

# State of Health Visiting in England

**Are babies and their families being  
adequately supported in England in 2020  
to get the best start in life?**

**December 2020**

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## The Institute of Health Visiting is a Centre of Excellence:

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

## Acknowledgements

We would like to thank the 1012 health visitors who took the time, often outside work, to complete our survey this year. Without your feedback, it would be impossible to get a true picture of health visiting from the point of view of those on the front line. This report has been prepared by the iHV professional team. We would also like to thank Lisa Jacobs, for bringing it to life with her design, and Julie Cooper, our Communications Manager, for handling its distribution and publication.

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## Executive Summary

Our 7<sup>th</sup> annual survey was completed by 1012 health visitors from across the UK during October and November 2020. This report presents the findings from 862 health visitors in practice in England and highlights the range of issues facing the profession, with significant unwarranted variation in the quality of services available to parents depending on where they live.

This year's survey findings particularly tell the story of the impact of the COVID-19 pandemic on babies and young children in England and the services intended to support them. As the world "locked down", the attention of the Government and policy makers was focused on stemming the spread of the coronavirus and treating infected patients, mostly adults. The secondary impacts of lockdown were initially poorly understood, with the needs of the youngest and most vulnerable in our society largely overlooked.

Our survey reveals health visitors' experiences of working with families with soaring rates of domestic violence and abuse, mental health problems, neglect, child behaviour problems, poverty affecting families and use of foodbanks, issues that were also of concern pre the pandemic. Whilst this very significant increase in need and subsequent demand for support was not unexpected by health visitors, the service was ill-prepared for the consequences of the pandemic following years of austerity and plummeting health visiting workforce numbers.

### Headline findings:

- **Widening inequalities with increased safeguarding risks and need.** Babies and young children in disadvantaged families have been disproportionately impacted by COVID-19 due to compounding factors like overcrowded housing with lack of outdoor space, the impact of poverty, and parental stress and anxiety, with more families tipped into vulnerability:
  - » 82% of health visitors reported an increase in domestic violence and abuse
  - » 81% an increase in perinatal mental illness and poverty
  - » 76% an increase in the use of food banks and speech/communication delay
  - » 61% reporting an increase in neglect
  - » 45% an increase in substance abuse.All of which represent key Government priorities to reduce inequality and the cumulative burden of late intervention across government departments.
- **A reduction in the capacity of the service to support families.** Health visiting entered the pandemic in an already depleted state, with its capacity to support families further reduced due to:
  - » the redeployment of over 50% of health visitors in some areas
  - » the NHS categorisation of the health visiting service as a "partial-stop" service in the Community Prioritisation Plan. The needs of vulnerable children known to the service were prioritised. Only 17% of health visitors were able to offer all families a 9-12 month review themselves this year, and this dropped to 10% for the 2-2.5 year review.
  - » the shift to "virtual contacts" in a service that was not designed to be delivered in this way and without the evidence to support effective implementation. Whilst technology has provided a useful alternative to face-to-face contacts for some parents,
    - 89% of health visitors felt that video contacts were not as effective as face-to-face contacts for identifying needs/enabling disclosure of risk factors in their work with vulnerable families. This will leave many vulnerable babies and young children invisible to services and without the support that they need.
- **Unmanageable caseloads:** Health visitors provide a universal "safety-net" for vulnerable babies and young children. Their capacity to support families and identify vulnerability is dependent on their ability to work with families and build trusting relationships to elicit need and broker engagement in early intervention:

- » 65% of health visitors had caseloads with over 300 children under 5 years.
- » 29% of health visitors report caseloads of 500+ children.
- » Worryingly 12% of health visitors report caseloads of over 700 children (one health visitor reported a caseload of 3000 children).

N.B. the optimum maximum caseload for effective practice is 250 children, and less in areas of high vulnerability.

A third of health visitors surveyed feel they are '*stretched and there may be a tragedy in our area at some point*'.

- **A lack of consistency in support offered to families dependent on where they live.** The unwarranted variation in the health visiting service has been recently described as the “Wild West”<sup>1</sup> of support, with calls for improved governance to ensure all families can access support proportionate to need, when they need it. Cuts have had consequences in all areas leaving vulnerable babies and children invisible:

- » 65% of health visitors said that, “Focusing solely on those most at risk (safeguarding) leaves limited capacity to deliver prevention/ early intervention”
- » 56% were concerned that they were only reaching the “tip of the iceberg”, raising concerns about families who are “seldom reached” by support services.

Despite this, the public health skills of health visitors have been showcased making a difference in this pandemic, with health visiting teams going above and beyond to keep children safe through local innovations - see ***Making History: health visiting during COVID-19***<sup>2</sup>.

- **The impact of the current state of health visiting on workforce wellbeing:**

- » 75% of health visitors report increased levels of work-related stress.

As a direct result:

- » 70% are working longer hours
- » 48% reported feeling demotivated
- » 34% of health visitors said that, due to stress, they would leave health visiting if they could

As we set out in this report, the pandemic has amplified the widening inequalities in our country and the impact of years of cuts to the health visiting service. Health visiting should provide a “universal safety-net” for all babies and young children, delivered by Specialist Community Public Health Nurses, ideally placed to reach out to families in the biggest public health challenge we have faced in our lifetime.

**With a growing body of evidence, we now know that many children are being harmed by the secondary impact of the pandemic. Whilst the vaccine presents a glimmer of hope of a “light at the end of the tunnel”, we cannot knowingly overlook the needs of children now and as we live with the virus for the foreseeable future.**

Out of the pandemic there is a unique opportunity to learn from the experiences of parents and frontline health visitors, to build a Healthy Child Programme of support that is fit for purpose and achieves the long-held ambition that every child should truly have the best start in life.



