Institute of Health Visiting
Excellence in Practice

Health Visiting in England:

State of Health Visiting in England

Results from a survey of 1040 practising health visitors

February 2020

www.ihv.org.uk

The Institute of Health Visiting is a Centre of Excellence:

- Supporting the development of universally high quality health visiting practice;
- so that health visitors can effectively respond to the health needs of all children, families and communities;
- enabling them to achieve their optimum level of health, thereby reducing health inequalities.

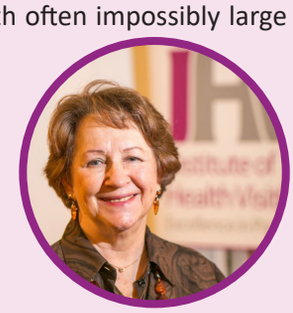
Foreword

"The Institute of Health Visiting supports excellence in health visiting practice. Last year, we published 'Health Visiting in England: A Vision for the Future', a statement of the unique contribution that health visiting makes to the health and prospects of babies and young children in every family across the country. Our Vision was based on the accumulated breadth and depth of evidence of what makes a difference. This was followed by two further papers, one offering ten case studies of what good looks like in health visiting, and the other the results of a survey of 1000 parents conducted with Channel Mum. It highlighted that some parents are receiving a very good service, however, in many areas, the under-resourced health visiting services are not providing many parents with the support they need.

Health visiting is not, of course, a single 'cure all', but a vital link within a wider system of professionals working at the level of individuals, families and communities to improve outcomes for children and families. In this new report, we share evidence from the front line of health visiting practice. While there are brilliant examples of health visiting practice that we have reported elsewhere as case studies, our survey data indicates that these occur despite the current cuts to public health funding, a dwindling and all too frequently demoralised workforce, and their combined impact on service quality.

This is not inevitable. The first five years of the last decade saw fresh investment in health visiting in England and similar investment is in progress in the rest of the UK. However, in England this has gone into reverse. Families in some areas are being denied access to the trusted advice and support of these highly trained professionals that they tell us they so value. Being a parent can bring great happiness for a family but it is also not easy. All parents may therefore require help at various points and, for some, it can become intensely difficult in the context of additional stresses like poverty, child disability or parental conflict. Traditionally, the health visitor's support has been vital for enabling parents to express their concerns freely and to build their self-belief and confidence to be effective and manage in the long term. The invisibility of vulnerable children will increase as the health visitors' universal services disintegrate.

Health visitors have the knowledge and skills to reach out to and support each and every family proportionately to their needs and circumstances. Unfortunately, many are now desperately frustrated to be forced into '*ticking the box, but missing the point*' due to the imperative to deliver on minimal mandatory standards with often impossibly large caseloads. Here we hold out for our positive vision for health visiting whilst reporting on these voices from the frontline and make recommendations to place this vital professional service back on a sound footing.



Surely, there is no more important action for a government than to safeguard the future wellbeing of its nation's children and their families".

Pamela Goldberg OBE, Chair
Institute of Health Visiting

Acknowledgements

We would like to thank the 1209 health visitors (1040 of whose results are presented in this report) who took the time, often outside work, to complete our survey last October/November. Without your feedback, it would be impossible to get a true picture of health visiting across England from the point of view of those on the front line. This report has been prepared by the iHV professional team. We would also like to thank Lisa Jacobs for bringing it to life with her design.

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Executive Summary

Health visiting is a unique profession and service that supports parents of children from pregnancy to school age, to lay foundations for life-long health and to fulfil their potential. Health visitors form a keystone service within wider provision and community resources. While the service has developed over more than a century, the strength of evidence supporting its significance for child and family public health has never been greater for the long-term impact throughout life into a healthy old age.

This document is one of a series that have set out:

- Our Vision for a modern evidence-based health visiting service
- Case studies of good practice that meet health challenges recognised across government departments
- A survey of what parents most value about this service – notably the opportunity of continuity of health visiting support from a trusted and knowledgeable health visitor

In this document, we report key findings of our most recent survey of frontline health visitors working with families and communities. Our survey, the latest of six conducted annually from 2014, indicates the impact on the quality of the service available to families, and workforce capacity and morale from sustained reductions in funding. It found:

- There is considerable unwarranted variation between local authorities in the quality of the health visiting service that health visitors are able to provide which may not be based on best practice or the family's level of need.
- The health visiting service has become increasingly driven to demonstrate compliance to key performance indicators, most notably uptake of the five mandated health reviews.
- This reductionist approach can result in "ticking the box but missing the point". It also reduces the health visitor's professional autonomy and capacity to respond to identified needs and utilise their skills to address key public health priorities and reduce inequalities.
- The provision of continuity of health visitor is becoming increasingly difficult to deliver in practice. Continuity and personalised care are key components of effective health visiting practice which are highly valued by parents and strongly associated with improved outcomes.
- Our survey highlights increasing levels of work-related stress within the health visiting workforce. Practitioners report distress and concerns about the risks to which "hidden" vulnerable children and families are exposed and how many are now left unsupported.
- There are many interrelated factors that have led to the current state of health visiting in England. To address these, we set out key recommendations within three urgent priority areas to:
    - Provide sustainable funding to ensure every child and family has access to a high quality, evidence-driven health visiting service with support based on their level of need, rather than where they live.
    - Improve the quality of health visiting practice.
    - Build capacity and capability within the health visiting workforce.

1.0 Introduction

Health visiting is a unique professional role providing a universal, non-stigmatising service to every family with pre-school children, or should be. A well-resourced health visiting service, as it was starting to become in 2015 following the then government's investment into increasing the number of health visitors by 50%, has the power to identify health needs early and to reduce health inequalities. Another unique feature of health visiting is that these professionals work not only at the level of the individual but also at the community level bringing organisations and individuals together to drive health improvements.

In October 2019, the Institute of Health Visiting published "Health Visiting in England: A Vision for the Future" which was developed in response to Public Health England's call for collaboration in its refresh of the health visiting 4-5-6 model and the Healthy Child Programme. The Vision sets out how an effective health visiting service is ideally placed to address numerous cross-government department priorities for children and families, providing an important part of the solution in a modern integrated health and social care system. To achieve these ambitions, we need a health visiting service that is "fit for the future".

This latest publication from the Institute of Health Visiting presents the findings from an annual health visiting survey completed in November 2019. This latest survey was responded to by 1209 health visitors in the UK, of whom 1040 were working in practice roles (see Appendix 3). The annual nature of this survey, and the fact that many questions have been repeated in an identical format, year on year, enables a "temperature check" to see how we are doing and the identification of trends by comparisons over time.

Staff engagement is now widely recognised as a key element needed to help the healthcare system meet the range of challenges that it faces. By listening to the experiences of staff and involving them in the co-production of services, we can maintain and improve staff morale, especially during periods of difficulty and change, and there is also a direct correlation between high staff engagement and improved quality of care.

The findings from this survey present a mixed picture of health visiting nationally with welcomed improvements in a few areas and considerable workforce pressures in others. Practitioner feedback highlights areas where the profession needs strengthening to ensure it is equipped to take its full place in an integrated systems model. This would allow maximum benefit to be gained from the specialist skills of the health visitor to ensure families are supported and every child has the "best start in life".

As we embark on the third decade of this century, it is now widely accepted that we need a radical shift in our strategies to improve health and wellbeing across the life-course. The policy messaging has a number of well-known straplines; "Prevention is better than cure"; "we need an upstream approach"; "place-based"; "population health" - aimed at improving the health of the whole population and reducing inequalities. We also have more evidence than any other generation on the importance of the "first 1001 days of life" as the foundation for future health and wellbeing.

However, there remains a well-documented lag between the evidence, policy rhetoric and realities of practice. The first step in quality improvement is to recognise that improving primary prevention and early intervention to children and families is an urgent priority. We hope that the findings from this survey will be used to shape a national health visiting workforce strategy to address the identified priority areas of:

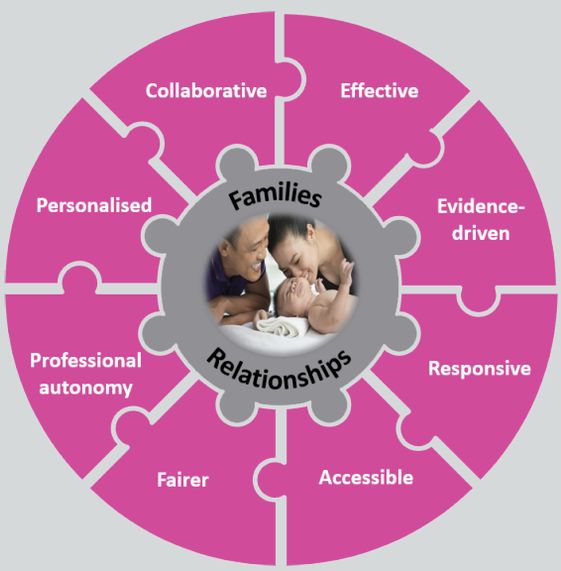
- **Funding** – Investing in our children is a smart investment and will save money in the long run, the benefits of that investment may not be realised until several years later and accrue to numerous other government departments. At present, health funding is skewed towards acute health services and late intervention with few incentives for integrated working and funding to support the contribution that health visitors make to numerous clinical pathways which straddle the NHS, public health and social care. Breaking out of this siloed way of working and taking a whole system approach to prevention is fundamental to making progress.
- **Workforce** – A workforce plan is needed to address training, recruitment and retention difficulties facing the health visiting profession.

- **Quality** – All families should receive a level of service based on their need, rather than where they live. Action needs to be taken to address any unwarranted variation in the quality and level of support that families receive. See Figure 1 for key elements of an effective health visiting service.

