Expanding the health visitor’s role to include the 6–8 week assessment

The 6–8 week baby assessment is usually performed by a GP. Rajeev Gupta argues that training health visitors to take on this role would not only save money for the health service but could result in better outcomes for infants and their parents.

Over the past decade, UK policy concerning universal preventive health services for preschool children has seen numerous changes. Health promotion contacts are increasingly targeted to those with the most significant health needs. This paper proposes training health visitors to undertake the 6–8 week assessment usually done by GPs. This practice has been successfully piloted in Barnsley, South Yorkshire, for more than three years, having been commissioned by the Barnsley Primary Care Trust and NHS Barnsley.

One benefit is that it means GPs have more time to focus on those infants with health problems requiring further investigation or treatment. In addition, the fact that the health visitor has already established a relationship with the parents means the process can be less daunting for new parents, leading to better outcomes for the family.

Background
A health visitor’s role is varied one and is an integral part of the NHS community health service, primarily focused on infants and young children but with a significant role in health promotion and the prevention of illness across the whole community.

The Health Visitor Implementation Plan 2011–2015 (Department of Health (DH), 2011) outlined strategies to develop and expand the health visiting service in England. It was proposed that health visitors will provide four tiers of service based on assessment of the needs of the child and family. Universal services will be available to all families with children aged 0–5; Universal Plus services will be offered to families with children aged 0–5 with specific issues; and Universal Partnership Plus services will be available to families with children aged 0–5 with complex needs. An assessment of the Health Visitor Implementation Plan in practice was published earlier this year (Russell, 2013).

Health visitors deliver the Healthy Child Programme (DH, 2009), which suggests six core contacts that health professionals should have with new parents and their children:

- By the 12th week of pregnancy
- The neonatal examination
- The new baby review (around 14 days old)
- The baby’s 6–8 week assessment
- By the time the child is 1 year old
- Between 2 and 2.5 years old.

The evidence of the effectiveness of early intervention on improving health and social inequalities outcomes throughout life is well established. There is also evidence that using a tiered model of service provision can lead to better engagement with families who are most in need of assistance (DH, 2011).

Prior to the implementation plan, Facing the Future asked an important question about whether health visitors deliver measurable health outcomes for individuals and communities (Lowe, 2007).

The implementation plan focused on growth of the workforce, but there is also considerable scope for individual health visitors to expand their roles and specialise in certain areas. The role of health visitor consultants has been identified in as early as 2000, and a study of the impact of the role of nurse, midwife and health visitor consultants showed that, as consultants become more established in their posts, they are able to identify improvements in practice, service reconfiguration and educational advantages for staff (Coster et al, 2006; Drennan and Goodman, 2011). There have been challenges in the past when the role of nurse consultant has been assimilated in a community setting (Drennan and Goodman, 2011). However, it is apparent that over the next 10 years the extended role of health visitors may become common and there might be health visitor consultants with expertise in preventive health advice, who

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would be able to guide and support other health visitors in their role. Some educationalists and managers are thinking of changing roles and preparing, recruiting and retaining nurses into public health roles in primary care (Drennan et al, 2013).

In the current age of austerity, the ability to demonstrate outcomes is key to getting commissioners to fund services. Health visitors must show that the preventive work they undertake has a beneficial effect. It is sometimes possible to demonstrate an economic argument; a recent paper on the health visitor’s role in identifying and intervening with infants at risk of developing obesity indicated that health visitors can play a vital role in prevention and thus save millions of pounds that would potentially be spent on anti-cholesterol, anti-hypertensives, anti-diabetic and other drugs in later life to deal with the consequent problems and complications of obesity (Redsell et al, 2012). This is just one example of the potential cost saving that could be made by demonstrating the beneficial outcomes of health visiting work in order to secure funding and resources.

The 6–8 week assessment
The NHS Newborn and Infant Physical Examination Programme (NIPE) is part of the Healthy Child Programme, a strategy to support the health and wellbeing of newborn babies and children. It offers parents of newborn babies the opportunity to have their child examined shortly after birth, and again at 6–8 weeks of age. The NIPE standards (UK National Screening Committee, 2008) were established to promote improvements and consistency in the newborn and infant physical examinations and the document’s recommendations are obligatory.

All babies are assessed at birth, but there are conditions that are undetected at birth due to difference in blood flow (e.g. a case of ventricular septal defect (VSD) would become clear later because the pulmonary blood resistance is high at birth but becomes low at 6 weeks, making the VSD murmur audible). Other conditions are also more apparent later, as the parents have had time to observe and discuss concerns, while there is little opportunity for this at the birth examination. The 6–8 week assessment is also a second opportunity for a general check of the body’s systems in case a congenital anomaly was missed at the newborn assessment. Box 1 gives an overview of what the 6–8 week assessment involves.