## 1.0 Introduction

This report captures the experiences of more than a thousand frontline health visitors working across the United Kingdom during 2020; the year that the world “locked-down” due to the COVID-19 pandemic. The enormous impact of the virus was felt across all sectors of society and cannot be underestimated. At the start of the pandemic, the overwhelming priority to stop the spread of COVID-19 and treat infected patients was clear for all to see. What was less clear was the secondary impact of lockdown on babies and young children, who were largely invisible to policy makers, and whose needs remain overlooked.

From the earliest weeks of the pandemic, evidence was being shared by countries, including China, France and Italy, of families feeling the strain of lockdown, with increased rates of domestic violence and abuse, and mental health problems. This was exacerbated by the cumulative impact of businesses shutting down, more families being tipped into poverty and the grinding impact of social isolation on “normal” human interaction. Families having babies during 2020 also missed out on the usual celebrations and support from family and friends, alongside significantly reduced levels of support from healthcare and voluntary agencies. Harrowing stories of women being separated from loved-ones during traumatic life events have emerged, with a call for system-wide learning from the first lockdown and a consensus that we need to “build back better”.

Sadly, the impact of this is borne out in the experiences of parents described in the “Babies in Lockdown”<sup>3</sup> report:

*“Thousands of parents across the UK are struggling and feel that services are not able to respond to their or their babies’ needs. While these are exceptional circumstances, the crisis has exposed deep issues that have been ignored for too long”*

It has taken a global public health pandemic to shine a spotlight on the vital safety net that health visitors provide to children and families, as well as the incredible resourcefulness of health visitors to go “above and beyond” to ensure that the needs of families were met. However, it has also exposed the gaps and pressures faced by the service for many years, leaving some to ask whether we are facing a ‘break or make’ decision for the health visiting service and profession across the UK, and in England in particular.

Our 7th annual survey was completed by 1012 health visitors from across the UK during October and November 2020. This report presents the findings from health visitors in England and highlights the range of issues facing the profession, with significant unwarranted variation in the quality of services available to parents depending on where they live.

## 2.0 Results of the State of Health Visiting Survey 2020

### 2.1 The impact of COVID-19 on families

Health visitors work with a very wide range of health and social issues, straddling the three types of vulnerability defined by the Government during the pandemic<sup>4</sup>: clinical vulnerability; vulnerability that requires a statutory response (e.g. child safeguarding – Child subject to a Child Protection/ Child in Need Plan; Looked After Children; children with Special Education Needs and Disabilities); and vulnerability due to the wider determinants of health on children and families (e.g. domestic violence and abuse; parental mental health problems; parental substance misuse; poverty, homelessness etc...).

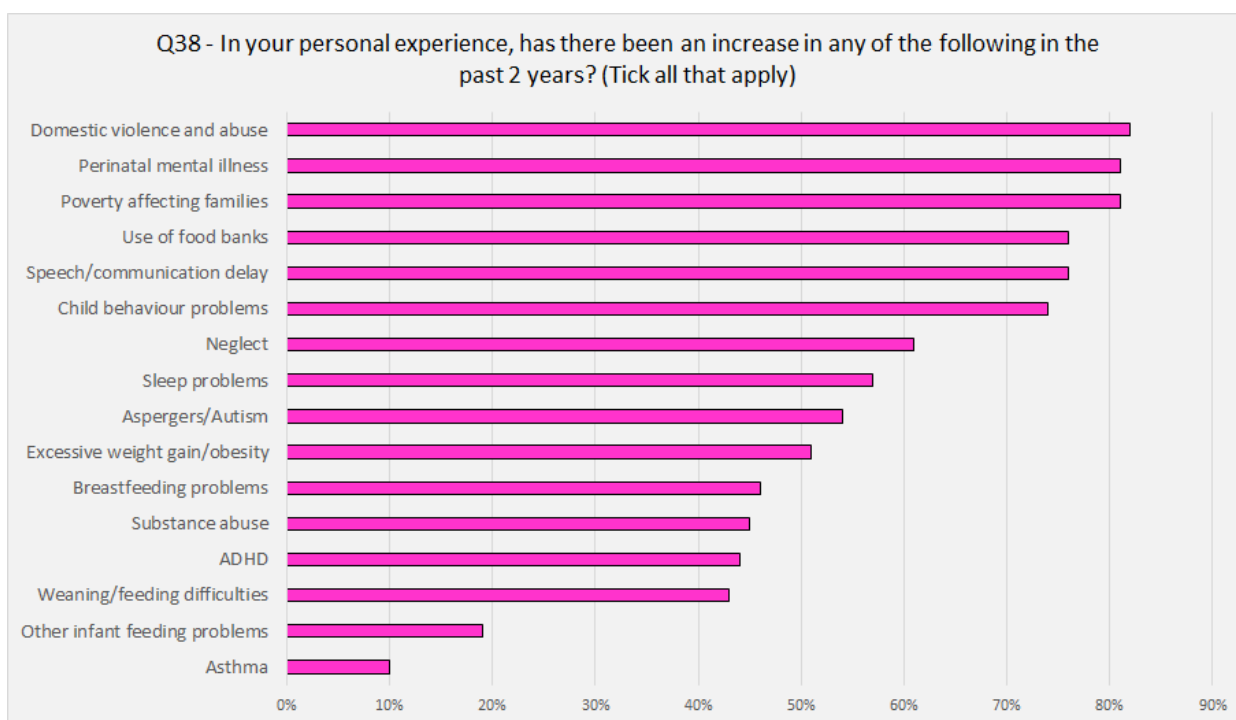
#### 2.1.1 Increased need/vulnerability during 2020

Unsurprisingly, this year health visitors have reported increasing levels of vulnerability and demand on their services, due to the additional impacts of the pandemic. Health visitors’ concerns for babies and young children are shared by others, with councils reporting a 20% rise in incidents of serious harm to children under one from suspected abuse or neglect, triggered by the “pressure cooker effect” experienced by families due to lockdown. Ofsted’s chief inspector, Amanda Spielman, has raised concerns that:

*“the alarming trend of increasing rates of intentional and unintentional harm to babies reflected the impact of deepening poverty, isolation and close family proximity as a result of the pandemic”<sup>5</sup>*

Health visitors work with all families, so with a diverse range of vulnerable and minority groups. As the only universal service reaching all families, health visitors are the “eyes and ears” for vulnerable babies and young children who are easily hidden from sight, being less visible than older children who are afforded some protection by the safety net provided by schools.