This document is the latest addition to our suite of supporting documents to our Vision:

- On 17 January 2020, we launched our "Health Visiting Good Practice Case Studies" which showcase best practice examples of the numerous ways in which health visitors are addressing key public health priorities that straddle both health and social care.
- On 30 January 2020, we published "What do parents want from a health visiting service?" a survey of 1000 parents by the Institute of Health Visiting (iHV) and Channel Mum. The survey found that parents are experiencing very different levels of support depending on where they live, rather than their level of need. Parents clearly described the vital support that they received from their health visitor - they valued being treated as an individual, with easy access to personalised support when they needed it and continuity of health visitor, rather than a 'one-size fits all' approach.

Figure 1. Key elements of an effective health visiting service



1.1 Funding the health visiting service

In 2015, health visiting services were moved into local authority commissioning with the acceptance that the shape of future services would depend on local decision making. This has created considerable unwarranted variation in the quality of the health visiting service that families receive based on where they live, rather than their level of need. Some areas have strengthened their health visiting services, whilst others have, for varying reasons, instigated significant disinvestment. Disinvestment has happened in part because of year on year cuts to the Public Health Grant[a], which has forced cuts to the health visiting establishment in order for local authorities to remain within budget. However, this does not adequately explain all the recent cuts in the health visiting workforce, as the fall in health visiting numbers is around twice the size of the reduction in 0-5 spend as reported by local authorities. This suggests that there are other factors driving these decisions, such as other budgetary demands.

Whilst there have been some examples of good evidence-based commissioning in recent years, even senior Directors of Public Health recognise that commissioning in some areas is not as good as it could be. In some areas, there is an apparent lack of understanding of the long-term benefits and value added by employing Specialist Community Public Health Nurses to deliver an evidence-driven Healthy Child Programme[1]. As a result, efforts to achieve short-term public health budget cuts have precipitated much more severe cuts to the number of qualified health visitors in practice in favour of a lower paid workforce. However, these cuts will have consequences as cheaper members of the children's workforce with a very different training and no nursing/midwifery background, whilst enhancing the health visiting service offer in many ways, will have a narrower scope and level of practice and should not be regarded as substitute health visitors.

2.0 Results of the State of Health Visiting survey 2019

2.1 Service quality

What we know of what parents want and appreciate from a health visiting service combined with our survey of health visitors indicates that there are significant unwarranted variations in what health visiting services are able to offer that have impacted on these key indicators of quality.

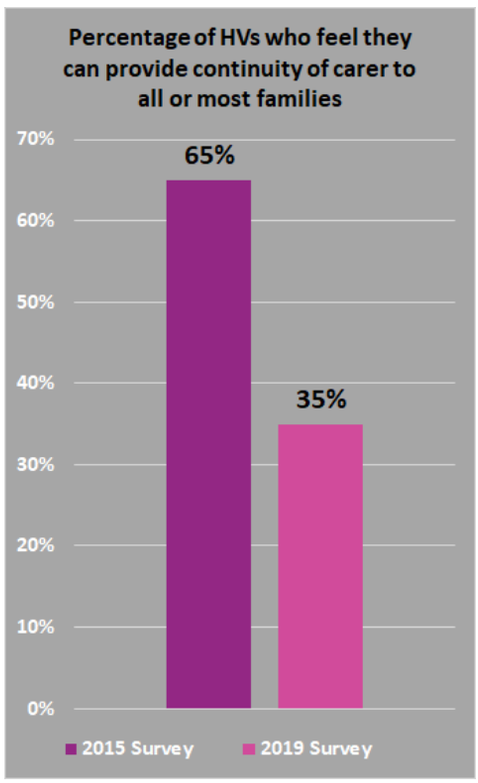
2.1.1 Continuity of carer and quality of relationships

2.8% Only 2.8% of health visitors told us they are now able to offer continuity of health visitor to families all the time.

35% of health visitors said they could offer continuity of health visitor to all or most families, a fall from 65% in 2015.

50% of health visitors were only able to offer continuity of their input to vulnerable families or those on child protection plans.

12% 12% of health visitors said they were "hardly ever" able to offer continuity of health visitor.



Health visitors told us that they are unable to provide continuity of carer to most families. This is despite there being strong evidence that "relationships" are the marker of quality for effectiveness of practice most valued by parents (see iHV "What do parents want from a health visiting service? Results of a Channel Mum survey", January 2020). Continuity of carer is also a key element to improving outcomes and reducing risks. Each universal health review provides an important opportunity to strengthen the health visitor/ client relationship – the health visitor and family develop a shared understanding of the family's priorities and needs, building on previous knowledge.

It is important that we avoid a system that is "health visitor-led" in name only as health visitors are professionally accountable for any delegated activity undertaken within skill-mixed teams. Parents value being known by their health visitor:

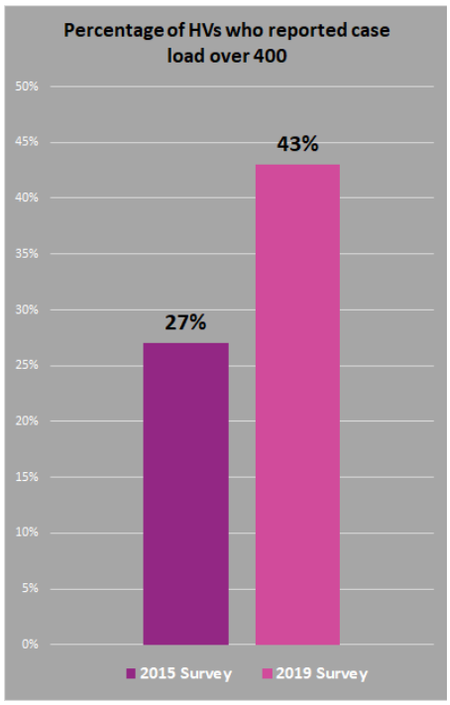
> *"My health visitor knows me and addressed my emotional needs when no one else understood. She supported me, gave me advice and pointed me in the right direction, boosting my confidence as a first-time parent. I felt completely comfortable knowing she had my interests and my baby's interest as a priority".*

Health visitors' concerns are represented in the following quotes:

> *"With the service stretched so thin and with so few contacts for universal families, we lose the ability to develop relationships with families. This is a barrier to being able to offer timely support to families as new concerns arise with children and families".*

> *"I am worried about the 'universal' clients who have a significantly reduced quality of support from the HV team – they do not even have office numbers to call any more – it is a hub they have to ring and the universal clients do not have an allocated HV".*

2.1.2 Workload - ratios of health visitors to under fives



80% Over 80% of health visitors reported that since 2015 the number of Whole Time Equivalent (WTE) qualified health visitors in their organisation had reduced.

23% are responsible for 300 or less children (38% in 2015).

23% are responsible for 301 - 400 children.

43% of health visitors are responsible for 400 to over 1000 children.

29% Almost 29% are responsible for 500 - 1000+ children (12% in 2015).

20 health visitors have responsibility for 1000+ children (0 in 2015).

'Caseloads' now take increasingly varied forms. Our survey asked for the numbers of children for which each frontline WTE is responsible, if they are unsure due to restructuring then we ask them to divide the total number of under fives in their area by the number of full time equivalent health visitors. The resulting number does not take account of the number of families requiring an antenatal assessment. The findings indicate a wide variation in the size of caseload reported. This will affect the quality and equity of service provided.

The numbers of health visitors per head of population (0-5) is the measure of 'caseload' for which health visitors take professional responsibility as they are a universal service responsible for all pre-school children. It is important that the 'caseload' size includes all families based on the concept of proportionate universalism which is widely accepted as the most effective means to reduce inequality[2]. This asserts that health needs will be spread across the whole population although with different levels of acuity, reflected at population level and at the level of the individual child and family. Health visitors working in areas of high vulnerability will require smaller caseloads to offset increased need.

From a pragmatic perspective, there is clearly a limit to the number of children that an individual health visitor can be accountable for, regardless of how the service is organised. Effective health visiting depends on the opportunity for the health visitor to establish trusting relationships with each family.

The iHV and CPHVA and others have recommended that the maximum caseload size is 250 children, this should be less in areas of high deprivation/ vulnerability.

Our 2019 survey asked several questions about caseloads and coverage of the service. This is what health visitors told us:

"1100, although Trust says it's ok because you have skill mix"[b].

Skill (and grade) mix refers to team colleagues such as staff nurses and community nursery nurses. They provide valuable support for families, assisting health visitors who remain fully accountable for their actions and family needs as registered Specialist Community Public Health Nurses.

Some health visitors reported that caseload sizes were only calculated for children up to the age of 2 years despite the health visitor remaining accountable for children up to school entry.

"This figure does not include all children as we have to discharge them after they have the 2-year review".

The Children's Commissioner's "Childhood vulnerability in England 2019" report[3] examined the latest scale of childhood vulnerability. 2.3 million children are living with risk because of a vulnerable family background and more than a third – 829,000 children – are 'invisible' (in the sense of not being known to services) and therefore not getting any support. If the children don't attend pre-school, they will be at risk of becoming hidden. To address this, the iHV recommends that all children receive eight mandated health reviews including a review of all pre-school children at three and a half, as is the case in Scotland and as supported in 2019 by the Health and Social Care Select Committee on the First 1000 days of life inquiry[4].

The mandated contacts were intended to be the minimum service with health visitors using their skill to determine which families required additional intervention and further reviews proportionate to their level of need. In reality, they quickly became the maximum service and official figures, and responses from this survey indicate that many children don't even get five reviews in England.

Some health visitors reported that they only have caseloads of vulnerable families, which totally shifts health visiting from its core purpose to provide a preventative public health service for all families based on the principles of proportionate universalism and risks expecting health visitors to instead work as social workers.

