Controversial questions (part one): what is the right size for a health visiting caseload?

Introduction

Questions are often asked that illustrate a lack of understanding about the nature of health visiting services. One example is the question of what constitutes a suitable 'caseload size' for a full-time health visitor – there is sometimes frustration at the lack of a single benchmark figure that is defined and accepted nationally. More hostile inquisitors question whether the notions of 'caseload', or even 'health visiting services', are helpful. A recent government directive requires commissioners to establish a portfolio of community services by target purpose, rather than describing services by the title of professionals delivering them. While acknowledging the value of this approach, this paper starts from the assumption that there is no nationally recognised alternative label as yet for 'health visiting services'. Health visiting services have been defined as those that are delivered and led by qualified health visitors, but provided in collaboration with colleagues such as children's centre staff and primary care teams. Some may wish to append to this 'as part of an overall public health service' or 'as part of a service for children and families', depending on how services are commissioned in their local area. Health visiting is delivered through both targeted and universal services that prioritise early child development, since this is a vital time for influencing life patterns that lead to health inequalities. Health inequalities are addressed only if concerns are identified sufficiently early to prevent the infant from entering an adverse life trajectory, with established physiological and behavioural patterns, which might have been changed in the first months and years of life. Once identified, these constitute health needs for which targeted (indicated) prevention is required. In this paper, it is argued that a combination of universal and targeted services directed at the earliest months and years of life is the best way to tackle health inequalities. However, health visiting caseload sizes are extremely variable across England and there is a lack of clear alignment to areas of deprivation. This paper develops published information about the time needed to deliver a universal service, varied according to levels of deprivation, indicating what the different levels of provision mean for the ratio of health visitors to pre-school children.

Background information

Health visiting

Health visiting services began as part of the Victorian philanthropic public health movement, becoming established as a statutory service located in local authorities early in the 20th Century. Health visitors, along with their public health and community nursing colleagues, moved from local authority employ into an 'integrated NHS' in 1974. The statute requiring local authorities to provide a universal health visiting service was not carried forward as an NHS duty at that time. Various reorganisations since then have seen health visitors employed by different NHS structures, including NHS community trusts, primary care trusts (PCTs) and occasionally in different contractual arrangements through social enterprise or other organisations. Different arrangements exist in Scotland, England, Wales and Northern Ireland. A 2001 review found enduring themes and similarities in policies across the UK, supporting the hypothesis that health visitors are, and should be, working with families, groups and communities. It showed their role to be perceived to be acting on determinants of health, empowerment, prevention and protection, with an input into policy making and service design. There is considerable focus on families, though other social groups are also mentioned, particularly when they have definite needs or where there are health inequalities. Service provision tied solely to caseloads of pre-school children can therefore inhibit the flexibility of the service.
Early child development (internationally defined as nought to eight years old) is now acknowledged as a social determinant of health and health inequalities. The family and community within which young children grow shape their health and early development, showing measurable differences through school age and into later life. These are the priority focus for health visiting services.

At present, statutory responsibility for the provision of children’s services – including to promote the health and wellbeing of children aged nought to 19 years – rests with local authorities through the roll-out of children’s centres and trusts across England. Public Service Agreements relating to these services, including the health, safety and development of children, reside primarily with the Department for Children, Schools and Families, though some are held jointly with the Department of Health. PCTs are required to co-operate with the planning and delivery of children’s services, but they do not have to provide a universal health visiting service. However, all NHS organisations have a statutory responsibility in relation to safeguarding and promoting the welfare of children. In practice, this is fulfilled largely through the health visiting and school nursing services.

**Universal provision**
The meaning of a ‘universal health visiting service’ has been debated over the years, but has minimally been interpreted as providing support to all families with newborn infants, until that child is five years old. Recently, a review of health visitors’ work in England has endorsed universal provision of parenting support and education, delivered through the Child Health Promotion Programme. This has been updated to reflect the importance attached to the early years, and recently renamed the Healthy Child programme. Under the epithet of ‘progressive universalism’, these two documents reaffirm an approach that is widely embedded within health visiting, of a ‘universal but not uniform’ service. This means making contact with all families – preferably in the antenatal period or soon after the birth of their baby – to offer initial support and an assessment of whether they need more contacts or a specific programme to help promote the health, wellbeing and early development of the infant and family.

