support continuity in relationships with families and also GPs, is unknown, though given how much continuity impacts on patient experience (Freeman and Hughes 2010) it is certainly something that needs attention. Indeed, continuity of health visitor is a key feature of practice than enables parents to develop a sense of trust in the service and leads to parents being proactive in contacting the health visitor when they have worries about their child's health (Cowley et al 2013; Cowley and Bidmead, 2020). A previous 2017 iHV survey indicated that contact between HVs and GPs can be very variable, and for some, sadly, it is a rare feature of practice (Bryar el al. 2017; iHV, 2017). Furthermore, the most recent report from the iHV (2020) indicates that practitioners in England believe that since service commissioning transferred to Local Authorities, contact with GPs has become more problematic with less than of third of members reporting that they met with GP colleagues at least monthly. The commentary provided by survey respondents alluded to a range of advantages and disadvantages for different service delivery models, resulting in a mixed and complex picture. Table 1 provides a summary of the main messages with respect to key service features, such as, relationships with clients or team communication. This illustrates the range of advantages and disadvantages, with no clear perfect model, though does draw attention to the challenge posed to communication in various circumstances. Collectively, the survey evidence indicates the lack of consistency in service provision across the country and the need to know more about the ways in which each model operates to influence child outcomes. From a family perspective, other evidence points to a preference for an individual model which allows for continuity of care and relationship building (Russell, 2008; iHV 2020c). Through the individual model it is argued that the health visitor can invest time in developing a partnership with the family and through this more easily tackle difficult or entrenched issues. Particular attention should be given to how the service delivery model impacts on the health visitor delivery of continuity of care and

safeguarding work, as without this understanding provider organisations may unwittingly be taking risks in the service delivery models that they either choose or fall into adopting. This is important because health visitors are critical to the maintenance of universal child health service provision (Conti and Dow, 2020); key infrastructure that will have increasing importance as society faces the detrimental impacts from lockdown (and social isolation measures) that particularly impact on the lives of women and children (Douglas, 2020).

Limitations

The survey reported here offers a snapshot of health visitor service delivery in the UK and it is noted that the picture is ever changing, particularly with the ongoing COVID pandemic requiring service adaptation. Nevertheless the data reveals practitioners concerns and experiences of working with different models and therefore provides learning when going forward with service design and commissioning to meet the needs of children and families.

Table 1. Advantages and disadvantages of each workload model against service features

Service feature	Individual	Corporate	Combined
Relationships with clients	Opportunity to offer continuity and develop relationships with client and their family over time.	Reduced opportunity for continuity of care	Relationship with one person in early weeks, though less continuity thereafter
GP communication	If linked to a GP practice opportunity for clear lines of communication	More difficult to build a relationship with GP and staff at GP surgery	Changes in named HV may disrupt lines of communication
Team support and communication	May challenge information sharing and need proactive action to work collegiately	Encourages closer team working and co-operation	May encourage closer team working, though changes to named HV may disrupt information flow
Communication with wider multidisciplinary team	Reliance on one individual, but continuity of team around the family.	Greater external facing visibility and opportunity for liaising	Changes in named HV may disrupt lines of communication
Safety – enough cover when demand is high or staff are absent	Inequity in service across different caseloads within a team. Previous continuity of care may improve realistic assessments of client capacity and need.	Opportunity to share workload fairly. Availability of team, may mask shortage of staff expertise and availability. Reduced continuity may negatively impact on realistic assessment of needs	Some opportunity to share workload fairly. Availability of team, may mask shortage of staff expertise and availability. Reduced continuity as child ages may negatively impact on realistic assessment of needs

Conclusion

The survey confirms a lack of consistency in health visor service provision across the UK and provides useful information about the different models for health visitor team and workload organisation in operation. Regardless of model, the commentary offered by respondents to this survey refers frequently to the challenge of working with few staff and as a result concerns about an ability to deliver a health visiting service that promotes good health and supports interventions that prevent or limit risks to children and families. Poor staffing was felt to compromise safety and the model of service delivery could depend on the best means to manage risk rather than on a quality service for the client. What remains unknown is whether there are particular advantages associated with each

service delivery model and importantly what outcomes for children and families are achieved when health visiting services are operationalised in different ways. Research in this area is required to support the development of evidence useful to inform service specification development and commissioning to ensure provision of services that address the needs and rights of children to access good quality health care.

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