In their responses to our survey, **many health visitors expressed concerns that they are only identifying the “tip of the iceberg”** as their capacity to identify need is curtailed by reduced face-to-face contact and caseload size. Health issues are exacerbated by social issues to the extent that they cannot be readily separated, for example the impact of poverty on parental mental health and child behaviour concerns.



**What health visitors said about increased need/vulnerability:**

*“Lockdown measures are hiding vulnerable children and families, and having a detrimental effect on mental health”*

*“Sadly, we are seeing an increase in deaths where there is history of domestic abuse, substance misuse, neglect, babies in unsafe sleep environments.”*

**2.1.2 Impact of other support services**

Health visitors report less availability of other services which families can access and higher thresholds of need for referrals to be accepted. Notably, 90% identify a reduction in children’s centre services and children’s social services. It is therefore unsurprising that health visitors report role drift towards carrying risk for other agencies (child protection) at the expense of preventative public health.

*“Children’s services do a lot of talking and assessing but getting actual hands on practical support for a family is really hard. E.g. mum with severe mental health difficulties, having frequent suicidal ideation - no local family support - really struggling to cope with meeting emotional needs of children aged 2 and 8, play, stimulation - clear attachment issues. I suggested family support worker to go in... This did not happen. All SW does is visit every 3 weeks or so and sit on sofa and ask her how she is!”*

*“I am concerned that the area we work in has such high levels of safeguarding. Thresholds for social care seem higher than other neighbouring local authorities and many families are not accepted who I feel should be under their care, leaving just the HV team involved which raises risks”*

*“Lack of services outside to help... Working with partner agencies who do not have the required resource”*

## 2.2 Health visiting in 2020

### 2.2.1 A system under strain

The COVID-19 pandemic imposed an unprecedented public health challenge on an already depleted service following year-on-year cuts to the public health grant and a **31% reduction in health visitors since 2015<sup>6</sup>**. The impact of the pandemic on health visiting is twofold:

- **Increased risk and need**; more families with babies and young children have been tipped into vulnerability due to the secondary impacts of lockdown, with health visitors reporting more families living in poverty, significant increases in cases of domestic violence and abuse, mental health problems and safeguarding concerns.

AND

- **A reduction in the capacity of the service to support families** due to:
  - » the initial categorisation of the health visiting service as a “partial stop” service in the NHS Community Prioritisation Plan which stopped many elements of the Healthy Child Programme;
  - » the redeployment of more than 50% of health visitors in some areas away from supporting families;
  - » requiring access to PPE to visit families;
  - » a need to rapidly introduce virtual contacts for many families but initially often without the systems in place;
  - » ever falling workforce numbers.

As a result, the ‘reach’ of health visitors’ was diminished for babies and young children already invisible to other agencies. Health visiting services have adapted and responded at an impressive pace and scale, working in partnership with others, to ensure that the needs of vulnerable families were prioritised. This has in many cases included working long hours, adapting to rapidly changing situations and new ways of working, often with inadequate IT equipment and PPE, and for months on end. The impact of working during the COVID-19 pandemic on staff wellbeing cannot be underestimated.

Despite these efforts, many families have not received the support that they needed during the COVID-19 lockdown: new parents reported increased need as well as challenges in accessing support to the *Petitions Committee*<sup>7</sup>, their experiences were captured in a report - *Babies in Lockdown*<sup>8</sup>, and the recent early years’ survey by the Royal Foundation<sup>9</sup>.

There is an urgent need to support babies and their families to prevent immediate and long-term harm. A wealth of evidence shows that exposure to significant stress in the womb, or early life, can have pervasive and lasting impacts on multiple domains of development<sup>10</sup>. The risks of early trauma and adversity can be mitigated with the right support. Rapid action is needed so that babies do not become the “collateral damage” of actions to protect the nation’s physical health, with long-term consequences for our children and our society.

### 2.2.2 Putting families first - opportunities to “build back better”

In the face of these challenges, health visiting teams have gone above and beyond through the pandemic to keep children safe and respond to increased need in innovative ways, as is seen in this recent iHV publication ***Making History: health visiting during COVID-19<sup>11</sup>***.

The annual iHV State of Health Visiting survey was undertaken deep in the trough of the 2nd wave of the COVID-19 pandemic, when its future course was unpredictable. However, there has been considerable learning from the wave 1 response, with greater recognition of the significant impact of lockdown on children and families. ***Now we know better, we need to do better***. It is clear that this crisis for the public’s health requires a public health response for which health visiting is a key component.

Green shoots of hope for the health visiting profession include: the planned refresh of the Healthy Child Programme in England; the Early Years Review<sup>12</sup> by Rt Hon Andrea Leadsom MP and her team; the cross-party Early Years Commission led by the Fabian Society and the Centre for Social Justice; as well as the Government's stated commitment to rebuild the economy in ways that are intended to 'level up' inequalities.

The professional regulator, the Nursing and Midwifery Council, is also reviewing standards for Specialist Community Public Health Nursing with bespoke standards for health visiting. These set an ambitious vision for health visiting leadership with a confirmed level of highly skilled practice for the future.