**Targeted and universal services**
Policies designed to tackle health inequalities may focus services directly upon disadvantaged, vulnerable or high-risk populations (targeted), or may operate through provision to the whole population (universal). There have been increasing debates about whether a universal health visiting service is required, or whether it would be best to concentrate on targeted services. Some selective prevention operates by targeting small geographical areas that have measurable levels of deprivation, as in local Sure Start programmes. National evaluation has shown these to be most effective where health visitors are actively engaged, suggesting that local links and knowledge of all pre-school children – derived from the universal service – are particularly significant. Another form of selective prevention targets specific vulnerable groups. For example, the Family Nurse Partnership intensive home visiting programme for first-time teenage parents that is being piloted at present is mainly delivered by health visitors.

The most frequent form of targeting by health visitors is that delivered from within the universal service. In a universal service, all new mothers are offered a ‘core service’ of home visits, invitations to baby clinics and various support groups, with telephone contacts where needed. The idea is that the health visitor will see enough of the mother, baby and any immediate family (including fathers) over a period of several weeks and months, to be able to assess whether any specific health needs exist. If they do, additional visits or other contacts will be planned to meet those needs, or health visitors will help families to access other services if required. A host of social changes, such as smaller and more mobile families, mean that new parents require support and reassurance about their infant’s health, development and wellbeing. Understandably, they are sensitive to judgemental attitudes and dislike structured approaches to assessment. There is some evidence that provision of a universal rather than a targeted service reduces stigma and so improves its acceptability to everyone, including so-called ‘hard-to-reach’ families who often find it difficult to access provision suited to their particular needs.

Development of a personal relationship and following the principles of partnership working appear to be central to this. Another key argument for providing services universally draws on what is sometimes known as the ‘population paradox’, which explains the distribution of health needs across society. Although problems are more likely to arise in specific areas where there is a high risk, they also occur elsewhere. The percentage of families experiencing health needs is lower in more affluent areas, but the actual number affected may be higher because fewer people overall live in very deprived areas. For example, the Social Exclusion Task Force mapped the extent to which ‘family disadvantage factors’ occurred in deprived areas. Compared to elsewhere, there is a clear increase in areas of deprivation. However, their mapping also showed that place of residence did not protect against family disadvantage factors. The seven key indicators of family disadvantage are:

- No parent is in work
- Family lives in poor quality or overcrowded housing
- No parent has qualifications
- Mother has mental health problems
- At least one parent has longstanding, limiting illness, disability or infirmity
- Family has a low income below 60% of the median
- Family cannot afford a number of food or clothing items.

Although the highest frequency occurs in the most disadvantaged areas, a rise in adverse outcomes for children becomes evident when their families experience only one or two of these indicators, so their presence highlights a need for health visiting support. Such families are not only far more widespread geographically, it is also possible to help them with timely preventive action in many more instances. An approximate distribution of need has been calculated by mapping the family disadvantage indicators against standard measures of deprivation within PCTs and the number of children in each area, as provided to the Family and Parenting Institute for December 2006 (see Table 1). Methods are explained in detail elsewhere.

It is important to view this as illustrative, since the figures are averages, they are changeable and inexact. As well, the number of children quoted is that within each whole PCT – in reality, deprivation scores within PCTs often vary as widely as they do across the country. However, the table helps to show that, because there are far more children in areas of relative...
affluence, the total number of families needing help is greater in these places, despite the actual percentage being lower. Targeting by area through Sure Start or other local programmes – or by selecting specific vulnerable groups such as primiparous teenage parents – to receive services reaches large numbers of disadvantaged families, but will also leave large numbers of needy families underserved, unless they can be identified through a comprehensive universal service.

