Institute of Health Visiting
Excellence in Practice

State of Health Visiting, UK survey report

From disparity to opportunity:
The case for rebuilding health visiting

11th iHV Annual Health Visiting Survey: data year ending November 2024

Publication date: 27 January 2025

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Who we are

The Institute of Health Visiting (iHV) is an independent charity, professional body and centre of excellence for health visiting – established to strengthen the quality and consistency of health visiting for the benefit of all babies, children, families and communities[1].

In the context of deteriorating child and family health, we are impatient for change and courageously challenge inequalities in outcomes and healthcare provision in the earliest years of life.

We believe in a better future and that change is possible! We will continue to focus our efforts and work with partners to influence policies affecting health, and act as a voice for our profession. And we won't stop!

We believe that health visiting is an important part of the solution to improving public health outcomes for babies, children, families and communities. When appropriately resourced, health visiting provides a vital infrastructure of support that is central to improving health and reducing inequalities.

We are committed to ensuring the highest standards of education, learning and development, innovation and research, and professional leadership, to support evidence-driven practice and enable world-class health visiting.

About the Institute of Health Visiting

Influencing policies affecting health:

In our annual survey, our members told us that being part of an organisation that acts as a "voice" for health visiting, to influence policy, was the most important reason for being a member of the iHV. We take this role seriously and it remains at the heart of our work.

Our Approach:

1 Understanding

Listening to, collating and sharing practitioner intelligence and evidence on the current state of health visiting and child/family health – we shine a light on the problem and speak truth to power.

2 Collaborating

Forming strong alliances with partners and key stakeholders to build support for health visiting and raise awareness on the importance of investing in the health and wellbeing of babies, children and families, at the earliest stages of life.

3 Providing solutions

Increasing decision-makers' understanding of the value of a well-resourced health visiting service, as a vital infrastructure of support for babies, children, families and communities, encouraging long-term thinking and influencing policies across health, education and social care.

4 Energising

Bringing energy, ideas, leadership and 'hope' to our profession. As the greatest threats to global health are due to conditions that are largely preventable, health visitors, as Specialist Community Public Health Nurses, are needed more than ever to lead our profession into the future, with the right conditions to flourish.

Acknowledgements:
We would like to thank everyone who took the time to complete our survey. We had a phenomenal 1,392 responses which capture valuable health visiting practitioner intelligence from across the UK.

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Executive Summary

Key messages from the State of Health Visiting survey report (January 2025)

The largest UK survey of health visiting

1,392 practitioners completed the survey between 9 September and 4 November 2024

This year, we received responses from health visiting practitioners in all four UK nations and all regions in England. The report presents data for the UK and compares key metrics between the different UK nations. For some metrics, specific data for England are highlighted where there is a big difference between England and the other UK nations.

Part I: Babies, young children and their families' needs – including child health, development and safety

Health visitors want to deliver a good service to all families – and to support the Government's ambition to create the "healthiest generation of children ever".

84%

of practitioners reported that the **demand for health visiting support had increased** over the last 12 months

Families required health visiting support for a wide range of issues that can make parenting harder, and can impact on child and family health outcomes and vulnerability.

Throughout the UK, the **top reason** why families needed extra help from health visitors was due to mental health problems during and after pregnancy:

MORE THAN **90%** of practitioners reported that **perinatal mental health problems** are a major issue for families in the UK, needing extra health visiting support

The other main concerns that families faced were ranked differently across the UK.

Child behaviour problems were ranked 2nd in Scotland, Wales and Northern Ireland:

AROUND **90%** of practitioners said that families needed extra health visiting support for child behaviour problems - with many wanting help for concerns around ASD and ADHD*

In contrast, practitioners in England said that their practice was dominated by social concerns. More families needed help with the impacts of poverty (ranked 2nd) and with babies/children who have safeguarding concerns below the threshold for Children's Social Care (ranked 3rd):

86% of practitioners in England said that poverty affecting families was a major issue for families, needing extra health visiting support

82% said that children with safeguarding concerns below the threshold for Children's Social Care was a major reason that families needed extra health visiting support

Practitioners across the UK also pointed out that many families needing extra help from health visitors were dealing with multiple problems, as family life has become more complex.

*ASD: Autistic Spectrum Disorders; ADHD: Attention Deficit Hyperactivity Disorder.

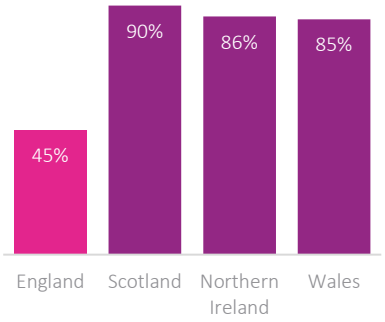
Part II: Health visiting services, responding to need across the UK: widening disparities

There are big differences in the level of health visiting support between the different countries in the UK and among local authorities in England. Families receive good levels of support in some areas, and barely any support in other areas.

Research shows that **families want personalised healthcare, not a one-size-fits-all "tick-box" approach**. Health visitors agree – and we know that having continuity of carer delivers better outcomes. However:

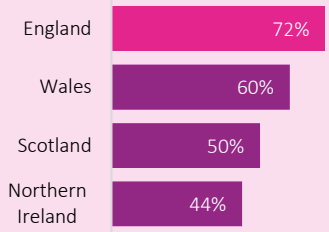
- **Only 45% of health visitors in England are able to provide continuity of carer to families "all or most of the time"**
- compared to 90% in Scotland, 86% in Northern Ireland and 85% in Wales.

Health visitor continuity of carer

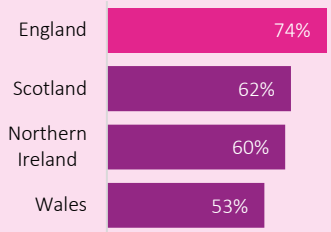


Top challenges affecting health visiting healthcare delivery:

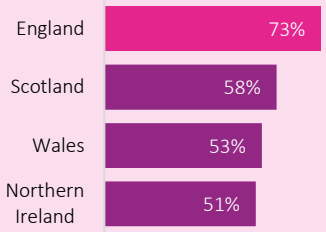
Percentage of health visitors **concerned about the erosion of the "health" aspects of health visiting, as child protection and child safeguarding were being prioritised**:



Percentage of health visitors who said **workforce shortages impacted on the delivery of the universal health visiting contacts**:



Percentage of health visitors who said **workforce shortages impacted on their ability to support families when a need was identified:**



In England, demand for health visiting support is currently far in excess of what services are commissioned and able to provide, with wide variation and a mixed picture of health visiting support for families. Practitioners were also experiencing additional challenges in <u>some</u> areas:

- Achieving service Key Performance Indicators (KPIs) were prioritised over safe and effective delivery of care - "Ticking the box but missing the point"
- Lack of other services in the community able to offer support to families
- Lack of venues/ issues with premises
- Local commissioning – ongoing cuts to scope and delivery model for some HV services.

Whilst health visiting in Scotland, Wales and Northern Ireland is not without challenges, fewer practitioners reported experiencing challenges compared to England.

Overall, practitioners working in Scotland, Wales Flying Start and Northern Ireland had much more positive experiences to share:

- *"I think we are very lucky in Scotland and in my area to be able to provide the full Scottish universal pathway and provide an additional pathway for all families who need this."* (HV Scotland)
- *"Health visiting is a valuable service offering support to all families with preschool children as well as targeted families."* (HV Northern Ireland)
- *"Due to the Healthy Child Wales programme and the additional Flying Start, we are able to offer continuity of carer with a named HV. Along with a full and comprehensive programme."* (HV Wales)

Part III: Health visiting workforce matters

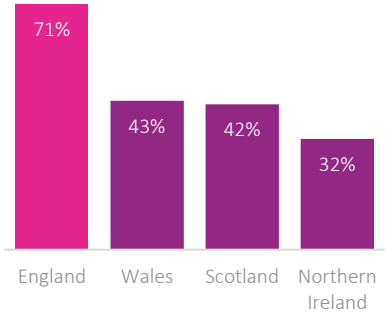
Across all four UK nations, practitioners reported a decrease in health visitor numbers:

71% of practitioners from England reported a reduction in qualified health visitors in the last year, with fewer reporting losses in other UK nations.

Disparity: There were excellent examples of health visiting innovations to address key public health priorities in some areas – whereas in other areas, health visitors expressed frustrations about their loss of autonomy and the lack of flexibility in some service models to enable personalised and responsive care.

Fewer health visitors has left many managing chronic excessive workloads - which damages employee health and their ability to provide high-quality and compassionate care.

Practitioners reporting ↓ health visitors



UK health visiting workforce – work environment, recruitment, retention and wellbeing:

58% of practitioners said they experienced work-related stress

54% work unpaid hours

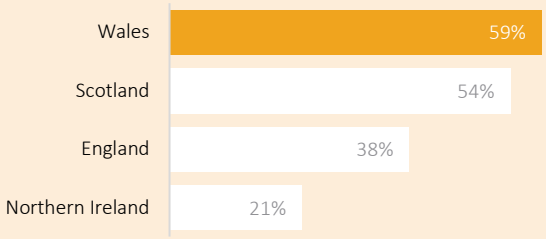
49% said they need more efficient IT systems

40% of health visitors are **intending to leave the profession** in the next 5 years.

The top reasons are:

1. Retirement **(35%)**
2. Lack of career progression **(14%)**
3. Role drift away from preventative public health **(12%).**

Practitioners reporting ↓ student health visitors



Part IV: Strengthening health visiting – train, retain, reform

Strengthening health visiting is not complex – many of the solutions are straightforward, well-known and well-evidenced.

Practitioners understand what is needed. And they have an important role to play in strengthening health visiting and improving the health and wellbeing of babies, children and families across the UK.

They told us that they want policymakers to **start by getting the basics right – start by rebuilding the workforce and strengthening services:**

- **Train** enough new health visitors to rebuild the workforce and replace those expected to leave.
- **Retain** the health visitors we have – plug the "leaky bucket", attract people who have left back into health visiting, and improve opportunities for career progression, including leadership development and specialist posts.
- **Reform** – put the needs of babies, children and families at the centre of health visiting care, and strengthen health visiting services, through:
  - Good leadership
  - Service models and commissioning that meets the needs of families
  - Focusing on preventative public health - put "health" back into health visiting
  - Valuing health visiting – provide stability and engage health visitors in building a health visiting service fit for the future, maximising the role of Specialist Community Public Health Nurses in the UK.

Conclusion and Recommendations

Despite numerous challenges which cannot be ignored, there is a groundswell of support within the health visiting profession wanting change for the better – and willing to play their part to ensure that the UK has a world-class health visiting service so every baby can have the best life from the start.

Health visiting plays a pivotal role in improving outcomes for babies, children and families. Despite the proven benefits of health visiting services, they have historically been under-resourced (particularly in England). The current level of funding and workforce capacity has not kept pace with the increasing needs. This has resulted in a shortage of qualified and experienced health visitors, increased caseloads, and significant gaps in service delivery in some areas - limiting support for families in need.

Investing in health visiting is an investment in the health and wellbeing of babies, children and families, and the future of our society as a whole.

We're calling for the following key changes:

Funding
A realistic and accurate level of funding that reflects the true scale of need for health visiting services. Adequate resourcing will ensure:

i. Accessible Services: Expanded reach of health visiting services to all families, particularly those in underserved communities.

ii. Increased Workforce: Recruitment and retention of skilled health visitors to manage appropriate caseloads.

iii. Enhanced Training: Continuous professional development to equip health visitors with up-to-date knowledge and skills to drive high-quality care.

iv. Strengthened health visiting services: Maximise the role of health visitors to reduce pressures in the NHS through a shift to the community and an increased focus on prevention, improving immunisation uptake, and reducing disparities in antenatal and postnatal healthcare.

Long-term investment will help services to plan and build world-class services, ending the uncertainty of short funding cycles.

Workforce
Train, retain and reform the health visiting workforce across the UK:

i. In England specifically: To deliver the national long-term workforce plan in full, ensure accurate workforce forecasting to meet the scale of need; and, in line with other UK nations, develop a robust, evidence-based safer staffing tool to ensure safe and effective care.

Quality
National government must do more to end the current postcode lottery of health visiting support:

i. The needs of babies, children and families must be at the centre of healthcare delivery, with system blockers removed to enable best practice and integrated healthcare.

ii. All areas must provide health visiting services that reflect best practice, and are proportionate to the scale of need, with mechanisms to hold failing areas to account. (In England, the Commissioning Guidance needs strengthening with explicit governance to reduce disparities and drive high-quality healthcare).

iii. "Health" must remain a central component of health visiting to enable health visitors to play their fullest part in improving health and reducing inequalities for babies, children and families.

iv. Health visiting research, workforce development and the sharing of evidence-driven models of best practice are supported.