> *"Larger caseloads and fewer staff mean families are not getting a tailor-made service to meet their needs. Vulnerable children are slipping through the net".*

The comment below reflects the impact on families highlighted by many health visitors:

> *"I love my job – I am well supported – but my caseload is relatively small… it is the 1000s on the universal caseload with no allocated HV that concerns me at present… we are not social workers we are specialist community public health nurses".*

And the impact on professionals due to the worry and stress from managing chronic excessive workload and carrying the risk for vulnerable families for whom they are professionally accountable, whilst not having the capacity to respond effectively to needs:

> *"This question does not work for us anymore because we are only allowed a limited number on our 'active caseload' that is about 30-50 and we get grilled about getting them off the caseload [because we're told] we should only be working with defined targeted families otherwise they get taken off the caseload. Caseload numbers about 400 but irrelevant now in this new world. Oh! Yes and if something slips through the net, we get scapegoated...you cannot win!"*

It is worrying for those health visitors finding themselves in this situation as they are well aware that if a child is involved in serious safeguarding procedures, or dies, they can expect to be held responsible.

2.1.3 Coverage of the mandated reviews/ delivery by a health visitor

There are five reviews of health and development that are mandatory components of the Healthy Child Programme that health visitors are expected to lead and deliver. All families should receive all of the five mandated contacts as a minimum universal level of service; PHE has recently confirmed that all five contacts should be provided by a health visitor and should be face-to-face.

Our snapshot of the wide variation in access to health visiting services is drawn from the most recent published data by Public Health England (November 2019 release[5]) and our survey data.

	PHE Data HV activity	iHV Survey
Antenatal contact	PHE does not publish a percentage for coverage of the antenatal contact as there is no accepted denominator.	Only **34%** of health visitors reported that they were able to offer the mandated antenatal contact to all families. **22%** reported that they only offered antenatal contacts to a few priority families.

There is a significant body of evidence to support the antenatal contact as the most crucial contact supporting transition to parenthood and early identification of needs. The antenatal contact provides an early opportunity to build a therapeutic health visitor/ client relationship. Working in partnership with families enables them to discuss their hopes and fears for becoming a family, providing anticipatory guidance to support transition to parenthood on a wide range of key public health priorities, including infant feeding and immunisation.

	PHE Data HV activity	iHV Survey
New birth visit(NBV) within 14 days	England aggregate = **86.9%** (South West = 77.0%)	Percentage of NBV completed by a health visitor = **85%**
6-8 week review	England aggregate: **86.5%** (South West= 78.3%)	Percentage of 6-8 week reviews completed by a health visitor = **73%**
12-month reviews (% received by 12 months)	England aggregate: **78.3%** (London region= 66.6%; South East= 73.8%; South West=71.6%)	Only **19%** of health visitors reported that all 12-month reviews were completed by a health visitor.
2-2.5 year review	England aggregate: **76.8%** (East of England =68%; London region = 68.1%; South west = 73.6%)	Only **10%** of health visitors reported that all 2-2.5 year reviews were completed by a health visitor in 2019.

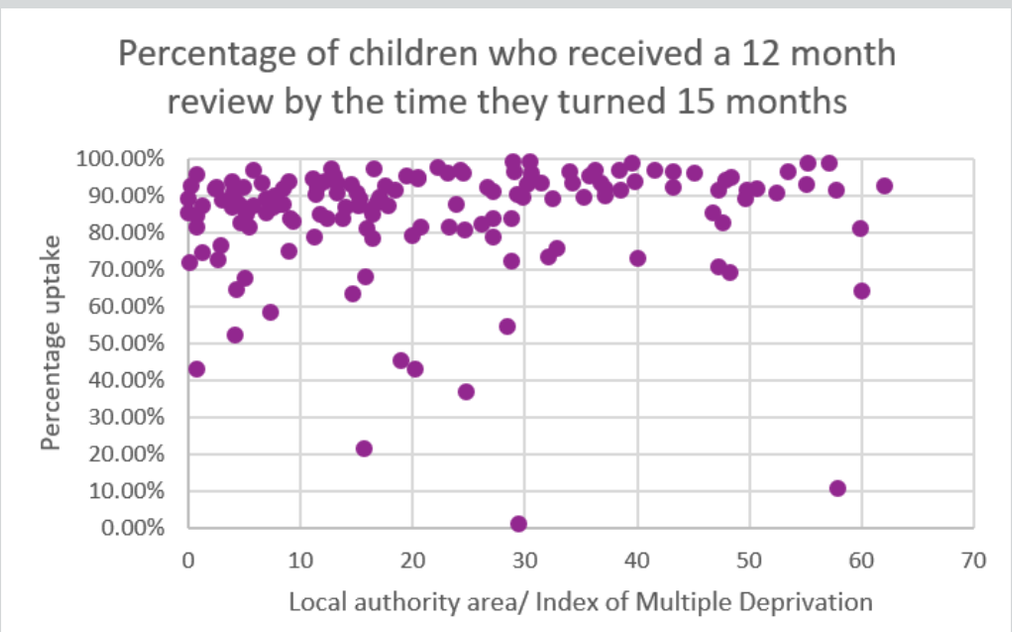
Health visitors expressed concerns about the Ages and Stages Questionnaire (ASQ-3™) being used as a screening tool. The ASQ is not a screening tool, it is a population measure and should be used to support clinical decision making as part of a holistic assessment completed during a face-to-face contact.

"Universal children are not offered a 1 or 2 year check – the parents are asked to complete the ASQ and post it back – Only Universal Plus are seen for the developmental review (by a Community Nursery Nurse)".

Data on health visiting activity is reported quarterly by Public Health England as "Health Visitor Service Delivery Metrics (Experimental Statistics)[6]". Improvement is measured against an historical benchmark set at the point of transfer of health visiting to local authorities in 2015. The headline findings published by Public Health England present gradual improvement in uptake of these reviews over time. However, this masks considerable unwarranted variation in uptake of these reviews between areas – for example uptake of the 12-month review has an England uptake rate of 83.8% with a range of 0.3% to 99.6% for individual local authorities (see Figure 2, below).

The graph depicts no correlation between deprivation, as a proxy for level of need, and service uptake – rather a postcode lottery of health visiting activity, with very poor provision in some areas:

Figure 2: Uptake of the 12-month health visiting health review by local authority area Index of Multiple Deprivation



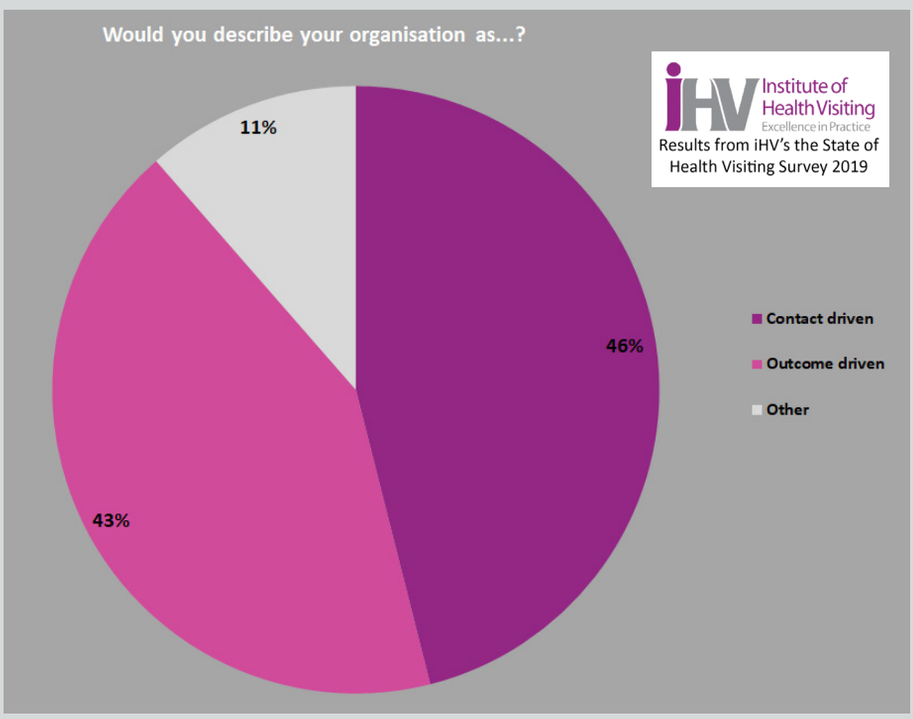
The average England metric for health visiting activity also provides no measure of quality as some areas are reporting:

- Reviews completed by parental self-report (completion of a postal child development questionnaire - ASQ-3™). It is worth noting that the ASQ-3 is only a small part of a holistic assessment of child/ family needs. It is also a population measure and not a screening tool, it is therefore not suitable to be used in this way and will produce false positives and negative responses and will not address the breadth of physical, emotional and social needs for children and their parents.
- Service "offer" rather than contacts achieved. PHE has confirmed that they have no mechanism of determining the extent of this practice within data submissions.
- Reviews completed by practitioners who are not health visitors. Our annual survey indicates that only 10% of 2-2.5 year reviews are completed by health visitors, despite this being recognised as best practice by PHE and all professional bodies.

2.1.4 Quality of mandated reviews: "Ticking the box but missing the point"

The universal health reviews provide a gateway for a targeted level of support for children and families with additional needs or at risk of poor outcomes. Health visitors have the specialist skills to assess physical, emotional and social needs of both children and adults, and provide holistic reviews in the context in which families live. It is only in so doing that a range of needs can be identified and appropriate interventions planned in partnership with families. Unfortunately in 2019, 82% of health visitors reported that there is now too much focus on "ticking boxes" rather than delivering quality services that can make a difference.

Figure 3. Percentage of health visitors who report that their organisation is focused primarily on achieving "contacts" compared to those focused on improving outcomes.