NIPE states that the ‘examinations should... be performed by a suitably trained and competent health-care professional who has appropriate levels of ongoing clinical experience’ (UK National Screening Committee, 2008: 7).

In general practice, the 6–8 week assessment is usually undertaken by a GP who has a particular interest in child development, while in some areas it is performed by a community paediatrician or health visitor (Newson, 2011). The skills required for an effective 6–8 week assessment are interpersonal skills, empathy with the parents and other family members, an interest in newborn babies, interest in understanding of the physiological and clinical conditions of babies at 6–8 weeks old, ability to undergo a competence assessment, and the ability to liaise and work effectively with a GP, midwife and paediatrician.

Advantages of health visitors performing the 6–8 week assessment
Training health visitors in the 6–8 week assessment so that they, rather than a GP, can perform it is a potential cost-saving measure that could lead to better outcomes. With adequate training and support from GPs and paediatricians, health

Box 1. What the 6–8 week assessment involves
The first scheduled examination in child health surveillance at 6–8 weeks forms part of a routine set of examinations which are standard practice (Hall and Elliman, 2006; UK National Screening Committee, 2008). The recommendation is that it should take place by 8 weeks at the latest and should include:

- A physical examination
- A review of development
- An opportunity to give health promotion advice
- An opportunity for the parent to express concerns.

The main purpose of the physical examination is to detect symptoms of potentially serious health problems:

- Congenital heart disease
- Developmental dysplasia of hip (previously known as congenital dislocation of hip)
- Congenital cataract
- Undescended testes.

The assessment should also include:

- A weight check
- Measurement of head circumference (and opportunity to palpate sutures and fontanelles, and assess head shape)
- Assessment of tone
- Check of spine, genitals, femoral pulse, hernias and palate
- Observation for and exclusion of jaundice, organomegaly and dysmorphic features.

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visitors could undertake this check effectively. A health visitor will usually have good rapport with their clients and gain the trust of parents (Davies, 1988), which aids communication. The skills for the 6–8 week assessment are specific and can be acquired through training and practice. A recent book has examined the possibility of ‘upgrading’ the skills of nurses and health visitors to undertake this role (Gupta, 2013). The potential changes to the health visitor’s role in undertaking the 6–8 week assessment are illustrated in Figure 1.

The idea of GPs training health visitors in the 6–8 week assessment is not entirely new. Most of the skills required can be fairly easily mastered. The greatest challenge is in understanding heart sounds and murmurs. In training it may be useful to provide health visitors with CDs of the heart sounds and murmur—once the ears get tuned to normal and abnormal heart sounds, the practitioner will become more confident to assess these sounds in practice. If health visitors were to take on the 6–8 week assessment, it would not become their job to diagnose a heart condition through different types of murmur; their role would be to identify what is normal and to refer anything that is doubtful or abnormal to a GP or paediatrician (depending on support and availability in the area). In such a situation, it would be important to give the message to the parents about the need to double-check the clinical finding. Health visitors’ skills in communicating with parents, building trust and sensitively explaining the situation would be of benefit here.

The process of health visitors undertaking the 6–8 week assessment would save money for the health service and mean that GPs would only see those patients who require medical attention, thus reducing waiting times at surgeries. In addition, it could be argued that it would be a more relaxed experience for the parents (and, by extension, the baby) if they were seen by a health visitor whom they have already met and begun to develop a relationship with. There have been questions raised about mothers missing out on being assessed for postnatal depression (PND) by a GP alongside the 6–8 week assessment. Morell et al (2009), in a study of 2749 women allocated to intervention and 1335 to control, concluded that training health visitors in approaches to assess women, identify symptoms of PND, and deliver psychologically informed sessions was clinically effective compared with usual care. The study mentioned that health visitors can be trained to develop further skills in the assessment of women and the detection of PND symptoms and in the provision of interventions based on person-centred or cognitive behavioural therapy principles. Most health visitors are already skilled in identifying and supporting women with PND, and it could therefore be argued that they are better placed than a GP to carry out a PND assessment, particularly if they have already begun to build a relationship with the mothers they are assessing.

Health visitors (particularly if they have had antenatal contact) have had an opportunity to build rapport with parents and gain their trust. They see parents and families in a variety of settings, including their homes, clinics, GP surgeries, Sure Start children’s centres etc, and could therefore offer to undertake the 6–8 week assessment in any one of these settings to make it easier to assess all the babies they need to see within the required time frame.

Health visitors are accustomed to working with other agencies and health-care professionals who share a common commitment to children’s development, including GPs, allied health professionals, voluntary agencies and paediatricians. They are able to be a point of liaison between such agencies and parents.

Potential challenges for a health visitor in undertaking the 6–8 week assessment include the practicalities of learning about what the examination involves, and having the confidence to perform it independently. It is therefore essential

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**Figure 1. Potential roles for health visitors. From: Gupta, 2013**
Training

A training programme for health visitors has been established, which comprises 3–5 days of training ending with an assessment. Following training, the health visitors then undertake baby assessments in general practice under the supervision of GP or a community paediatrician. Once the GP or paediatrician is satisfied with the health visitor’s competence in this area, they get certified to undertake the 6–8 week assessment independently. This model has been successful in some areas (Box 2).

