Institute of Health Visiting
Excellence in Practice

Understanding the rise in 0-4-year-old Emergency Department (ED) attendances and changing health visiting practice

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Contents

This report forms part of a suite of resources produced through a programme of work led by the Institute of Health Visiting. The ultimate goal is to strengthen health visiting services to ensure that all families with babies and young children are able to access the right support at the right time, to increase their confidence in managing minor childhood illnesses in the community and reduce the growing pressures on Emergency Departments. Four supporting documents are presented as standalone appendices:

Appendix 1: A narrative summary of literature exploring the health visitor's role in supporting parents with babies and young children with minor illnesses.

Appendix 2: Hampshire case studies (A&B) - Supporting and improving parental confidence in managing minor illnesses.

Appendix 3: ChatHealth case study - Boosting literacy and care: digital parental support via ChatHealth messaging.

Appendix 4: An analysis of a randomly selected group of 100 infants under 12 months old who attended Northwick Park Emergency Department, North West London.

The Institute of Health Visiting (iHV) is an independent charity, professional body and Centre of Excellence - established to strengthen the quality and consistency of health visiting practice, so that health visitors can effectively respond to the health needs of all babies, children, families and communities enabling them to achieve their optimum level of health, thereby reducing health inequalities.

Acknowledgements:

This report was written by the Institute of Health Visiting and is the product of rich collaboration with leading paediatricians and experts in this field to explore an area of shared concern.

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The case studies in the appendix were written by Chat Health, Professor Mitch Blair, Dr Aditya Garg and Dr Sanjay Patel.

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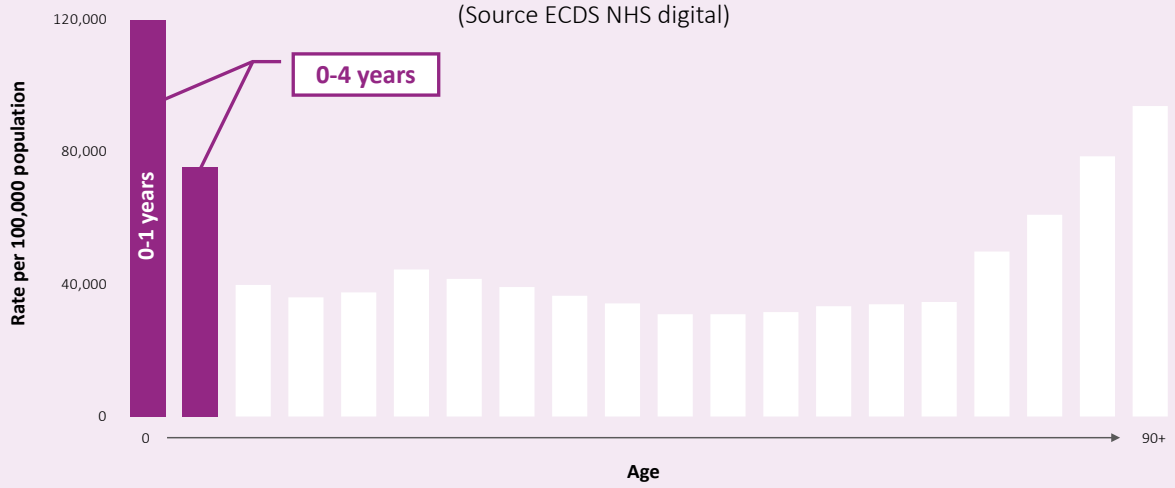
Executive Summary

Emergency Department (ED) attendance rates in children aged 0-4 years reach an all-time high:

- Nearly **2.6 million** children aged 0-4 years attend ED every year, with **rates increasing by 42%** in the last 10 years[1,2].
- Compared to all other age groups, **babies under one have the highest rate of ED attendance**.
- The number of children who attend the ED and do not require investigations, treatment or hospital admission is increasing nationally.

England ED attendance by age 2022 – 2023
(Source ECDS NHS digital)



Addressing soaring rates of ED attendance is a national priority[3].

- Too many patients are waiting too long in overcrowded EDs up and down the country.
- A focus on prevention and meeting people's care needs outside hospital is an important part of the NHS Urgent Care Recovery Plan – this needs to include children aged 0-4 years.
- Across the whole population, 20% of emergency admissions are potentially avoidable with the right care in place[4].
- **The rate of potentially avoidable ED attendances is much higher in babies and young children** - in North West London, a review found that 59% of babies who attended ED did not need investigations, treatment, or hospital admission and were sent home after reassurance – **costing an estimated £1.8 million per year** in this once area of London alone.

The most common presenting conditions for 0-4 ED attendances are:

- Upper respiratory tract infections (cough/colds)
- No abnormality detected (nothing was found to be wrong)
- Tonsillitis (inflamed tonsils)
- Gastroenteritis (sickness and diarrhoea)
- Bronchiolitis (a common chest infection)

Parents do not take the decision to attend the ED lightly:

Factors that influence parental decisions to attend ED:

Parents want peace of mind, the need for reassurance on:

- The severity of their child's symptoms/ to rule out a serious illness
- The best course of treatment for their child's symptoms
- To avoid being judged for "doing the wrong thing"

First-time parents are more likely to attend ED as they learn to manage common childhood illnesses.

Geographical location – Those who live close to hospitals and in deprived, urban areas are more likely to make frequent visits to the ED.

Those with **lower health literacy** were more likely to seek care immediately.

Those with good **support networks**, with people to turn to for advice, had greater confidence around managing their child's illnesses.

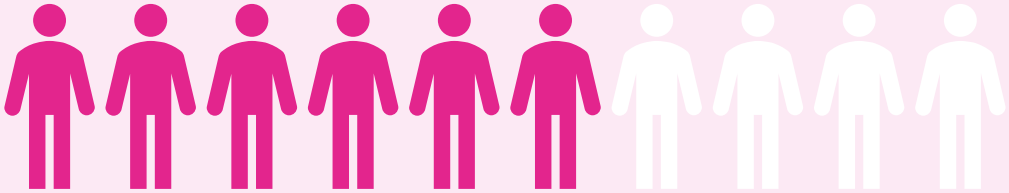
Access to services – lack of accessible alternative support in communities can be a driver for ED attendance. Parents wanted their baby/ young child to be seen in person.

Health visitors are an important part of the solution:

- Supporting parents to manage minor illnesses is a central function of health visiting. Health visitors are often parents' first point of contact when they are concerned about their child's health, providing a **trusted source** of advice and support.

However, there is an estimated national **shortage of 5,000**[5] **health visitors in England** and the Public Health Grant that funds the service has been **cut by £1 billion** since 2015[6].

- Despite health visitors' best efforts, families are getting less support now as there aren't enough health visitors to meet the scale of need.
- Health visiting drop-in baby and child health clinics have closed or been scaled back in many areas, in recent years, and more parents are turning to the ED for help with minor childhood illnesses.
- These cuts are a false economy as they put pressure on other services including EDs - families need access to health visiting support in the heart of their communities.



40% fewer health visitors in England

Policy recommendations:

1. **The Government's Delivery Plan for Urgent and Emergency Care Services needs to include a plan for babies and young children as ED attendance is highest amongst the youngest.** Reducing pressure on urgent care requires a national plan, with funding that extends beyond the NHS to address the needs of families with babies and young children through prevention and by expanding services in the community.

2. **Mechanisms are needed to support better integration of local services to reduce pressure on EDs. Integrated Care Systems provide opportunities to strengthen clinical pathways that extend beyond the NHS to include health visiting and other community services.** This includes better national and local policy 'join-up' between Family Hubs, the NHS and community services with shared priorities to include supporting babies' and children's physical health needs. Services need to be co-produced with families and built around their needs. There is no single solution – a range of options will be needed to address the different needs of different families, particularly those who have the highest rate of ED attendance.

3. **Investment in health visiting is needed to ensure that all families with babies and young children can access the full offer of health visiting support set out in the National Health Visiting Model for England and the Healthy Child Programme.** 5,000 more health visitors in England are needed to achieve this, with the required investment in the NHS Long Term Workforce Plan's priorities to "train, retain and reform" to build workforce capacity and capability. Investing in health visiting will provide families with more health visiting support to confidently manage minor illnesses and improve their health literacy, alongside the reinstatement of health visitor baby and child health clinics to increase the accessibility and visibility of support in the heart of communities.

4. **A national model of effective practice is needed to reduce ED attendances in children 0-4 years with relatively minor and self-limiting conditions. This model should support local Integrated Care Systems to improve prevention and early intervention through health visiting services and maximise digital solutions.** One model under consideration would be the Healthier Together model (see Appendix 2), which provides: simple and easy to navigate resources including prominent risk assessment information while in contact with NHS and health visiting services; key messages reinforced with digital solutions; and training to improve communication by health professionals to reassure and empower parents. Local evaluation found that when parents received consistent, explicit safety-netting advice from a health practitioner, they were less likely to re-attend and the model is currently being rolled out across an increasing number of NHS regions.

5. **Further research is needed to**:

    - Evaluate health visiting baby and child health clinics, including the impact that different models (drop-in, or appointment only) have on the identification of need or the improvement of outcomes (comprising access, experience, child/ family health indicators, the reduction of inequalities, and wider system benefits including impact on ED attendance rates for children aged 0-4 years).
    - Examine how health visiting skill mix teams operate and the impact that different levels of staffing have on the identification of need or the improvement of outcomes (comprising access, experience, child/ family health indicators, the reduction of inequalities, and wider system benefits including impact on ED attendance rates for children aged 0-4 years).

1.0 Introduction

This report presents the findings from a rapid review to understand changing Emergency Department attendance rates in children aged 0-4 years, alongside changes in health visiting practice to support parents to manage minor illnesses in England.

Tackling increasing demands on urgent care services is a national priority[7] as too many patients are currently waiting too long in overcrowded EDs across the country. This review was undertaken due to heightened concerns about ED attendance rates for children aged 0-4 years which have continued to increase year-on-year (with the exception of the first year of the pandemic) for more than a decade[8]. It sought to understand the reasons for this trend and the role that health visitors provide as part of the solution through their 'upstream' work in prevention and early intervention to manage minor childhood illnesses in the community.

The review was completed by the Institute of Health Visiting (iHV), in partnership with paediatricians in three large Emergency Departments in England, using mixed methods including: reviews of national and selected local ED attendance data; a narrative summary of literature; and a national survey of health visiting practitioners. Case study examples are presented as appendices to provide more granular detail on the topics of enquiry and to showcase health visiting initiatives to support parents to manage minor childhood illnesses.

The review is focused on England, due to ongoing concerns about the wider impacts of significant health visiting workforce shortages across the health, education and social care system. However, it is anticipated that the findings will provide considerable transferable learning for policymakers and providers of health visiting and urgent care services in other UK nations.

2.0 Background and context

ED attendance rates are influenced by a range of factors including access to services as well as families' needs[9]. The health visitor's role in the management of minor illnesses and supporting parental health literacy is well described in UK health visiting policy[10,11,12,13]. However, in recent years, health visiting services in England have experienced falling workforce numbers[14,15] and cuts to the public health grant that funds the service[16]. This has led to significant health visitor workforce shortages and changes to the level of support that services are able to offer to families. There is an estimated workforce shortage of about 5,000 health visitors[17]. Consequently, access to a health visitor is much more limited, with a wide postcode lottery of health visiting support[18] and many drop-in health visiting health clinics have closed. The situation has been further exacerbated by the rising levels of need experienced by babies, children and families due to the impacts of the COVID-19 pandemic and the ongoing cost-of-living crisis[19].

When adequately resourced, health visitors can provide help and support to all new parents on a range of common minor illnesses, as well as providing proactive 'anticipatory guidance' through their universal reach to all families. Managing minor illness and reducing accidents is one of the six High Impact Areas for health visiting in England[20]. This policy sets out that health visitors should be:

> *Accessible to all parents and provide a trusted source of knowledge, advice and information, and are often the first point of contact for parents who are unsure on the best course of action when their child is unwell. They can support families to be more confident increasing parental self-efficacy and empowering the family to make the changes required to improve home safety. Health visitors play an important role in the primary care team and can help to reduce unnecessary visits to emergency departments and pressure on primary care. If a child sustains an unintentional injury, the health visitor can follow up this attendance to offer preventative solutions, which could prevent further or repeat attendances.* (OHID, 2021)[21]

The Government's Start for Life Vision has also listed health visitors as one of six essential services in the early years and has pledged to ensure that the Start for Life Vision and associated Family Hub programme delivers '***rapid and visible support***' for families[22,23]. However, since the Start for Life Vision was announced in March 2021, there has been a further loss of 1,257[24,25] full time equivalent (FTE) health visitors in England.

Health visitors provide an important part of the solution to address rising ED attendances in children aged 0-4 years. Concerns have been raised about increasing demands on urgent and emergency care services in England for more than a decade[26,27,28]. The Royal College of Emergency Medicine[29] summarised why this needs urgent attention in a recent report, stating that "too many patients are in the wrong place for their needs, and this creates inefficiency, waste, poor patient experience and avoidable harm."

In January 2023, following what was described as a "perfect storm of pressures" with long ED waiting times, NHS England set out their Delivery Plan for Urgent and Emergency Care Services as a national priority[30]. The Plan sets out key areas for action focused on addressing pressures in adult social care, increasing capacity in hospitals, improving discharge, supporting paramedics, and expanding services in communities (mostly focused on joined-up care for older people, with 'virtual wards')[31]. Much of the plan is focused on adults not babies and children, reflecting a "baby blind spot" that is prevalent across other policy areas[32]. Action to address soaring ED attendance rates for babies and children is also needed because they are high users of the ED. Nearly 2.6 million children aged 0-4 years attended the ED in the year 2022/23, with rates increasing by 42% in the last 10 years[33,34]. Compared to all other age groups, babies under one have the highest rate of ED attendance[35], with non-urgent attendances being the highest amongst this age group[36]. Analysis shows many of these presentations are avoidable or preventable and will be for relatively minor or self-limiting illnesses and unintentional injuries. It is therefore essential that any plans to reduce pressure on urgent care services also consider the needs of families with babies and young children.