From our survey findings there is a strong indication, therefore, that data returns to PHE are highly likely to over-estimate both the number of mandated reviews undertaken and the quality of these reviews. This calls into question the effectiveness of the current delivery of the Healthy Child Programme.

Representative quotes:

"There is emphasis on data and even children who are not brought (Did Not Attend) appointments are being counted in the data as activity delivered so they can meet percentage targets. Health visitors are just concentrating on completing forms even if they have not done the activity so they can achieve targets".

"Focus has completely changed to meeting KPIs rather than providing a quality equitable service aimed at improving outcomes. This has led to focus on offering service and documenting this rather than actually carrying out a meaningful contact based on identified needs".

"Due to staffing, any need we identify is passed to other organisations and sometimes they are not the best placed to help. Mental health is best addressed with trusted working relationships and passing to others with long waiting lists and not medical backgrounds (i.e. Children Centres) is not good for families. I am sad we cannot provide a good quality holistic service".

"Focused far too much on the things that are not important. Totally misses the point. There is a totally disproportionate amount of time spent completing the myriad of electronic templates which miss capturing important information".

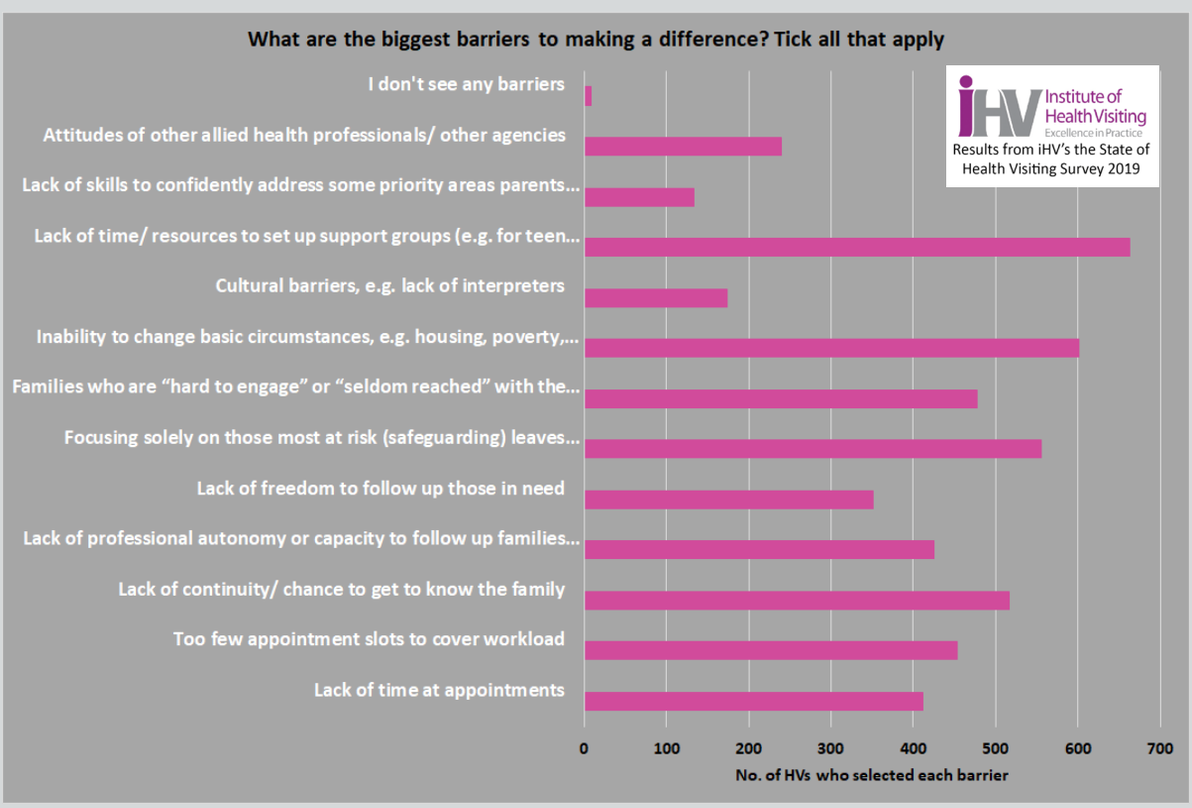
"Service is increasingly task orientated with health visitors struggling to build relationships with families – often seeing them for only two visits and no continuity between who does the antenatal and who does the birth visit".

"I feel as if I have let down a lot of my families who need support to ensure that safeguarding is covered".

"Numbers [are] wanted, ticking boxes wanted, not particularly interested in quality of service".

2.1.5 What are the biggest barriers to making a difference?

Figure 4. Biggest barriers reported to making a difference



It is widely recognised that improving health and reducing inequalities requires a population health approach which focuses on:

- The wider determinants of health;
- our health behaviours and lifestyles;
- the places and communities we live in;
- an integrated health and care system, in which the health visiting service plays an important part.

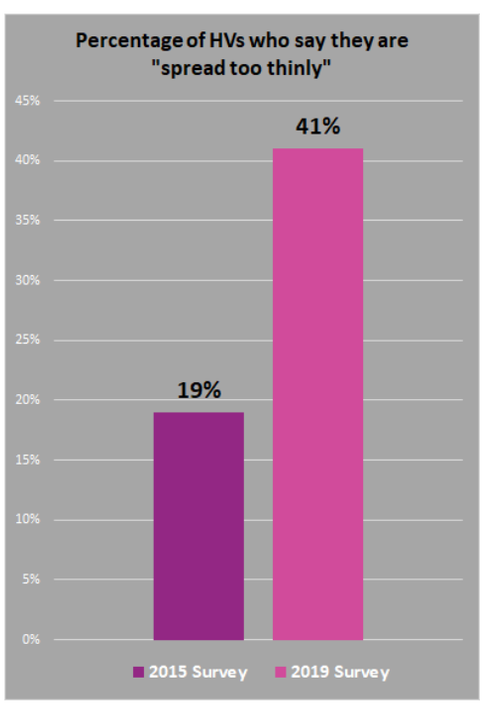
Barriers to improving outcomes include the lack of strategies at a population level to address the key determinants of poverty and the on-going effects of austerity for many families, alongside a lack of capacity to provide individual level support for families with additional needs or at risk of poor outcomes. As shown in Figure 4 above, health visitors consider lack of time, lack of continuity of a relationship with families and a focus on the most vulnerable families are those features most impacting on them making a difference, alongside their inability to change basic life circumstances.

2.1.6 Professional autonomy

49% of health visitors reported that they have the professional autonomy to follow up families with additional needs when these are identified at the mandated contacts. However, a worrying 51% reported that they no longer have the capacity or professional autonomy to follow up families with needs identified at the mandated contacts. This suggests that these senior professionals no longer have the capacity or autonomy to prioritise their work, resulting in unmet needs.

2.1.7 Delivering positive outcomes for children and families

Only 10% of HVs told the iHV they are making a difference to families, while 48% believe that although they do make a difference they would like the opportunity to do more and 40% doubt they can make a difference because their time is spread too thinly to be able to make much of a difference. 48% told us that they were so stretched they feared a tragedy at some point.



2.1.8 Contributing fully to the care of under fives in the future

75% of health visitors reported that they are not confident that health visiting will be able to contribute fully to the care of under fives in the future.

This low level of staff autonomy and belief in their capacity to deliver high quality, effective support is a concern given the recruitment and retention difficulties faced by the health visiting profession. It is encouraging to see the NHS and The Point of Care Foundation taking similar issues in the NHS seriously with actions aimed at re-connecting staff with their intrinsic motivation for entering caring professions. Transformation takes a system-wide approach to enable a working environment with a greater focus on the relational aspects of care. This change is underpinned by a growing body of evidence to support recruitment and retention of staff through a culture change in which human aspects of care are placed centre-stage, thereby making environments of care more human for staff and patients[6].

2.1.9 Role drift – carrying risk for other agencies (child protection) at the expense of preventative public health

Health visitors are trained to promote health and to identify risk early. The results of the survey have highlighted that many health visitors are now struggling to deliver this unique aspect of their role due to other pressures on local authorities. 66.4% of respondents stated that their work was increasingly focused solely on working with at risk families (safeguarding and child protection), thereby eroding their primary “upstream” universal role of prevention and early intervention.

Representative comments:

"The early mother and child services have been eroded and I'm being used as a mini social worker (plugging their gaps) and now a school nurse. It's just to save money and distribute workloads".

"Feel that we are expected to pick up slack from other services such as social care. Universal aspect is being undermined and due to cuts in HVs due to funding we lose continuity - key contacts are now delivered by non HV staff".

"As health visitors, we are now focused on the children with additional needs and safeguarding… families who are not on child protection plans have what I would consider a poor service".

Health visitors should work at the level of the individual as well as the community, some community initiatives being a more effective way of addressing need. However, 78% of health visitors reported a lack of time/ resources to set up support groups or develop the "community/ place-based" role of the health visitor (this is one of the four levels stipulated in Public Health England's model for health visiting in the Commissioning Guidance[7]).

2.1.10 Vulnerability of Caseloads

Health visitors are uniquely placed to reach all families through their proportionate universalism approach. Most of the health visitors that responded to our survey regularly work with families in disadvantaged groups at the highest risk of poor outcomes, as shown in Figure 5 below.