Please also read our Appendix which is focused on improving vaccination uptake in England, with valuable practitioner intelligence to support implementation.

Content

1.0 About the Institute of Health Visiting (iHV) UK survey report

Every year, the iHV conducts a "State of Health Visiting" survey to provide key insights into the evolving needs of babies, young children and their families, alongside valuable intelligence on the current context of health visiting services across the UK.

Our survey uncovered key insights into the multitude of issues that families with babies and young children are currently facing, from the perspective of health visiting practitioners working across the UK. The findings also act as a barometer, capturing the pressures and challenges being faced by the health visiting services that support them.

This report paints a picture of increasing levels of need and widening disparities in health visiting provision across the UK. It highlights the urgent need for investment in health visiting services to ensure that all families receive the high-quality, personalised, and equitable healthcare that they need, and that health visiting practitioners want to provide. The findings position health visiting as a safety-critical workforce, essential to safeguarding and improving outcomes for babies, children and families.

Whilst the current picture is bleak, we remain optimistic for a better future. The findings demonstrate that, despite the current challenges and unacceptable disparities in healthcare, change is possible. The health visiting workforce is ready, willing and able to play its part to halt the decline and rebuild, to ensure that the UK has a world-class health visiting service so every baby can have the best start in life.

Objectives

The survey findings are presented in four themed sections:

I. Babies, young children and their families' needs – including child health, development and safety
II. Health visiting services, responding to need across the UK: widening disparities
III. Health visiting workforce matters
IV. Strengthening health visiting – train, retain, reform.

Method, data collection and analysis

This year, we worked collaboratively with our iHV Health Visiting Advisory Forum (HVAF) members to co-design a brand-new, streamlined survey to ensure we asked the right questions to capture the realities of health visiting practice and practitioners' experiences on the ground.

Our survey was open to all health visitors and practitioners working in health visiting teams across the UK. 1,392 practitioners completed the survey between 9 September and 4 November 2024. This represents a 17% increase in our annual survey response rate compared to our survey last year. This higher response rate strengthens the reliability of the findings (England sample size calculation: 95% confidence level with a 3.0% margin of error).

Both quantitative and qualitative data were collected using an online survey. The qualitative data were analysed inductively to identify key themes, supported by direct quotes from survey respondents to represent their experiences. Data sufficiency was achieved early in the data collection process, whereby headline statistics and themes remained consistent with the addition of new responses to the sample. This supports a high level of confidence in the reliability of the findings.

UK reach

We received responses from health visiting practitioners working in all four UK nations and every region in England, with improved reach in the devolved UK nations compared to previous years. 88% (n=1,229) of respondents were health visitors, and 12% (n=163) were members of the health visiting skill mix team, or in other health visiting roles. Most respondents (73%) were from England; 15% were from Scotland; 7% were from Wales and 5% were from Northern Ireland, which compares very well with the population distribution across the UK[2] (see Table 1).

Most findings are presented as UK-aggregate data. Where country-specific data are presented, we have indicated where these are "England-only". Like all surveys, when interpreting the findings, it is important to remember that the results are based on a sample of the population, not the entire population. Consequently, results are subject to margins of error and readers should exercise caution with comparisons between UK nations where the sample sizes are smaller.

Table 1: Percentage of survey respondents by UK nation compared to UK population distribution

Nation	Percentage of survey respondents	UK population distribution (percentage)
England	73%	84%
Scotland	15%	8%
Wales	7%	5%
Northern Ireland	5%	3%

Context

Our annual survey is now in its eleventh year. During this time, the state of child health has deteriorated across a range of metrics and the disparity in health visiting support for families across the UK has increased. The Government has committed to change the trajectory to raise the '***healthiest generation of children ever***'[3] and '**strengthen health visiting**'[4]. There is a clear imperative to act now for the benefit of all babies, children and families, but there is much work to be done to achieve this.

Children in the UK have some of the worst health outcomes compared to other similar nations[5] and health inequalities are widening, especially for those living in more deprived neighbourhoods where the poorest children have the worst outcomes[6]. In 2023, UNICEF ranked 42 high income and upper middle-income peer countries on the outcomes of policy responses to child poverty. The UK was placed at the "**bottom of the rankings**" based on two indicators: rates of child income poverty between 2019 and 2021 and the proportional change in child income poverty over a seven-year period (2012–2014 and 2019–2021)[7].

Families across the UK are navigating a complex web of challenges which can profoundly impact their children's health, wellbeing, safety, and development. From unmet Special Educational Needs and Disabilities (SEND), to the widespread effects of poverty and perinatal mental health issues, or even just needing advice on a minor childhood illness to avoid an A&E attendance, many families find themselves struggling without adequate support.

Health visiting services have also been impacted by soaring levels of need, with more babies, children and families needing health visiting support. And there are huge disparities in the quality and quantity of health visiting provision across the UK. All four nations are experiencing challenges, but the problems are most severe in England which has seen the number of health visitors cut by more than 40% since health visiting services were moved from the NHS to local authority commissioning in 2015.

The reduction in the number of health visitors in England is due to a combination of factors including significant reductions in the Public Health Grant that funds the service, workforce shortages, and locally-driven cuts to health visiting service delivery models. This, in turn, has had a significant and negative impact on health visitors and their ability to work effectively with families.

Getting it right for families in the earliest years matters, and health visitors have a vital role to play in ensuring that every child has the best life from the start. There is strong evidence that pre-birth and early childhood experiences lay the foundations for future health and wellbeing and can have lifelong impacts on: physical and mental health, social and emotional development, learning and future attainment, and lifetime success[8]. The early years also provide the greatest opportunity to influence a child's health and development, supporting them to achieve their full potential.

2.0 Survey findings

Part I: Babies, young children and their families' needs – including child health, development and safety

In our survey, we asked respondents to share their experiences of working with families across the UK and their perceptions on whether demand for health visiting support had changed over the last twelve months. There was no significant difference in reporting between countries and UK data are presented:

- 84% of survey respondents reported that the demand for health visiting support had increased over the last 12 months
- 15% reported that the demand had stayed the same
- Only 1% reported that demand for health visiting support had decreased.

Range and complexity of needs

We were also interested to learn more about the biggest issues that families with babies and young children were facing, requiring health visiting support. Practitioners reported that families required health visiting support for a wide range of issues which can make parenting harder and can impact on child and family health outcomes and vulnerability – with findings presented in Figure 1.

Figure 1: The issues that families are facing across the UK (UK-aggregate data)

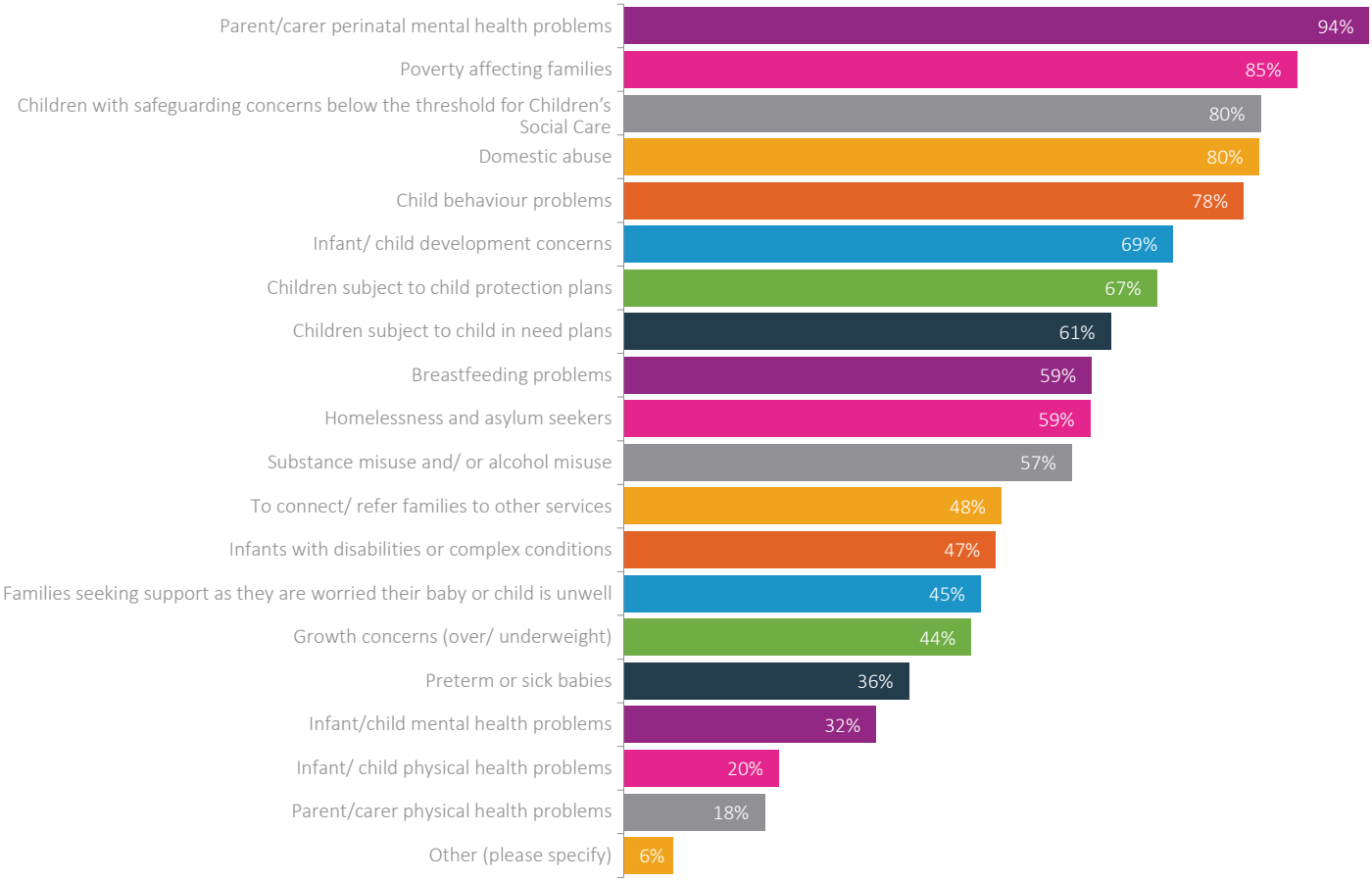


Figure 1 highlights the important work of health visiting, supporting families with a wide range of needs, across multiple clinical pathways for child and adult physical health and mental health, as well as child development (including special educational needs and disability (SEND), social needs, and safeguarding.

The ranking of priority issues requiring health visiting support varied across the UK nations - Table 2 presents disaggregated data for each UK nation. Our survey findings show that it doesn't matter where you live in the UK, life can be hard as a parent.

Table 2: Comparing the biggest issues that families are facing across the 4 Nations

Issues affecting families, requiring health visiting support	Percentage of health visiting practitioners in each UK nation who reported that this was an issue affecting families, requiring health visiting support (Ranking of top issues in brackets, 1=highest)			
	England	Scotland	Wales	Northern Ireland
Parent/carer perinatal mental health problems	94% (1)	94% (1)	96% (1)	92% (=1)
Child behaviour problems	74 % (5)	87% (2)	88% (2)	92% (=1)
Poverty affecting families	86% (2)	86% (3)	83% (4)	70% (10)
Children with safeguarding concerns below the threshold for Children's Social Care	82% (3)	69% (6)	84% (3)	76% (7)
Children subject to child protection plans	69% (6)	58 % (8)	63% (7)	84% (3)
Domestic abuse	81% (4)	75% (4)	75% (5)	80% (4)

Across all UK nations, **perinatal mental health problems** were ranked as the top reason for families needing additional support from health visiting teams.

Child behaviour problems were ranked as the second highest issue affecting families across Scotland, Wales and Northern Ireland. In the free text box, many practitioners reported that they had seen an increase in parents who were concerned that their child may have an Autistic Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD). In contrast, child behaviour problems were ranked fifth by practitioners in England, after domestic abuse which was ranked as the fourth highest issue that families were facing, requiring health visiting support.

In England, practitioners reported that more of their time was being requested to support families struggling with the **impacts of child poverty** and families with **children with safeguarding concerns below the threshold for Children's Social Care** (see Table 2).

Whilst supporting families living in poverty and with safeguarding concerns is important, the fact that it is now ranked so highly as a top priority for health visitors in England is significant. As Specialist Community Public Health Nurses, health visitors also have a key role in providing healthcare across multiple clinical pathways to address pressing public health priorities (including postnatal health pathways, vaccinations, managing minor illnesses, accident prevention, oral health, obesity… and the list of "health" priorities goes on)[9]. Many health visitors in England reported that they feel more and more like social workers than public health nurses (see Part III on role drift from preventative public health).