During the winter months of 2022/23, NHS England reported that there had been a 60% increase in children's ED attendance at the height of the 'winter pressures'[37]. During this time period, there were high rates of invasive Group A Streptococcus in Children (iGAS) and, as a result, there was a significant increase in health-seeking behaviour following national alerts[38]. In line with recent research, a high number of these attendances did not result in hospital admission, suggesting that these conditions were relatively minor and could have been managed elsewhere in the health and care system. Consequently, families are experiencing long waits in the ED and not accessing the right care when they need it. This then adds to the 'bottleneck' of patients in the ED, with patients being cared for in hospital corridors. This is not only a worrying experience for patients, but it also creates a tough working environment for staff, impacting on staff wellbeing, retention, and recruitment[39].

When ED working environments are conducive to enabling rapid assessments, clinicians can identify sick children more easily, which can reduce delays in the access of urgent treatment and improve the outcomes of critically ill children[40]. While ED is the right place for very sick infants and young children, improving access to high-quality care in the community could help to reduce ED attendance in babies and young children.

The aim of this rapid review was to gain a greater understanding of the changing trend of ED presentations for children aged 0-4 years. The review also sought to consider the role that health visiting services play in the management of minor illnesses and to gain a greater understanding of how this has changed over time, with implications for national policy.

3.0 Method

A mixed methods approach was used to meet the aims of this rapid review which comprised four parts:

1. **Exploration of how ED attendance rates for children aged 0-4 years have changed over time.** National and local ED data were reviewed. Local ED data were drawn from the following EDs:

   - London North West University Healthcare - Northwick Park Hospital
   - University Hospital Southampton NHS Foundation Trust – Southampton General Hospital
   - University Hospital of Leicester NHS Trust – Leicester Royal Infirmary

   Routinely collected open access data were used with no patient-identifiable information, therefore ethical approval was not required.

2. **A narrative summary of literature exploring the health visitor's role in supporting parents with babies and young children with minor illnesses** (presented in Appendix 1).

3. **A national survey of health visiting practitioners to understand how health visiting services have changed since 2015**, with a focus on parental access to support for health literacy and the management of minor illnesses.

4. **Case studies:** to showcase health visiting initiatives to improve parental health literacy and the management of minor childhood illnesses in the community, and a deep dive into local data to provide more granular detail on the topic of enquiry:

   - Appendix 2 - Hampshire Case Studies A&B - Supporting and improving parental confidence in managing minor illnesses.
   - Appendix 3 - ChatHealth case study - Boosting literacy and care: digital parental support via ChatHealth messaging.
   - Appendix 4 - An analysis of a randomly selected group of 100 infants under 12 months old who attended Northwick Park Emergency Department, North West London.

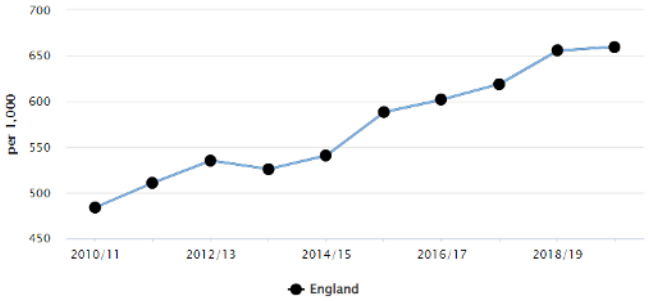
Section four presents a triangulation of key findings from all four components of the rapid review.

4.0 Rapid review findings

4.1 National data

The number of children aged 0-4 years attending the ED in England has risen substantially over time (see Figure 1).

Figure 1: ED attendances 0-4 years in England (source - Fingertips)



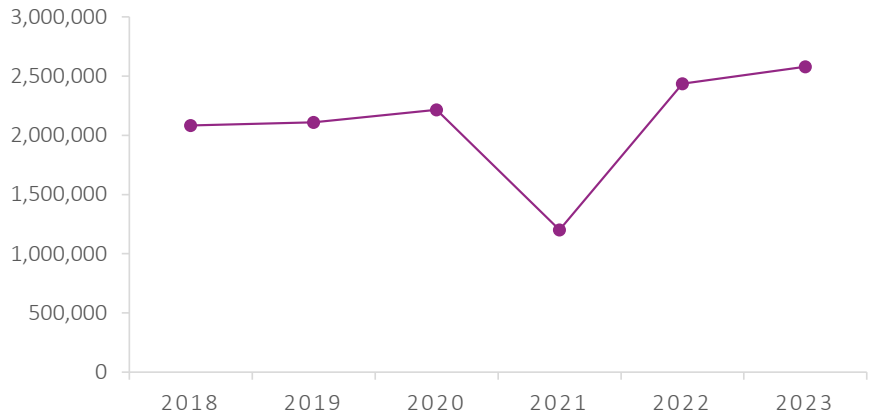
Recent trend: ↑ Increasing & getting worse

Period		England Count	Value	95% Lower CI	95% Upper CI
2010/11	●	1,580,943	483.9	483.2	484.7
2011/12	●	1,700,419	510.8	510.1	511.6
2012/13	●	1,815,823	535.1	534.3	535.9
2013/14	●	1,795,105	525.8	525.0	526.6
2014/15	●	1,855,068	540.7	539.9	541.5
2015/16	●	2,019,926	588.1	587.3	588.9
2016/17	●	2,063,580	601.8	601.0	602.6
2017/18	●	2,095,158	619.0	618.1	619.8
2018/19	●	2,193,044	655.3	654.4	656.1
2019/20	●	2,177,170	659.8	658.9	660.7

Nearly 2.6 million children aged 0-4 years attended the ED in the year 2022/23; with the rates of attendances increasing from 1,815,823 in 2012/13 to 2,577,839 in 2022/23, which equates to a 42% increase in the last 10 years[41,42].

Figure 2 highlights the increase in ED attendance for 0-4s in the last 5 years and also demonstrates a significant drop in ED attendance during the first year of the COVID-19 pandemic. Despite this decrease, the graph shows how ED rates quickly recovered, and are now exceeding pre-pandemic levels.

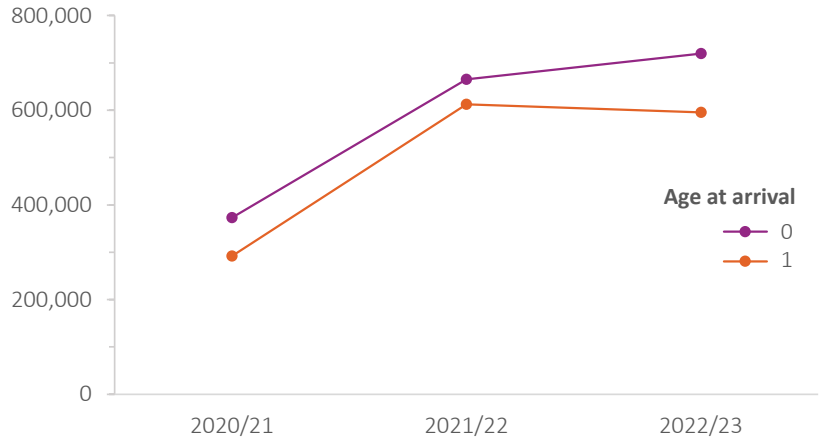
Figure 2: ED attendances in England for children aged 0-4 2017/18 – 2022/23 (Source NHS Digital and Fingertips)



Year	Attendance
2017 - 2018	2,083,036
2018 - 2019	2,110,411
2019 - 2021	2,214,936
2020 - 2021	1,200,815
2021 - 2022	2,435,000
2022 - 2023	2,577,839

The national data show that the attendance rates for 0-1s have also continued to increase in recent years (with the exception of the first year of the pandemic - see Figure 3). ED attendance rates for this age group have now reached an 'all-time-high', exceeding pre-pandemic levels and increasing each year.

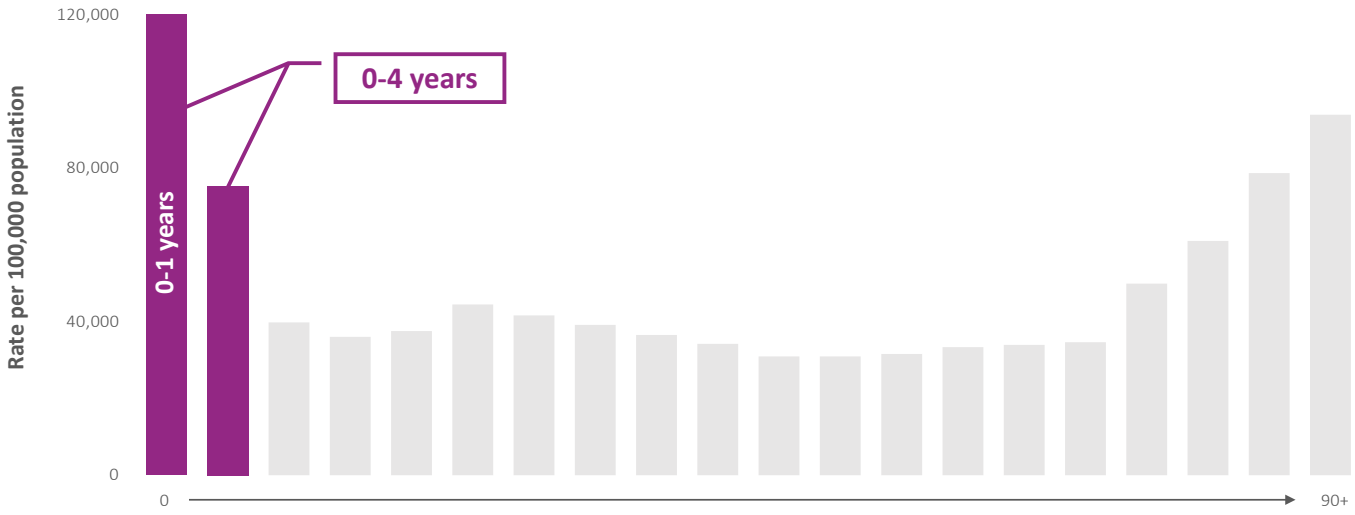
Figure 3: NHSE data – 0-1 attendance at ED (Source NHSE 2023 - CYP Transformation Programme)



Age at arrival	Financial Year	ED attendances
0	2020/21	372,949
0	2021/22	664,973
0	2022/23	719,399
1	2020/21	291,969
1	2021/22	612,435
1	2022/23	595,490

Children aged 0-4 years are amongst the **highest users of ED**, with the under ones being the highest group of any age group to attend the ED (see Figure 4).

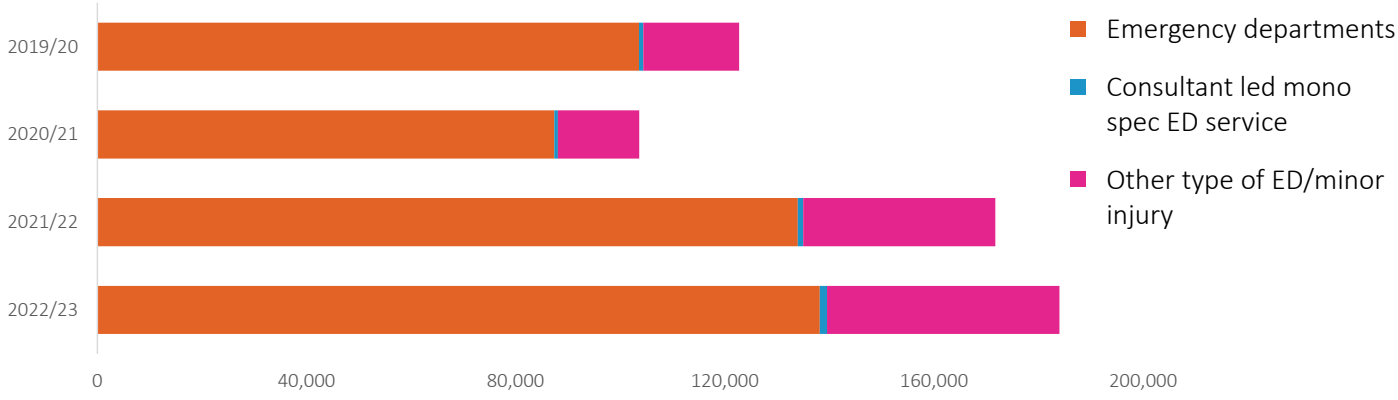
Figure 4: England ED attendance by age. Rate per 100,000 population 2022-23 (Source ECDS NHS digital)



The number of children who attended the ED where nothing abnormal was detected has also risen over the last 5 years (see Figure 5). In line with the overall reduction in ED attendance for 0-4s during the first year of the pandemic (2020/21), the number of children attending with 'no abnormality detected' also temporarily reduced during that year.