Although the seven family disadvantage factors are particularly useful for illustrating the widespread nature of need and how they contribute to health inequalities, it is important to bear in mind the wealth of other factors that can affect outcomes for children adversely. Family violence is a major concern, with child maltreatment being a common cause of death, serious injury and long-term consequences that affect the child’s life into adulthood, their family and society in general.26 Also, both physical and learning disabilities in childhood are increasing,27 and the high rates of obesity among UK children are continuing to rise.28 The birth rate in England is rising too,29 with one in five births to mothers who were born outside the UK, and who have a higher risk of delivering low birthweight babies and of experiencing disadvantage in other forms.30 The majority of these needs follow a similar pattern of high concentration in areas of disadvantage and among lower socioeconomic groups. However, they are also widespread across the community, again showing that the highest number of ‘identified cases’ will be found among more numerous, but lower risk, populations.31 Building on earlier papers2,6 that have explained how the number of routine contacts needs to vary according to deprivation, these illustrative figures offer a basis for identifying the distribution of health visitors needed. If adopted, this approach would help to overcome the problem – described in evidence to the Health Select Committee on Health Inequalities31 and elsewhere – that the level of ‘core health visiting services’ not only varies across England,4,31 but that the intensity of provision bears no relationship to the level of deprivation.5 The probable number of health visitors needed can be calculated using suggested ratios of health visitors to pre-school children for areas with different deprivation scores (see Table 2). These proposed caseload sizes should allow enough time to provide an effective universal service, with needs assessed at both an area (population) level and for individual families.

These ratios were devised to allow time to deliver services as described in earlier funding model papers,2,6 which promote practice based on existing evidence. Although the evidence is not conclusive, it suggests that six to 12 home visits spread with one in five births to mothers who were born outside the UK, and who have a higher risk of delivering low birthweight babies and of experiencing disadvantage in other forms. The majority of these needs follow a similar pattern of high concentration in areas of disadvantage and among lower socioeconomic groups. However, they are also widespread across the community, again showing that the highest number of ‘identified cases’ will be found among more numerous, but lower risk, populations. Building on earlier papers2,6 that have explained how the number of routine contacts needs to vary according to deprivation, these illustrative figures offer a basis for identifying the distribution of health visitors needed. If adopted, this approach would help to overcome the problem – described in evidence to the Health Select Committee on Health Inequalities and elsewhere – that the level of ‘core health visiting services’ not only varies across England, but that the intensity of provision bears no relationship to the level of deprivation. The probable number of health visitors needed can be calculated using suggested ratios of health visitors to pre-school children for areas with different deprivation scores (see Table 2). These proposed caseload sizes should allow enough time to provide an effective universal service, with needs assessed at both an area (population) level and for individual families.

Table 1. Illustration of family disadvantage indicators by area December 2006

<table>
<thead>
<tr>
<th>Primary care trusts (children aged under five years)</th>
<th>PCT average IMD score</th>
<th>Children aged under five years with a number of family disadvantage indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Five indicators</td>
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<tr>
<td></td>
<td></td>
<td>Three or four</td>
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<td></td>
<td></td>
<td>One or two</td>
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<tr>
<td></td>
<td></td>
<td>At least one</td>
</tr>
<tr>
<td>Most deprived 10% (238,016)</td>
<td>35.4 to 52.5</td>
<td>5.5% (13,091)</td>
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<tr>
<td></td>
<td></td>
<td>25.9% (61,884)</td>
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<tr>
<td></td>
<td></td>
<td>45% (107,107)</td>
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<tr>
<td></td>
<td></td>
<td>76% (182,082)</td>
</tr>
<tr>
<td>70th to 90th centiles (752,714)</td>
<td>25.67 to 35.39</td>
<td>2.9% (21,829)</td>
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<tr>
<td></td>
<td></td>
<td>13% (97,853)</td>
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<tr>
<td></td>
<td></td>
<td>35% (263,450)</td>
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<tr>
<td></td>
<td></td>
<td>51% (383,132)</td>
</tr>
<tr>
<td>40th to 70th centiles (719,094)</td>
<td>17.20 to 27.48</td>
<td>0.6% (4,314)</td>
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<tr>
<td></td>
<td></td>
<td>6.6% (47,460)</td>
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<td></td>
<td></td>
<td>27.4% (197,031)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>35% (248,805)</td>
</tr>
<tr>
<td>Least deprived 30% (1051,849)</td>
<td>7.7 to 16.23</td>
<td>0.5% (5,259)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.4% (25,244)</td>
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<td></td>
<td></td>
<td>20% (210,370)</td>
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<td></td>
<td></td>
<td>23% (240,873)</td>
</tr>
</tbody>
</table>