Complexity – multiple co-existing needs:

Survey respondents also highlighted that many families requiring additional health visiting support were grappling with more than one issue, as family life has become increasingly complex:

> *"Post-Covid families appear much more complex."* (HV England)
>
> *"There has been a massive increase in HV workload… Complexities of new movements in, rise in children with additional needs where parents are requiring support due to the length of waiting lists to be seen by other services, for example for autistic spectrum disorders, mental health issues, drug misuse – and lack of specialist teams, are now all falling to health visitors as they do home visits and can access families."*
> (HV Northern Ireland)

There is strong evidence that the coexistence of multiple forms of need, or disadvantage, can have a compounding and cumulative impact[10] which can exacerbate inequalities and leave a lasting shadow across the life course[11].

The next section of this report will shine a spotlight on some of the biggest issues that families face across the UK.

Spotlight on the greatest needs

Perinatal mental health:

It is extremely concerning that more than 9 out of 10 survey respondents reported that parent/carer perinatal mental health problems were one of the biggest issues facing families across the UK that required additional health visiting support:

> *"Capacity and demand - vast increase in mental health issues which all need **time** [respondent's emphasis in bold] to address supportively."* (HV England)

Practitioners' concerns need to be taken seriously, especially in light of the recent findings from the UK Maternal Death Enquiries (MBRRACE-UK) report which reported suicide as one of the leading causes of maternal deaths[12]; the majority of the deaths by suicide occurred between six weeks and a year after pregnancy[13], a period when midwifery support has ended, and health visitors are the only healthcare professionals who are universally reaching out to all families during this critical time.

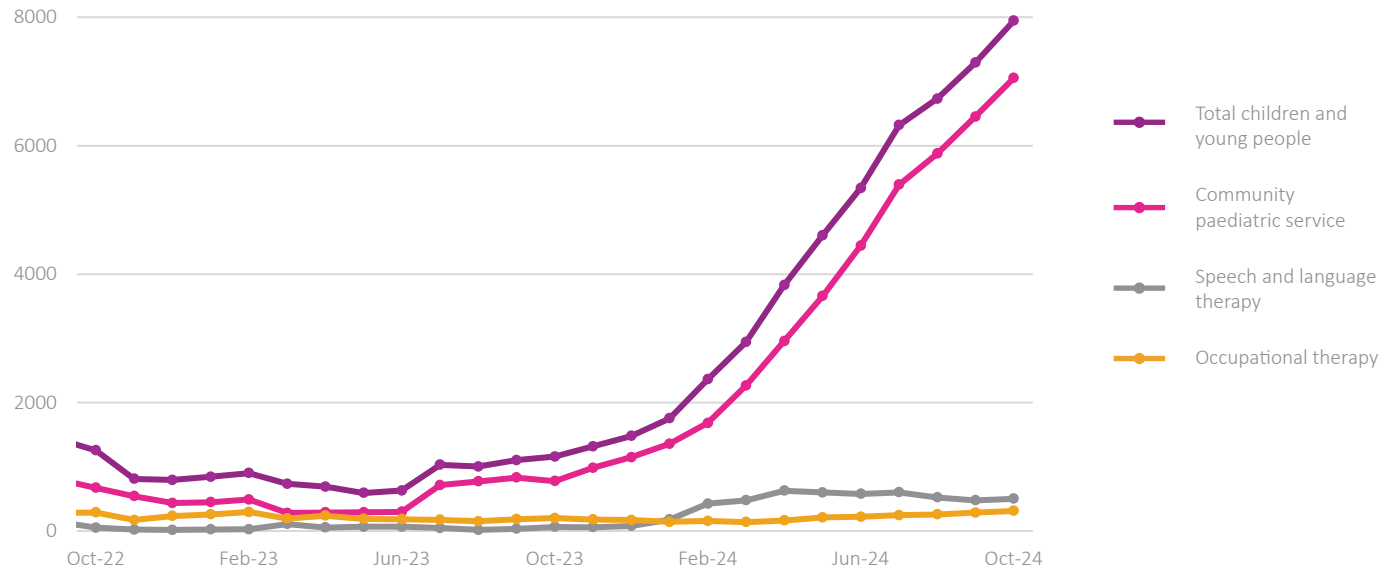
Although not inevitable, the mental health of parents in the perinatal period can have long-term effects on the infant, especially in relation to their later emotional and behavioural development. The first 1001 days - from pregnancy to age two - is a critical period for babies' brain development, their developing sense of self, and understanding of the world that is shaped by their experiences and environments. Early identification of parental mental health needs and the provision of tailored support is essential in ensuring that babies have the best start in life.

Child behaviour problems – concerns about ASD, ADHD and Special Educational Needs and Disabilities (SEND)

It is well documented that demand for SEND support is growing – not just for the 2 million children in England who are known to have disabilities, but for a larger population including those who are waiting for a formal diagnosis or require additional support to thrive[14]. There are also concerns about the huge increase in referrals for ASD and ADHD, with long waiting lists for diagnosis; and more parents raising concerns that their child might have ASD or ADHD.

Figures published by NHS England show that the number of children waiting two years (104 weeks) or more for a community health service more than tripled between February and October 2024, to 7,946; this is many times greater than the waits for elective hospital services (see Figure 2).

Figure 2: Number of adults and children waiting at least two years for community and elective hospital services – from October 2022 to October 2024 (Source: Unpublished NHS England data, 2025 – FOI data, Health Service Journal[15], shared with consent)



This national picture of increased need for support for families experiencing ASD, ADHD or SEND issues was reflected in our survey findings (see Table 2). This was also a strong theme in the qualitative analysis of the free-text comments:

> *"The amount of children who are presenting with neuro-diverse behaviours has more than tripled over the last few years."* (HV England)
>
> *"[More parents] thinking that their child has ADHD &/or autism. Neurodiversity - the demand has increased for the whole team."* (HV England)

Health visiting practitioners also told us about the profound impact that lack of support for SEND in general, as well as ASD/ ADHD in particular, is having on families; many families are desperate for support, and experience long delays in accessing specialist services for diagnosis and treatment (see Figure 2):

> *"SEND needs in babies and children are now so common to see."* (HV Scotland)
>
> *"We need to improve the SEND system - families are stressed and falling apart …"* (HV England)
>
> *"Huge increase in need / unacceptable long waiting times / lack of support for parents… difficulty getting children seen by various services."* (HV England)
>
> *"Families face lengthy waiting lists even after a need is identified by the HV."* (HV Wales)
>
> *"A lot of my time is taken up 'holding' families, as services I had referred children to are so backed up, there was no realistic prospect of being seen for many months, if not years. Neurodevelopmental review service was sitting at a 3 year wait."* (HV Scotland)
>
> *"Lots of ASD referrals, long waiting lists, limited support services. Nursery schools contact HV frequently regarding children."* (HV Northern Ireland)

The impacts of long waits for babies and children can be devastating and this can be a particularly anxious time for parents. Childhood matters because it is short; and long waits for treatment and support are much more harmful for babies and children, compared to adults, since intervention is needed by a specific age or developmental stage to improve outcomes and reduce harm[16].

Notwithstanding the challenges, there are some good examples where health visiting teams have responded to rising levels of need, developed specialist health visitor roles for SEND, and strengthened partnership working to improve support to families. It will be important to learn from excellence, to ensure that all families with children with SEND (or suspected SEND) receive the support that they need:

> *"I am really proud to have a Neurodiversity and Paediatric Global developmental pathway up and running through active and robust co-production with mental health services, early years teams and GPs which accepts referrals for emerging SEND from any age."* (HV Manager, England)

Poverty affecting families

4.3 million children (around 3 in 10 children) across the UK now live in poverty. This has increased from 3.6 million in 2010-11[17]. Children have consistently had the highest rates of poverty compared to any other age group since 1994[18]. Poverty and its impacts have a "human face" which health visiting practitioners witness every day.

86% of health visiting practitioners in England and Scotland reported that poverty was one of the biggest issues facing families who required health visiting support.

The rates were fractionally lower in Wales (83%) and Northern Ireland (70%), but it is clear that the impacts of poverty on babies, children and families are significant.

Addressing child poverty matters as it can have a negative impact on child health, development and wellbeing now[19] and in the future[20], affecting:

- Physical health (such as respiratory problems, dental decay, low-birth weight, obesity, faltering growth and increased mortality[21,22])
- Social circumstances (such as homelessness or social isolation)
- Development (including poor educational attainment which is socially driven)
- Mental health.

Health visitors described the impacts of poverty on families' lives:

> *"We are in an area of SIGNIFICANT deprivation and many women return to work when babies are 6-weeks-old, families survive on foodbanks… Housing and temporary housing is BAD! Caravan and hotel accommodation is inappropriate for a family to thrive in."* (HV England)
>
> *"High levels of deprivation with significant maternal mental health issues."* (HV Wales)
>
> *"Working in a high risk, high deprivation area and how this impacts the level of need for families. This can impact ability to provide a high level of care across all families due to families requiring a lot of time and/or onward referrals following visits."* (HV Scotland)

Safeguarding concerns

The strains and stressors on babies, children and families' lives have increased over the past decade, with family life becoming more complex - the COVID-19 pandemic and its wider impacts on babies and children are still not fully understood or addressed, more families are living in poverty, and services across the health and care system lack the capacity to meet the level of increased need[23,24]. As a result, safeguarding our most vulnerable babies and children has become more challenging[25], with concerns raised about the human costs of the current situation on the lives of so many, alongside the soaring financial costs of late intervention[26].

On aggregate, 4 out of 5 survey respondents across the UK reported that child safeguarding concerns which fall below the threshold for Children's Social Care were an issue that required extra health visiting support (with higher rates in England and Wales, see Table 2):

> *"[We need to manage] expectations from other providers. Universal [health visiting services] are asked to cover contacts where social workers aren't able to gain entry. GPs are also asking [health visitors] to support their poor engagers for vaccines. Hospitals are asking for welfare checks when there are no medical needs."* (HV England)
>
> *"It's a wonderful service and everyone should get it. We are spread too thinly. Sadly, it has been taken over with safeguarding. We have less time for families."* (HV Northern Ireland)

Whilst England data on the number of children categorised as "Child in Need" or subject to a "Child Protection Plan" show a slight downward trend (see Figure 3), our survey findings paint a different picture, highlighting that the reality on the ground feels very different.

Figure 3: Reporting year 2024. Children in need in England[27]

Number of Children in Need (CIN):

399,500

(↓ 0.9% since 2023 but ↑ 2.6% since 2020).

Number of Children on Child Protection Plans (CPP):

49,900

(↓ 1.7% since 2023 and ↓ 3.1% since 2020).

In England specifically, practitioners were concerned that changes in the Working Together to Safeguard Children 2023 Guidance[28] would further erode the public health and upstream functions of health visitors to deliver the Healthy Child Programme[29], to try and avoid situations reaching crisis point. Alongside workforce shortages and growing demand for health visiting support, it is no surprise – and also hugely worrying – that:

- **Only 46%** of health visiting practitioners in **England** were confident that they could **meet the needs of vulnerable babies and children "all or most of the time"**.

In response to growing concerns about health visitors' role drift away from "health", in 2024 the Institute of Health Visiting, in partnership with the Association of Directors of Public Health and the School and Public Health Nurses Association, published a joint policy position, "The Safeguarding Role of Public Health 0-19 Services"[30].

Part II: Health visiting services, responding to need across the UK: widening disparities

Our survey findings presented in Part I, lay bare the struggles that babies, children and families are experiencing across the whole of the UK. Part II of our report shines a spotlight on the disparity of health visiting support that is seen between the UK nations and also across local authorities in England.

It is important to celebrate success and learn from best practice. Our survey findings highlight that there are lots of places where health visitors are delivering excellence in practice, as well as examples of successful partnership working, all focused on improving support for families:

> *"[We deliver] high standards of care despite the current picture of health visiting: new pathway developments that reflect public health outcomes, service development to reach those 'hard to reach', 2-year reviews in nurseries and joint assessment with education, involvement in planning of Family First children's pathway, increasing the digital platform to promote the importance of health visiting to families. New role development, health inclusion workers, immunisation post within health visiting. Working collaboratively with partners in preventative work."* (HV Manager, England)

However, the disparity in health visiting was a strong theme in this year's survey, with families receiving a postcode lottery of support. Families receive good levels of support in some areas, and barely any support in other areas. This disparity is not what babies, children and families need or want[31], or what health visiting practitioners want to deliver[32].

Health visitors want to deliver a good service to all families:

> *"I believe in providing the best service possible to give all families the best outcomes; identifying parental need, support and help to give those babies and children a good start in life... Everything matters including empowering parents to be able to get the services they need."* (HV England)
>
> *"Health visitors try to do a good job but poor staffing etc. makes this difficult to provide the service you would like to provide."* (HV England)
>
> *"All my colleagues try to provide a good service, but it is very challenging at this time."* (HV Scotland)

In particular, health visiting practitioners in England were keen to support the Government's plans to strengthen health visiting through their focus on: improving vaccination uptake; improving support for children with SEND; achieving better birth outcomes through improved antenatal and postnatal care; and reducing pressures in A&E. A summary of the findings on health visitors in England supporting vaccination uptake are presented in Appendix 1. We will be publishing briefings on the remaining topics as separate publications in in spring 2025.