Figure 5: NHSE data of the number of children who attended the ED where nothing abnormal was detected (Source NHSE 2023 - CYP Transformation Programme)

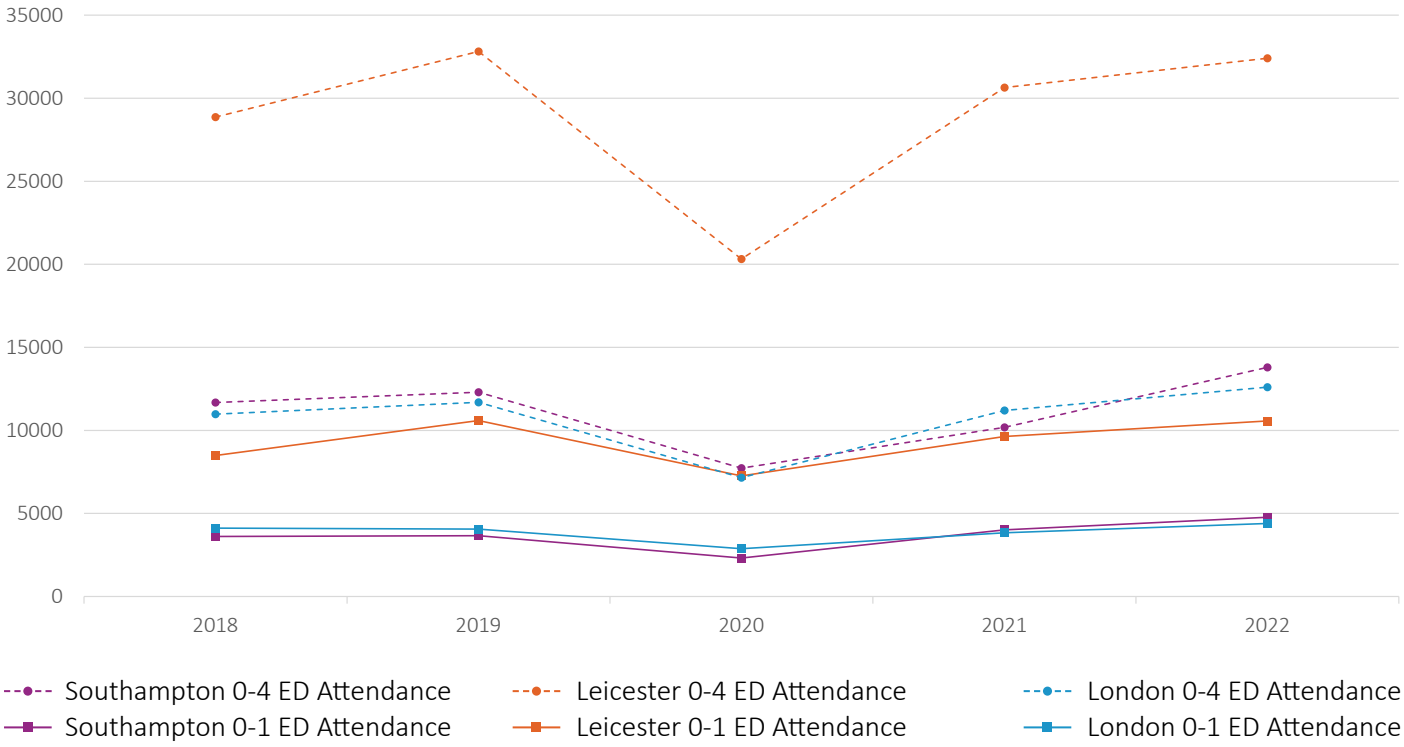
Financial Year	01 - Emergency departments	02 - Consultant led mono spec ED service	03 - Other type of ED/ minor injury	Grand Total
2019/20	103,578	818	18,315	122,711
2020/21	87,398	664	15,583	103,645
2021/22	133,940	1,042	36,719	171,701
2022/23	138,151	1,370	44,437	183,958



4.2 Local data

Local data from three EDs (Southampton, Leicester and North West London) show similar trends to the national picture (see Figure 6). All sites experienced an overall steady increase in 0-4s attending the ED, with a temporary reduction during the first year of the COVID-19 pandemic.

Figure 6: ED attendance for children (0-1 years and 0-4 years): comparisons of local data for Southampton, Leicester and North West London



More detailed analysis of ED attendance rates within 28 days of birth was completed in North West London (NWL). The characteristics of babies and mothers attending the ED were analysed to identify the reasons for attendance and to support the development of effective and efficient ways of reducing variation in health outcomes and experiences across the Integrated Care System. The findings for baby-related ED attendances within 28 days of birth over the three year period (2020-2023) in NWL highlighted:

1. There had been an increase in ED attendances for babies aged 0-28 days.
2. ED attendances within 28 days of birth (for babies born in 2022/2023) are presented in Figure 7. In summary:
    a. 17.6% of babies (of total 28,823 births) attended the ED. Of these, only 22.7% of babies were subsequently admitted.
    b. Variation in ED attendance in NWL:
        i. range across different local authorities was 15.1% - 34.7%
        ii. range across different health boroughs was 16.9% - 34%
    c. Estimated annual cost of these ED attendances to NWL Trusts is £1,298,025.
3. Parent characteristics of babies attending the ED within 28 days of birth:
    a. The majority were babies of first-time mothers (66.5%)
    b. The majority of mothers were aged 25-39 years, and this age group contributed to the highest number of births.
    c. NWL has an ethnic diverse population where 23% of the overall population is Asian/British Asian. The highest rates of attendances were seen in babies from “Other ethnic groups” (25.3%) and “Asian or British Asian” (24.9%) ethnic groups.

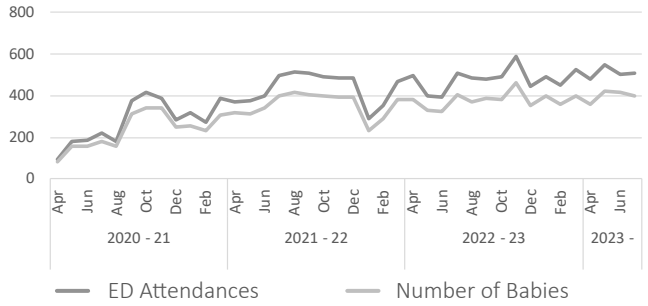
4. Figure 8 also shows how ED attendance is socially driven – the poorest families had the highest rate of ED attendance within 28 days of birth. Looking at the number of babies born in all settings by the parents' deprivation decile, for those babies born in a NWL trust with parents living in NWL or registered to a NWL GP, 75% of babies born in April 22 to July 23 were from parents from Index of multiple deprivation (IMD) groups 1-6 (29,217). Deprivation was unknown for 1.1% of parents whose baby was born in April 22 to July 23 (443) (Figure 8).

Figure 7: NWL Baby ED attendances within 28 days of birth: Summary 22/23. Data Source: MSDS (Maternity Services Data Set), ECDS (Emergency Care Data Set)

The estimated cost is calculated using the average ED unit cost in 22/23 across each provider regardless of HRG multiplied by the activity. The average unit costs: LNWHT - £206, THH - £157, ChelWest - £257 & Imperial - £218.

No. of ED Attendances within 28 days of Birth in 22/23 (ED Attendance Date in 22/23): 6,440 (5,772 to NWL Trust)

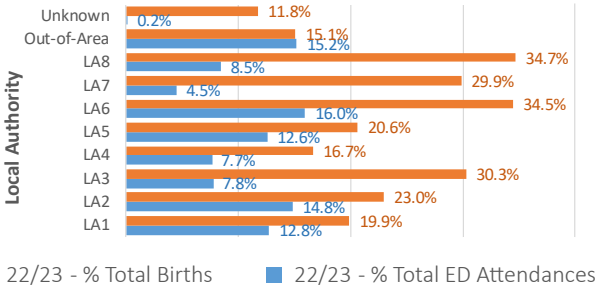
No. of ED Attendances within 28 days of Birth in 22/23 (Birth Date in 22/23): 5,071



Over the last 3years the number has increased, with a peak seen in November 22 (where the ED attendances were in November and the births 0-28days prior)

No. of Babies with ED Attendances within 28 days of Birth (ED Attendance Date in 22/23): 5,100 - 1.26 Ave. Att. (4,557 to NWL Trust)

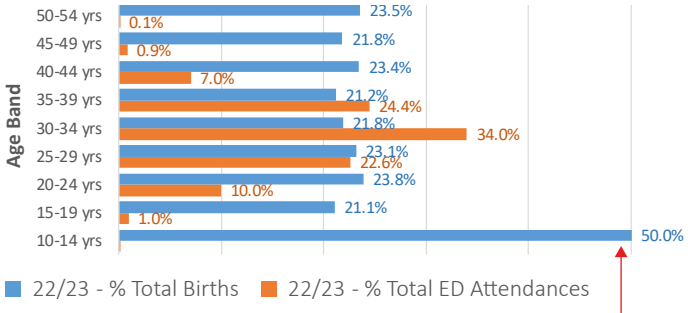
% of ED Attendances within 28 days of Birth (Babies) (Birth Date in 22/23): 17.6% (28,823 total births)



LA6 has the largest % of babies with ED attendances within 28days of birth (blue bar) and is the 2nd largest LA when considering the % of total births (orange bar)

% of Patients with an ED Attendances within 28 days of Birth that were subsequently admitted/ Estimated Cost (ED Attendance Date in 22/23): 22.8%/£1,298,025 (NWL Trusts only)

% of Patients with an ED Attendances within 28 days of Birth that were subsequently admitted (Birth Date in 22/23) 22.7&



As expected, majority of births occur from mothers aged 25-39yrs, which is why the % of total ED attendances is high in these age bands.

This is possibly a data quality issue

The orange bars are the percentage of births in the particular LA, HB or population demographic that result in an ED attendances within 28days post birth

The blue bars represent the population split of the babies with an ED attendance up to 28days age. The blue percentages always add up to 100%.

Examples can be seen below.

22/23 - % Total Births

E.g. Brent LA Percentage = Babies with an ED attendance within 28days of birth for those with mothers living in the Brent LA / All babies born to mothers from the Brent LA

22/23 - % Total ED Attendances

E.g. Brent LA Percentage = Babies with an ED attendance within 28days of birth for those with mothers living in the Brent LA / All babies with an ED attendance within 28days of birth

North West London Integrated Care System

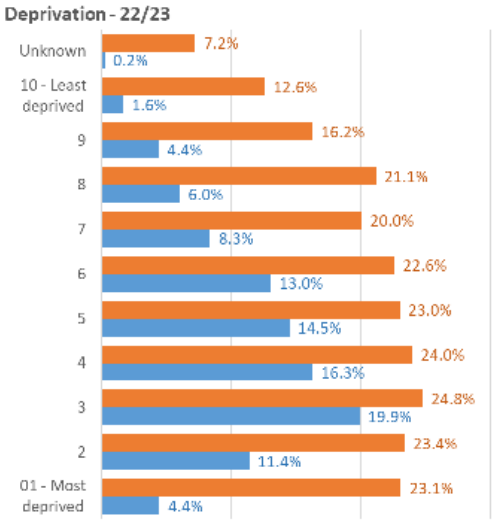
Figure 8: NWL ED attendances 28 days postnatal (Babies and mothers): Deprivation Summary. Data Source: MSDS (Maternity Services Data Set), ECDS (Emergency Care Data Set)

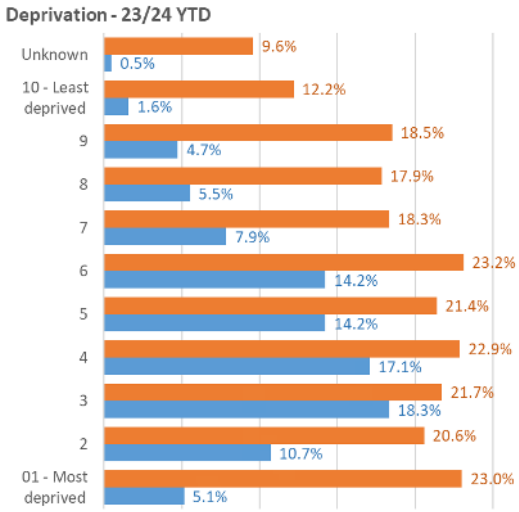
Deprivation Decile: The deciles are calculated by ranking the 32,844 LSOAs in England from most deprived to least deprived and dividing them into 10 equal groups. LSOAs in decile 1 fall within the most deprived 10% of LSOAs nationally and LSOAs in decile 10 fall within the least deprived 10% of LSOAs nationally.

Babies

- 23/24 YTD - % Total Births
- 23/24 YTD - % Total ED Attendances

The greatest percentage of ED attendances within 28-days of birth are from mothers who live in more deprived areas, particularly deprivation decile 3 – show on the blue bars. This is the case in both 22/23 and 23/24 YTD.

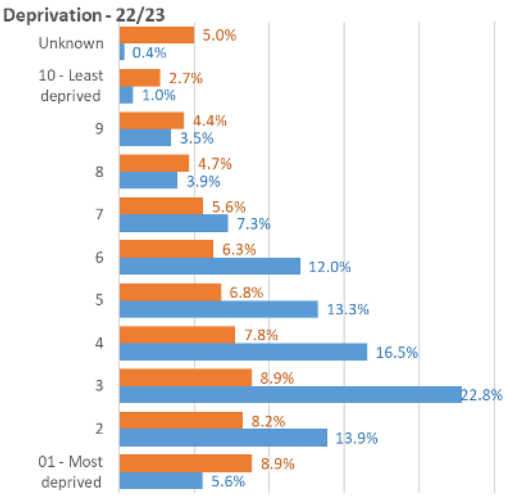


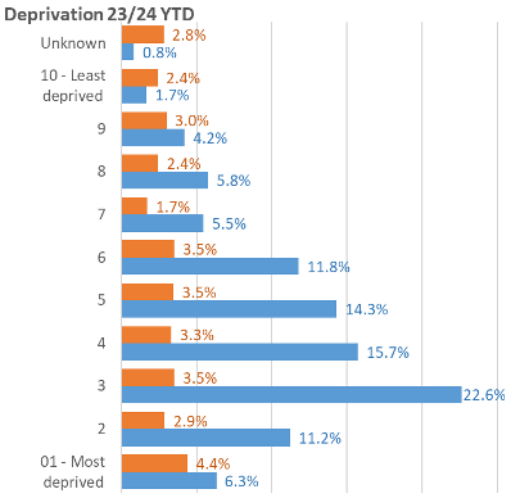


Mothers

- 23/24 YTD - % Total Mothers
- 23/24 YTD - % Total ED Attendances

The orange bars show the percentage of each deprivation decile that have mothers with ED attendances 28-days post birth. There is a slightly higher percentage seen in the most deprived populations.





The orange bars are the percentage of births in the particular LA, HB or population demographic that result in an ED attendances within 28days post birth.

The blue bars represent the population split of the babies with an ED attendance up to 28days age. The blue percentages always add up to 100%.

Examples can be seen below.