## 2.3 Service quality

Variations in the service level and quality have widened across the four nations of the UK in recent years, with a dramatic downturn in England as a whole and between local authorities.

### 2.3.1 Continuity of carer and quality of relationships

The provision of continuity of practitioner which enables the development of a health visitor-client relationship is widely recognised as an important factor in parents' satisfaction with the health visiting service. Parents want to be treated as an individual, with a personalised service which is responsive to their individual circumstances and needs, rather than a "one-size fits all" approach. The findings from our survey for this quality indicator remain substantially unchanged from 2019:

**3.1%**

Only 3.1% of health visitors told us they are able to offer continuity of health visitor to families all the time.

**45%**

of health visitors said they could offer continuity of health visitor "most of the time", a fall from 65% in 2015.

**44%**

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

*"I feel families need more continuity of care, practitioners should be responsible for their own caseload to build rapport and trusting relationships however this is not happening. Families often say 'they don't know who their HV is'"*

### 2.3.2 Service delivery methods - video contacts

Health visiting services followed government advice, adapting their practices to incorporate the Guidance on prioritisation within community health services<sup>13</sup>. The guidance stopped many elements of the Healthy Child Programme except antenatal and new birth contacts, with advice that other contacts should be assessed and stratified for 'vulnerability or clinical need'. The method of delivery was changed to virtual contacts, unless there was a compelling need, i.e. from face-to-face home visiting to phone, or video, contacts. Necessity was clearly the mother of innovation with 84% reporting that they were able to undertake video contacts when our survey was completed in late autumn.

We asked health visitors for their views on the use of video contacts to effectively support their work with universal and targeted families with risk/ vulnerability:

**89%**

disagreed or strongly disagreed with the statement that, "video contacts are as effective as face-to-face contacts for identifying needs/ enabling disclosure of risk factors in my work with vulnerable families."

**85%**

felt that contacts could be delivered effectively using video when families required quick advice or information between universal contacts,

**65%**

disagreed or strongly disagreed with the use of video contacts for families requiring additional support/ universal plus service offer, for example, perinatal mental health problems.

88%

disagreed or strongly disagreed with the statement that video contacts were “fit for purpose for universal partnership plus contacts (e.g. safeguarding, domestic violence and abuse, substance misuse, vulnerable families)”.

While under COVID-19 restrictions, health visitors rapidly adopted video contacts, only 26% felt that there was enough evidence to safely roll out video-enabled contacts in health visiting. Many respondents were concerned that video contacts would become the “new normal” as a replacement for face-to-face, without consideration of the wider impact on quality of care or effectiveness, once the lockdown restrictions had eased:

*“Feel we are in danger of being phased out and replaced by video calls from family centres.”*

*“[Future contract] Reduced funding with 2 priority face to face visits from April 2021”*

*“I feel we are being stretched and can see virtual visits being the norm which is a concern”*

*“I believe the service is being actively run down to lower parents’ expectations and the cost of provision and increase profits. I believe COVID-19 is providing an excellent excuse for this.”*

#### What health visitors said about the impact of video contacts on service quality and effectiveness:

*“The pandemic has hugely affected the quality of service. Families with babies born during the first wave suffered greatly with no face-to-face contacts.”*

*“COVID-19 restrictions prevent holistic assessment. Communication by telephone is limited and although video calls give a little more insight it is not the same as completing a home visit”*

*“It is my belief that [video contacts] cannot match face to face contacts, but in the absence of this possibility, due to COVID-19, it is an excellent alternative!”*

*“I feel that that the restrictions on face-to-face contacts during COVID-19 has made the difficult task of safeguarding children even harder. Families with children who need the most support are typically the hardest to reach, parents are non-compliant and difficult to engage... the proportion of safeguarding contacts has now significantly increased (now completing face-to-face), with many more cases of domestic violence and neglect being particularly highlighted”*

*“I feel that we are able to access more people via video and phone, however as other services are closed there is a lot more pressure to meet the needs of new parents. It has therefore increased the level of pressure and practice.”*

*“Using video calls is OK but you lose the real essence of a proper face-to-face contact. Clients often say they miss the group activities at the children’s centres and the drop-in weighing clinics. Both these provide contact with other mums and professionals. I know that a video call is the next best thing I can offer my families but it’s not as good as meeting face to face even wearing PPE.”*

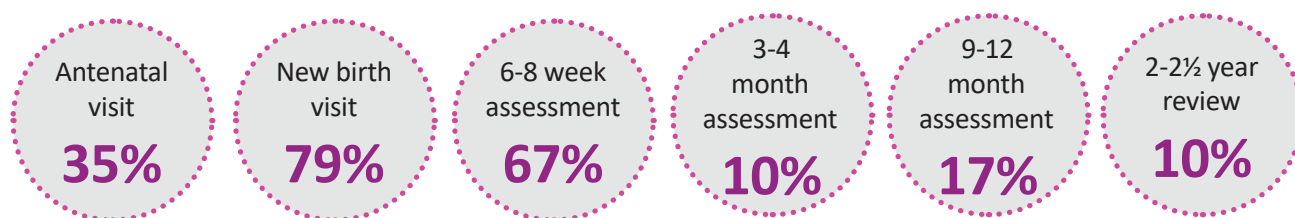
*“Video contacts do not allow a sense for the family’s circumstances to develop. It’s hard to assess if it is safe to ask about domestic abuse”*

### 2.3.3 Coverage of the mandated reviews/ delivery by a health visitor

There are five reviews of health and development in England that are mandated components of the Healthy Child Programme that health visitors are expected to lead and deliver. All families in England should receive all of the five mandated contacts (more in the rest of the UK) as a minimum universal level of service. Prior to the pandemic, PHE confirmed that all five contacts should be provided by a health visitor and should be face-to-face. During the early weeks of the pandemic, PHE paused the requirement for submission of health visiting service delivery metrics. Last year, we highlighted the considerable unwarranted variation in uptake of these reviews, which is likely to have been further impacted by the pandemic.