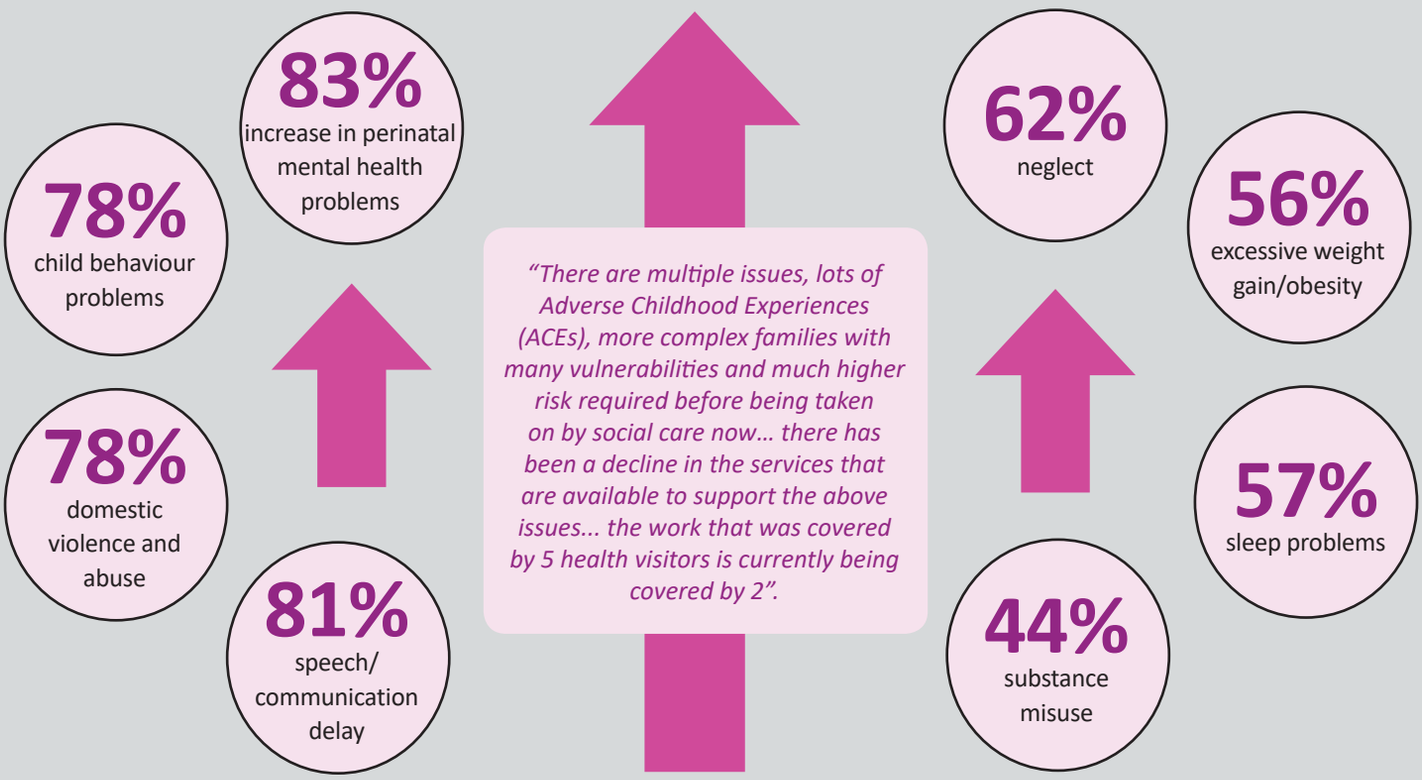
Figure 5. Percentage of health visitors reporting they work with each of vulnerable groups

Travellers	64%
Homeless	77%
Looked After Children	91%
Families of concern	95%
Families with children subject to a Child protection Plan	93%
Teenage mums	90%

Refugees/ Asylum seekers	83%
Perinatal mental health	95%
Adults/ children with disabilities	93%
People with drug/ alcohol problems	94%
People who need interpreters	92%
Children with speech, language and communication needs	94%

Many health visitors reported that they had seen increasing vulnerability (demand) in their caseloads over the past two years. It is of significant concern, not only for these professionals, but also for the public's health that health visitors report the following percentage increases across the vulnerabilities identified in Figure 6.

Figure 6. Conditions where health visitors perceive increased demand in the past two years



2.1.10 Other services to refer onto

Health visitors also reported reductions in services to which they can refer families for support, notably children's centres and social services (68%), Child and Adolescent Mental Health Service (CAMHS) (44%), Speech and Language Therapy (25%) and the charitable sector (75%). This will mean that health visitors are having to either intervene themselves, or families will wait longer for support from other agencies. As stated above, 51% of health visitors reported a lack of capacity to follow up families with needs identified at the mandated contacts which will further compromise the system's response to meet the increasing level of demand, resulting in reduced provision of early intervention and unmet need. This is likely to prove much more costly in the long run as the burden will shift towards crisis and late intervention.

2.1.11 Quality of support for identified needs

We asked health visitors to rate the "quality" of service that they were able to provide to families in the last year (based on their capacity to build relationships with families, provide continuity of care and an accessible service with adequate time to assess and respond to need as it arises).

21.4% of health visitors rated the quality of care that they were able to offer families in the last year as "good" or "excellent".

38.4% of health visitors rated the care that they provided in the last year as "inadequate" or "poor", with the rest rating it satisfactory.

Health visitors also reported inconsistent care pathways and opportunities to facilitate and support effective access to help with identified needs. For example:

72% of health visitors reported that children are not routinely followed up at 3 years if early language difficulties/ delay are identified at the 2-year check.

28% of health visitors do not have a clear pathway of support for children with faltering growth.

61% of health visitors do not have a clear pathway of support for a baby/child who is overweight/obese.

51% of health visitors are not able to provide support for the couple relationship (78% of health visitors said they would like training and capacity to provide this support).

2.1.12 Contact with GPs

Health visitors also reported being more detached from GPs.

49% reported that their contact with GPs had reduced since transferring commissioning to the Local Authority.

28% Only 28% reported that they were able to meet with their GP colleagues at least monthly. Many stated that they have never met with the GPs since commissioning transferred to the Local Authority.

10% Only 10% are co-located with GPs.

This is particularly worrying as general practice is a universal service like health visiting and these two professionals both benefit by being able to share concerns they may have regarding children.

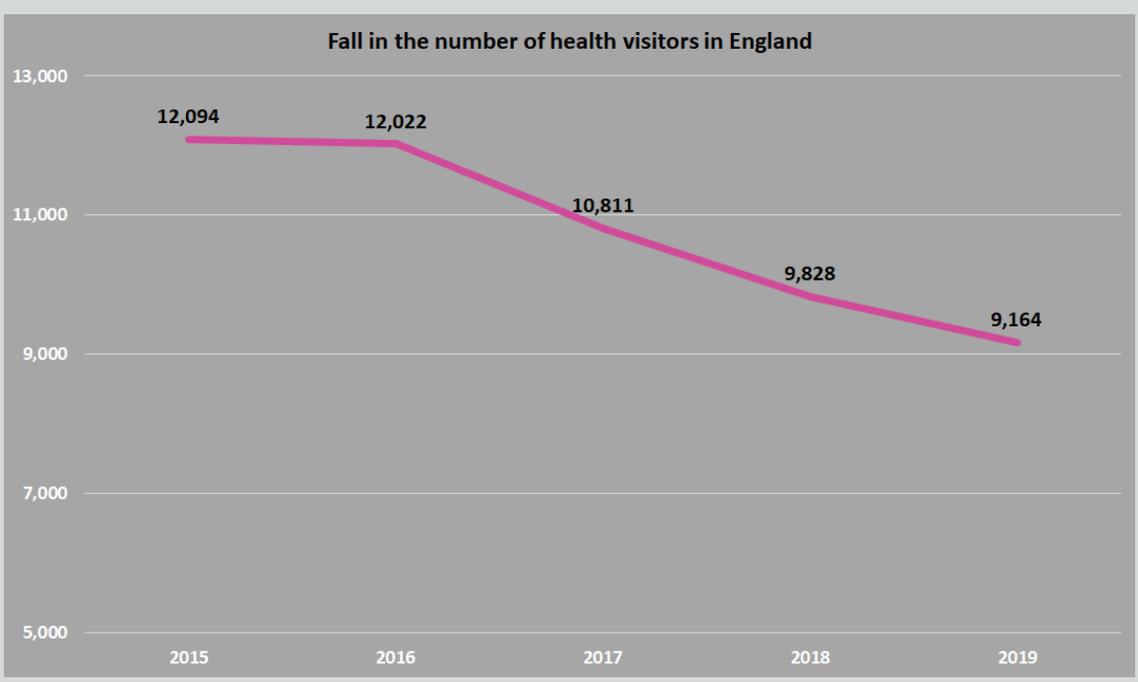
Health visitors also told us that collaboration with wider healthcare services had also reduced in recent years with 35% of health visitors reporting limited liaison with NHS services e.g. midwives, CAMHS, A&E and paediatricians.

The findings from our 2019 survey indicate a deterioration in some service quality indicators reported by health visitors since 2015. This is despite the mandate on local authority commissioners to maintain or improve on service delivery from the point of transfer from NHS commissioning in 2015.

2.2 Workforce-related findings

Key to delivering an effective, quality service is a well-trained professional workforce in sufficient numbers that is well motivated and supported to provide a personalised public health approach to families with young children. We have outlined in Section 2.1 above, the increase in health visitors' caseload size due to service cuts. This is due to the fall in the numbers of health visitors in England since 2015[8], see Figure 7 below.

*Figure 7. Fall in the numbers of health visitors in England since 2015**



*Taken from the Hospital and Community Health Services (HCHS): Nursing and Health Visitor Staff by level in NHS Trusts and CCGs in England, March 2010 to March 2019, Headcount

N.B. The way that health visiting numbers are calculated in England is not straightforward. Currently data is collected in two national datasets[9] [10] which include the numbers of health visitors working in the NHS and those recorded as employed in independent healthcare providers. However, Public Health England have recently confirmed to the iHV that these datasets are incomplete and their most recent analysis (November 2019) shows an **18.6% fall in numbers of full time equivalent health visitors** in post from a peak in September 2015 to June 2019. This fall in the number of health visitors is about **twice the size of the reduction in spend** as reported by LAs on all 0-5 services.