National and local disparities in health visiting service delivery models (universal support)

Health visitors are unique in that they are the only practitioners who systematically and proactively reach out to every family with babies and young children through their universal contacts, providing support for all and a vital safety-net for the most vulnerable - as well as bringing wider system benefit. The importance of a service that sees all babies and young children in-person cannot be underestimated[33]. In particular, health visitors provide a safety-critical role for those with safeguarding or clinical vulnerabilities, who may not be known by other services and are often invisible unless their caregivers reach out; unable to advocate for themselves, they are our most vulnerable citizens.

Health visitors offer universal key contacts to all children from pregnancy to school entry which aim to:

- promote child health and development
- prevent harm
- ensure that families at risk are identified at the earliest opportunity
- improve babies', children's and young people's health outcomes across a breadth of topics – providing personalised support and connecting them to other services where indicated.

In England[34], families are only offered five mandated universal health visiting contacts which is considerably less than Scotland[35] where families are offered eleven home visits, Wales Flying Start[36] where thirteen contacts are offered (Wales' generic health visiting programme[37] offers eight contacts), and Northern Ireland[38] where nine contacts are offered.

There is also disparity between the UK nations in terms of the proportion of these universal contacts that are actually delivered by qualified health visitors, with increasing frontline health visiting skills dilution in England as skill mix team members are used to plug gaps in depleted services.

Our survey compared the delivery of five key health visitor contacts which are included in the universal pathways of all UK nations, as a point of comparison (the antenatal contact, new birth visit, 6–8-week review, health review at one year, health review at two years) (see Table 3):

- England is clearly the outlier, with the lowest provision of all five universal contacts by a health visitor.
- Northern Ireland has the highest level of provision of health visitor support to all families, followed closely by Scotland, then Wales.
- In Northern Ireland, health visitors deliver the highest proportion of antenatal contacts to all families.

An evaluation of the Universal Health Visiting Pathway (UHVP) in Scotland[39] highlighted the importance of the antenatal visit to build positive and trusting relationships between families and health visitors, and to facilitate the identification of maternal mental health concerns. However, when capacity is stretched, the antenatal contact is often the visit that is removed when health visitors' workloads need to be prioritised[40].

Table 3: Percentage of universal reviews delivered by health visitors to all families

Type of contact	England	Scotland	Wales	Northern Ireland
AN	26%	44%	28%	65%
NBV	86%	99%	98%	98%
6-8 week	70%	99%	97%	98%
1 year	40%	62%	44%	81%
2 year	39%	88%	72%	95%

Not only is there variation in healthcare delivery across the four nations, there is also huge variation between Local Authorities (LA) in England. And there does not appear to be any logic behind this – the variation is not linked to deprivation, levels of population need, or funding (national data on annual health visitor performance metrics in England is presented in Table 4).

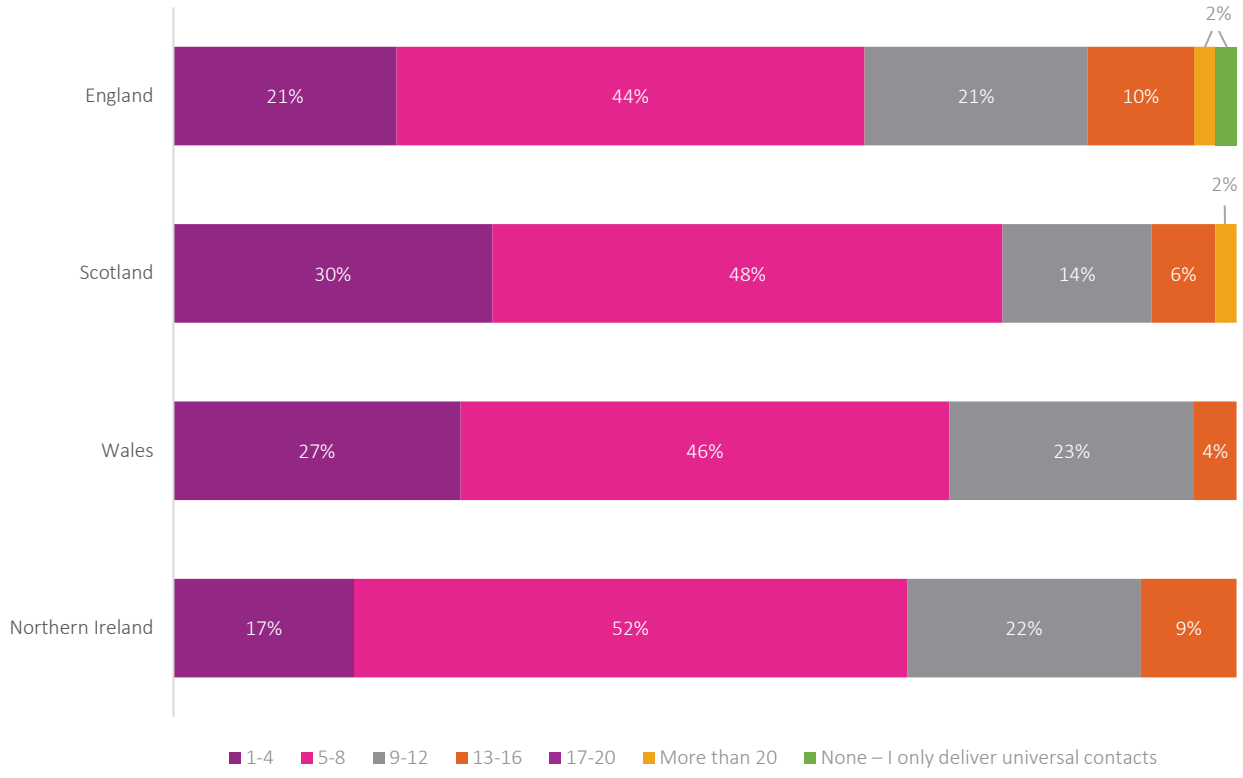
Table 4: Office of Health Improvement and Disparities (OHID) - Annual HV performance metrics: mandated contacts 2023/2024[41]

Health visiting contact	England average	Lowest performing LA	Highest performing LA
New birth visit by 14 days	83%	18.9%	99%
6-week review by 8 weeks	81.8%	3%	99%
12-month review by 15 months	86.5%	26.9	99.5%
2-2½ year review	78.4%	5.1	100%
Note: No national data comparisons are published on antenatal contacts due to the lack of a reliable denominator.			

National and local disparities in health visiting service delivery models (additional, targeted and specialist support)

In our survey we asked health visitors, in a typical working week, how many additional contacts or visits they completed beyond the universal contacts scheduled in their national health visiting programme. The findings show that there is wide variation in health visiting practice; they also demonstrate that health visiting is so much more than the universal core contacts (see Figure 4).

Figure 4: The number of additional contacts or visits that full-time health visitors complete in a typical working week beyond the universal contacts scheduled in their national health visiting programme



Health visitors in Scotland described how they offer additional support contacts (above the UHVP offer of 11 contacts) when needed – the level of support is personalised to meet the needs of the family:

> *"For families who require additional support e.g., substance misuse, mental health etc. we would make these families 'additional', and they would get extra visits out with the Universal Health Visiting Pathway."* (HV Scotland)
>
> *"We use the UHVP - however I regularly assess whether families require additional support on top of the eleven core contacts offered."* (HV Scotland)

The Institute of Health Visiting has repeatedly raised concerns about the postcode lottery of health visiting support and its "knock-on" impacts across the health, education and social care system if not addressed[42-44]. And partners across the early years and health system have echoed our concerns and called for investment to rebuild health visiting services in England[45-47]. Whilst it is difficult to attribute direct causation, a recent report on school readiness in England[48] highlighted teachers' growing concerns about the increasing number of children who are not ready to learn when they start school.

Health visiting's role in prevention, identification of need and early intervention can make a big difference to outcomes across a range of public health priority areas (for example breastfeeding[49], vaccination uptake[50], oral health[51], managing minor illnesses[52], perinatal mental health[53], and improving uptake of the 2-year offer[54]). The evaluation of Scotland's enhanced Universal Health Visiting Pathway (UHVP)[55] reported positive outcomes for parental satisfaction and the identification of needs that were previously unknown, supporting better uptake of early intervention. Since the UHVP was introduced, breastfeeding rates in Scotland have also significantly increased[56] and A&E attendances in children have slightly reduced[57]. Again, whilst it is not possible to attribute direct causation as these metrics will be influenced by a range of variables, at the same time in England, A&E attendance in under-ones has increased by 42% in the last 10 years and uptake of childhood vaccinations in Scotland remain much higher than in England[58,59].

Health visitors in Scotland, Wales and Northern Ireland recognise the value of being able to offer additional contacts to families and described the difference this makes:

> *"The level of intensity I am able to provide in Wales, as opposed to previously experienced in England, means I am able to listen and actually have options to support families."* (HV in Wales)
>
> *"I'm proud of the service that we are able to provide in Scotland, this is why I left the England HV team. The GIRFEC policies, partnership working, training and support from management… England could take a cue from Scottish services and invest in services."* (HV in Scotland)
>
> *"I am able to make all HCHF (Healthy Child Healthy Futures) contacts, plus extra contacts to all families… I love that I have the opportunity to help, sometimes it feels like I was there just at the right time."* (HV Northern Ireland)

In contrast, health visitors in England described a mixed picture of practice – with many areas falling well short of the standards for health visiting and quality of support provided to families in the devolved UK nations:

> *"Not enough staff so service is pressured, meaning families may not get a consistent approach compared to other areas."* (HV England)

This mirrors feedback that the Institute of Health Visiting received through other forums in 2024:

> *"I feel a little deflated about how far England is behind the other nations…"* (iHV Leadership Conference 2024 delegate)
>
> *"Level of health visiting inputs/contacts clearly varies across UK. Wales and Scotland are able to provide all or nearly all of the mandated contacts... In [local authority in England] this is not possible because of increasing caseloads."* (iHV Leadership Conference 2024 delegate)

Intensive health visiting programmes for targeted groups

We asked our survey respondents whether they offer intensive home visiting/ health visiting programmes for targeted groups at greater risk of experiencing problems, such as young parents or economic hardship (see Table 5).

Table 5 – Intensive health visiting programmes offer for targeted groups (by UK nation)

Nation	Do you offer intensive health visiting programmes for targeted groups at risk of experiencing problems, such as young parents and economic hardship?		
	Yes	No	N/A
England	61%	31%	8%
Scotland	59%	28%	14%
Wales	86%	9%	5%
NI	72%	14%	14%

Not all areas offer intensive health visiting programmes. And where programmes are being offered, a range of programme models are being used - including well-known, licensed, evidence-based programmes and locally developed models (where the level of evidence of impact is unknown, or untested) (see Table 6).

Table 6 – Intensive health visiting programme models provided (by UK nation)

Nation	Family Nurse Partnership (FNP)	Maternal Early Childhood Sustained Home-visiting (MECSH)	Wales Flying Start	Locally developed offer	Other
England	33%	13%	0%	38%	15%
Scotland	66%	1%	0%	13%	21%
Wales	0%	0%	64%	24%	12%
NI	40%	0%	0%	30%	30%

Rigorously evaluated intensive and targeted programmes have been shown to be effective for specified target groups and can achieve good outcomes for eligible local families[60]. And it is important that effective, intensive, personalised and specialist support is available to all families when they are experiencing complex issues which require intensive support for a range of needs. For some families, an intensive home visiting programme is the most appropriate option. But family life is complex in the messy real world, and "off-the peg" licensed or locally developed programmes will not meet the needs of all families[61] and more bespoke programmes of personalised care will be required.

Meta-analyses of intensive home visiting programmes[62] have identified that targeted interventions, by definition, may leave many high-risk families ineligible for their services (for example, the Family Nurse Partnership Programme is only available to young parents, and across limited sites in the UK). Some areas have sought to increase their reach through the introduction of locally developed models for intensive health visiting. To ensure that these programmes achieve their aims to improve child and family outcomes, it will be important that they are implemented with a high level of rigour and a strong evaluation arm to monitor progress and outcomes across a range of indicators over the short, medium and longer term[63].

Note: Funding and commissioning requirements to deliver in-year cashable savings do not work for many public health approaches – as evidenced in the evaluations of SureStart[64] and the Family Nurse Partnership programme[65] which demonstrated meaningful impact in the medium and longer term.

The importance of personalised healthcare

The Institute of Health Visiting welcomes the Government's pledge to deliver more proactive and personalised healthcare[66]. Continuity of carer is identified as key to facilitating personalised healthcare[67] and improving outcomes – resulting in a more positive and personal experience[68], better identification of need and uptake of health-promoting messages[69,70].