Table 2. Suggested health visiting caseload sizes

<table>
<thead>
<tr>
<th>PCTs mapped to IMD scores (children aged under five years)</th>
<th>PCT average IMD score</th>
<th>Total family disadvantage</th>
<th>Suggested ratio of whole-time equivalent (WTE) health visitors to children aged under five</th>
<th>WTE health visitors needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived 10% (238,016)</td>
<td>35.4 to 52.5</td>
<td>76% (182,082)</td>
<td>one to 100</td>
<td>2380</td>
</tr>
<tr>
<td>70th to 90th centiles (752,714)</td>
<td>25.67 to 35.39</td>
<td>51% (383,132)</td>
<td>one to 150</td>
<td>5018</td>
</tr>
<tr>
<td>40th to 70th centiles (719,094)</td>
<td>17.20 to 27.48</td>
<td>35% (248,805)</td>
<td>one to 300</td>
<td>2396</td>
</tr>
<tr>
<td>Least deprived 30% (1051,849)</td>
<td>7.7 to 16.23</td>
<td>23% (240,873)</td>
<td>one to 400</td>
<td>2630</td>
</tr>
</tbody>
</table>

Total WTE health visitors needed: 12,424

Total numbers of children calculated from numbers supplied to the Family and Parenting Institute.4 PCTs mapped to 2004 Index of Multiple Deprivation (IMD) scores averaged across their areas, and numbers of children totalled. There were missing data from six PCTs.5 Family disadvantage factors derived from Social Exclusion Taskforce analysis.9 Where centiles are aggregated, range mid-points are used.
including those specified within the Healthy Child programme.\textsuperscript{1,3} A higher number of contacts is required routinely where greater need is expected in more deprived areas,\textsuperscript{2,4} and so proportionately smaller caseload sizes are required.

Given current staffing shortages, these proposals may seem overly demanding, particularly for the more deprived areas. However, if the figures are compared to those tried and tested by the Family Nurse Partnership approach, they appear more reasonable. That programme was developed in the US,\textsuperscript{3,4} with selected vulnerable families being visited weekly or fortnightly from the second trimester of pregnancy until the infant is two years old. There is strong evidence to support the effectiveness of this programme, so practitioners implementing it have caseloads of 25 mother-and-baby dyads. In England, ‘family nurses’ are piloting the approach with mothers aged under 23 years and expecting their first baby, but have struggled to find enough time to visit according to the programme, suggesting the caseload size is too large for the intensity of the visiting.\textsuperscript{1,9} In comparison, many health visitors are struggling with caseloads of 500 families or more at present,\textsuperscript{4} often including well over 25 vulnerable families who require support.\textsuperscript{3,5}

The ‘Starting Well’ health demonstration project in Scotland was a similarly intensive programme of support to families living in very deprived circumstances, and suggested that a caseload of 80 to 90 families for each health visitor, working with health support workers in the team, is probably optimal.\textsuperscript{3,6} This is closer to the figure proposed for the most deprived 10\% of areas in this paper. In another example, a caseload of 100 families per health visitor was required for the First Parent Visitor programme, which was wide-spread in deprived areas.\textsuperscript{3,7}

Families living in poverty require around twice as much health visiting time as those in affluent areas, and up to seven times as many other services.\textsuperscript{3,8} The purpose of a universal service is to allow health needs to be identified soon enough for early interventions and evidence-based support to be offered to those who are identified as likely to benefit (‘indicated prevention’), wherever a family lives. However, health inequalities follow a gradient, with a corresponding gradient in the level of need. Services are therefore needed in all areas, but with increasing provision as areas become more deprived. This is what is meant by the policy of ‘progressive universalism’\textsuperscript{3} that health visiting services are required to adopt.\textsuperscript{1,11-13}

Deprivation is the key marker for health need, and it is certainly necessary to take this into account. However, it is not sufficient alone as a mechanism to plan caseload size. As well as an assessment of other health needs within an area, there are two further, major elements to take into account when considering caseload size that can only be summarised here. These are the local service context within which health visiting operates, and the chosen working patterns and organisation of the service.

### Other issues

#### Local service context

Health visiting services are one part of the provision to be prioritised when commissioning services for children and families, or for health and wellbeing,\textsuperscript{1} and these priorities are set out in the NHS operating framework for 2009 to 2010 (see Box 1).