- 22/23 - % Total Births

E.g. Brent LA Percentage = Babies with an ED attendance within 28-days of birth for those with mothers living in the Brent LA / All babies born to mothers from the Brent LA

- 22/23 - % Total ED Attendances

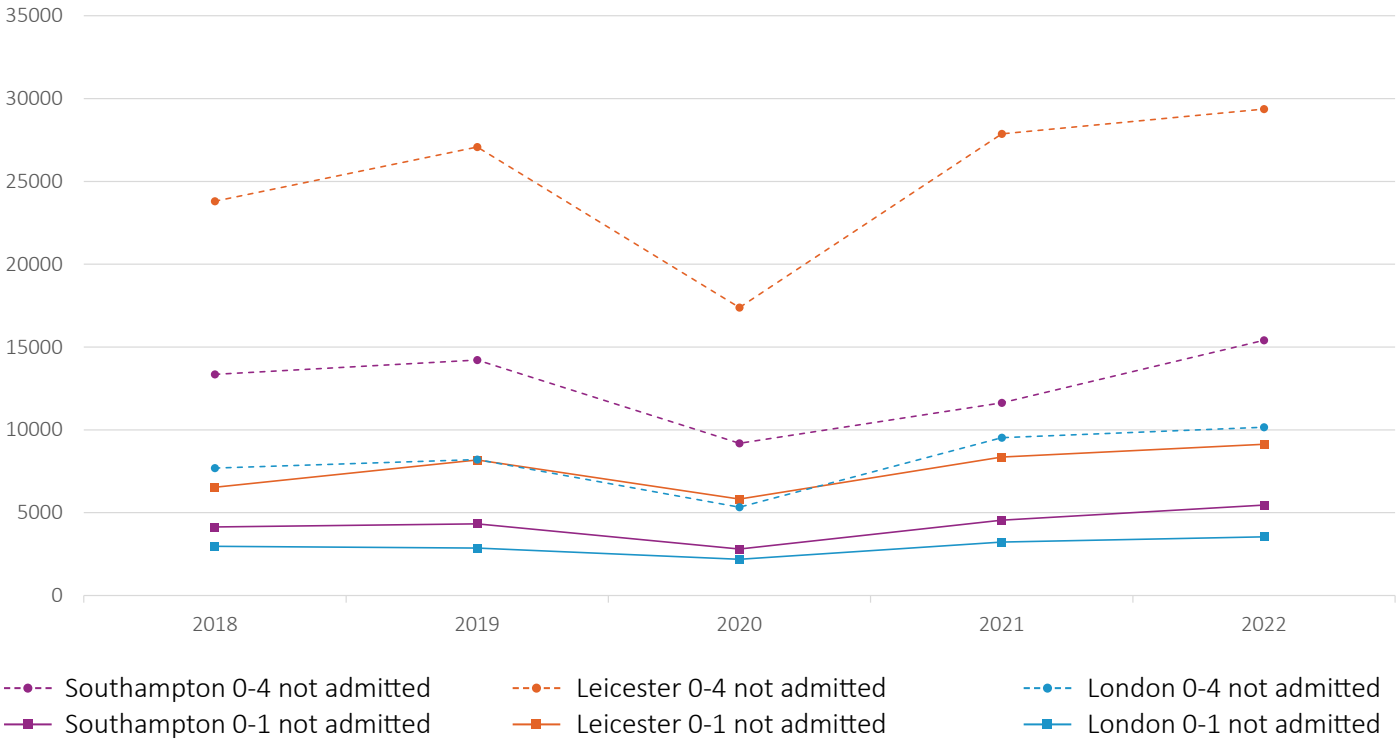
E.g. Brent LA Percentage = Babies with an ED attendance within 28-days of birth for those with mothers living in the Brent LA / All babies with an ED attendance within 28-days of birth

North West London Integrated Care System

4.3 Local ED attendances and non-admission rates

Local ED data show an increase in non-admission rates for children aged 0-4 for Southampton, Leicester and North West London (see figure 9). All three sites experienced a drop in non-admission rates during the first year of the COVID-19 pandemic. Rates quickly recovered and are now exceeding pre-pandemic levels in all sites.

Figure 9: Local data - Number of non-admissions following ED attendance in Southampton, Leicester and North West London



Local analysis of data

The North West London site completed an additional 'deep dive' analysis of a randomly selected group of 100 infants under twelve months old who attended Northwick Park ED (see Appendix 4). Of the one hundred cases analysed:

- 70 infants were sent home.
- 29 infants were admitted.
- One infant was transferred to a tertiary hospital.

Northwick Park ED has approximately 5,000-6,000 infants attending per annum. 70% of infants attending in this random sample were sent home, often after very long waits alongside ill children, with 9 out of 10 requiring no investigations or pharmacological treatment. The paediatricians who completed this review identified that over 75% of these infants could have been seen in a community setting by well-trained health visitors or midwives, as part of their role to support parents to "manage minor illnesses"[43] assuming sufficient capacity. Findings from this local audit align with findings from wider research[44] which shows that the majority of infants up to one year of age who attended the ED were attending for minor conditions such as upper respiratory tract infections (coughs and colds), feeding difficulties and gastroenteritis.

4.4 What are the most common presentations for 0-4 ED attendances?

The majority of ED attendances in babies and young children are due to a relatively small number of high-volume conditions. NHSE 2023 - CYP Transformation Programme shared their data on the top ten presenting conditions for 0-4s attending the ED in England which consisted of:

1. Upper respiratory infection
2. No abnormality detected
3. Tonsillitis
4. Infectious gastroenteritis
5. Bronchiolitis
6. Viral wheeze
7. Traumatic brain injury with no loss of consciousness
8. Croup
9. Lower respiratory tract infection
10. Otitis media

The national data reflect our analysis of the local data. Figure 10 shows the most common presenting conditions for 0-4s attending the ED in Southampton, Leicester and North West London. 'No abnormality detected' was recorded as one of the top 3 presentations for all sites.

Figure 10: Most common presentations for 0-4 ED attendances for Leicester, Southampton and North West London

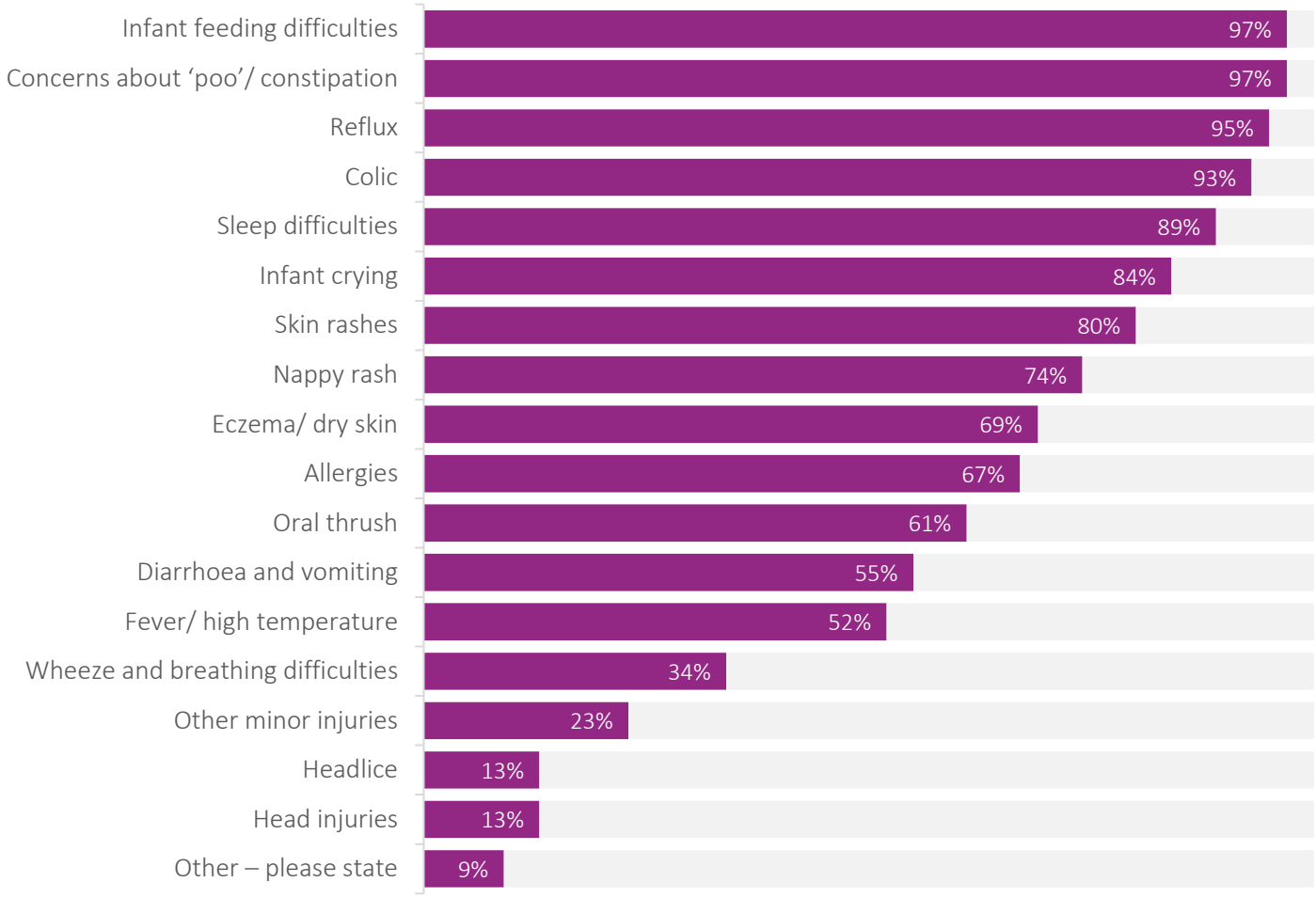
	Rank	Leicester	Southampton	North West London
Most common →	1	Breathing Difficulty (wheeze, bronchiolitis, croup & pneumonia)	Upper Respiratory Infection (cough/cold)	Upper Respiratory Infection (cough/cold)
	2	Upper Respiratory Infection (cold/ cough)	No abnormality detected	No abnormality detected
	3	No abnormality detected	Gastroenteritis	Tonsilitis
	4	Gastroenteritis	Minor head injury	Gastroenteritis
	5	Tonsilitis	Viral wheeze	Bronchiolitis

National health visiting survey findings on the most common reasons parents sought health visiting advice for childhood illnesses.

Figure 11 presents the findings from the Institute of Health Visiting survey of frontline health visiting practitioners completed in 2023 (n=563). Health visitors said the top 5 minor illnesses that families seek support about are:

1. infant feeding difficulties
2. concerns about constipation
3. reflux
4. colic
5. sleeping difficulties

Figure 11: Health visitors' main reasons for families seeking minor illness support



The top 5 conditions highlighted by health visitors could potentially be categorised in an ED department as 'nothing abnormal detected' or not requiring medical or secondary care. Aligning with our survey findings are ChatHealth case study findings (see Appendix 3 and Figure 12).

ChatHealth is a risk-managed messaging helpline platform, providing a way for service users to get in touch with a healthcare professional for advice and support. The under 5 services are managed by health visiting teams in many areas. Incoming messages are delivered to a centrally managed inbox. Staff respond via the web-based application to send a message back to the service user.

Figure 12: ChatHealth - Main reason for why parents contact a health professional.

infant feeding
general health of the child
constipation/stool queries
reflux
colic

Findings on common presentations from the narrative summary of literature (full findings are presented in Appendix 1):

Findings from a number of large systematic reviews[45,46,47] reported that the highest numbers of ED attendances in children were attributable to upper respiratory tract infections (coughs and colds), followed by viral infections and gastroenteritis (diarrhoea and vomiting, (D&V)).

In 2018, Jones et al., published a cross-sectional analysis[48] of routinely collected national data on 1,387,677 babies, up to the age of one year, admitted to English hospitals. This study aimed to develop a working definition of "potentially avoidable" infant admissions in the context of postnatal care provision. The findings highlighted that the great majority of these hospital admissions in the early neonatal period were due to three potentially avoidable conditions of jaundice, feeding difficulties and gastroenteritis. The review found that admissions to hospital for feeding difficulties after one month of age became less common and the rate consistently decreased with age up to one year. The authors concluded that there may be missed opportunities to provide better support for families with young infants within the postnatal care pathway. While ED is the right place for very sick infants and young children, our narrative review of the literature highlighted that improving access to high-quality care in the community could help to reduce some admissions.

4.5 Factors that influence parental decisions to attend ED

Our narrative review of the literature (Appendix 1) identified a number of factors that influence parents' decisions to attend the ED:

- **Parents want 'peace of mind', the need for reassurance**

The need for reassurance was a common reason for parents attending the ED. Specifically, parents wanted reassurance about the severity of their child's illness and to rule out any serious illnesses. Parents also attend ED for guidance on how to manage their child's condition.

The decision to consult a healthcare professional is not taken lightly by parents. Media reports have seen parents being "blamed" for taking their child to the ED "unnecessarily" and "wasting resources". However, it's important to emphasise that **it is normal for parents to worry when their baby or young child is unwell**, particularly first-time parents who are managing these childhood conditions for the first time – it can feel quite frightening and overwhelming for some parents. If parents are unable to find the reassurance and support that they need elsewhere, then it's likely that more parents will feel that they have no other option than to attend the ED.

Seeking "peace of mind", avoiding being judged for "doing the wrong thing", and wanting to have their baby/ young child seen in person were all important drivers in parents' decision-making . GPs are trusted by parents to deliver urgent care to children but being able to access health services without difficulty or delay is also important.

- **First-time parents**

Our local data analysis has highlighted that first-time parents of babies under one have the highest rate of ED attendance. This has been reinforced by wider research[49] which explored parental decision-making on non-urgent attendance among under 5s and found that first-time parents are more likely to attend ED. The ChatHealth case study (Appendix 3) also highlights the needs of first-time parents:

> *As a first-time mum always second guessing what to do in different situations, this service provided a fast easy way to communicate with a professional about non-emergency type queries we may have.*

> *I'm a new mum winging it and having this service, really helps*

- **Geographical location**

There is strong evidence to show that individuals who make frequent visits to the ED are most likely to live in areas close to hospitals or in areas with a high deprivation score[50,51]. Data[52] from the Office for National Statistics show that after adjusting for age, sex and ethnicity, the odds of ED attendance for infants (aged 0 to 5 years), living in the most deprived 10% of areas were 1.56 times greater, respectively, than their counterparts living in the least deprived 10% of areas.

- **Health literacy**

A parent's perception of the urgency or severity of their child's illness also plays an important role in their decision to attend the ED. An increased perception of an illness as being urgent was found to be associated with lower levels of parental health literacy and these parents were more likely to seek care immediately[53].

Our narrative review of the literature (Appendix 1), highlighted that supporting parental health literacy can reduce repeat ED attendances. However, information needs to be relevant to their needs, presented in an accessible format, and comprehensive with 'safety-netting' advice to enable parents to confidently manage an episode of minor illness. Incomplete information leaves parents needing to seek help and irrelevant information appears to reduce parents' trust in an intervention. Interventions are more likely to be effective if they are delivered in non-stressful environments, such as their home, and are coproduced with parents[54]. Research has shown that parents who receive consistent, explicit safety-netting advice, explained to them and relevant for their child, are less likely to re-attend the ED[55].

Health visitors predominantly home visit and work in partnership with parents. Their specialist public health role in the community places them in an ideal position to undertake this type of work.

- **Erosion of support networks**

Research[56] has shown that those with good support networks of families and friends often expressed greater confidence around managing their child's health because they had more people to turn to for advice, as well as greater exposure to other children to recognise the signs of minor childhood illnesses. Increasingly complex family structures[57] and the geographical dispersal of families means that more parents have less access to the expertise of grandparents than previous generations and are likely to feel more isolated and unsupported when managing childhood illnesses.