There is a plethora of research[71] which shows that parents want a consistent relationship with the same health visitor, with their views captured in the following quotes from recent research by the NSPCC (2024)[72]:

> *I've been really lucky with my second two, I had the same health visitor which I found really, really helpful when I was pregnant again, because I already knew her and had a relationship with her. But it's really difficult when they change like your midwives all the time and change your health visitor."*
>
> Parent

> *It's like you don't have to keep on telling your story, she already knows. Instead of meeting different people, every time telling your story, and my story was really sad, I didn't feel like I wanted to keep on telling people."*
>
> Parent

Health visitors agree with parents – they want to provide continuity of carer and recognise the value of relationship-based healthcare.

55% of our survey respondents stated that **continuity of carer** was a needed to enable the delivery of high-quality and effective care to all families in the antenatal and postnatal period for their physical and mental health:

> *"Continuity of practitioner is at the forefront to positive impact of care for families."* (HV England)
>
> *"Often with continuity we pick up issues and support with these early. No continuity often means missing things which come to light later as bigger issues."* (HV England)
>
> *"Building relationships with families over a long period. Being able to offer continuity and relationship-based support and advice to empower parents, increase their confidence and work with their strengths and priorities to improve the lives of some of the most vulnerable children."* (HV England)

Sadly, the reality is that **only 45% of health visitors in England reported that they were able to provide continuity of carer to families "all or most of the time"**, compared to 90% in Scotland, 86% in Northern Ireland and 85% in Wales.

Respondents from England described the challenges affecting continuity of carer:

> *"The health visiting model does not allow for continuity of carer."* (HV England)
>
> *"We try, but it's so busy, it's not always possible to keep up the best standard."* (HV England)
>
> *"Due to new way of working, visits are just booked into spaces in anyone's diary, not necessarily always the same HV."* (HV England)
>
> *"We have our own caseloads, and we try to keep our families at least up until 6 weeks... However, it is likely that for those on universal caseload, they will receive care from the staff nurse or the family health practitioners for the 3-month, one year and 2-year contact."* (HV England)

Parents also want personalised healthcare that takes account of their own unique context and needs, rather than a one-size-fits-all "tick-box" approach. A recent review, "What do parents, professionals and policy colleagues want from a universal assessment of child development in the early years?" by the NIHR Children and Families Policy Research Unit, published its findings on social media in December 2024, stating:

> *Parents and health visiting professionals in England want a measure of child development […] to be 'warm conversation about what's going on' covering child, sibling, and parent wellbeing. Not just 'tick, tick, tick'."*[74]

Challenges affecting health visiting healthcare delivery

We asked health visitors what they felt were the main challenges affecting care delivery and families' access to health visiting support. There were variations in the perceived challenges experienced by practitioners working in the different UK nations. The top challenges included workforce shortages, erosion of the "health" aspects of the health visitor's role, and challenges of collaborating with other agencies – nation-specific data is presented in Table 7, with workforce issues presented in Parts III and IV of this report.

Table 7 - The biggest challenges affecting care delivery and families' access to health visiting support across the UK

Challenges	Percentage of health visitors in each UK nation who reported the challenge (with ranking of top 3 challenges in brackets, 1=highest)			
	England	Northern Ireland	Wales	Scotland
Workforce shortages – impacts on the delivery of **universal contacts**	74% (1)	60% (1)	53%	62% (2)
Workforce shortages - impacts on the delivery of **additional targeted or specialist support** when a need is identified	73% (2)	51% (2)	53% (3)	58% (3)
Erosion of "health" aspects of health visiting as child protection/child safeguarding is prioritised	72% (3)	44%	60% (1)	50%
Challenges of collaborating with other agencies or services	58%	49% (3)	58% (2)	69% (1)

For England specifically, some additional challenges in care delivery were identified:

i. **"Ticking the box but missing the point" - achieving service Key Performance Indicators (KPIs) prioritised over safe and effective delivery of care in some areas:**

The current national outcome measures for health visiting are largely process measures designed to prove compliance to external bodies. Health visitors were concerned that, in some areas, achieving KPIs ("ticking the box") had become the primary focus and measure of service effectiveness, at the expense of person-centred care, or actual measures of impact on child and family health outcomes ("missing the point"):

> *"Universal contacts, especially antenatal contacts, involve delivering needs of service and not meeting needs of families. Information giving has increased and is too much during one antenatal contact - feel that has become a tick-box exercise and lost quality."* (HV England)
>
> *"Always given more to do! Tick boxes instead of therapeutic work with families."* (HV England)
>
> *"The service changing to become more streamlined but losing sight of what the families need from the service."* (HV England)
>
> *"Services are cost driven rather than person centred."* (HV England)
>
> *"The service has become very much a tick-box exercise, rather than a needs-led service, which means we struggle with capacity to deliver the correct support for the families that need it."* (HV England)

ii. **Lack of other services in the community which can offer support to families:**

Survey respondents highlighted that funding cuts, workforce shortages and long waits were also being felt across other healthcare services (see Part I), and the Voluntary, Community, and Social Enterprise (VCSE) sector, with cumulative impacts affecting families and health visiting services:

> *"Voluntary agencies - lacking funding and no longer available, for example, Home Start no longer available."* (HV England)
>
> *"Everything seems to fall on the health visitors, this should not be the case."* (HV England)

iii. Lack of venue/premises:

Since the shift of health visiting services to local authorities in 2015, many services have been forced to streamline facilities' budgets and non-pay costs, with closure of smaller health visiting bases (often in rural areas), consolidating staff in fewer premises with "hot desk" arrangements, and directives for staff to work from home to reduce travel costs. Whilst this might be a helpful cost-saving initiative for commissioners, there have been some knock-on consequences – reducing families' access to health visitors in local clinic venues, impacting on staff wellbeing and opportunities for peer support and supervision, and limiting student health visitors' ability to learn from more experienced qualified health visitors (see Part IV):

> *"The buildings that were Family Hubs/children's centres have either closed completely or only open limited hours. Families with new babies are expected to travel miles plus with no parking available for routine contacts."* (HV England)
>
> *"Lack of office and dedicated health and clinic space to see families."* (HV England)
>
> *"Venues to deliver services are a huge challenge due to costs."* (HV England)

iv. Local commissioning – ongoing cuts to scope and delivery model for HV services:

Health visitors in England had a mixed experience of local authority commissioning of health visiting services. Some described positive experiences where they felt that the role of health visiting within a complex integrated system of support for families was well understood – with some published case study examples of good practice to support this[75]. Others described how health visiting services had struggled since the transfer to the local authority, and felt that the quality of services and support available to families had deteriorated significantly:

> *"We are delivering the absolute bare minimum; it is not a good enough service. Most support is virtual, they can look online for this, which kind of makes the service redundant. Clinics are self-weigh, so again no benefit of seeing a professional."* (HV England)
>
> *"Local authority commissioning dilutes the ability for HV services to be truly client focused within each individual community. Old Sure Start venues closed down. The political undertone governs delivery of our service - often with narrow agendas."* (HV England)

Whilst health visiting in Scotland, Wales and Northern Ireland is not without challenges, fewer practitioners reported experiencing challenges compared to England. There were also differences in the rating of challenges between the UK nations. Overall, practitioners working in Scotland, Wales Flying Start and Northern Ireland had much more positive experiences to share:

> *"I think we are very lucky in Scotland and in my area to be able to provide the full Scottish universal pathway and provide an additional pathway for all families who need this."* (HV Scotland)
>
> *"Health visiting is a valuable service offering support to all families with preschool children as well as targeted families."* (HV Northern Ireland)
>
> *"Due to the Healthy Child Wales programme and the additional Flying Start, we are able to offer continuity of care with a named HV. Along with a full and comprehensive programme."* (HV Wales)

Part III: Health visiting workforce matters

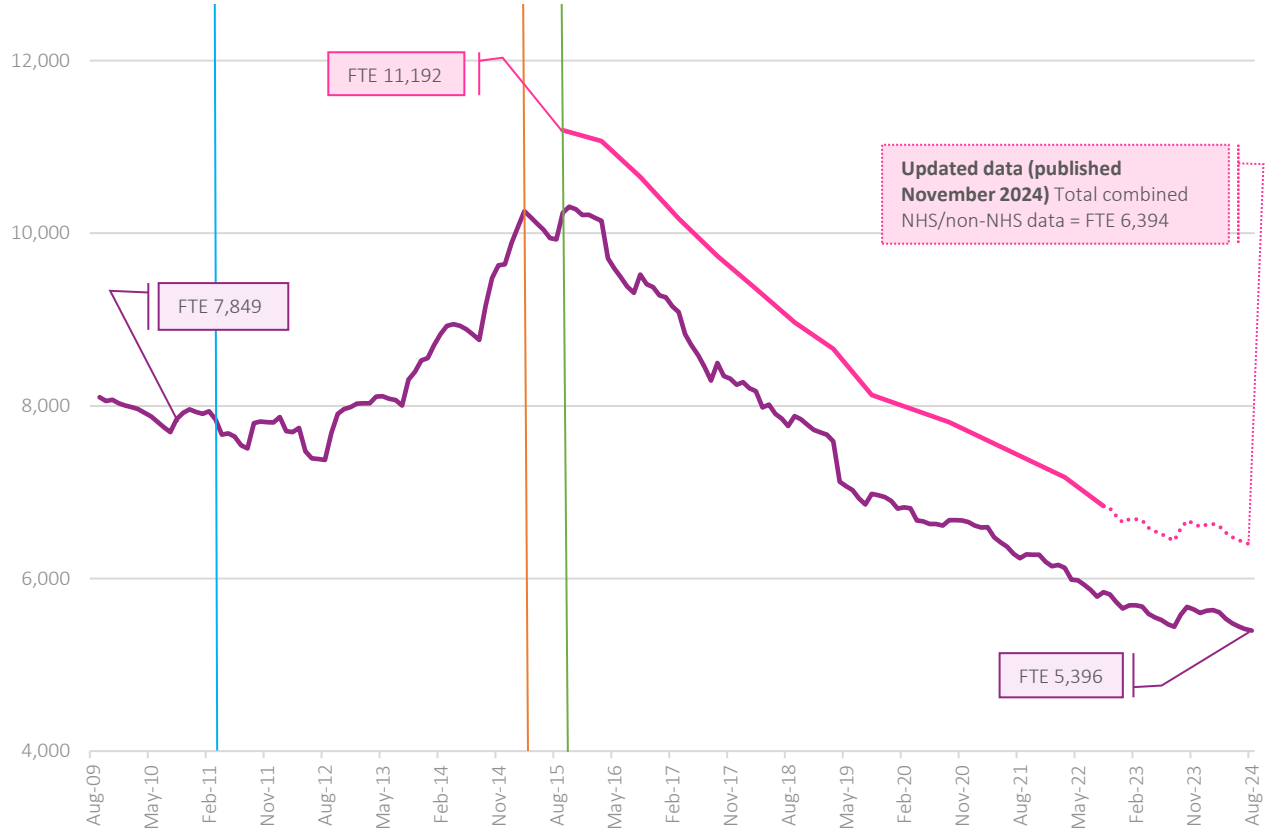
Health visitor workforce shortages:

Across all four UK nations, health visiting practitioners reported a decrease in health visitor numbers:

- 71% of survey respondents from England reported a reduction in qualified health visitors in the last year. This reflects the national published health visitor workforce data which show a loss of more than 40% of health visitors in England since 2015[76,77].
- Whilst the number of practitioners reporting falling health visitor workforce numbers was lower in the devolved UK nations, this was still a concern reported by some practitioners in Scotland (42%), Wales (43%) and Northern Ireland (32%).

Health visiting has become a "political football" with repeated "boom and bust" cycles of investment and disinvestment in England. And it will be important that Scotland retains the gains of their investment in the Universal Health Visiting Pathway[78] and does not follow England's trajectory. Following the Cameron Government's "Call to Action"[79] between 2011 and 2015, England benefitted from an increase of 4,200 health visitors – however, this was followed by a significant year-on-year erosion of health visitor workforce numbers since the programme ended, with numbers now well below their previous all-time low in in 2011[80,81](see Figure 5).

Figure 5 – Total health visitor workforce numbers in England (2009-2024)



Published NHS and Independent Healthcare Provider workforce data:

The NHS workforce data (using data from Aug 2024 - published Nov 2024) = 5,396 FTE HVs employed by NHS organisations - bit.ly/42jgNF1

Total combined workforce - including Independent healthcare workforce statistics (using data from Sep 2022) = 6,394 FTE HVs employed by NHS/non-NHS organisations - bit.ly/3N8WFxY

Note: the Independent Healthcare Provider Workforce Statistics has not published data post-September 2022 (to avoid underestimating HV workforce numbers, we have based our calculation on the assumption that there have been no HV losses at all in non-NHS providers since September 2022).