Our survey and an NSPCC survey<sup>14</sup> indicate that coverage of mandated universal reviews is clearly not achieved universally in England, or in keeping with their mandated status. Only 11% of parents of under twos who responded to the “Babies in Lockdown”<sup>15</sup> survey had seen a health visitor face-to-face.

We asked all frontline health visitors with a caseload in England, **“Which of the following mandated (in England) five assessments and the recommended 3-4 month assessment ‘service offer’ to ALL families do you, a practising health visitor, complete yourself?”**



#### What health visitors say:

*“Low numbers of health visitors, more of the core contacts are been delegated to the skill mix teams.”*

*“The biggest barrier is the lack of respect and investment in the HV service and the idea from senior managers / commissioners that staff nurses / Family Support Workers or Community Nursery Nurses can do the HV job and for less money. They do not allow us to work at the capacity of our skills such as manage minor illness and prescribe - and they do not respect our skills and contributions - they just see us as expensive and they run the HV service in a tick box manner because it is reviews that generate income - and what we do is difficult to quantify and measure (but that does not mean it is impossible) and there is a poor focus on the long-term strategy for supporting vulnerable children and poor investment in the early years”*

### 2.3.4 Workload - ratios of health visitors to under fives

The findings from our survey highlight that:

**65%** of health visitors had caseloads with over 300 children under 5 years.

**29%** of health visitors report caseloads of 500+ children.

**12%** Worryingly 12% of health visitors report caseloads of over 700 children (one health visitor reported a caseload of 3000 children).

The optimum maximum caseload is 250 children and less in areas of high vulnerability.

*“Increased caseloads due to inappropriate contracts being agreed where HVs are expected to manage higher and higher numbers of children and families. This leads to stress in the team which leads to sickness and people leaving. The turnover of staff is significantly high and there is less job satisfaction.”*

The survey findings emphasise significant variation in caseload size, depending on where health visitors work. Caseload size is important as it directly impacts on the amount of time that a health visitor is able to spend with families on their caseload, which in turn will impact on the quality and effectiveness of the service.

However, these results on health visitor caseload size should be viewed with caution as many comments from respondents indicate that estimating this number is very difficult:

*“I’ve no idea! This is not due to lack of interest or attention but, rather, a lack of systematic data and inconsistent approaches to population coverage.”*

The configuration of caseloads has also changed in recent years with some health visitors only covering caseloads which count children 0-2 years of age; others have entirely “universal partnership plus” or high-risk children.

#### What health visitors say:

*“My team is quite well staffed, this isn’t the same throughout the trust”*

*“We have been trying to get this info from management for ages. Not sure how many whole-time equivalents we are on at the moment, as I said, we are employing agency [staff], also team leaders and management get included in the head-count, but they do no clinical work.”*

*“Massive lack of staff and huge caseloads. Community nursery nurses are included in our WTE caseload numbers. HV caseloads are over 700 clients per WTE HV but this is hidden by including the nursery nurses, making our caseloads look a lot smaller. HV always hold all the responsibility so this should NOT happen”*

*“You are kidding?! Do you think anyone pays any attention to that?”*

*“After the 2-year review we have to discharge from caseload, so the numbers of under 5s are higher than this.”*

*“It’s miserable and we are going to end up with no HV’s by default. How can I safely run a case load of 3000 in [borough]...and when a child dies, I will end up in a Serious Case Review and being pilloried and have to live with this.”*

#### 2.3.5 Safeguarding and protecting children

A third of health visitors surveyed feel they are ‘stretched and there may be a tragedy in our area at some point’ while 42% ‘sometimes worry that we can’t quite do enough’.

#### What health visitors say:

*“We had a baby death this year – our reduced service didn’t pick up problems which may have avoided this tragedy.”*

*“The entire service is on a knife edge waiting to be involved in the next Serious Case Review and hung out to dry by management due to a lack of risk assessments that reflect the work we are doing. I am petrified for my registration with the NMC.”*

*“60%+ reduction in health visitors (most of our highly experienced health visitors left). There is massively reduced peer support. Introduction of frequently changing and complicated multi-system IT approaches to managing diary, meetings & safeguarding communication - feels unsafe, [so it’s] very easy for things to get missed & children to ‘fall through the net’.”*

*“The threshold for referrals into social care is very high.”*

*“The threshold for [name of local authority] is high, it often seems impossible to get children services to accept anything except physical harm, everything else is downgraded to [Early Help] and then cases are closed when parents don’t engage. It’s very frustrating.”*