Six years ago, one of our health visitor respondents said:

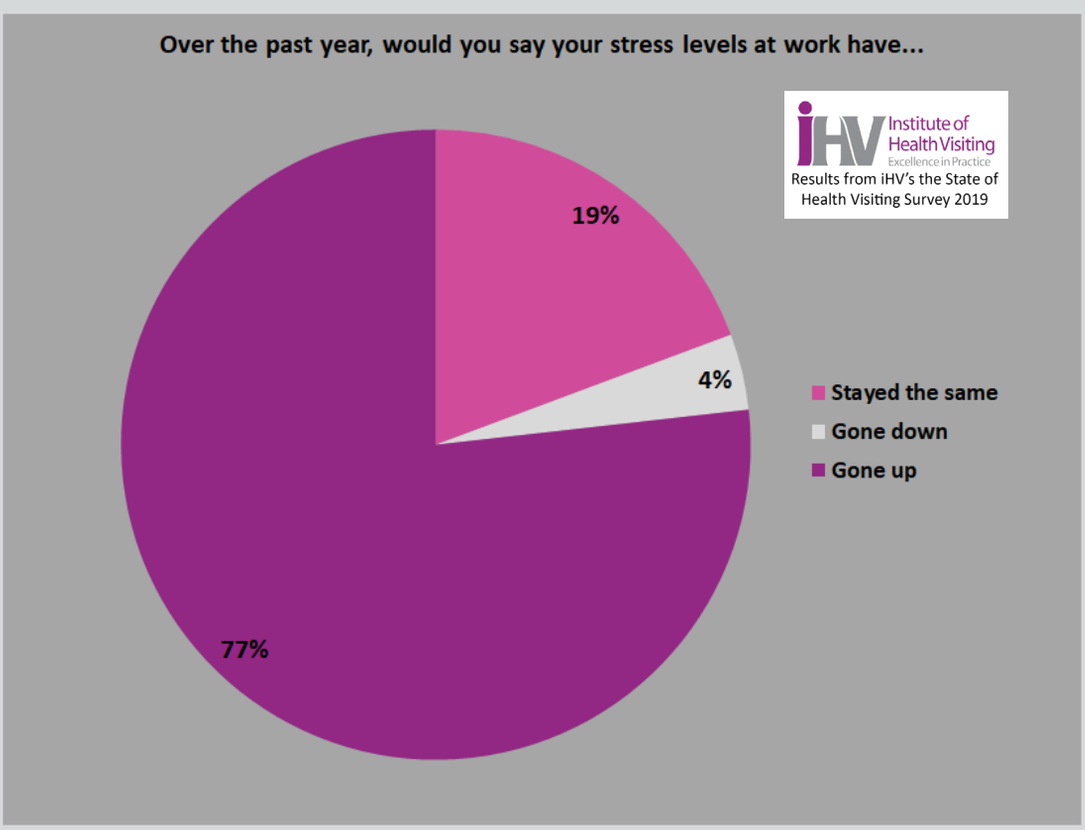
> *"I had imagined retiring this year. I have always been one for planning my career, I usually think in cycles of five years. They have rarely delivered what I had expected and the same goes for now. There is no way I'm leaving my health visiting career just as things have become so exciting!"*

Our most recent survey provides evidence that the promise that motivated a profession and mobilised the workforce with renewed energy during "The Health Visiting Implementation Plan: A Call to Action"[11] has not always turned out as expected.

In our survey, we asked several questions about the impact of the organisational context of practice and delivering care on the health visiting workforce. Our survey indicates that it is not only a matter of numbers, but of personal and professional impact on health visitors who report distress and concern about the risks to which 'hidden' vulnerable children and families are exposed and how many are left unsupported.

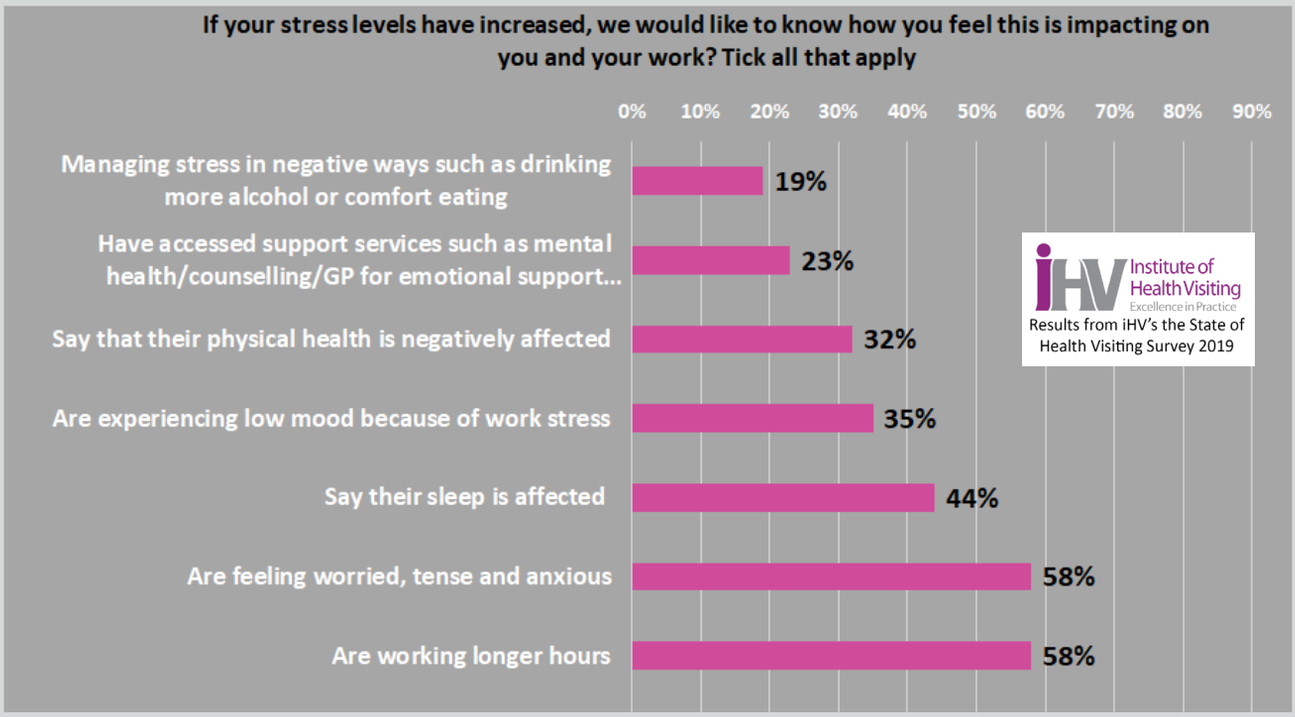
2.2.1 High levels of personal stress

Figure 8. How HVs reported levels of stress have changed



These reported levels of increasing work-related stress are particularly worrying and are reflected in recent NHS staff surveys. It is particularly unacceptable that almost one in four health visitors told the Institute that they were having to access GP or other services for their mental health due to work-related stress. Furthermore, that almost one in five reported managing their stress in negative ways such as comfort eating or drinking alcohol, see Figure 9.

Figure 9. Outcomes for health visitors as a direct result of stress at work



"All of the above apply to me. Working outside my hours to get the basic documentation and reports completed".

"Yes, I have had to be off work for 5 months due to stress which impacted on my mental health. I was juggling a heavy caseload, safeguarding, covering skill mix work, I had a student who was not progressing, I had to attend suicidal call outs to families, I have been attacked at home visit on domestic abuse family, I deal with lots of families with mental health problems, I have often stayed late at work, waking up at night writing records and doing visits on my days off to cover the workload. My colleagues are suffering the same. Staff are leaving. In the end I was not sleeping as I was so worried, I was going to miss something on my caseload… We need to find better ways of getting managers to understand that health visitor's work is being taken for granted and the emotional impact of that work is being paid "lip service" to. I had counselling and was helped to understand that systems are failing health visitors" – skill mix staff do not feel supported and are leaving too".

"I am exhausted. I am working so hard to try and do the best for my families in need, but at the expense of my own family. I missed my son's sports day because I had a child protection conference to attend for a child I was incredibly worried about… my son said, 'Don't worry mummy, I know it's because there are children who need you more than we do' – this is not ok".

2.2.2 Professional impact of stress

In addition to this personal impact, health visitors reported that workplace stress had an impact on their work:

51% report feeling demotivated.

24% struggle to concentrate at work.

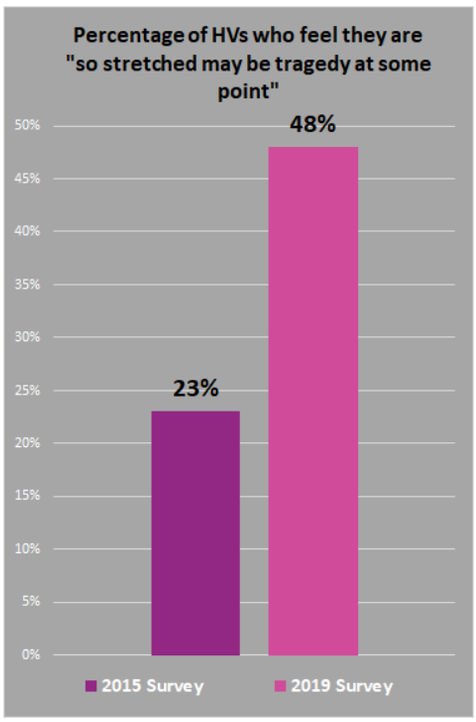
11% have had more sickness/time off.