- **Access to services**

Shorter waiting times, availability (including out of hours), and accessibility of advice and support without the need to make an appointment, were shown to be significant factors in parents' decisions to attend the ED[58]. In particular, parents wanted their baby/ young child to be seen in-person. Many parents also had a perception that they would receive higher quality of care at the ED. With more and more parents turning to the ED for support with minor illnesses, without addressing these issues, we risk socialising current and future generations to a system that requires medical equipment (a doctor with a stethoscope/ or medical equipment) to manage common childhood illnesses[59]. In the past, these conditions would have been managed successfully in communities. Research[60] has shown that gaps in support in the community, and restrictive eligibility criteria, can lead to people starting to attend the ED more frequently.

One systematic review[61] reported that:

> *[Parents and carers] are willing to wait as long as it takes to get the best care for their child... and it is likely that a positive experience in a child-friendly, specialist environment will reinforce paediatric attendance.*

One parent cited in the review[62] said:

> *It feels like the NHS is constantly changing but A&E is always open, so we come here.*

4.6 Cost of ED attendances

The cost of an individual going to the ED depends on the type of ED they attend. Figure 13 outlines the cost of ED attendances and ambulance trips:

Figure 13: The cost of going to the ED (Source: The King's Fund, 2023).

	Lowest level of investigation and treatment in ED / urgent care/walk in	More complex investigation and treatment in the ED	Ambulance trip to the ED	Ambulance call out which didn't result in a trip to the ED
Cost	£86	£418	£367	£276

The King's Fund[63] suggests that an average day in the NHS looks like this:

- more than 1.2 million people would attend a GP appointment
- nearly 260,000 people would attend an outpatient appointment
- more than 37,000 people would call 999
- more than 44,000 people would attend a major ED, and about 25 per cent of ED patients would be admitted into hospital
- around 675 patients would go into critical care

Across the whole population, 20% of emergency admissions are potentially avoidable with the right care in place[64]. **The rate of potentially avoidable attendances is much higher in babies and young children.** A local case study (see Appendix 4) shows an analysis of 20,889 infant attendances in one ED in North West London covering 8 Boroughs, for the period April 2022 – Dec 2022. The percentage of patients who received no investigations, no treatments and were discharged was **59%**. Using the relevant Healthcare Resource Groups (HRG) category, this amounts to **approximately £1.8m per annum** which is spent on such services in this one area of London alone. This funding could arguably be better spent in strengthening community and primary care services.

The NHS England Delivery Plan for Urgent and Emergency Care Services has identified that expanding services in the community offers an important part of the solution to reduce pressures on EDs[65]. Similarly, other recent government policy[66,67,68,69] has highlighted the importance of prevention and an upstream shift in health care to manage increasing demand[70]. Health visitors have a vital preventative role and can use their specialist community public health nursing skills to not only reduce ED attendances for children attending with minor illnesses, but also reduce pressures on other parts of the system.

4.7 How has health visiting practice changed over time?

To capture how health visiting services have changed over time, a national survey of health visiting practitioners was completed by the Institute of Health Visiting between between June and July 2023. The survey enabled us to gain a greater understanding of current health visiting practice and service delivery models related to health visitors' work to improve parental health literacy and the management of minor illnesses pre- and post-COVID-19 pandemic.

The survey had 563 respondents, with the majority (89%) from England and the remainder from Scotland, Wales and Northern Ireland. As the sample size was so small from the other nations, the focus of the findings is on England.

The survey responses were analysed using quantitative and qualitative methods to explore and further understand the key themes identified in the national and local data analysis, narrative review of the literature and case studies. These included:

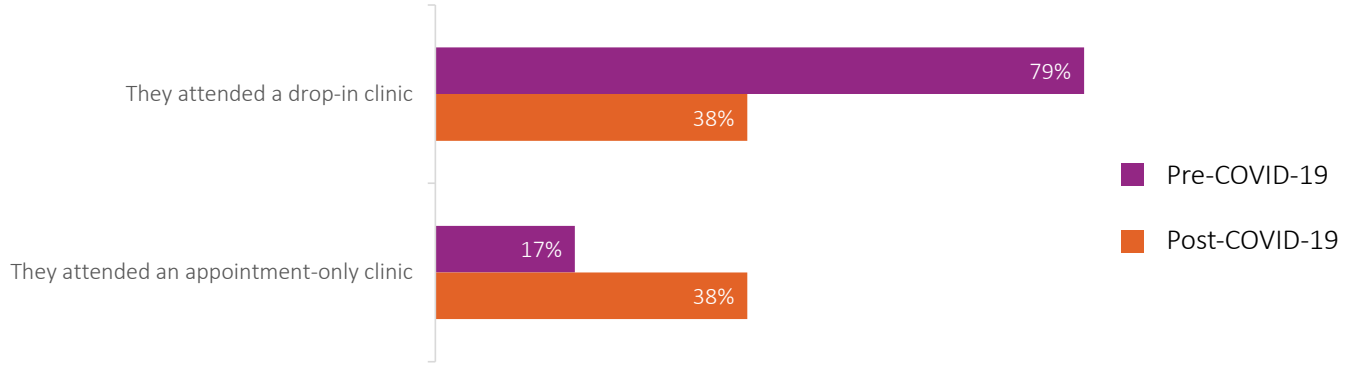
- Visibility and accessibility of health visitors in the community
- Health visitor workforce
- Health visitor training
- Use of digital technology

4.8 Visibility and accessibility of health visitors in the community

One of the biggest changes to health visiting, following the COVID-19 pandemic, has been the reduction of health visitor drop-in baby and child health clinics in community-based settings. 76% of health visitors reported that families attended drop-in clinics before the pandemic compared to only 39% now. Drop-in baby clinics were also one of health visitors' most frequently used methods of delivering the Healthy Child Programme to support the management of minor illnesses and a range of other parental concerns and health needs[71]. In the past, health visitors played a key role in the well-documented success of Sure Start centres supporting parental health literacy through their clinics and health promotion groups for parents. The health impacts of Sure Start included a reduction in hospital admissions in later childhood, with differences extending into adolescence, nearly a decade after children had left the programme[72].

Our survey showed that, since the pandemic, there has been a significant shift away from 'drop-in' clinics with an increase in appointment-only clinics - however these are attended by fewer families (see figure 14).

Figure 14: How families seek support for minor illnesses pre- and post-COVID-19 pandemic



Alongside the closure of health visitor drop-in clinics, staffing shortages, sickness absence and prioritisation of safeguarding tasks were highlighted by respondents as barriers to the accessibility of health visitors to families:

> *There were more drop-in clinic sessions, families had easier access to the children centres for support and there were more HVs so families were able to access them more easily.*

Health visitors reported how much they valued drop-in clinics and would like them to be part of the service offer:

> *We're not 'visible' in the community, we aren't seeing people at clinics and having the opportunity to give ad hoc health promotion advice or answer specific questions. Parents want that face-to-face reassurance.*

The absence of clinics has reduced health visitors' face-to-face contact with families - this was highlighted as a key driver for increasing ED attendances for minor childhood illnesses:

> *I feel that the absence of clinics and difficulty getting a GP appt long before the [COVID-19] pandemic hit has encouraged families to turn up at ED for medical advice /support. Particularly affecting worried first-time parents. The lack of clinic face-to-face contact may be impacting on parents' choice of where to seek advice.*

When asked about solutions, the reintroduction of clinics was frequently cited by survey respondents who felt this would allow them to address concerns related to minor illnesses and the management of common issues like colic, infant feeding problems, and crying:

> *[We need] quality and regular well-baby clinics - where you can drip feed health promotion messages -have a higher and positive presence in the community.*

Some health visitors reported that they had tried to reinstate clinics since the pandemic, but they had not been supported by their senior leadership team to do this:

> *The leadership team have not responded to repeated requests from health visitors to start clinics up again, they say people do not want them. But health visitors I know do not agree. And feel people would like them and would attend and lots of positive work could come from them.*

Baby and child health clinics have been a "taken-for-granted" part of health visiting since they were established in 1899[73]. They are still prevalent across the UK, however, there is limited research about their structure, process or anticipated outcomes[74]. Some have questioned their purpose, evaluating them at face value as a service that is solely focused on weighing babies. This was echoed in our survey findings:

> *Clinics were stopped 5 years prior to the pandemic. It was said that the clinics were outdated and were set up to weigh babies after the war. This was not the way we were running clinics. It was an opportunity to safeguard, support families, deliver health promotion, utilise prescribing skills and assess healthy growth using the WHO guidelines.*

The seminal work of leading Child Psychotherapist, Dilys Daws, "*Standing next to the weighing scales*"[75], presents a different view, exploring the purpose of baby clinics through observations of parent-infant and health visitor interactions in a health visitor-led baby clinic over many years. Daws' work highlighted the anxieties that many new parents feel as they adjust to parenthood and manage the responsibility to "*keep their baby alive*" which can feel overwhelming. The clinic provides a vital opportunity for health visitors to identify families who are struggling. It is clear from Daws' work that the main reason that parents go to health visitor clinics is not to get their babies weighed but more for affirmation and reassurance which builds their confidence.

Clinics also provided a helpful forum for health visitors to observe parent-infant relationships and identify families who were experiencing problems and might benefit from more targeted or specialist support. The act of weighing provided an acceptable and non-stigmatising gateway into the health visiting service[76]. There is evidence that drop-in health visiting baby and child health clinics are especially liked by families living in social deprivation as they are easy to access and provide a helpful means to get concrete information about their baby's progress and baby care advice in these universal, non-stigmatising settings[77].

The shift to pre-booked 'appointment-only' clinics during the pandemic was also identified in the literature[78]. This change was accelerated during the pandemic as a means to manage infection control. However, there is little evaluation of the impact of these changes on the accessibility of health visiting services, or the identification of unmet needs and vulnerability. Booked clinic appointments may work well for some families. However, there is good evidence that the families who need the most support are often the least likely to be able to access the support that they need or make the most of 'appointment-only' clinics which require them to plan ahead. Our survey respondents reported that appointment-only clinic slots often get booked quickly with parents having to wait several weeks for appointments. This arrangement favours the most organised parents and also precludes health visitors' ability to support parents with the management of minor illnesses which require a more immediate response.

A large survey of 1,000 parents by the iHV, published in January 2020, found that parents value drop-in health visiting baby and child health clinics and groups that are both accessible and flexible to meet their needs[79]. It is therefore vital that a range of options are offered to ensure that health visiting services are accessible to all groups[80], particularly those individuals and groups who do not currently experience easy access to services (for example, the Gypsy/Traveller community, asylum seekers and individuals who are not registered with a GP), and consequently do not experience the same health outcomes as the rest of the population[81,82].

Health visitor survey respondents from Scotland shared that they do not offer any clinics to families as their Universal Health Visiting Pathway (UHVP)[83] prioritises a more intensive home visiting model for all families:

> *The UHVP is home visits only. Very occasionally a clinic is run in our health board, but only due to staff absence to cover mandated contacts - for example the pre-school reviews as there is a deadline for the start of the school year and discharging the children from caseload.*

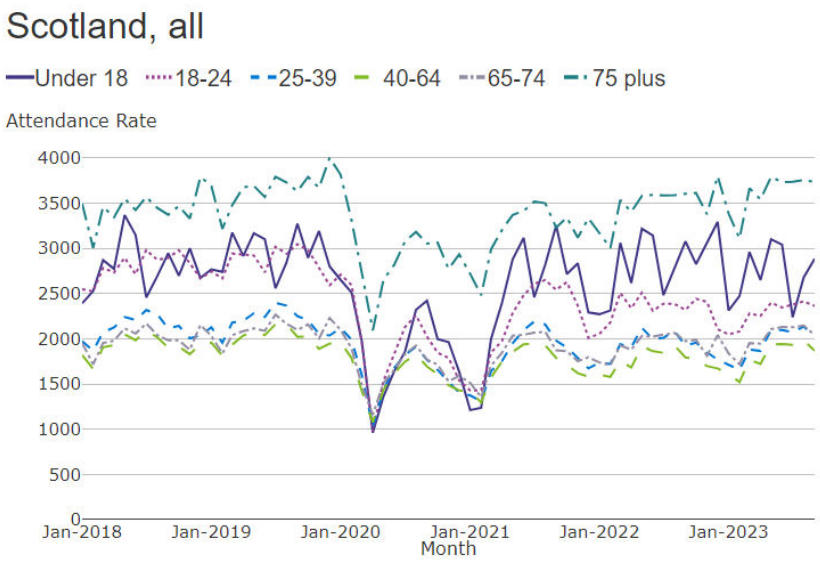
Scotland does, however, provide extra safety netting, offering eleven home visits to all families with children aged 0-3 years and the majority of Scottish health visitors have the recommended caseload size[84]. In contrast, England only offers five health visiting contacts between the age of 0-2 years. The English health visiting caseloads are also much larger than the recommended average caseload size of 250 children per full time equivalent health visitor[85]. Universal reach to all families is crucial for identifying needs and high caseloads impact on the health visitor's accessibility and time to support families and identify need. Figure 14 shows the ratio of children 0-5 per full time equivalent health visitor for England compared to Scotland[86].