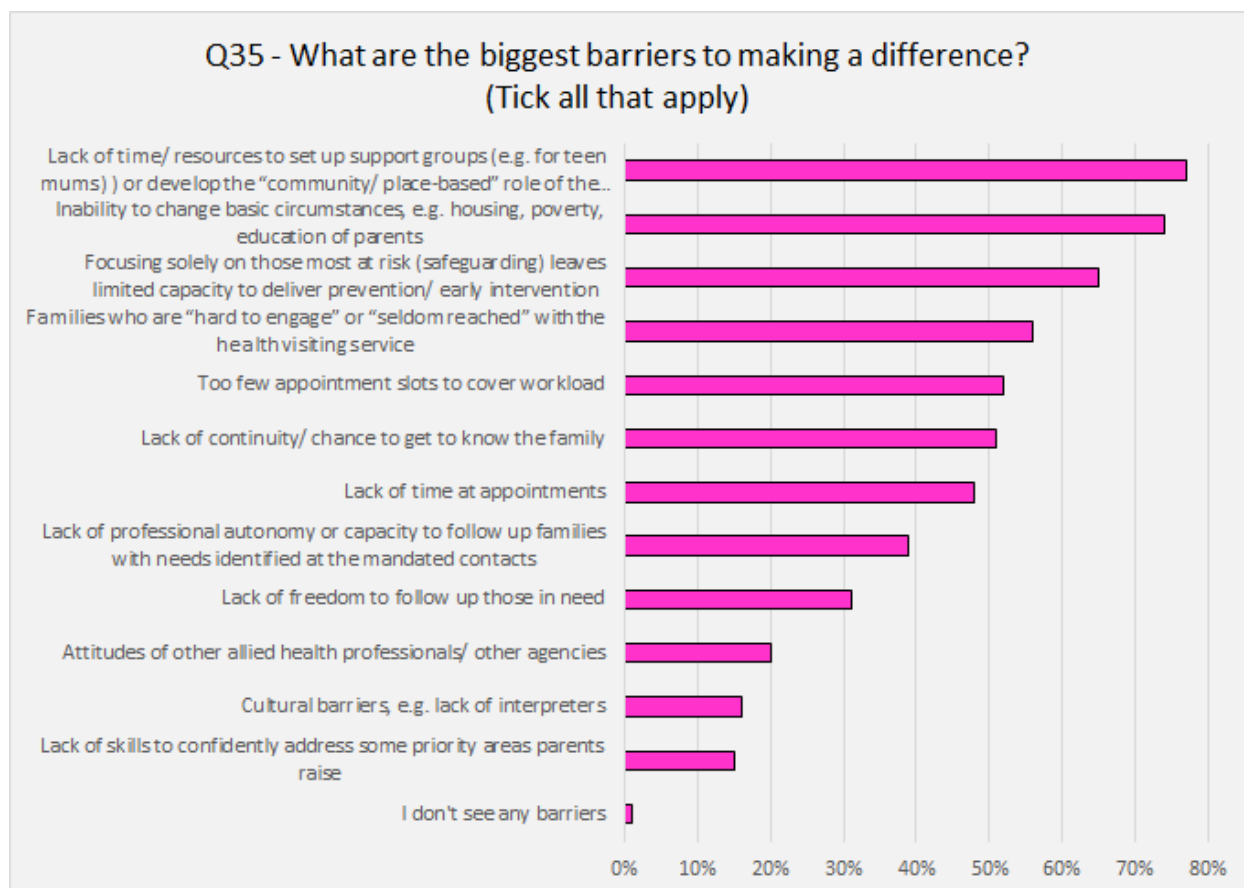
Other surveys indicate a surge in child protection referrals following ‘lockdown’<sup>16 17</sup> when children and young people were ‘invisible’ to schools. Babies at home are all the more ‘invisible’ to services. Pre-COVID, the Children’s Commissioner highlighted that in England only 20,000 babies are identified by children’s services to be at risk, raising concerns about the number of invisible children, estimated to be more than a third of all vulnerable children<sup>18</sup> who are not known to services and therefore not getting any support. Health visitors are the only universal service that systematically reaches to all of these on a preventative basis as an essential ‘safety net’ and support.

### 2.3.6 What are the biggest barriers to making a difference?

While 17% of health visitors reported feeling that they were able to ‘make a difference’ to children and families, a further 51% believed that they were able to make a difference but would like the opportunities do more. However, 31% answered, “No, my time is spread too thinly to be able to make much of a difference.”

There are many reported barriers to making a difference, tabulated below. Many of these reflect the reductions in health visiting and other services resulting in less time and fewer resources available to health visitors. The Child Safeguarding Practice Review Panel’s *Review of sudden unexpected death in infancy (SUDI) in families with children at risk*<sup>19</sup> reports that the pressure from health visitors’ caseloads and the time constraints means that the opportunity to build relationships and explore vulnerabilities is limited, particularly in areas of high deprivation.

Lack of continuity of care and relationships with families correspond precisely to what we know parents most value about the service<sup>20</sup>. Health visitors report they are diverted from following up needs identified, and they are limited in their capacity to develop community initiatives that support prevention. In the meantime, focusing solely on those most at risk (safeguarding) leaves limited capacity to reduce the number of children requiring these interventions through “upstream” early intervention and prevention. Health visitors also described their concern at the inability to change basic circumstances, e.g. housing, poverty, education of parents, with widespread awareness of the importance of collaborative approaches across sectors to improve public health at a community level.



### 2.3.7 Can health visitors contribute fully to the care of under-fives in the future?

#### What health visitors say:

*“If properly resourced, health visitors can make a huge difference in the lives of both universal and targeted families.”*

*“Families are already receiving little support from health visitors and this has worsened due to COVID-19. It is heart breaking to read the negative comments on social media from families about our role and how they have not seen a health visitor. We are stretched to capacity due to being short staffed, sickness etc. Yes the workload is forever increasing.”*

*“HV Service is fragmented, no longer searching for health need, but focused on KPI targets and vulnerable (children/families) only.”*

*“I think universal care is dead to qualified HV’s and will be completed by band 3/4/5 support staff in the first instance by video contact. Qualified HV’s will do targeted work at UPP level and above, compensating for social work cuts – (vulnerable children will be missed).”*

*“Not unless there is an understanding that building relationships and home visiting is vital for early prevention and recognition of the health needs of the family to include the fathers”*

*“We need the balance between safeguarding and our true public health role to be re examined. Our time is increasingly being taken up with safeguarding, leaving us as highly skilled public health practitioners being unable to carry out the role we trained for and qualified.”*

*“...watered down service , not seen as important by local authority”*

### 2.3.8 Contact with GPs

Last year we reported our survey finding that health visitors were becoming more detached from GPs. This year’s findings indicate that this trend has continued with regular contact being the exception and almost a quarter reporting meeting either ‘occasionally / not often’ or ‘as needed’, respectively. Health visiting and primary care are the two universal child health services that together provide for prevention and healthcare when operating in a seamless manner. The fragmenting of child health services since the transfer of commissioning of child and family public health to local authority commissioning implies a structural issue that should be addressed, perhaps through Primary Care Networks and Integrated Care Systems.