Apr 2011 - Call to action commenced

Apr 2015 - Call to action ended

Oct 2015 - Health visiting transferred to Local Authority commissioning

Impact of health visitor workforce shortages

Fewer health visitors means that less time is available to provide families with the support that they need. It is also well documented that chronic excessive workload damages employee health and their ability to provide high-quality and compassionate care[82].

Our survey respondents in England reported that demand for health visiting support is currently far in excess of what services are commissioned and able to provide, with wide-ranging impacts:

> *"HVs within the team are struggling due to low staffing numbers and are at risk of burnout. Despite wanting to spend more time on visits or [provide] continuity of care, this is not always possible, which I feel impacts the quality of service given."* (HV England)
>
> *"We provide a really good service but the number of staff in our team is decreasing which is going to impact on the quality of the service in the future."* (HV England)

Across a breadth of priority topic areas (for example, postnatal physical and mental healthcare, supporting parents to manage minor illnesses, vaccinations and SEND), our survey highlighted that there are not enough health visitors to meet the scale of need and the demand for additional targeted health visiting support – with a call to get the basics right. Qualitative findings are illustrated in the quotes below which focus on health visitors' capacity to support families with perinatal and infant mental health problems:

> *"We need more health visitors - there are not enough of us to provide high-quality physical and mental health support at present."* (HV Scotland)
>
> *"More support [needed] antenatally to normalise the ups and downs that a new mother can experience, gentle and sensitive sharing of the reality of parenting and perinatal mental health."* (HV Northern Ireland)

Specialist health visitors

Specialist health visitors are health visitors with post-qualifying training and experience in a specific field of practice – for example, perinatal and infant mental health, homeless healthcare, and infant feeding; in the past, many areas also had specialist A&E liaison health visitor posts. Specialist health visitors have key roles in providing local leadership in their area of expertise, and supporting high-quality service delivery, training and education, supervision, quality assurance, service improvement, and research[83].

Our survey respondents called for more specialist health visitors to support excellence in practice, recognising the potential of these roles across a breadth of public health priority topics (vaccinations, reducing A&E attendance, and to improve pregnancy outcomes through antenatal and postnatal healthcare):

> *"[We need] increased budget to employ specialist HVs."* (HV England)
>
> *"I would like to see the development of specialist HV roles in Wales."* (HV Wales)
>
> *"We need health visitors who have a specialist SEND role."* (HV Northern Ireland)
>
> *"We need more Specialist Perinatal Mental Health HVs."* (HV England)
>
> *"We need specialist perinatal health visitors that are able to support mums with their mental health and concentrate on the parent/infant relationship - this is not available where I work."* (HV Scotland)

Specialist health visitors working in perinatal and infant mental health spoke about the positive impacts of their work:

> *"Currently I am most proud of the support I provide to parents/women with perinatal mental health issues. The help I can offer is empowering… my clients trust me and can talk to me."* (HV England)
>
> *"Supporting parents in their journey to overcome a mental health crisis. Watching the lives of the children improving and their relationships with their parents becoming more positive and stronger."* (HV England)

Health visitor career intentions

We asked health visitors about their future career intentions. It is good news that 60% plan to remain in health visiting (this includes 19% who told us about their aspirations for career progression within health visiting). Despite workforce challenges, many practitioners still felt passionately about health visiting and the difference it can make and were committed to the profession:

> *"Whilst we are unable to deliver the service we would like to - I still strongly believe that our service is essential and offers support to parents."* (HV England)
>
> *"I still believe in the support and work we do."* (HV England)
>
> *"I am passionate about my role… I love the job."* (HV England)
>
> *"I would like to become the SEND specialist HV in my area. I also have aspirations to be the Team Lead in the future… or advanced practitioner."* (HV Northern Ireland)

However, it is very concerning that 40% of health visitors are planning to leave the profession in the next 5 years. The three main reasons for wanting to leave the profession were:

1. **Retirement (35%)**

> *"Hoping to retire in around 5 years."* (HV in Wales)
>
> *"I have had a long-fulfilled career, and I can evidence 'making a difference'. I retired and returned 7 years ago."* (HV England)

Whilst retirement is a natural career endpoint, hopefully after a long and fulfilling career, in the absence of sound workforce forecasting and planning, it creates big problems for health visiting services and the remaining practitioners who are asked to plug gaps and take on even bigger caseloads:

> *"I'm worried that locally there are a lot of health visitors due to retire in the next 1-5 years, and due to a national shortage of health visitors, uncertainty about how these jobs will be covered."* (HV England)

2. Lack of career progression (14%)

Lack of career progression opportunities within health visiting was highlighted as a reason for leaving the profession, with other professions and branches of nursing offering greater opportunities for advancement:

> *"I hope to become a practice educator, however this role is sadly being phased out so reducing career development opportunities and progression."* (HV England)
>
> *"Lack of career progression."* (HV Scotland)
>
> *"I have just completed MSc Psychology BPS accredited conversion. I had hoped to develop my practice and move into a specialist infant mental health/neurodevelopmental role. However, there is no capacity for this in my area, so I plan to leave health visiting."* (HV Wales)
>
> *"I would like more professional recognition and career development options. If we want to retain experience and confidence in teams, we need to ensure all bands within the team have career progression options."* (HV England)
>
> *"I would like to see SCPHN supported to develop enhanced and advanced skills."* (HV England)

3. Role drift away from preventative public health (12%)

Practitioners across the UK told us that they were concerned that health visiting was drifting away from its core "health" functions. This was a stronger theme for health visitors in England who were concerned about prescriptive commissioning in some areas and increased pressure to plug gaps in children's social care, making it much more difficult to provide family-centred and personalised healthcare.

> *"At the moment I really just want out. But, if I could see a return to public health rather than firefighting, if I could see a place where we had caseloads that were not destroying us, where there was a service we could be proud of, that delivered the best care to our families, then I would want to stay forever and do the job that I trained for, because then it is the best job in the world."* (HV England)
>
> *"The role is no longer preventative public health and community development… Working more like social workers."* (HV Scotland)
>
> *"We are losing our public health identity and becoming a stop gap to support lack of social care services."* (HV in England)
>
> *"I love health visiting but it has become too prescriptive. Managers want visits 'done' quickly and asap. Unfortunately, that doesn't always 'fit' families."* (HV Northern Ireland)

Safer staffing, caseload management and personalised care

Safer staffing

There is variation in the organisation and delivery of health visiting services across the UK . This makes it very difficult to make direct caseload comparisons between services (or calculate the ratio of health visitors to the under-5 population).

England does not currently have a health visiting caseload weighting tool or safer staffing tool to support safe and effective care, with practitioners calling for a tool to guide commissioning, workload distribution and best practice:

> *"I would like staff workloads to be measured accurately so that they are not overloaded."* (HV England)

In contrast, Northern Ireland[85], Wales[86] and Scotland[87] all have robust safer staffing tools with recommended maximum caseload sizes which take account of a number of factors, including levels of deprivation and vulnerability:

> *"HV holds caseload responsibility and can delegate appropriate duties to skill mix staff in adherence to NIPEC[88] delegation framework."* (HV in Northern Ireland)
>
> *"Community nursery nurse support HV, but HV hold overall responsibility."* (HV in Scotland)
>
> *"HV responsible for care planning but supported and evaluated by specialist roles and management, through safeguarding supervision and audits, also through SPR."* (HV in Wales)

Caseload management

Our survey findings highlighted that caseload management is varied in England and is diverging from the models of the other UK nations (and models of health visiting across the world which generally have caseloads managed by an individual health visitor, for a distinct population):

- Only 34% of health visitors in England now manage their own caseloads, with a further 30% working in corporate caseloads whereby caseload management is shared between a group of health visitors working in a team.
- Around a third of respondents in England stated that health visitor work was allocated by administrators, managers, or members of the skill mix team.
- In contrast, 86% of health visitors in Scotland, 85% in Wales, and 84% in Northern Ireland, manage their own caseload. The remainder stated that caseloads were managed by a health visitor team leader, with very few (3%) stating that non-health visitors were involved in caseload management.

Why does this matter? Whilst skill mix teams can bring many benefits, having the right practitioner with the right skills at the right time is the bedrock of safe and effective care[89]. This is particularly important when skills are needed for assessment, care planning and risk management which often involve ***"pulling together the disparate parts of the jigsaw of a child's life"*** (Child Protection in England, 2022)[90].

Alison Leary, professor of healthcare and workforce modelling, has stressed that the workforce must be recognised as ***"the biggest safety critical asset that we have"***[91].

Allocation of health visiting work requires risk management skills, including the ability to understand the complexity of the work, foresee potential risks, and ensure that work is delegated to staff within the team who have the right clinical skills and experience to provide high-quality, safe and effective healthcare. Health visiting allocation can be compared to hospital triage. Triage is a highly complex, person-centred decision about risk that must be made by an experienced practitioner capable of making a reasoned and balanced decision about foreseeable harm[92]. It is a clinical decision and an important part of person-centred care, not a process.

In some areas of England, health visiting caseload management is shifting towards being a process activity, led by practitioners who are not regulated or registered health practitioners rather than a clinical triage activity undertaken by an experienced health visitor. Instead of health visitors delegating work to members of the skill mix team, the roles have been reversed, and work is being delegated to health visitors. This lack of professional oversight was a significant cause for concern for practitioners in England and poses risks for the "safety-critical" nature of their work:

> *"Allocation is chaotic. All are involved in the whole team, no real follow-up for work being completed. Limited clinical supervision or discussion around caseloads and allocations."* (HV England)
>
> *"Admin allocate the 10 month and 2.5 year reviews to Community Nursery Nurses. Band 5 have their own caseloads with [families requiring specialist support] / safeguarding families."* (HV England)
>
> *"Each contact is managed by skill mix and escalated as needed to band 6."* (HV England)
>
> *"Health visitors no longer manage our own dairies… we have far too much work and feel like we are constantly chasing our tails. It has become difficult, even blocking days out for our [families requiring specialist support] because our admin book our diaries up well in advance… This has taken away our autonomy and has left us overwhelmed… some days [we] don't know what's happening."* (HV England)

Personalised care: the importance of relationships

The evidence is clear that trusting relationships lead to more accurate identification of needs and better uptake of health-promoting messages (see Part II). Health visitors told us that being able to provide continuity of carer was important as it helped them to get to know the families on their caseload and deliver personalised care. They also told us how much they missed this when services were redesigned, and efficiencies were prioritised through corporate caseloads:

"I would love to hold my own caseload rather than corporate, and deliver care to my caseload/families and complete all the contacts and to be able to offer a clinic contact as currently we do not offer clinics." (HV England)

"[Need to] go back to community working, knowing our families and communities closely, continuity of care and preventative public health." (HV England)

"There is a lack of personalised relationship building which impacts on engagement and what you can offer families." (HV England)

Work environment challenges – workforce wellbeing

Table 8 presents the three main challenges that health visiting practitioners experience with their work environment across the UK. 58% of health visiting practitioners said that they experience work-related stress; whilst this is unacceptably high, it is less than last year's iHV survey findings where 71% of practitioners reported work-related stress.

Table 8 - Main challenges that UK health visiting practitioners experience with their work environment

Work environment challenges	Percentage of health visiting practitioners reporting
1. Work-related stress	58%
2. Working unpaid hours	54%
3. Need more efficient IT systems	49%

Some survey respondents from England stated that estate issues were a significant work environment challenge. It was deeply shocking to hear about the poor conditions that some health visiting practitioners are working in and the impact that this has on their practice, as well as their wellbeing and sense of self-worth:

*"The workplace is extremely cold and unfit for purpose… many of us don't have access to the local authority (LA) main building. Although employed by LA, we must sign in when attending Child Protection Conferences or training - **it screams you are not valued** as part of the service. We must be accompanied to a room, I could not go and buy a drink in the canteen as there was no-one to accompany me. It feels as if we are not recognised for our worth or value."* (HV England)

"Little or no office space to carry out private conversations online or by phone with clients, or to write up notes. This impacts on team working and sharing knowledge. I don't want to work from home but often have no choice." (HV England)

"Having to hot desk and no space allocated to each person therefore working from home. No peer support or mixing with colleagues, can be lonely." (HV England)

"Poor working environment, currently working in a portacabin which is very hot in the summer and cold in the winter, the unit also frequently has leaks." (HV England)

"No office and clinical space to re-develop team culture and see families locally in clinic or multi-agency setting." (HV England)

Part IV: Strengthening health visiting – train, retain, reform

Health visitors in the UK told us about their hopes for the future of health visiting, with many telling us how much they love their job and want to improve health outcomes for babies, children and families; they believe that their work matters and have witnessed the difference that it made to families:

> *"Whilst we are unable to deliver the service we would like to, I still strongly believe that our service is essential and offers support to parents."* (HV England)
>
> *"I still believe in the support and work we do."* (HV England)
>
> *"I am passionate about my role… I love the job."* (HV England)

Strengthening health visiting is not complex – many of the solutions are straightforward, well-known and well-evidenced. Our survey respondents were clear, they are hungry for change that makes services better, rather than papering over the cracks. And this needs to start with **getting the basics right by rebuilding the health visiting workforce and reforming the service** to improve health visiting support for babies, children and families.