The training is currently available in Barnsley, London and Peterborough. The programme is run and approved by eTraining Skill and educational institute WOLC. It was established after a consultation with experienced paediatricians, health visitors and educators, and was designed and developed to deliver competency skills.

The course is modular and includes an online distance-learning element followed by face-to-face practical training to develop and refine the skills learned. Online videos are available for ongoing updates. A mentor is allocated to the health visitor during the training process, with whom any queries or problems can be discussed.

The training comprises 17 modules to develop the competencies necessary to perform the 6–8 week assessment. A list of the modules and further information on accessing the training is provided in Box 3.

Following completion of the training programme, the health visitor is observed and assessed by a GP or paediatrician. In addition, health visitors are advised to refer to a GP or specialist in any cases of doubt or concern. Going forward, random supervision of up to 3% of the 6–8 week assessments performed by the health visitor can ensure the service is effective in the long term. The mechanism by which such supervision is provided would need to

Box 2. Case study

Tracey Lake, Health Visitor Advanced Nurse Practitioner, South West Yorkshire Partnership NHS Foundation Trust, was trained in undertaking the 6–8 week assessment in 2009. Here she shares her experience of taking on the new role:

‘I was initially approached by service managers to consider doing the 6–8 week assessment training for two GPs in my area, as they had opted out of the Child Health Surveillance programme. I was looking for a new challenge and was flattered when the managers recommended me. After giving it some consideration, I believed there were some factors in favour of health visitors taking on this specific assessment. Indeed, I thought my knowledge and skills as a health visitor around the health and wellbeing of mother and child—including health education and promotion advice—could be invaluable at this important and vital screening examination. I had the added skills of delivering vaccinations and qualified as an independent nurse prescriber, which could be used at the same time as the assessment. I would not be under the time constraints of a GP and felt that this could lend itself to a thorough examination alongside health promotion advice.

The training module emphasised the importance of history-taking from the antenatal to the postnatal period. As an experienced nurse, I was comfortable in my patient assessment skills and the principles of undertaking holistic assessments. I attended a training course in 2009. Dr Gupta, who led the course, explained that the object of the 6–8 week assessment and child health surveillance was to complete a physical examination. The main emphasis was to detect abnormalities such as heart disease, developmental dysplasia of the hip, cataracts etc. At this point I began to feel less confident in my abilities. Despite my concerns, the training was enlightening and I was able to gain a greater understanding of the physiological wellbeing of infants. I wanted to make a positive contribution to my service and felt empowered to progress and accomplish what I had set out to do. Following the training I identified a GP to help me with gaining the necessary competencies, and I received a good deal of support from her.

I have now been doing the 6–8 week assessment for three years. In retrospect, there has not really been any adversity. I don’t profess to be an expert in all the medical problems that can emerge in infants; indeed, one of my biggest fears was missing a problem such as a heart murmur or hip dysplasia and at first I relied heavily on the GP for support. Over time this has lessened, but my rule of thumb remains as it was at the start—if in doubt, don’t take risks, and ask for confirmation from the GP. Obviously, I have to practise by the Nursing and Midwifery Council code (2008) in being accountable for my actions. Occasionally, I have picked up problems missed by other professionals; my responsibility is to work in partnership with the GP, family and other agencies when issues or concerns may arise from the assessment, including following my organisational policies and procedures. I have never had a parent refuse consent for me to complete the 6–8 week assessment when I inform them that I am a health visitor trained in undertaking the assessment.

‘I have grown in both confidence and competence over time. At times I have felt quite lonely and vulnerable, being the only health visitor in my area doing this assessment, but knowing that I was making a difference renewed my enthusiasm. I identified that I needed to look at support and supervision mechanisms. Now I feel privileged to be delivering this service. The true test of whether a professional other than a GP or paediatrician can deliver the 6–8 week assessment successfully is to examine the experience from the service users themselves, and a future plan is in place to evaluate my effectiveness by asking the clients.’
be decided at a local level, based on the availability of resources.

**Conclusion**

Training health visitors to undertake the 6–8 week assessment is a useful step both in terms of broadening their skills and allowing GPs to focus on the babies that require medical attention. Most health visitors have established rapport with parents, so parents are more likely to feel comfortable when asking questions. Health visitors can give holistic advice at 6–8 weeks on topics including immunisation, health promotion and feeding. They can assess the mother for postnatal depression at the same time. In areas where a health-visitor-led assessment has been trialled, no significant problems have been encountered, and parents have expressed satisfaction. It is possible that it could be rolled out on a national scale; however, this would require further research and the agreement of GPs and commissioners.

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**References**


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