### 2.3.9 Burden of KPIs and administrative functions

Health visitors reported that time spent on lengthy record keeping tasks and data collection to comply with performance targets were reducing the amount of time that they had available to provide direct support to families:

*“We spend a high proportion of our time as glorified administrators - ticking endless boxes, lots of training which ticks boxes for the organisation but isn’t what we need”*

*“We need to increase numbers, scrap nonsense KPIs, focus on patient’s needs and support staff wellbeing”*

### Summary of service quality findings

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

## 3.0 Workforce-related findings

### 3.1 Redeployment

Health visiting services followed government advice, adapting their practices to incorporate the *Guidance on prioritisation within community health services* (NHS England and NHS Improvement, 2020 – now redacted from .gov website). The guidance included a statement that services should ‘prepare staff for redeployment’, which was interpreted in different ways by local emergency planning teams.

In our survey:

**20%**

of respondents reported that they were redeployed during the restrictions and service priorities applied from March<sup>21</sup>.

There was significant variation in the level of redeployment between areas:

- » Almost 20% of health visitors reported that **50% or more** of their team were redeployed.
- » However, in contrast, 58% of health visitors reported that **10% or less** of their team were redeployed.

Redeployment significantly reduced the workforce in some areas, leaving the remaining health visitors to manage increased caseloads, reducing the amount of time available to support individual families.

*“During redeployment families were left with little to no support”*

### 3.2 Unmanageable workloads

Since 2015, there has been an estimated 31% reduction in health visitors<sup>22</sup>. This year, 90% of health visitors reported that their workload had increased over the last 2 years with 50% attributing this to there being fewer health visitors. However, many reported that their workload had been impacted by multiple factors with cumulative impact:

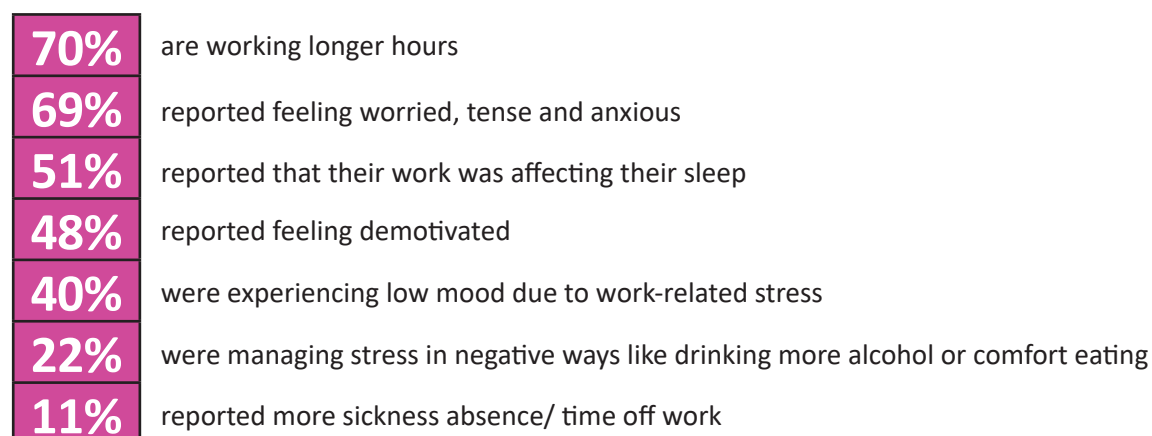
*“There isn’t one sole reason, there are fewer staff in post, other services have been reduced or disappeared completely, KPI’s have driven a more tick box focused way of working meaning more time is spent on IT to ensure data is recorded in the correct way to capture outcomes, the needs of the population is steadily increasing and, with COVID-19 then hitting, this has only increased further! This leads to stress in the team which leads to sickness and people leaving. The turnover of staff is significantly high and there is no job satisfaction for anyone.”*

*“Workload has increased for a number of reasons, too few HV’s, HV sickness, increased birthrate and trying to spread our skills over a 0-19 service.”*

### 3.3 Workforce wellbeing: The impact of work-related stress

The current COVID-19 pandemic has changed the way in which health visiting services are delivered in the UK. Health visitors are now having to work more remotely, using virtual methods for service delivery as well as using Personal Protective Equipment (PPE) for face-to-face contacts. This rapid change has resulted in many health visiting staff working under greater levels of pressure, feeling isolated, anxious and unsettled.

Stress levels are reported as increased by 75% of health visitors. As a direct result:



Our findings are consistent with research from University College London<sup>23</sup> that reported:

**“The COVID-19 pandemic, lockdown and associated changes to the health visiting service have put the health visiting workforce under significant stress at a time when the service has already sustained significant funding and workforce cuts over the past few years. Our survey data paints a bleak picture of the wellbeing and mental health of staff working in health visiting during COVID-19. 67% of respondents reported that their stress levels at work have increased over the past year.”**

Health visitors are a highly skilled workforce, used to managing complex situations and multiple competing priorities. However, the impact that redeployment, ever-increasing caseloads and escalating need has had on families and the health visiting workforce cannot be underestimated.