Local knowledge and intelligence are also required in order to ensure that the effect of availability (or otherwise) of other services is taken into account, along with a multitude of other time-relevant issues, such as travel, position and availability of staff bases, attachment to general practice, integration with children’s centres and many more. Paradoxically, the number of health visitors may need to be increased

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### Key points

- Health inequalities are a major public concern and key area of interest for health visitors
- At a national level, health visiting services are not aligned with areas of deprivation and caseload sizes are very variable, leading some to question the value of universal services
- Using published research about the distribution of family disadvantage factors as an example, the ‘population paradox’ and the relevance of universal services are explained
- This paper builds on previous work about the need to vary the number of routine contacts according to deprivation levels, to propose baseline recommended caseload sizes in different areas
- While factors other than deprivation are relevant, having an agreed norm from which to develop service plans will help demonstrate that caseload sizes can and should vary in a planned and meaningful way

### Box 1. NHS operating framework in England 2009 to 2010\textsuperscript{1}

PCTs should have community service portfolios that are described in terms other than professional groups, such as ‘health and wellbeing’ and ‘children and families’.

Key priorities include keeping adults and children well, improving their health and reducing health inequalities. Priorities for children are to:

- Reduce childhood obesity
- Increase breastfeeding, expanding ‘baby friendly’ initiatives
- Offer services in line with the Child Health Strategy and local priorities, for example:
  - Delivering a high quality Healthy Child programme
  - Implement the adolescent-friendly ‘You’re Welcome’ standards
  - Improving the experience of services for children with a disability and their families, including palliative care
  - Reviewing and evaluating the effectiveness of child and adolescent mental health services to ensure that vulnerable children have swift and easy access to services
  - Services to reduce teenage pregnancy rates, including provision of a full range of contraceptive services
- For their statutory responsibilities in relation to safeguarding and promoting the welfare of children, keep under review arrangements to:
  - Make sure that they have the policies, skills, competencies, partnership arrangements with other agencies, monitoring and assurance procedures
  - Ensure that their statutory responsibilities are being met.

Strategic health authorities

- Strategic workforce plans need to be developed, which deliver improved health outcomes in maternity, neonatal and children’s services and help tackle inequalities
- PCTs to consider how their local workforce plans support the local services offered.
where other children's services are limited, typically in the more affluent or 'elderly' areas, because there is no-one else to whom families can be referred. Conversely, in some deprived areas, instead of boosting generic services, it may seem appropriate to develop specialist (selective prevention) services for vulnerable population groups who are not reached easily by universal services, such as asylum-seekers, homeless populations or travellers.

Local working patterns

So far in this paper, the term 'caseload' has been used to signify the ratio of one full-time health visitor to the number of pre-school children for whom she or he holds case responsibility. Figures need to be adjusted where various forms of corporate and team working are used, or in respect of part-time staff. These ratios take no account of skill mix, or of the time needed to carry out the community-based and public health activities for which health visitors are responsible, in addition to one-to-one activities with clients. Interagency and interdisciplinary liaison, student teaching, travel, organisational activities such as covering sick and annual leave, clinical supervision and team meetings, all also need to be factored into a working day, and the extent to which they affect caseload size will vary from one area to another. Staffing ratios need to be adjusted in order to allow time for these activities, in addition to meeting the health needs of pre-school children and their families for whom the health visitor is responsible.

Conclusion

This paper has explained in detail why a universal health visiting service is a key requirement for tackling health inequalities, but offers a possible way of ensuring a more equitable distribution across the country than at present. This is needed so that all children and families who would benefit from early interventions can be identified, wherever they live. The population paradox was explained, making use of illustrative figures showing the known distribution of ‘family disadvantage factors’ in relation to area deprivation, and suggesting a suitable ratio of health visitors to pre-school children. There is no single recipe, so it is not feasible to give a simple answer to the complex question ‘what is the right size for a health visiting caseload?’ The question may remain controversial, but if the figures proposed in this paper are accepted as a useful guiding baseline, then a case can be made for variation from these caseload sizes as necessary, according to local situation.

Acknowledgment

This paper draws on data submitted as evidence to the UK Government Health Select Committee on health inequalities, Session 2007 to 2008, and is reproduced under terms of Click-use PSI license number: C2008002077.

References