Figure 15: Ratio of children 0-5 per full time equivalent health visitor in 2022 (Source Public Health Scotland data)

Ratio of children 0-5 per full time equivalent health visitor	England	Scotland
250 and under	6%	69%
251-500	36%	28%
501-750	30%	1%
751-1000	17%	0%
More than 1000	11%	1%
This information is not known to me	26%	9%

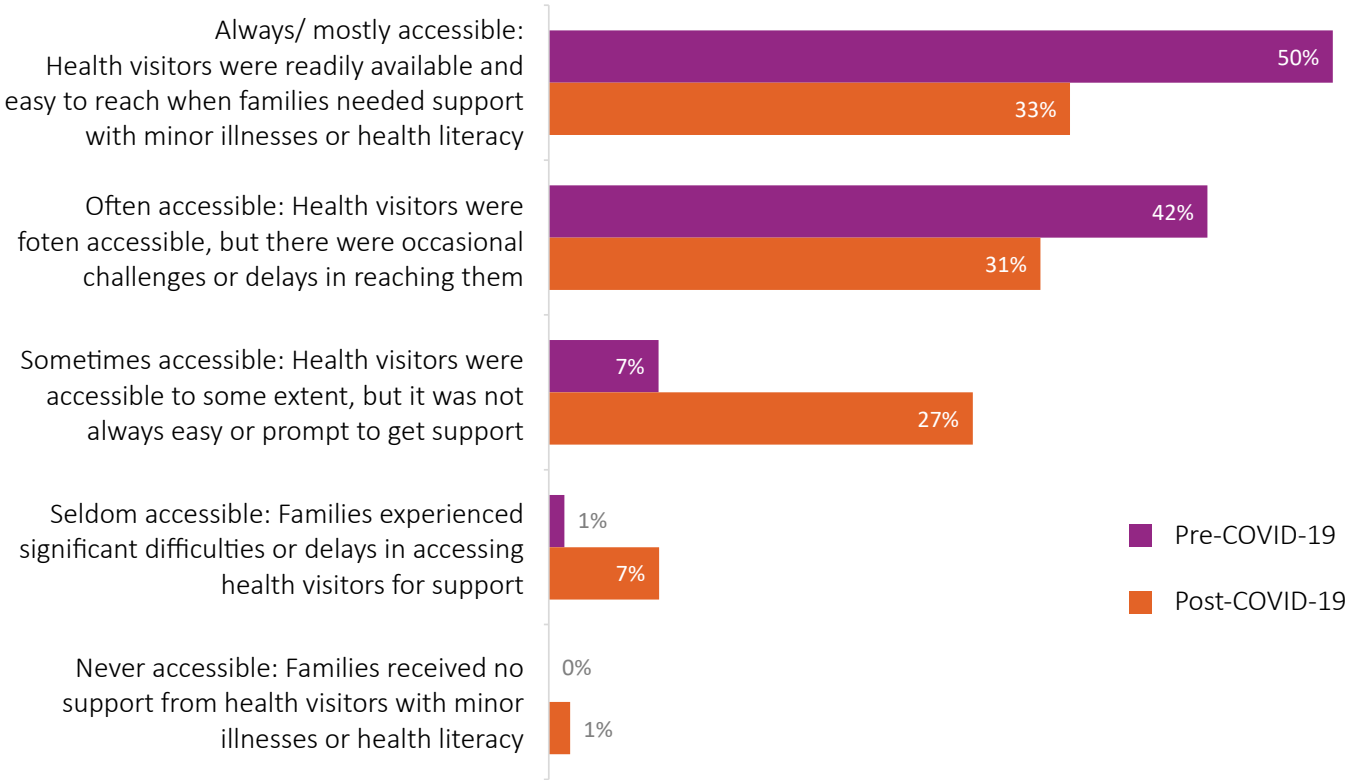
In 2015, Scotland invested in health visiting to enable health visitors to deliver the Universal Health Visiting Pathway (UHVP) to all families[87]. Interestingly, since the introduction of the UHVP, Scotland Public Health Data[88] show a reduction in the number of ED attendances for children aged 0-18 years (see figure 16).

Figure 16: The number of ED attendances in Scotland 2018 - 2023



Survey respondents were also asked how accessible health visitors are to families if they need support with minor illnesses and health literacy (see Figure 17). The responses show that health visitors were much more accessible pre-pandemic when their services were better resourced.

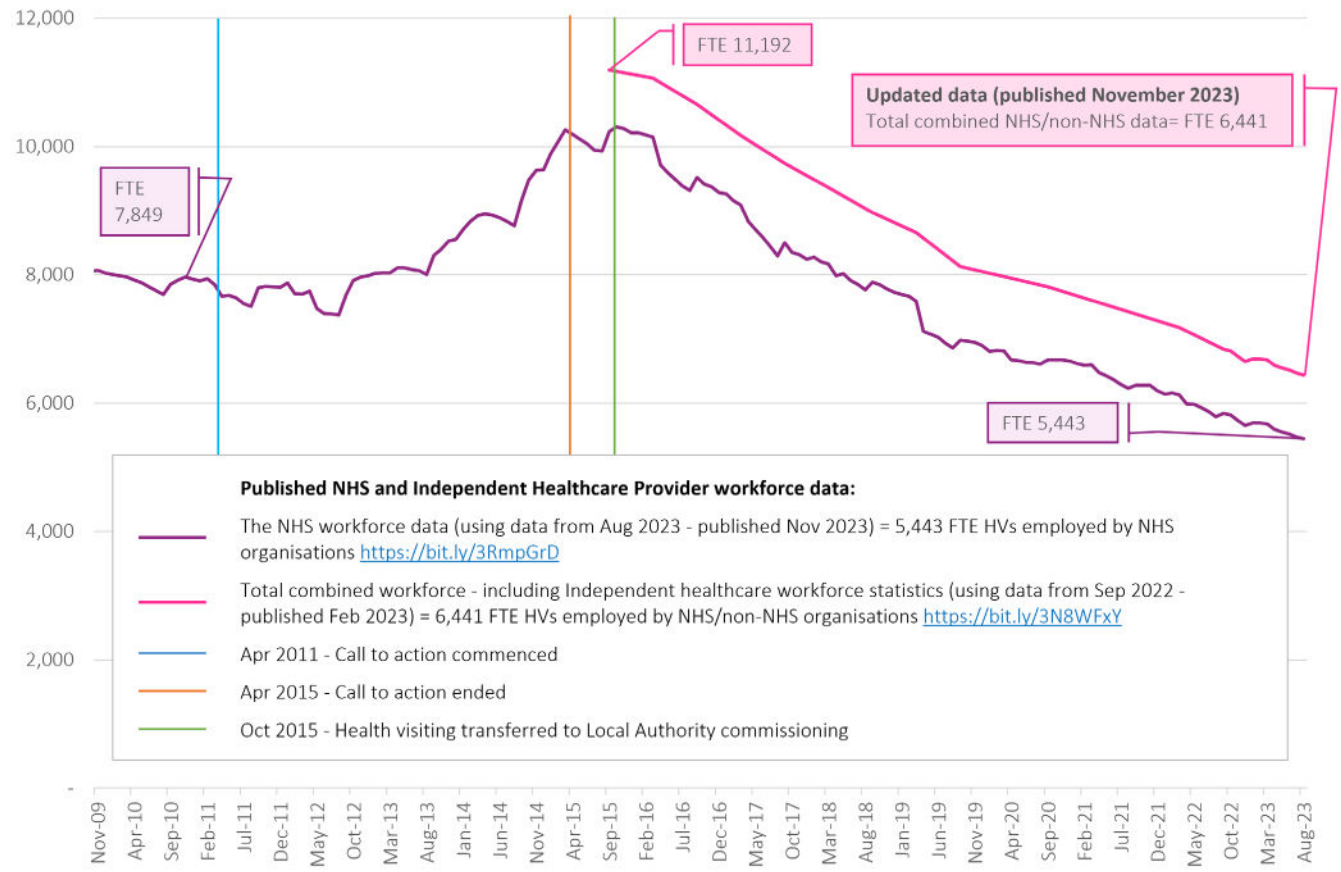
Figure 17: How accessible are health visitors to families if they need support with managing minor illnesses and health literacy? A comparison pre- and post-COVID-19 pandemic



4.9 Health visitor Workforce

Published health visiting workforce numbers in England are captured in two different datasets: with 5,443 full time equivalent health visitors recorded in the latest NHS Workforce Statistics for August 2023, published in November 2023, and a further 998 FTE health visitors recorded in the most recent Independent Healthcare Provider Workforce statistics published in February 2023, with a combined workforce count of 6,441 FTE health visitors in England. Overall, health visitor numbers have fallen by more than 40% since 2015 (see Figure 18).

Figure 18: Total health visitor workforce in England. Combined published data from NHS and Non-NHS providers (updated November 2023)



The findings from the health visitor survey paint a deteriorating picture of a health visiting workforce under immense pressure as practitioners struggle to meet the scale of rising need. As is sadly often the case, this affects the most vulnerable people who may struggle to access health services and actually depend on their health visitor the most.

76% of health visitors stated that more health visitors are needed to support families with minor illnesses and health literacy. A common theme in the survey responses was the significant shortage of health visitors which was seen as a contributory factor to the increase in ED attendances:

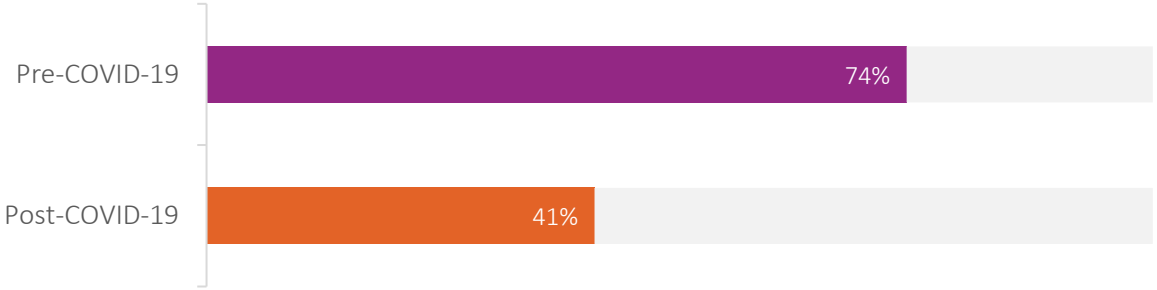
> *There is not enough staff to work in a more proactive and preventative way.*

> *I believe the massive cut back on universal provision is having a negative impact on ED attendances.*

Health visiting workforce shortages are also impacting on whether qualified health visitors are present at clinics. 74% of respondents reported that qualified health visitors were present at all or most health visitor clinics before the pandemic, compared to only 41% post pandemic (see Figure 19).

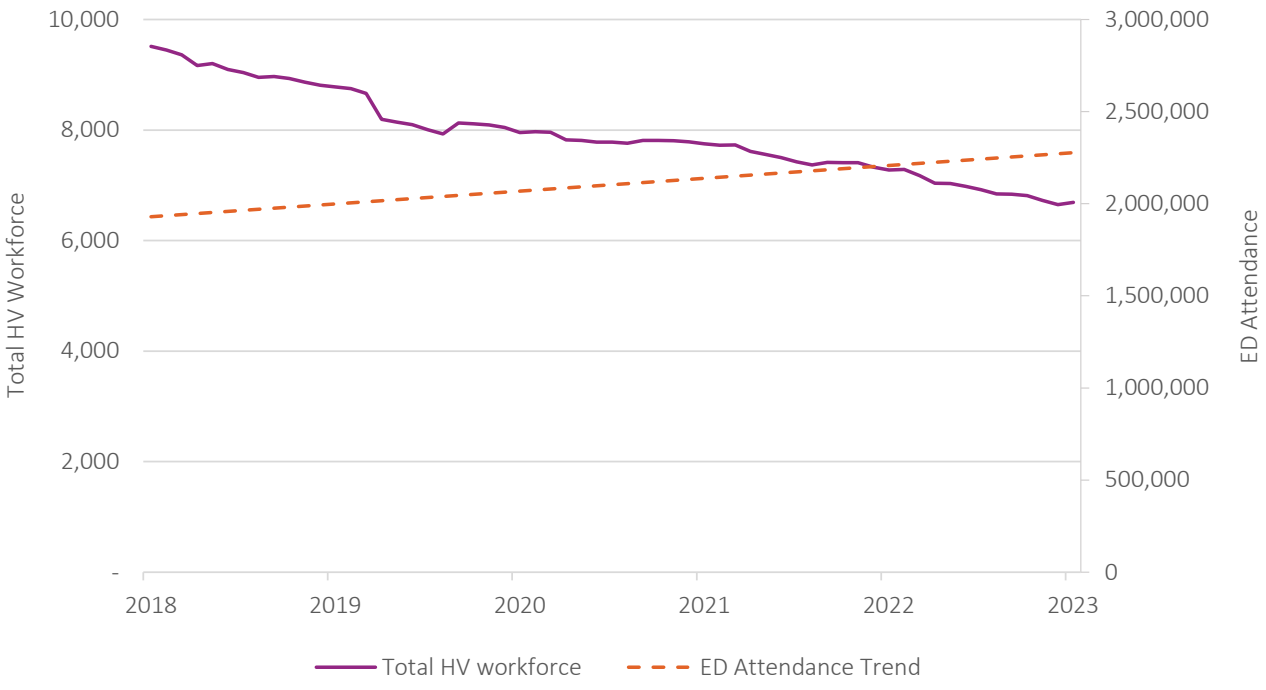
The use of skill mix teams in health visiting is now commonplace in England[89]. However, research examining how teams operate and the impact that different levels of staffing have on the identification of need or the improvement of outcomes (access, experience, child/ family health indicators and the reduction of inequalities), is limited and the implications are largely unknown[90]. This is an area that requires further research.

Figure 19: Percentage of qualified Specialist Community Public Health Nursing (SCPHN) health visitors present at clinics.



There are numerous variables that impact on parents' decisions to attend the ED when their baby or child is unwell, and we are unable to attribute direct causation of rising ED attendances to any single factor. However, the increase in ED attendances in babies and young children in recent years has coincided with the significant reduction in health visitor support, falling health visitor workforce numbers, and the closure of easily accessible health visitor drop-in baby and child health clinics in the heart of communities over the same time period.