Train student health visitors

Against a backdrop of falling health visitor workforce numbers, forecasted future losses, and reduced numbers of student health visitors, a robust workforce plan is needed to train and retain health visitors.

In Wales, 59% of respondents reported a reduction in the number of student health visitors, which was higher than the other nations – with 54% reporting a reduction in the number of student health visitors in Scotland, 38% in England, and 21% in Northern Ireland. National data from Scotland show the number of health visitor students has fallen every year in Scotland since 2017[93]. Health visitors in Scotland highlighted their growing concerns about workforce challenges:

> *"We have a pause on recruitment so not filling vacancies when someone retires or leaves."* (HV Scotland)
>
> *"Reduced numbers and diluted system."* (HV Scotland)
>
> *"The HV role is a fantastic support to new parents, but the role is being eroded through poor staffing."* (HV Scotland)
>
> *"Not enough HVs available to complete workload."* (HV Scotland)
>
> *"Due to our area being on a restricted pathway… due to staffing issues, the service has not been able to offer all routine visits to all families. This has led to HV profile and visibility being reduced and some negativity from the public about their ability to see their HV."* (HV Scotland)

Learning environment

Our survey asked, **"What needs to be in place to support an increase in the number of student health visitors trained each year and the quality of the learning environment?"**

Only 3% of survey respondents in England stated that no changes were required and that they had everything that they needed to deliver this. The top changes needed are:

- 57% of respondents wanted - **Strategies to inspire and attract future health visitors**
- 44% - **Smaller and more manageable caseloads for assessors and supervisors**
- 37% - **Strategies to 'grow your own health visitors' (with a career progression from Registered Nurse posts)**
- 36% - **To ensure university course content meets the learning needs of student health visitors.**

Additional themes to support a good learning environment were also captured in the qualitative data, with a call for the **reinstatement of Practice Teachers/ practitioners with higher-level skills to support high-quality learning in practice** (and a suitable recognised training programme to enable practitioners to develop these skills in education and learning in practice):

> *"More succession planning with additional Practice Teachers trained to support our SCPHN and pre-reg students and to develop more support for them post qualifying."* (HV England)

In addition, some respondents were concerned that work environment challenges (highlighted in Part III) meant that learners had less opportunity to share an office with more experienced health visitors. And this was impacting on the quality of the learning environment for qualified and student health visitors alike:

> *"Staff continuing to work from home which means they do not get the peer support they require. This is 2-fold, some of the issue is due to estate issues however there is great reluctance from some staff to come into the office. This is particularly challenging in ensuring that new starters/ learners are in the team, and they really need a team presence."* (HV England)

These results align with the findings from the iHV "Roadmap to success" for enabling a good learning environment to recruit and retain student SCPHNs[94].

Workforce recruitment and retention

Health visiting workforce shortages have also been caused by recruitment and retention issues of qualified health visitors. In some areas, our survey respondents also told us that health visitor posts had been reduced and vacancies were not being filled to cut costs:

> *"Not recruiting into vacant caseloads - jobs freeze to save money from overspend in other services."* (HV England)

Workforce retention in the NHS is supported through a combination of strategies and initiatives aimed at creating a positive work environment and addressing the needs of healthcare staff[95]. Many of the themes identified in our survey are well known, and have been widely reported, including:

- Valuing and supporting staff
- Work-life balance
- Career development (including opportunities for leadership development, specialist roles and supporting health visiting research careers)
- Positive work environment
- Recruitment programmes, including "grow your own" models that support career progression to health visitor training, and return to practice options
- Retention programmes (including good preceptorship) to plug the "leaky bucket"[96]
- Staff engagement – encouraging open communication to help identify areas for improvement
- Engaging staff in quality improvement and research
- Financial incentives – fair pay to make health visiting an attractive career.

Our survey findings highlight the urgency to move beyond "admiring the problem", to taking action to address health visiting workforce issues. Some survey respondents spoke about a vicious circle whereby practitioners felt that their concerns had been ignored, resulting in low morale; in turn, alongside significant workforce shortages, this impacted on the quality of care that practitioners were able to provide, it also affected their engagement in learning and quality improvement initiatives – leaving both managers and staff feeling demoralised and without "hope" that things would change:

> *"Staff have access to a wide variety of training to ensure evidence-based care is delivered. Health visiting is suffering from the fatigue that all areas in the NHS face. The fatigue can be linked to reduced compassion, reduced confidence in practice, resistance to accessing training and supervision. This creates a risk of reduced quality care although Friends and Family Test [feedback] does not indicate concerns from service users at present."* (HV Service Lead, England)
>
> *"Reduced wellbeing of the workforce, with a perpetual cycle that this will not improve..."* (HV England)
>
> *"[I have] no aspirations - which is really sad that I am feeling like this."* (HV England)
>
> *"Staff morale is the worst I have ever experienced in my 20 years of nursing. When morale is low, usually there are one or two people who are able to remain positive and pull everyone up. At the moment, I have no one. I am doing my best, but this is me 'faking it' and it is having a detrimental effect on my wellbeing."* (HV England)
>
> *"It just feels that we have been absolutely decimated, but the management are telling us that we are appropriately staffed because their staffing tool tells them we are."* (HV England)
>
> *"Overwhelming caseloads - staff wellbeing and mental health not top priority."* (HV England)
>
> *"Other health visitors going on repeated sick leave and then their safeguarding families are being 'dumped' on colleagues. Our managers need to look at why some many members of staff appear to be disillusioned with the job."* (HV Northern Ireland)

Reform:

The importance of leadership

The importance of having good leaders was an important theme in our survey findings. Practitioners spoke about the difference that good leadership can make to the delivery of services and health visiting team morale. It is important to celebrate success and share good practice - there are some brilliant health visiting leaders, striving for excellence and supporting their teams to deliver the best care possible to babies, children and families:

> *"I'm proud to manage a resilient ever-changing workforce that provides advice and support using the Healthy Child Programme and many targeted contacts… All staff [are] very dedicated and caring, very knowledgeable and experienced to give up-to-date advice and support."* (Senior Manager HV service, England)

Managers recognised the disparities in health visiting in England and were proactive in calling for changes to ensure that all families had access to high-quality health visiting support:

> *"Ideally [we need] more funding to enable more health visitors so that they can have smaller caseloads, so ALL health visitors can offer gold standard care."* (Senior Manager HV service, England)

However, we cannot ignore the fact that there is poor leadership in some local authorities[97] and in the NHS[98]. Our survey findings presented a mixed picture of health visiting leadership - some practitioners reported feeling well-supported by good leaders, whereas others felt that health visiting leadership was poor. Legitimate concerns were either ignored or dismissed, driving poor quality of care and negatively impacting on staff morale and wellbeing:

> *"I have an excellent manager who is forward thinking and improving the service we offer continuously. She also supports staff to fully develop their aspirations within different specialities to improve the service we offer to families."* (HV Wales)
>
> *"I feel listened to by some managers and get paid lip service by the others."* (HV England)
>
> *"Poor leadership/managers who don't understand the HV role or where senior managers are so out of touch with practice today."* (HV England)

The evidence is clear[99], great services require great leaders to lead them. Good leadership in the NHS has been linked to a range of positive outcomes:

- Improved quality and safety of care improving health and reducing inequalities
- Higher staff engagement, retention and career progression
- Strengthened leadership capacity within the healthcare system
- Greater innovation and efficiency in healthcare delivery.

The need to strengthen health visiting leadership was identified as a key theme for improving health visiting services:

> *"I would like to see a more robust strategic vision and better management of health visiting."* (HV England)
>
> *"Improved leadership and management of teams."* (HV Wales)
>
> *"I would like kindness from management. Knowing they have your back would be great."* (HV Northern Ireland)
>
> *"For our leadership, senior management and national leaders to acknowledge and believe in what we do."* (HV England)

Practitioners also wanted more opportunities to use and develop their leadership skills to drive quality improvement:

> *"I would like to see better use of the leadership skills gained when training as a SCPHN HV."* (HV England)
>
> *"I aspire to lead a service that has the right skilled and knowledgeable workforce to support families though a public health approach… I also want to undertake further study around my leadership and sphere of influence."* (HV England)
>
> *"I would like a service where staff are listened to and encouraged to help develop the service."* (HV England)

Service models and commissioning that meet the needs of families

Putting the needs of babies, children and families at the centre of health visiting care was a strong theme. Some survey respondents (especially in England) reported that the needs of the service, and pressure to cut costs, had overshadowed person-centred care.

In England, weak health visiting commissioning guidance, cost-cutting, and depleted health visiting contracts (with some important priorities no longer commissioned in some areas – like antenatal and postnatal healthcare, managing minor illnesses, supporting vaccinations etc…) were highlighted as barriers to high-quality care and had failed to respond to the scale of need:

> *"[I want to] focus on providing quality care instead of feeling like am just ticking boxes to meet KPIs."* (HV England)
>
> *"[I want] managers to work within real practice, for better family outcomes - NOT financial reasons."* (HV England)
>
> *"The specialist and targeted work have significantly increased… yet not acknowledged as we are not commissioned to do it but are expected to do it. Increasing workload and stress. This is really important work that we should be commissioned for."* (HV England)
>
> *"Be able to offer support to vulnerable families to reduce the gap in health inequality and not be confined to just meeting KPIs."* (HV England)

Inadequate IT equipment, lengthy record-keeping requirements and service models, that focused on process outcome measures at the expense of person-centred care, were also identified as barriers:

> *"I would like our documentation to be scaled back and our referral pathways made easier to be able to devote more of my time with my families' concerns."* (HV England)
>
> *"There must be an easier way to record keep. Record keeping puts a health visitor in an office for the whole afternoon instead of being seen out in the community. I would like to get involved more with our community and help parents know our faces. Become more visible."* (HV England)

The message was clear, health visiting practitioners want more resources to work "upstream" through prevention and early intervention to improve health and reduce inequalities. Many practitioners from England reflected on how much had been lost from the health visiting service in recent years and the damaging impact that this has had on the level of support that they are able to provide to families with babies and young children:

> *"We used to deliver the First Steps postnatal groups that focus on parent and infant relationships, maternal mental health, best start in life. They made a huge difference in reducing maternal mental health problems, allowing parents to receive health education to support their child's progress and development. It allowed early identification of need and allowed early intervention."*
> (HV England)

> ***"Prevention is expensive, but it is the MOST effective long term."***
> (HV England)

Valuing health visiting – the future of Specialist Community Public Health Nurses

Knowing that your work is valued, and you have job security, significantly boosts employee morale, retention, motivation and quality of care[100]. Again, our survey findings presented a mixed picture, with some practitioners stating that they felt valued:

> *"We are skilled and valued in many areas and provide a unique service."* (HV England)

However, others felt uncertain about the future of health visiting (particularly in England):

> *"[We need] policy maker and commissioner acknowledgement about the value of investing in an appropriately trained HV workforce, able to deliver an increased service offer for all families... Let's put a stop to this dumbing down and dilution of our profession, skills and education!"*(HV England)
>
> *"I am planning to look at other career opportunities… I don't feel that the job is worthwhile or valued anymore."* (HV England)
>
> *"Health visiting needs to be invested in, we are sinking."* (HV England)
>
> *"I urge the government to invest in early years… For investment in children's health and health visiting to be seen as a priority."* (HV England)

Practitioners working in areas where budgets were being cut, or their post relied on the current practice of short-term funding for specific projects, were concerned about their job security:

> *"I want to remain in my specialist role but unsure what will happen in 2026 when the funding ends. I do not wish to return to generic health visiting."* (HV England)

3.0 Conclusion and policy recommendations

Our survey report is published at a time of great flux for healthcare in the UK, with well-recognised challenges due to increased demand, long waiting lists, and soaring costs of late intervention for conditions that are largely preventable. For babies, children and families, there is an even greater sense of urgency to tackle long-standing and systemic issues which have resulted in the UK having some of the worst maternal and child health outcomes when ranked against comparable nations.

Our survey findings bring together the voices of health visiting practitioners from across the UK. Their valuable practitioner intelligence provides important insights needed to drive change. Whilst there is excellent work and innovation being led by health visiting teams across the UK to tackle the root causes of poor health through prevention and early intervention, the main message is clear – as a nation, we need to do better!