36% say that they would leave health visiting if they could.

When asked 'How confident do you feel that children are being sufficiently safeguarded locally?'

33% told us that they 'worry that they can't quite do enough'.

48% A massive 48% felt they were so 'stretched and there may be a tragedy in their area at some point'. (24% in 2015).



"I have taught myself to become numb to what is happening within health visiting as a coping mechanism".

"Stress levels have decreased as I left health visiting job where I was becoming unwell because of the job pressure and no leadership or management in place. The job I am in now couldn't be more different".

"I am leaving to do other nursing work in the NHS".

2.2.3 Sources of support

It is well documented that lone workers such as health visitors who frequently have to manage very stressful situations and have personal responsibility for decision making require supportive structures around them to help minimise the personal impact of this. The most common support is the provision of clinical supervision. We were told that only 51% of health visitors responding to the survey received clinical supervision, with only 51% receiving specific child protection supervision.

52% 52% of those offered it reported that it was not always possible to make time to attend their scheduled sessions.

70.3% reported that their primary source of support was informal support from colleagues sharing an office (unfortunately this support has been lost for the over 10% who are now mobile working).

62% 62% reported that they received the support they needed from family/ friends.

"At work we are about to embark on restorative supervision, this may assist, although I don't feel very confident. I have supportive colleagues, but we are not constructive in directing our concerns and this results in general moaning which isn't productive. I feel that the current demands at work are unsustainable in the long term. The rate at which [vulnerable families] are allocated makes it stressful to keep abreast of! Over the past 2 years I have seen many colleagues take early retirement and the organisation has been unable to recruit at the same rate as staff leave".

"I now get regular supervision and I truly believe the lack of meaningful supervision in my previous HV post is one of the main reasons I left".

2.2.4 Working conditions - Professional isolation

Whilst mobile and 'agile' working is increasingly becoming the norm for many health visitors, health visitors reported that the conditions under which this is implemented often affects the level of personal and professional support that comes from face-to-face contact with colleagues:

"This organization gave us laptops so that we can just pull into a layby to do our records, Yes, carry all your kit with you, don't start and finish at base, don't talk to colleagues – just keep meeting your targets".

"We are employed by a social enterprise that can no longer afford to continue to run the service and will shortly go into another organization. It feels insecure and money driven. Working conditions are becoming less satisfactory with hot-desking and desire to move teams to cheaper office space, making working life unpleasant. Laptops and IT are seen as the solution to the issue, but it creates its own problems such as people taking more work home, less "teamwork" and more individualized work patterns which reduce team support".

The above reports of the lived-experience of frontline health visitors mirror the impact on service quality as indicated by the iHV survey of parents' views of health visiting, published in January 2020.

2.2.5 Training places

A graph in Appendix 2 demonstrates a significant reduction in the number of training place for student health visitors since 2015.

4% Only 4% of respondents thought there were enough training commissions.

68% told us that there were not enough training commissions.

17% told us that available commissions were not being filled.

3.0 Conclusion

Since 2015, local authorities have been expected to secure continuous improvement in the health visiting service, with a level of flexibility to ensure that services were responsive to local needs. At the heart of the plan was improved access, experience and outcomes for all families. Whilst there was logic to some restructuring/integration to support the health visiting service fitting in with other local authority children's services, what hadn't been anticipated was that, due to the policy of localism, the profession would face a wide variation in restructuring decisions and levels of budgetary cuts across the country.

Our survey results over this period of time indicate how the reductions in funding to local authorities have thwarted policy intentions. The number of health visitors in the workforce has fallen and continues to fall. Moreover, while parents report how much they appreciate and benefit from health visitors, they also describe their disappointment at lack of access and continuity of the support from a known, trusted professional. Health visitors themselves describe in detail their professional concern at the impact of service cuts on the service they can offer and their personal distress as they carry risk for vulnerable families and unsustainable workload pressures. In 2015, 42% of health visitors felt it made sense to be integrated with other public health services, but by 2019 that had fallen to just 18%.

In short, there is a predictable and significant deterioration in the quality and quantity of health visiting provision in many areas of England with considerable unwarranted variation in the level of service that families receive, dependent on where they live rather than their level of need. Yet this is not inevitable. Political and professional goodwill and commitment can reverse and recover the lost vision of continuous improvement in the health visiting service, providing the key actors nationally and locally take action.

The current situation must not be allowed to deteriorate further. With the UK poorly positioned in the league tables for child health in Europe and the developed nations, there is much to be concerned about.

The Institute is now calling for greater collaborative working with GPs and the NHS to provide a much more integrated and seamless system delivering against the evidence for positive health improvements for children and families. It could be that Primary Care Networks will provide a vehicle to 'think differently'.

4.0 Recommendations

We set out key recommendations to address three urgent priority areas to:

- improve the quality of health visiting practice;
- build capacity and capability within the workforce; and
- provide sustainable funding to ensure every child and family has access to a high quality, evidence-driven health visiting service with support based on their level of need, rather than where they live.

Our recommendations build on those set out in our iHV 'Health Visiting in England: A Vision for the Future' around these three related issues:

Funding:

1. A radical shift in government policy is needed to provide sustainable funding for prevention and early intervention services for children in England. All government departments who accrue the benefits of an effective health visiting service should collectively commit to support immediate investment back into public health with pooled ring-fenced budgets for high quality health visiting services with protection into the future.
2. Dedicated funding needs to be supported by formal commitments between PHE, DHSC, NHSE and local government to overcome current fragmentation at the strategic level to support an effective child and family public health service led and delivered in the early years by health visitors.
3. Restoration of the Public Health Grant to levels sufficient to provide professional heath visiting service to lead and deliver the Healthy Child Programme (currently under review) and reflecting the cross-departmental benefits realisation for key policy issues in health, education, social mobility and cohesion.

Workforce:

4. Urgent action is needed to reverse the current decline in the health visiting workforce. As we await the refreshed Healthy Child Programme, as an interim measure, the proposed metric should be a floor of 12,000 WTE to restore the workforce to the target figure calculated for the Health Visiting Implementation Plan, 2011-2015.
5. Workforce modelling will be needed to establish workforce requirements to deliver the refreshed Healthy Child Programme and all levels of the health visiting service offer. This should include current work demands, as well as essential and desirable work that is currently not completed, for example, reaching and supporting 'invisible' children and their families. Due to the lack of capacity within the current workforce, a workforce plan will be needed to build capacity to implement the recommendations in full.
6. 'Safer staffing' methodology and metrics should be developed equivalent to those for nursing in the NHS but applied to child and family public health, drawing on work in progress in the devolved administrations.
7. The ambitions of the NHS People Plan should be applied to the health visiting workforce with a national health visiting workforce strategy to strengthen leadership, provide opportunities for career progression and address high levels of sickness, recruitment and retention difficulties. A plan for health visitor training, which takes account of the proposed new standards being developed by the NMC is needed. This should include a risk assessment for the implementation of the Apprenticeship Standard and training funded via the Apprenticeship Levy.
8. Consolidate and improve the quality of centrally-held data on health visiting workforce numbers. This should include all publicly-funded health visitors, student health visitors and members of the skill-mix health visiting team (differentiated by grade and qualification) employed in NHS and non-NHS organisations, including local authorities.

9. Data should be collected from all local authorities to determine the ratio of health visitors to the 0-5 population for which services are commissioned using metrics including Indices of Multiple Deprivation (IMD) and other factors such as rurality. The ACRA (2015)[12] proposed formula for 0-5 children's public health should be refreshed and applied to funding.

10. To address current workforce gaps, career paths towards and beyond registration as a SCPHN (health visitor) should be prepared and promoted including Apprenticeship, preceptorship and further post-qualifying professional learning and development. More rapid graduate entry to end-point qualification as a nurse / SCPHN-HV should be developed as an attractive career option. Safe and effective practice should be underpinned by an entitlement to skilled professional supervision with a restorative function.

Service quality:

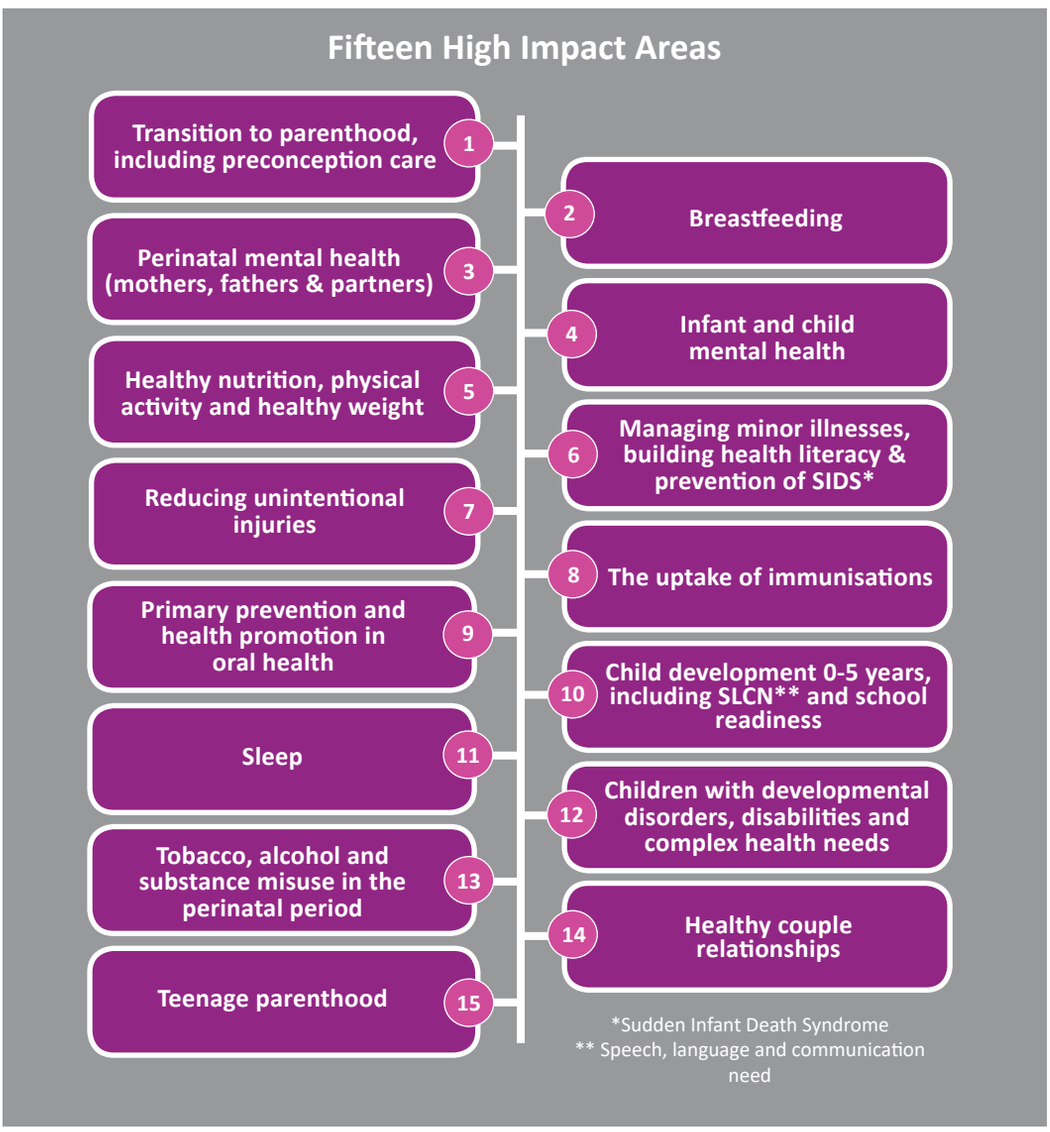
11. Government should develop and set high level goals for children's population health and an outcome measure for integrated care, with a clear line of accountability between national goals, ambitions or targets and regional and local systems. To drive quality improvement and reduce unwarranted variation, this requires a shift away from the current emphasis on process outcome measurement and benchmarking against a historical baseline at point of transfer in 2015. Services need to be focused on the outcomes that matter to the people who use the health visiting service which should be easy to access, based on best evidence, and built around the needs of children and their families.

12. A Healthy Child Programme oversight function at national and local level should be established which includes workforce standards, training and development of staff at all levels with access to HEE CPD monies.

13. Support a quality service through a more broadly based quality specification, extending the Government's ambition to ensure continuity of practitioner and personalised care within maternity services to include the midwifery-health visitor transfer and continuity of health visitor from the antenatal review to school entry.

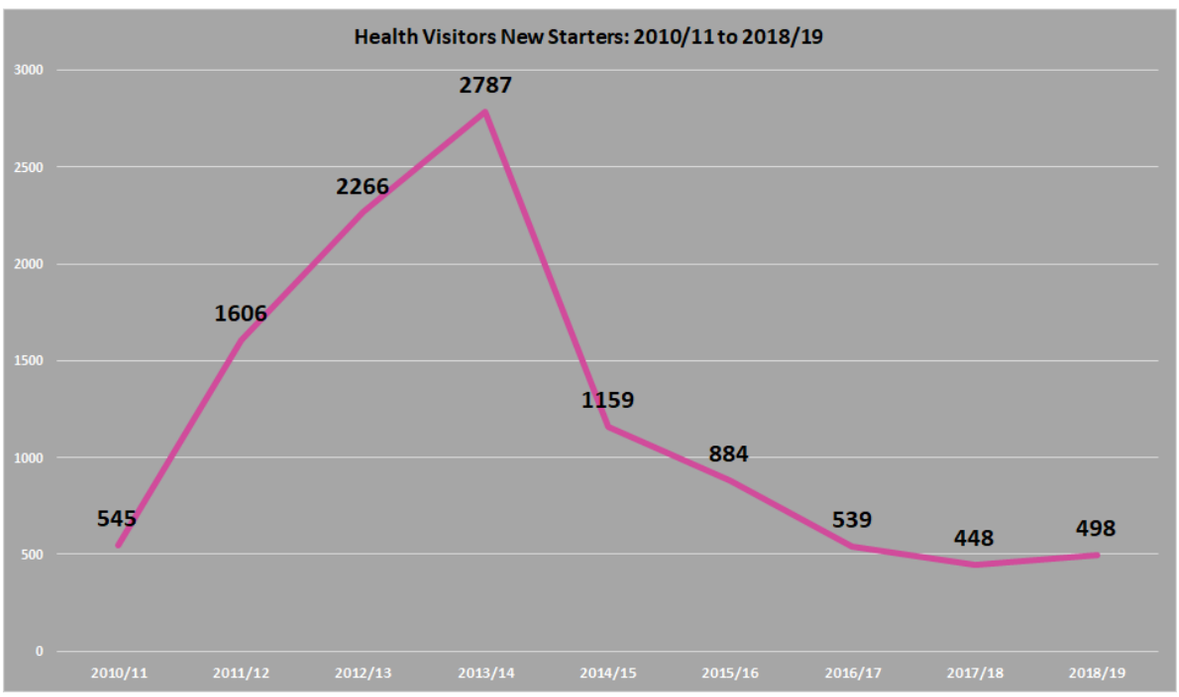
14. Employer standards for health visitors and health visiting teams should be reviewed and refreshed within new clinical governance structures and integrated within Sector-Led improvement. Establishing best practice in delegation and supervision of skill-mix staff is needed to support delivery of the HCP, including the role of the Nursing Associate.

Appendix 1: Fifteen High Impact Areas delivered by health visiting services



Appendix 2: Reductions and risks to student health visitor training

Health Education England figures show the number of health visitors who started training from 2010. Following the Health Visiting Implementation Plan[13], there was an immediate fall in student health visitor training places. The number of entrants for training in England has significantly reduced from **2787** in 2013-14 to **448** in 2017-18.



Integral to this plan was 'sustainability', but this has not been realised. There has been a 31.8% reduction in health visitors in England's NHS, from 10,309 FTE in October 2015 to 7,026 FTE in June 2019. Most recent published data from the Independent Health Care Provider Workforce Statistics shows a reduction of 13.5% from 1,240 at its peak in 2017 to 1,073 in the latest data reported for March 2019.

There are further risks to the workforce 'pipeline' from the prospective introduction of an Apprenticeship approach to funding health visitor training that does not support salary costs presently supported by Health Education England and that are not factored into local authority contract budgets. This and other risks concerning roll-out of this new funding mechanism require an urgent risk assessment and support for implementation of transition.

Appendix 3: Survey responses

The Institute of Health Visiting circulates its State of Health Visiting survey every year in October/November.

The survey is electronic and hosted by the Survey Monkey software. It is widely circulated to members and other health visitors with a total reach of over 9000 individuals across the UK. Whilst managers, educationists and other health visitors not directly in practice are encouraged not to take part, invariably some still do - these are removed from the dataset and the analysis focuses solely on the experiences and feedback from frontline practice. This year, the final number of respondents included in the analysis was 1040 of the 1209 responding.

Where do you currently live?	%
East of England	**6.09%**
East Midlands	**5.96%**
London	**12.67%**
North East	**5.59%**
North West	**14.41%**
Northern Ireland	**0.37%**
Scotland	**0.50%**
South East	**19.38%**
South West	**9.44%**
Wales	**0.62%**
West Midlands	**6.71%**
Yorkshire and the Humber	**14.53%**
Outside of UK	**0.50%**

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4 Health and Social Care Committee (2019) First 1000 days of life. House of Commons. https://publications. parliament.uk/pa/cm201719/cmselect/cmhealth/1496/1496.pdf

5 Public Health England Health Visitor Service Delivery Metrics (experimental Statistics https://www.gov.uk/government/statistics/health-visitor-service-delivery-metrics-2019-to-2020)

6 The Point of Care Foundation (2019) Impact Report 2019 https://s16682.pcdn.co/wp-content/uploads/2019/10/PoC_ImpactReport_2019_DigitalA4Landscape_FINAL_3.pdf

7 Public Health England (2018) Healthy child programme 0 to 19: health visitor and school nurse commissioning https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning

8 NHS Workforce Statistics (2019), Hospital and Community Health Services (HCHS): Nursing and Health Visitor Staff by level in NHS Trusts and CCGs in England, March 2010 to March 2019 https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

9 NHS Workforce Statistics: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

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11 Department of Health (2011) Health Visitor Implementation Plan 2011–15 A Call to Action. https://www.gov. uk/government/publications/health-visitor-implementation-plan-2011-to-2015

12 Department of Health (2015) Public Health Grant: proposed target allocation formula 2016/17 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/468964/1_Public_Health_Grant_-_Proposed_Target_Allocation_Formula_2016-17_-_amended.pdf

13 Department of Health (2011) Health Visitor Implementation Plan 2011–15 A Call to Action. https://www.gov. uk/government/publications/health-visitor-implementation-plan-2011-to-2015

Endnotes

a The value of the public health ring-fenced grant has reduced from £3.388 billion to £3.134 billion which is a reduction of 7.5% from 2016/17 and 2019/20. PHE report that the actual spend for the same time period equates to a 9.1% reduction in the same time period. As the bulk of the spend is on workforce, these reductions will impact on workforce numbers and HV caseload size.

b In reality, health visiting is a universal service and the health visitor, under her NMC registration remains accountable for all the children on her caseload and should be able to make professional decisions regarding which children are delegated to her skill mix team who should still report back to her.

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