Health Visitors in England fear for some children's futures as their numbers are reduced

Results from a Survey of English Health Visitors

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Institute of Health Visiting
Excellence in Practice

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Two years on from a move to local authority commissioning in England

For the last five years, the Institute of Health Visiting has surveyed its members on the 'State of Health Visiting'. Here, we report some of the findings of our most recent UK-wide survey, which had a response rate of over 1400 health visitors. This brief report is based on responses from health visitors in practice in England, by far the largest part of the sample. The Institute is very anxious regarding the speed at which local authorities are reducing health visiting posts as this will impact on the wellbeing of children and families, this year's survey has borne out that anxiety.

The timing of the move of health visitors to local authority commissioning was unfortunate, being accompanied by cuts to public health budgets on top of the significant cuts to local authority budgets. Despite the Government mandating five health visitor led contacts for every child, many local authorities have sought ways of delivering these contacts more economically, using a less qualified children's workforce under the supervision of health visitors – which is likely to be less effective. The iHV has been given inside information that even greater cuts to the health visitor workforce would have been made in some areas without the mandate.

The most recent NHS digital workforce figures demonstrate a fall of over 2000 whole time equivalent (WTE) health visitors between October 2015 and August 2017 - although this is not a complete figure, as data is no longer collected on how many health visitors are employed outside the NHS. From our survey, 51% reported cuts to HV posts, 16% reported cuts to their skill-mix team, 12% were awaiting news of the scale of expected cuts, or reported frozen posts and students not employed, only 22% said there had been no cuts where they worked.

1. Leading and delivering the Healthy Child Programme

The Healthy Child Programme (HCP) is a national programme of health prevention and health promotion (Department of Health, 2009). At its heart is a schedule of health and development reviews that should be provided to all families with children under five. This forms the basis for searching for and identifying health needs.

The HCP is designed to improve breastfeeding rates, transition to parenthood and perinatal mental health amongst other public health priorities. Our survey responses indicate that health visitors' capacity to deliver all of the five mandated health and development reviews of the HCP in England is now seriously reduced. These reviews are the minimum required by the HCP in England. In the rest of the UK, more contacts are specified (11 in Scotland and 8-10 in Wales), which must be carried out by health visitors - yet in England, reviews are being increasingly delegated to less qualified practitioners and/or not carried out.

We asked: ***'Thinking about the Healthy Child Programme/Universal Provision, are you or a team member able to deliver each of the following mandatory (in England) five assessments and the recommended 3-4 month assessment 'service offer' to all families on your caseload, either personally or by delegating to a team colleague?'***

Our respondents reported that their teams were offering these contacts to **all** families in the following proportions:

- >90% New Birth Visit
- 76% 6-8 week assessment – otherwise reviews are provided on a 'targeted' basis by health visitors
- 29% Antenatal visit to all families – otherwise reviews are targeted
- 67% to all families, 9-12 month developmental review
- 66% of health visiting teams can offer a 2-2.5 year review to all families.
- Only 12.5% can offer the 3-4 month maternal mental health assessment advised by NICE to all families (in 2015 – 25%)
- 15% are always able to offer listening visits to mothers identified as experiencing postnatal depression, with 36% offering them mostly and 27% some of the time. This is worse than in 2015, when 27% were able to offer listening visits all of the time.

The survey results indicate that health visitors are increasingly focused on the most vulnerable children and families at the expense of the five reviews, and that the Healthy Child Programme is being implemented in an increasingly 'targeted' manner, against its fundamental design principles of full access to it being the right of every baby born in England.

The result is that HVs cannot be confident that they are identifying needs or providing early primary prevention. 60% state their ability to make a difference is hampered by ***'Focusing only on those most at risk [that] dilutes universal service'***; rather, they are managing risk with children and families with known needs.

2. Safeguarding and protecting children at risk

We asked: ***'How confident do you feel that children are being sufficiently safeguarded locally?'***

More than a third of health visitors said ***'we are stretched and there may be a tragedy in our area at some point'*** and, therefore, they are carrying risk whilst threshold criteria for other services, including children centre services, speech and language, social services etc., have risen. This is up from 25% in 2015 and suggests a very unsafe situation both for children and for health visitors who have to manage that risk and worry, and know they may be blamed if a child is injured.