Figure 20: ED attendances for 0-4 year olds compared to health visiting workforce numbers from 2018-2023

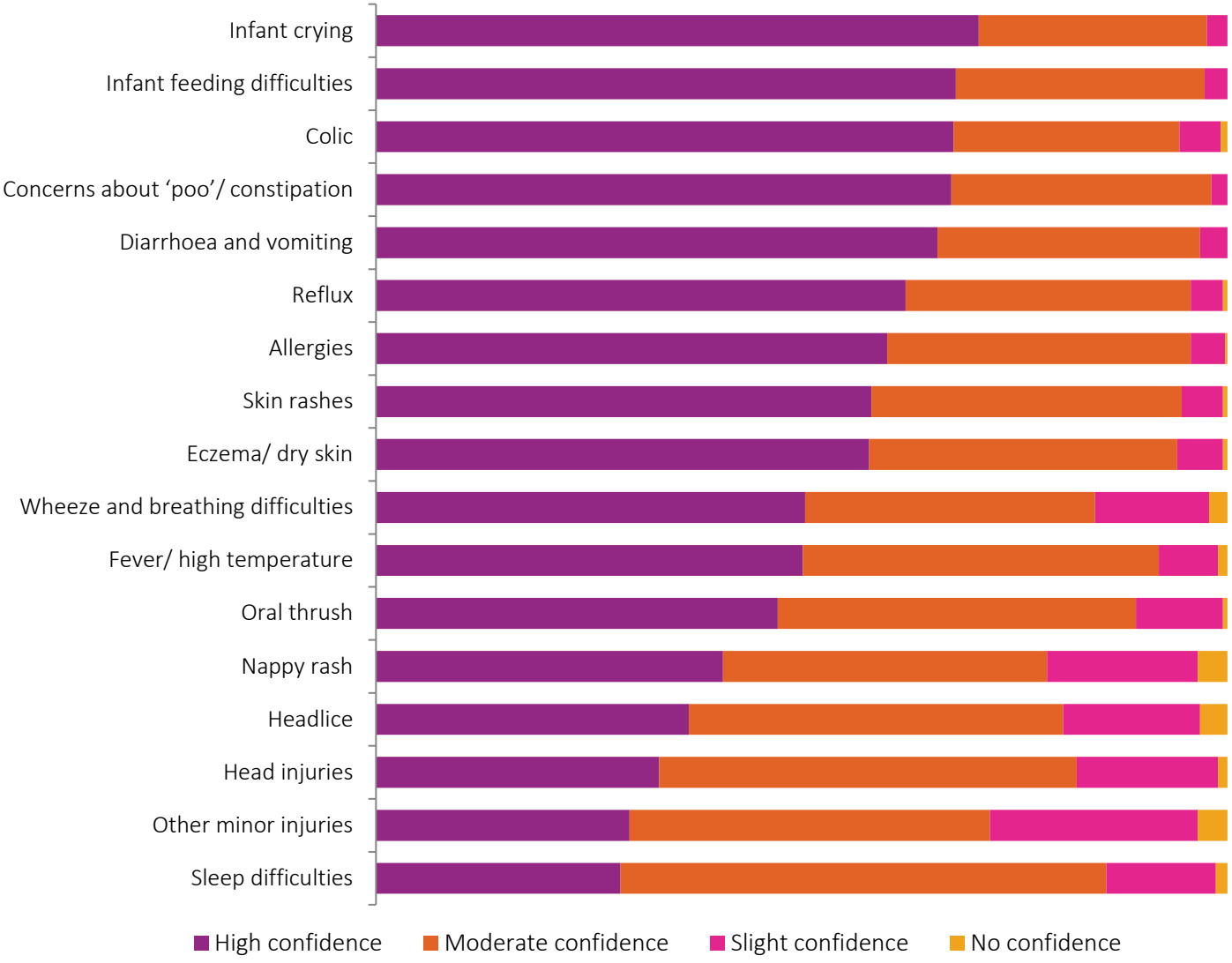


4.10 Health visitor confidence in managing childhood minor illnesses

When we asked health visitors to rate their confidence levels and skills to support families with a range of conditions (see Figure 21), health visitors felt most confident about supporting families with the following conditions:

- Nappy rash – 71%
- Infant crying – 68%
- Oral thrush – 68%
- Infant feeding difficulties 68%
- Constipation – 66%
- Colic – 62%
- Reflux – 60%

Figure 21: Confidence rating of health visitors' knowledge and skills to support families with a range of conditions.



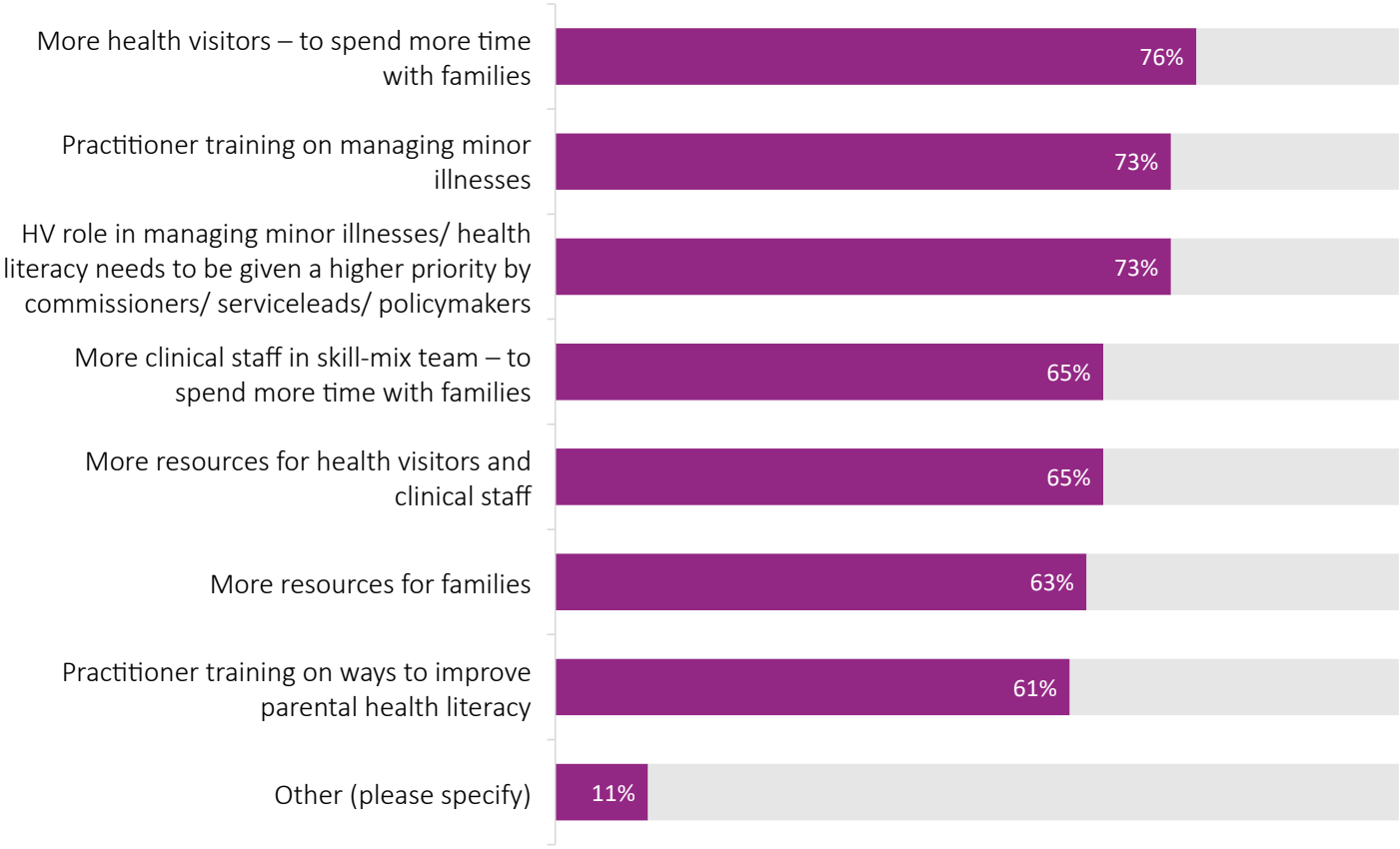
There is regional variation in health visiting training and continuous professional development. This variation has increased since the responsibility for health visiting was devolved to local authorities in England in 2015. Health visitors require continuous professional development to keep their knowledge and skills up to date and ensure that they are able to practise effectively and work with families. This includes promoting awareness of common childhood illnesses and their management, helping parents to recognise early signs of serious illness/ "when to worry" and providing advice, including swift referral/ signposting to appropriate services where needed. Services provided by health visitors are not intended to provide a diagnostic service. However, when an unwell child attends their service, the practitioner must have the knowledge to support parents to make a decision about the most suitable course of action and signpost them to the appropriate help based on the child's presenting symptoms[92].

Some health visitors stated that they felt less confident in managing the following conditions (see Figure 21):

- Wheeze and breathing difficulties – 28%
- Skin rashes – 18%
- Other minor injuries – 19%
- Headlice – 16%
- Allergies – 14%
- Eczema – 11%

73% of health visitors said that further training on managing minor illnesses would help them to support parents to access help and health literacy information, which was the second highest rating behind 'needing more health visitors' (see Figure 22).

Figure 22: What would help to support parents accessing minor illness support?



Some respondents felt that the current Specialist Community Public Health Nurse (health visiting) training does not equip practitioners with the required knowledge to support families- captured in this quote from one health visitor:

> *In many locations, due to HV retirement and mixed clinical background of new SCPHNs and the difference in course content, many newly and recently qualified SCPHNs do not have the knowledge or experience to deal appropriately with minor illnesses and minor ailments.*

Concerns were raised about the reduced opportunities for experiential learning by more junior members of the team from experienced health visitors, due to changes in working practices with fewer face-to-face interactions and lack of continuous professional development on this topic in some areas - captured in this quote from one health visitor:

> *In the past when we had regular drop-in clinic, skill mix staff would hear the HV giving advice regularly, so it was an ideal informal training opportunity. Likewise when based in office and calls were responded to - newer members of staff learnt consistently from advisory telephone calls given to parents by health visitors. Staff that have joined the team in past 3 years will not be skilled in giving this type of advice as there is no standard training for this.*

Other health visitors said:

> *Training in minor illnesses would be fantastic and increase confidence.*

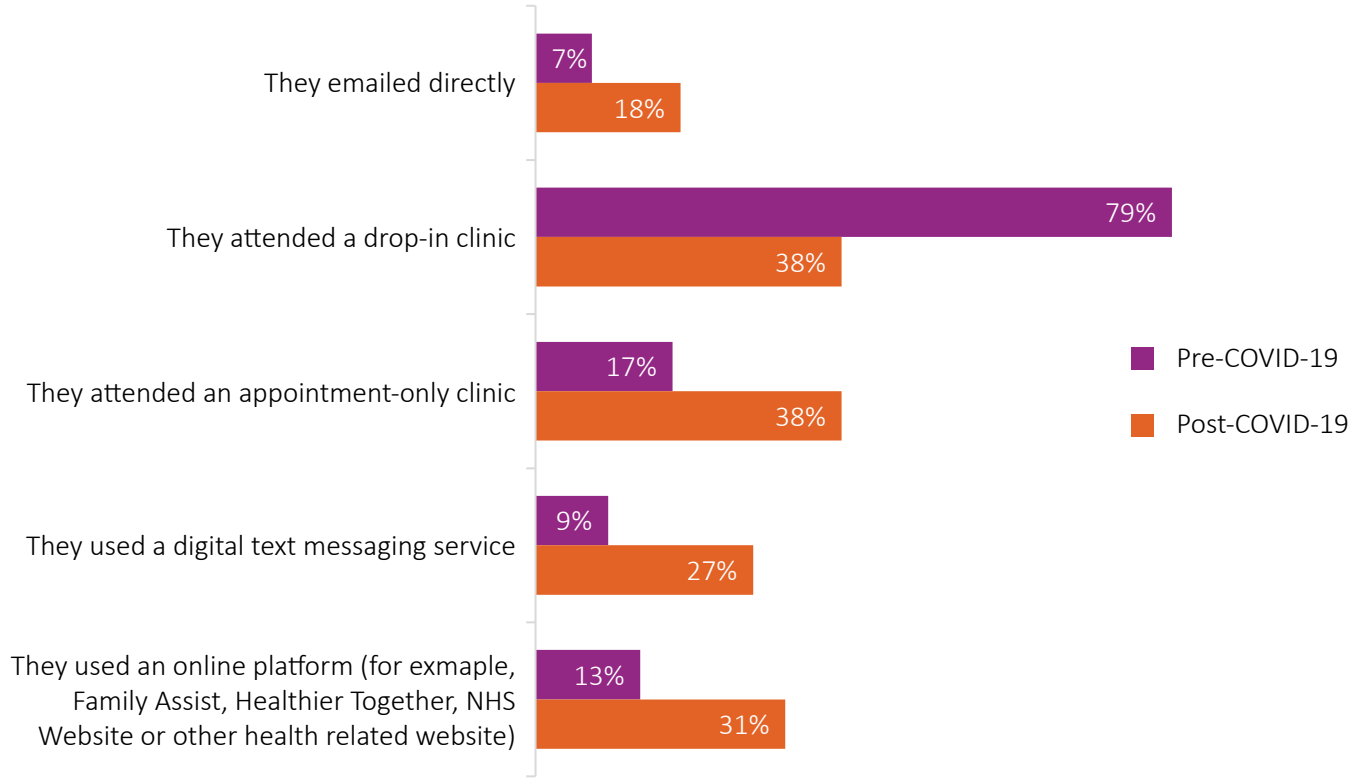
> *We need adequate training, train the trainer would be a good approach.*

> *Staff to have more confidence and have the possibility of training for extended prescribing.*

4.11 Use of digital technology

The survey findings showed that 92% of health visitors offered anticipatory guidance and health promotion at universal contacts, both pre- and post-COVID-19 pandemic. However, there was a significant change in the way families contacted the health visitor service to seek advice and support for minor illnesses following the COVID-19 pandemic (see Figure 23) with more families using digital communication to ask for help.

Figure 23: How families seek support for minor illnesses - comparing pre- and post-COVID-19 times



A digital text messaging service, ChatHealth, is one of the case studies presented in this rapid review (see Appendix 3). More than 40 health visiting services across the UK have implemented ChatHealth to offer safe and secure messaging to parents. Between April 2022 and March 2023, 67,200 conversations took place with parents and carers of 0–5-year-olds using the ChatHealth service. Of these, 18,900 (26%) related to enquiries about minor illnesses. Feedback from parents who used ChatHealth with their health visiting service included:

> *The quick response and advice was really helpful. Would have gone to A&E because the GP would not see us today.*

> *I would have called 111 if I didn't access this service for support.*

As part of this review, we present a case study of a successful collaborative approach to reduce ED attendance in Hampshire, the Isle of Wight and Dorset, with transferable learning for other areas (see Appendix 2). The Healthier Together programme was set up in 2014 and is founded on collaborative working across the healthcare system. Its aim is to improve the delivery of care to children and young people through effective integration between local authorities (including health visitors and school nurses), primary and secondary care. The case study includes a detailed evaluation of the digital website Healthier Together (HT) and health visitor training. HT resources were designed to provide easily accessible information on the management of common childhood conditions, with 'safety-netting' advice and actions to take in the event of certain symptoms including when and where to seek appropriate medical help. The resources also provided healthcare professionals with standardised clinical pathways to assist in the delivery of consistent and explicit messaging to parents. The case study includes details of the programme's implementation in practice in Hampshire, highlighting improved staff confidence with managing minor illnesses which in turn increased parental confidence in managing their child's minor illness at home.