Demand for health visiting support has increased significantly over the last 12 months. Families needed extra support from health visitors for multiple reasons, with perinatal mental health problems being the top reason across the UK. Practitioners have also seen soaring demand for support for child behaviour problems, including growing concerns about neurodevelopmental issues like autism and ADHD that need to be taken seriously (and were ranked as the 2nd highest reason why families needed extra help from health visitors in Scotland, Wales and Northern Ireland).

In contrast, practitioners in England said that their practice was dominated by social concerns; with more families needing help with the impacts of poverty and with babies/children who have safeguarding concerns below the threshold for Children's Social Care.

Our report shines a spotlight on the need to end the postcode lottery of health visiting support across the UK. Families face universal challenges, and it cannot be right that in different areas they receive vastly different healthcare support. There is no obvious logic driving this disparity. Fundamentally for health visiting services, the key driver is that there are not enough health visitors to meet the scale of need – with a call from practitioners to "get the basics right"; ensure services are adequately resourced to deliver the national policy blueprint for preventative child health as intended and rebuild the health visiting workforce.

In England in particular, demand for health visiting support is currently far in excess of what services are commissioned and able to provide. Practitioners reported unacceptably high rates of work-related stress due to the nature of their work, as well as the trauma of being the frontline practitioner who must tell families that they cannot provide the care that they need due to a "broken NHS". We also heard numerous accounts of system blockers which were hampering the delivery of personalised, high-quality and joined-up care that all families with babies and children want; and health visiting practitioners want to deliver. Health visitors in England were particularly concerned about their role drift away from their core specialist public health nursing functions, with a call to "put health back into health visiting".

The good news is that our survey findings identified many examples of excellence and health visiting innovations to address key public health priority areas. These need to be celebrated and used as exemplars to drive quality improvement. With the growing burden of preventable disease impacting healthcare systems across the globe, as a nation, we stand at a crossroads. We have a choice to do things differently – or continue with more of the same. If we have ever needed health visitors, as Specialist Community Public Health Nurses, we really need them now. Despite numerous challenges which cannot be ignored, there is a groundswell of support within the health visiting profession wanting change for the better – and willing to play their part to halt the decline and rebuild, to ensure that the UK has a world-class health visiting service so every baby can have the best life from the start.

We urge policymakers to maximise the role of health visitors to support the shift from hospital to community, and from treatment to prevention. Strengthening health visiting will ensure that this vital service can play its fullest part in improving the health, wellbeing and life chances of all babies, children and families across the UK.

We're calling for the following key changes:

1. **Funding** – A realistic and accurate level of funding that reflects the true scale of need for health visiting services. Adequate resourcing will ensure:
    i. Accessible Services: Expanded reach of health visiting services to all families, particularly those in underserved communities.
    ii. Increased Workforce: Recruitment and retention of skilled health visitors to manage appropriate caseloads.
    iii. Enhanced Training: Continuous professional development to equip health visitors with up-to-date knowledge and skills to drive high-quality care.
    iv. Strengthened health visiting services: Maximise the role of health visitors to reduce pressures in the NHS through a shift to the community and an increased focus on prevention, improving immunisation uptake, and reducing disparities in antenatal and postnatal healthcare.

    Long-term investment will help services to plan and build world-class services, ending the uncertainty of short funding cycles.

2. **Workforce** – Train, retain and reform the health visiting workforce across the UK

    i. In England specifically: To deliver the national long-term workforce plan in full, ensure accurate workforce forecasting to meet the scale of need; and, in line with other UK nations, develop a robust, evidence-based safer staffing tool to ensure safe and effective care.

3. **Quality** – National government must do more to end the current postcode lottery of health visiting support:

    i. The needs of babies, children and families must be at the centre of healthcare delivery, with system blockers removed to enable best practice and integrated healthcare.

    ii. All areas must provide health visiting services that reflect best practice, and are proportionate to the scale of need, with mechanisms to hold failing areas to account. (In England, the Commissioning Guidance needs strengthening with explicit governance to reduce disparities and drive high-quality healthcare).

    iii. "Health" must remain a central component of health visiting to enable health visitors to play their fullest part in improving health and reducing inequalities for babies, children and families.

    iv. Health visiting research, workforce development and the sharing of evidence-driven models of best practice are supported.

Please also read our Appendix which is focused on improving vaccination uptake in England, with valuable practitioner intelligence to support implementation.

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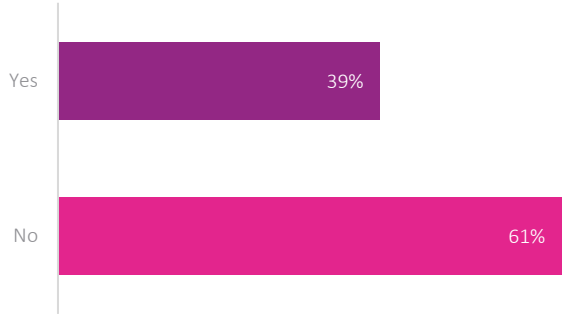
Appendix 1: Health visitors in England – supporting vaccination uptake

Each year in our annual survey, we ask additional topical questions on key areas of enquiry for health visiting practice. In this year's survey, we focused on childhood immunisations in response to the new Government's Child Health Action Plan and manifesto pledge to strengthen health visiting and reform the role of the health visitor to include administering vaccinations to "vulnerable and at risk" children. Improving uptake of childhood[i,ii] immunisations is a core public health function for health visitors, however very few practitioners currently administer vaccinations themselves. So, we asked health visitors what needed to be in place for this to happen (see Table 1).

Table 1 – Health visitors' top 3 priorities to enable them to support vaccination uptake

Top 3 priorities	What needs to be in place	Percentage of health visitors who rated this at a priority (n=866)
1	More health visitors	69%
2	More training on vaccination programmes so they can answer parents' questions confidently and accurately	48%
3	More training to support practitioners to administer vaccinations safely and effectively to specific groups	48%

We asked health visitors if they had the knowledge, skills and confidence to support families with immunisations (advice/administration to vulnerable groups) in line with the Government's aspirations for health visiting?



Identified enablers and barriers to health visitors vaccinating:

Enablers

Direct administration of vaccines by health visitors

"The option for us to deliver a domiciliary immunisation programme if necessary has been removed for some time but would make a huge difference to the most vulnerable children."

"To offer vaccinations in the home is by far the best solution."

"Uptake was higher and a great contact when we were routinely involved in the administration and delivery of the vaccines."

"I gave immunisation when training and in my last Trust, I feel it is a valuable contact with families."

Access

"In rural settings I think you would need a vaccination bus but then you have to consider anaphylactic reactions."

"Considering out-of-hour clinics to accommodate families that work Mon-Fri."

"Home immunisations and or immunisation within nursery settings/ weekend clinics."

"Provide health visiting service with support needed to administer immunisation to hard-to-reach families."

i. Gov.UK. Break Down Barriers to opportunity. 2024. [accessed 7 January 2025]. Available from: bit.ly/3E7zaCG

ii. Nursing Times. Health visitors key to Labour's child health action plan. 2024. [accessed 15 January 2025]. Available from: bit.ly/4aiydn6

Enablers

Infrastructure

"Ensuring services have Infrastructure is also up as number one!"

"Ensure services have the infrastructure to support implementation of this policy (ordering vaccines, safe storage and transportation, policies, regulations etc…"

Training

"Deeper understanding of why parents are not choosing to vaccinate & work with parents to educate in non-judgemental way."

"For health visiting teams to have more time and training to actually be able to discuss vaccinations with families."

"Training on vaccination programmes would help with face-to-face contacts."

Health promotion

"Wider public health messages on platforms that parents/carers access and trust."

"Better education of society about importance of vaccines and dangers of the illness they protect against."

"National campaigns to support reasons e.g. use of social media/TV to promote."

Barriers

Workforce shortages

"Without a huge increase in staffing and ring-fenced and dedicated funding, this has the risk of putting excessive pressure on an already stressed system that is at breaking point."

"We struggle to complete our role currently due to caseload sizes, the documentation and complete the pathway without adding to the service."

"Immunisation Teams are much better placed to undertake immunisations. There aren't enough HVs to take on this level of additional workload."

"A lot more staff would be needed."

Public health functions of health visitors need to be prioritised – services are overwhelmed with child safeguarding

"I would not be in support of HVs administering vaccines. There aren't enough staff to do the universal contacts and feeling pressured with safeguarding needs."

"It feels as though health visitors are 'bridging the gap' between targeted support and children's social care intervention at present, and I fear attempting to implement this strategy during the current climate may result in an exodus of the remaining already-too-far-stretched health visitors."

"With safeguarding, I think this would be hard to deliver from this service."

Misinformation and social media influence

"HVs face more challenges educating parents on immunisations, undoing what parents are learning from social media - more support is needed for this."

"Combat public misinformation re vaccinations."

"Parental education on vaccination and myth busting of conspiracy theories and anti vax ideology."

"Social media campaigns. Parents sceptical of vaccines and trust in government since covid."

Access

"There are no healthy child/HV clinics now in my area - so there are no opportunistic contacts to give proactive health information."

"We need to have appropriate safe venues, all of which we have lost."

Staff 'buy-in' to public health role in immunisations – need to understand how this can work in practice

"I do not feel HVs should revert back to administration of vaccine, however, should be proactive in health promotion and signposting."

"HVs should not administer vaccines this will reduce capacity to work with children and families in need."

Workforce capability/ training needs

"I can recall for those who had played no part in vaccinations directly, that this caused apprehension and anxiety for practitioners about getting up to speed with all aspects of running a clinic."

"HV to be able to deliver immunisations."

"Training on vaccination programmes and to answer parents' questions confidently and accurately."

"Training to administer vaccinations safely and effectively to specific groups."

Conclusion and recommendations

Whilst there was strong support for health visitors being involved in improving vaccination uptake for vulnerable groups, with many seeing it as a fundamental public health function, there was a clear message that we need to "get the basics right", with a plan to address the barriers and harness the enablers captured in our survey findings.

Almost 4 in 10 health visitors felt able to support the rollout of vaccinations, with some volunteering to get involved as "early implementer sites" to support wider system learning.

There is clearly a need to ensure that any large-scale change is implemented safely before any national rollout. Further learning is needed on the best methods of delivery. There is likely to be a range of models that could prove to be effective, with transferable learning from other parts of the healthcare system (for example, school nursing immunisation outreach teams for schools, successful TB schemes for homeless people, and the learning from the rapid roll out of the COVID-19 vaccination to presumed "hard-to-reach" groups, for example the boat people in Wiltshire). The assumptions on the most appropriate models need to be tested using an implementation science approach[iii], with rapid cycle "test and learn" and an evaluation arm to drive change with the best evidence.

Headline messages

There was strong support for health visitors helping vulnerable and at-risk groups get vaccinated:

- **Almost 4 in 10 health visitors** felt able to support the rollout of vaccinations, with some volunteering to get involved as "early implementer sites" to support wider system learning.

What changes are needed to support the Government's plans to enable system-wide rollout of health visiting schemes to improve vaccine uptake in vulnerable and at-risk groups?

What needs to change to enable system-wide rollout to vulnerable groups?

1. Get the basics right – strengthen health visiting
2. Address the barriers and harness the enablers of health visitors vaccinating
3. Get the implementation right - test and learn in early implementer sites first, to support wider system learning and successful implementation at scale.

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iii. There are a range of implementation science methods to support the embedding of new approaches in healthcare. For example, Normalization Process Theory (NPT) was developed by Professor Carl May in the UK. The approach addresses the realities of healthcare provision within highly contextualised organisational environments, often operationalised under pressure, involving complex interactions and multiple competing demands – and is now being used to support change in healthcare systems across the globe. NPT provides a roadmap for understanding how new ideas, practices, or technologies become part of everyday routines in workplaces or communities, taking account of key patient safety, operational and workforce considerations. It is used to study why some innovations are successfully adopted and why others aren't, providing important learning before innovations are implemented at scale. In simple terms, the core constructs of NPT are:

1. **Coherence:** This is about making sense of the new practice. People need to understand what the new "thing" is, why it's important, and how it will help them.
2. **Cognitive Participation:** This focuses on the people involved. It's about getting everyone on board, ensuring they are engaged and willing to invest their time and energy into adopting the new practice.
3. **Collective Action:** This is the "doing" part. It includes the practical efforts and core components needed to implement the new practice, such as training, resources (including workforce, infrastructure and funding), safety-critical considerations and teamwork.
4. **Reflexive Monitoring:** This involves evaluating the new practice, during and after it's been implemented. People need to assess how well it's working, what benefits it brings, and whether any adjustments are needed.

Together, these constructs help explain the process of safely embedding new practices into business as usual, ensuring they become routine and sustainable.

Further information – reference: bit.ly/3C9eLwE

May C, Finch T, Rapley T. Normalization Process Theory. In: Handbook on Implementation Science. Edward Elgar; 2020. pp. 144-167. https://doi.org/10.4337/9781788975995.00013

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