Repeated comments were offered about raised thresholds of risk applied by children's social services in accepting or acting on referrals for safeguarding concerns:

> *'I see the HVs in my area struggling with increased safeguarding and, because social care thresholds are so high now, there's nowhere to refer to and HVs are holding a greater level of risk.'*

> *'Thresholds for identifying children at risk have been raised in my county meaning that HVs are dealing with more vulnerability and working with families at risk of harm but Children's*

Services are less likely to accept referrals. Numbers of children on a Child Protection or Child in Need plan have reduced which gives a misleading picture of safeguarding here and increases risk to children in my opinion.'

This has an impact on the capacity of health visitors to provide a universal preventive service:

'I feel that health visitors are doing more because of the families that do not reach thresholds of children's social care… I find we are in more and more positions of monitoring families, or doing welfare checks, even if there are no specific health needs, where other services can step back we have to stay involved. It is worrying that it is left to the accountability of the health visitor when children's social care do not accept referrals.'

Practitioners also report that 'Early Help', rather than facilitating preventative support, hinders access to help by its bureaucratic nature and association by families with child protection:

'The biggest concern is that our partners in social care are also stretched & that access to support for families is often via the completion of an Early Help Assessment - that is time consuming so that help that is available may not be accessed due to our pressures & clients not wanting an Early Help Plan.'

3. Caseloads

21% or 1 in 5 of health visitors said they are working with caseloads of over 500 children as against 12% in 2015, when funding was transferred from NHS to local government and set at a recommended 'minimum floor' of three whole time equivalent health visitor for 1000 children. The iHV recommends an average of 250 children per health visitor.

The survey shows there is great variety in how caseloads are calculated and defined as local arrangements proliferate, departing from national norms and the evidence base. These reflect more targeting of work away from a universal primary preventative service, more delegation to less qualified staff, combined with increasing use of 'corporate caseloads'. Rather than managing their own diaries and prioritising their work, some are even having their diary management being undertaken by a clerk with no knowledge of how health visitors work, which undermines their flexibility. It is not surprising that health visitors report that they can no longer offer continuity of relationships to their families – which is what families most value from the service, and what improves outcomes.

4. Quality of services: Impact on children and their families

- Only 48% of health visitors report they can now offer continuity of care to families 'all or most of the time', as against 67% in 2015.
- 73% of health visitors say that they are not confident that health visitors will be able to contribute fully to the care of pre-school children in the future
- 73% report seeing a rise in poverty affecting families they visit in the past 2 years, which increases the need for health visiting support to mitigate the potential harm to pre-school children
- 46% describe their service as contact driven, whilst 41% describe it as outcome driven.

The results indicate that with increased caseloads, unmet need, and high thresholds for 'early help', health visitors are struggling to deliver their commitment to universal coverage of the mandatory review included in the HCP, while also meeting other needs within their caseloads. Increasingly, they also report productivity is being measured by the number of visits, rather than what takes place within them.

The biggest **barriers to 'making a difference'** to families include:

- Focusing only on those most at risk 62%
- 42% can *only* offer continuity of care to vulnerable children and those subject to child protection processes (26% in 2015)
- Inability to change basic circumstances – 67%
- 'Lack of time' to set up support groups – 70%
- Lack of continuity/ chance to get to know the family 49% (35% in 2015)

Research shows that what clients value most about health visitors is a trusted relationship over time that can provide authoritative support and advice in a way that is tailored to their family circumstances. The service is especially valued by those who find group and centre-based services stigmatising (Scottish Government, 2015).

This is in tune with the research that demonstrates that effective health visiting is predicated on health visitors having the time and skill to build a trusting relationship with every family (Cowley et al, 2013). This allows them to explore each family's unique needs, and if necessary to embrace difficult discussions, supporting families to make positive changes in their lives, or in the care of their children, or alternatively, to accept referrals to other services. Health visitors develop their unique skills over many years of professional training and have the ability to flex them to meet the needs of each and every family.

These survey results suggest that many health visitors are no longer able to deliver a quality health visiting service and hence to identify families in need early, thereby protecting the children they have responsibility for.

The impact of this situation is not just on families, it is also on the emotional wellbeing of health visitors with many reporting very high levels of stress and working very long hours.

The iHV plans to share these results with all those who have the power to act, influence or drive positive change. The change required isn't just to increase public health budgets, although we see that as the most fundamental change particularly since the Return on Investment from public health interventions is high, largely because they reduce later demands on health and social care services (Masters et al 2017). In addition, local authorities need to better understand health visiting and its power to promote and protect children's health and reduce the burden of safeguarding and care proceedings and indeed their future costs from these areas.

Health visitors across the country continue to strive to deliver an excellent service to children and families. However, it is essential to engage with our local authority colleagues and providers, to share best practice and innovation at this challenging time.

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