The qualitative evaluation of HT (Appendix 2) included feedback from 18 parents who were interviewed about the HT resources. The evaluation suggested that the provision of advice through HT resources for parents at home could reduce unnecessary trips to the ED or the GP. Some direct quotes from parents who participated in this study are presented below. They highlight how parents may change their behaviour in future as a result of the HT resources:

> *I think it's very good, to be honest. It's very good that you're having this kind of help to the people because I know that A&E and GPs, they can get really busy with simple stuff that you can fix at home. It is much better for you and your baby if you can help just staying at home.*

> *It's like a mini doctor for you at home, that's how it is, that's how I see it. It gives all information, what should I do, in what cases I need to go to hospital or how I can treat my baby at home.*

The graph in Figure 24 depicts HT usage since its launch in 2017 to 2020, highlighting increased reach over the 3-year period. This reinforces the health visiting survey findings with more parents using digital platforms to seek advice on minor illnesses. The HT evaluation case study also shows the reduction in primary care presentations in Hampshire and the Isle of Wight following the implementation of the HT programme (see Figure 25).

Figure 24: The number of hits and sessions on the HT website, from their launch in 2017 to 2020

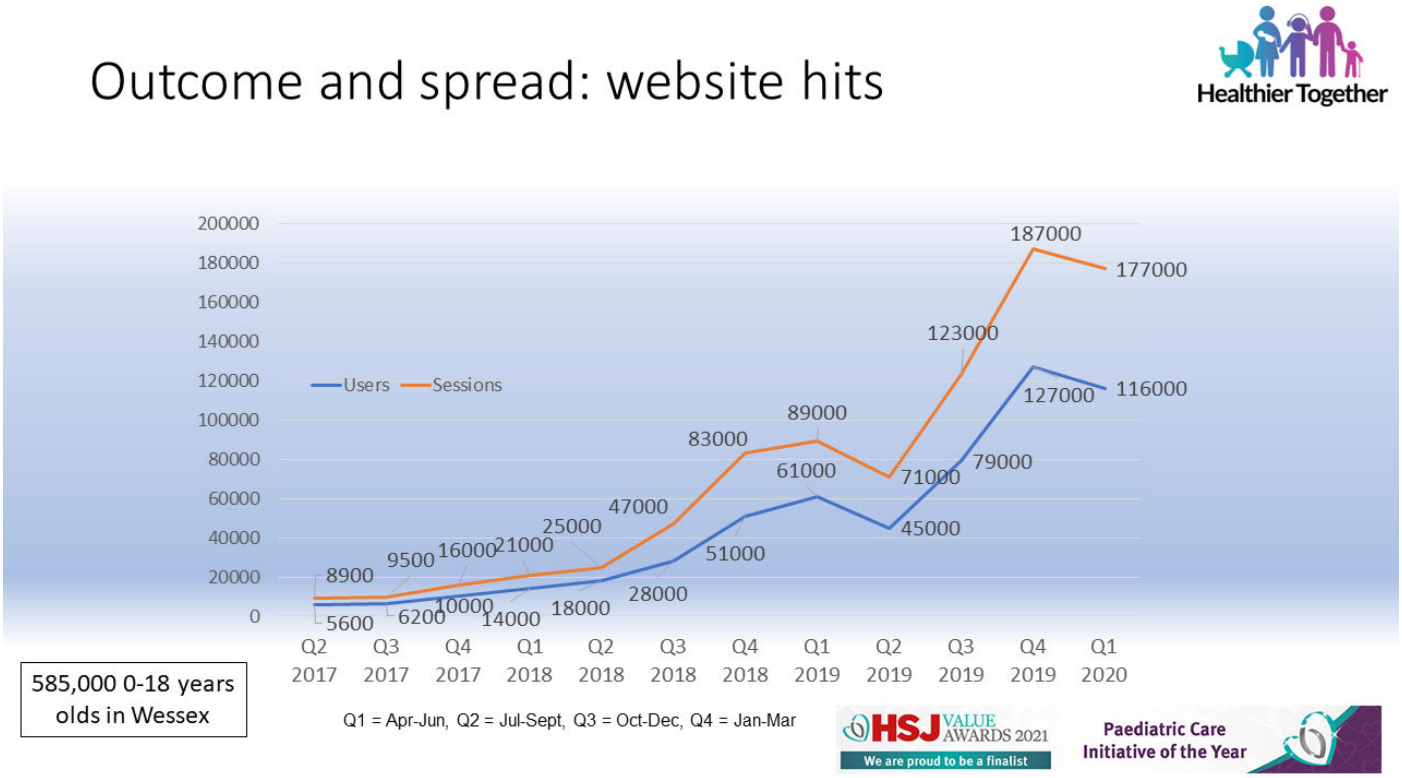
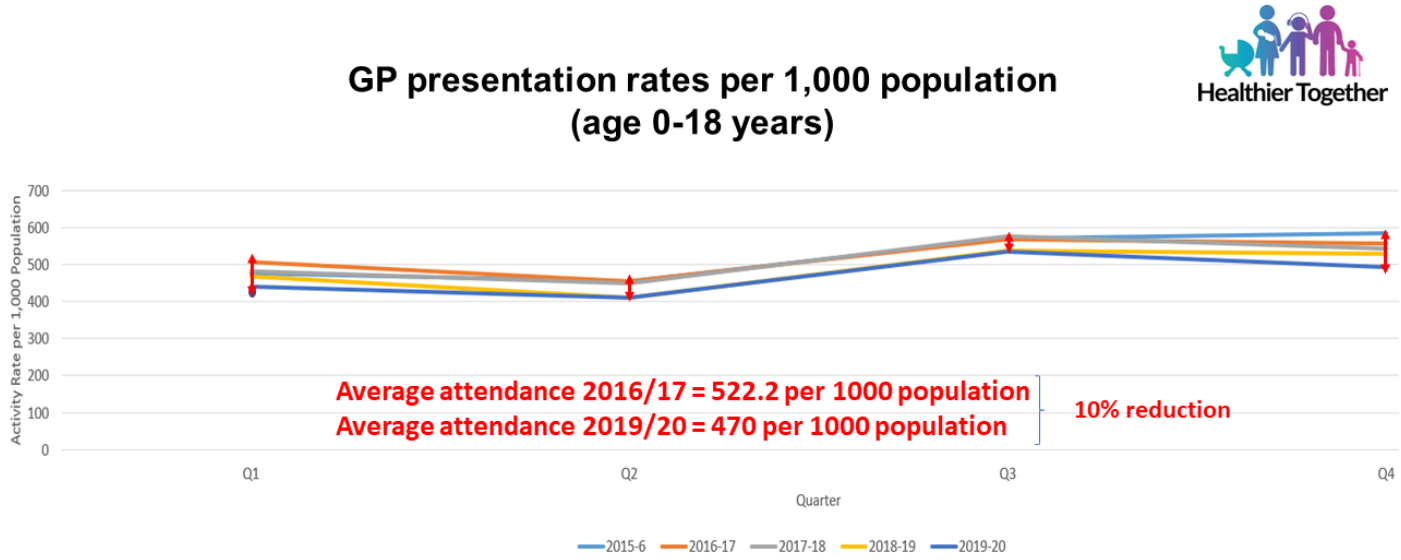


Figure 25: The reduction in primary care presentations in Hampshire and the Isle of Wight after the implementation of the Healthier Together programme



The HT evaluation found that safety-netting resources were more effective when they were explained to parents by a health visitor, with support tailored to their needs (rather than just giving a link to an online resource alone). One parent from the HT evaluation study stated:

> *The health visitors, they come to the house and do a check-up on the baby…. They gave it (HT resources) to me… they explained how… Like if there's something wrong to go straightaway to the red but if not, that one, this section, to stay at home and just ring the doctors…It made me feel better because I was scared because it's my first baby…*

There is high quality evidence[92] that face-to-face educational intervention targeting specific childhood conditions are effective at reducing ED re-attendance rates and reduce the rate of hospital admissions. Whilst digital support can enhance and improve parental choice, it cannot replace face-to-face health visiting. Our literature review highlighted that parents wanted their baby or child to be seen in-person for reassurance and this was a key driver for ED attendance. This theme is captured in the following quote from a health visitor in our survey:

> *You can't beat face-to-face advice and that has all gone since COVID due to funding. Digital platforms help but families still say they miss baby clinics, the opportunity to see other parents and connect with a health visitor.*

The ChatHealth case study (Appendix 4) highlighted that 34% of text queries required further support by a health visitor, demonstrating that quick and simple questions can be swiftly responded to. However, it is important that queries are assessed by a qualified health visitor or nurse to determine if extra support is required, so parents can get the right help, by the right person, at the right time.

5.0 Conclusion

Addressing pressures in urgent care is a national priority that requires more than building more hospitals, increasing ED capacity, and expanding services in the community for older adults. It is essential that any plans also consider the needs of families with babies and young children.

ED attendances for children aged 0-4 in England are increasing year-on-year despite a falling birth rate, and babies under one year have the highest rate of attendance compared to any other age group. A large proportion of these attendances are for non-urgent conditions, or are recorded as 'nothing abnormal detected', suggesting that they could be managed and supported by other means, including health visitors in the community.

The most effective healthcare solutions are built around the needs of the people they serve. Our review explored the reasons for parental decisions to attend ED and found that parents do not take the decision to attend ED lightly. Instead, it is perfectly normal for them to worry when their baby or child is unwell, particularly when they are new parents and learning to manage common childhood conditions for the first time.

In order to provide person-centred care and create a culture that empowers people to take control of their health and care, consideration needs to be given to the range of factors that influence parents' ED attendance. These include the levels of parental anxiety and need for reassurance (this is higher amongst first-time parents), geographical location, socio-economic deprivation, levels of parental health literacy, wider support from family and friends, and access to services in the community.

A greater focus on prevention is needed to take the pressure off EDs. Integrated Care Systems (ICSs) provide an important opportunity to improve joined-up care for families with babies and young children across the system to include NHS services, as well as public health services like health visiting, and greater involvement of local communities and voluntary sector organisations. ICSs can take a lead in addressing the increasing rates of 0-4s attending the ED in their areas, as the solution to reducing ED attendances is clearly multifaceted. This should include plans to maximise the role of health visitors across multiple clinical pathways by preventing, identifying and treating problems to avoid them becoming 'emergencies'.

Our review has identified that health visitors are ideally placed to support families with the management of minor illnesses in communities to take pressure off EDs. However, health visiting services are experiencing a workforce crisis in England with a reduction of more than 40% of health visitors and cuts to the public health grant that funds the service, since 2015. In contrast in Scotland, ED attendances have fallen at a time when their health visiting services have been invested in, with all families receiving 11 home visits compared to just five visits in England.

This review identified changes to the way that health visiting services are now provided in England, with a shift away from 'drop-in' health visitor baby and child health clinics and a reduction in the amount of contact that health visitors have with families in many areas. Many of these changes were accelerated during the pandemic without consideration of their impacts on parents and other health and care services, including EDs. In the past, parents would have attended drop-in health visiting baby and child health clinics in the heart of their community. These clinics provided parents with an opportunity to discuss their worries about their child's health and development, including minor illnesses, infant crying, feeding and sleep concerns, with a health visitor. If parents are not able to find the reassurance and support that they need elsewhere, then it's likely that they will turn to the ED for advice. It is important that we avoid blaming parents for attending the ED 'unnecessarily' and instead ensure we provide better services in the community to support them.

Urgent investment into health visiting is needed now to reverse years of cuts to the Public Health Grant and the health visiting workforce. These cuts have been a false economy as more and more families have turned to ED for more costly support for common childhood conditions and minor illnesses that would previously have been managed by health visitors in the community.

Rebuilding the health visiting workforce will ensure that all families can access the health visiting support that they need. This is not only needed to manage minor childhood illnesses in the community and relieve pressure from EDs, but to ensure that all families can access the full offer of support set out in the Government's blueprint for preventative child health in the national 'Healthy Child Programme'.

Policy recommendations:

1. **The Government's Delivery Plan for Urgent and Emergency Care Services needs to include a plan for babies and young children as ED attendance is highest amongst the youngest.** Reducing pressure on urgent care requires a national plan, with funding that extends beyond the NHS to address the needs of families with babies and young children through prevention and by expanding services in the community.

2. **Mechanisms are needed to support better integration of local services to reduce pressure on EDs. Integrated Care Systems provide opportunities to strengthen clinical pathways that extend beyond the NHS to include health visiting and other community services.** This includes better national and local policy 'join-up' between Family Hubs, the NHS and community services with shared priorities to include supporting babies' and children's physical health needs. Services need to be co-produced with families and built around their needs. There is no single solution – a range of options will be needed to address the different needs of different families, particularly those who have the highest rate of ED attendance.

3. **Investment in health visiting is needed to ensure that all families with babies and young children can access the full offer of health visiting support set out in the National Health Visiting Model for England and the Healthy Child Programme.** 5,000 more health visitors in England are needed to achieve this, with the required investment in the NHS Long Term Workforce Plan's priorities to "train, retain and reform" to build workforce capacity and capability. Investing in health visiting will provide families with more health visiting support to confidently manage minor illnesses and improve their health literacy, alongside the reinstatement of health visitor baby and child health clinics to increase the accessibility and visibility of support in the heart of communities.

4. **A national model of effective practice is needed to reduce ED attendances in children 0-4 years with relatively minor and self-limiting conditions. This model should support local Integrated Care Systems to improve prevention and early intervention through health visiting services and maximise digital solutions.** One model under consideration would be the Healthier Together model (see Appendix 2), which provides: simple and easy to navigate resources including prominent risk assessment information while in contact with NHS and health visiting services; key messages reinforced with digital solutions; and training to improve communication by health professionals to reassure and empower parents. Local evaluation found that when parents received consistent, explicit safety-netting advice from a health practitioner, they were less likely to re-attend and the model is currently being rolled out across an increasing number of NHS regions.

5. **Further research is needed to**:

   - Evaluate health visiting baby and child health clinics, including the impact that different models (drop-in, or appointment only) have on the identification of need or the improvement of outcomes (comprising access, experience, child/ family health indicators, the reduction of inequalities, and wider system benefits including impact on ED attendance rates for children aged 0-4 years).

   - Examine how health visiting skill mix teams operate and the impact that different levels of staffing have on the identification of need or the improvement of outcomes (comprising access, experience, child/ family health indicators, the reduction of inequalities, and wider system benefits including impact on ED attendance rates for children aged 0-4 years).

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