There is a well-evidenced link between staff wellbeing and quality of care delivery. The WHO<sup>24</sup> recently highlighted that:

**“...keeping all staff protected from chronic stress and poor mental health during this response means that they will have a better capacity to fulfil their roles.”**

A recent report by the King’s Fund<sup>25</sup> also highlighted the importance of focusing on the health and wellbeing of nurses and midwives, which is essential to the quality of care they can provide for people and communities, affecting their compassion, professionalism and effectiveness.

### 3.4 Sources of support

While there are sources of support that can be identified, pre-eminent is the support of family and friends, closely followed by informal support from work-based peers.

Only 49% of health visitors had access to clinical supervision. Some respondents described how they had positively adapted their support to staff, using platforms like Zoom. Although others described how the COVID-19 pandemic has made accessing these informal sources of support more difficult, resulting in more isolation as they worked from their own homes:

*“Sometimes it’s hard to protect this time”*

*“COVID-19 has made informal support from peers (in the office/over lunch) almost impossible and this is one of the hardest things to deal with over the last 6 months especially being a newly qualified HV”*

Only 19% of health visitors reported having access to restorative supervision.

*"We haven't had restorative supervision since pre-COVID. I have just escalated this as a concern to the service lead as we have never needed it more"*

### 3.5 Will the 2020s break or make health visiting?

Our survey indicates that many health visitors are at breaking point. Redeployment gave a message that their essential work was in fact regarded as non-essential and those health visitors remaining at their front line, reaching out virtually and from behind PPE, report being overwhelmed by the level of need and anxiety for vulnerable babies, young children and their families. A cut-down 'light touch', routinely-delegated service is a broken service that is a parody of what we know families value and makes a difference to them<sup>26</sup>.

Those parts of the UK and English local authority areas that have maintained and supported health visiting services have, on the other hand, shown vision and often exemplary practice, with survey respondents reporting:

*"I feel our HV's have done an excellent job in supporting families despite the restrictions put upon them"*

*"HVs were not redeployed, work processes were streamlined, video consultations have been introduced increasing uptake of AN contacts, continuity of care has been provided"*

*"We have maintained all mandated contacts throughout COVID-19, including face-to-face if needed"*

### 3.6 Reflections on health visiting

Many health visitors took the opportunity to say how they loved their job and their profession with the high level of training and skills they are able to offer to families.

Whilst all health visitors reported the negative impact of COVID-19 on their service to a greater or lesser degree, compassionate leadership and integrated partnership working underpinned successful services and improved staff wellbeing:

*"Our managers have been fantastic at how they have adapted to the COVID-19 pandemic and innovative in the ways they have been able to offer support and contacts to families."*

*"It is a fabulous profession and we have the opportunity to help change outcomes for families but our work is hard to quantify and we need to get smarter in the way we measure our outcomes (less numbers based) and we need to shout more about what we do to media and government and just generally raise the level of awareness of our role."*

*"I do love my job and enjoy working with the families even though it can be very stressful at times as the clients have become even more needy since COVID-19."*

Health visitors were keen to see the learning from COVID-19 being used to improve the service in the future, but were not confident that this was being maximised:

*"We do not always learn from what has happened before and basic common sense do not always apply when changes are being made."*

*"What a time to be completing this! I am feeling thoroughly unsupported, demotivated and isolated. I have asked my manager for support but she doesn't know what to do or say and just says take a holiday. I just need some encouragement and recognition of my work. I have been a HV for almost 30 years, I have coped with a lot of change and challenging situations in my time. This pandemic is so hard to cope in I am close to going off sick with the stress and strain of constantly supporting colleagues who have gone off sick long term."*

*"I would like more autonomy to make changes in my practice that I believe would improve service provision and make outcomes better for children."*

Sadly, 34% of health visitors said that, due to work-related stress, they would leave health visiting if they could:

*"I have been qualified for 1 year and I am already feeling very stressed due to the heavy workload. This is my dream job and one that I love almost every aspect. I am reluctantly looking at alternative jobs because of this."*

*"I am planning to end my career as a HV despite my previous love of the job for many years. My redeployment made me realise just how awful the role has become and I can no longer continue trying to deliver the high standard of care that I would like as its detrimental to my own health as I have to do so much in my own time to achieve this. I cannot be the tick box robot that is expected now so I will be returning to nursing and wasting all the specialist skills I have. I am one of many feeling this way! It's too late for me but hopefully this survey will help to keep others."*

*"I dislike what we have become I feel ashamed and embarrassed when a new parent asks when will I see you again."*

## 4.0 Conclusion

The pandemic has brought further strain to the already depleted health visiting workforce in England, with escalating levels of need against a backdrop of reduced service provision. However, the response to the pandemic has not been consistent; some areas retained all of their health visiting workforce to ensure that the care of children and families was prioritised, while others experienced high levels of redeployment.

It is important that we learn from the first wave of the pandemic. In the words of Maya Angelou:

***"I did then what I knew how to do. Now that I know better, I do better."***

The findings from our survey this year provide a window into the experiences of babies, young children and families who have faced the cumulative impact of stress from a variety of sources pre and during the pandemic, as well as the impact on the health visiting service intended to support them. COVID-19 spread and hit families and the healthcare system at an unexpected pace and scale at the beginning of the year.

Whilst the vaccine brings the glimmer of a "light at the end of the tunnel", **considerable learning from the first wave of the pandemic presents a policy imperative to better support babies, young children and their families NOW**; they cannot wait and failing to effectively address their needs will only store up significant problems for the future.

**Prevention and early intervention are not only kinder than cure - they are also an awful lot cheaper.**

Out of the pandemic there is a unique opportunity to learn from the experiences of parents and frontline health visitors and build a Healthy Child Programme of support that is fit for purpose and achieves the long-held ambition that every child should truly have the best start in life. Whilst children were largely forgotten in the first wave of the pandemic, with the justification being that we did not know what the impact on them would be - this is no longer the case.

**With a growing body of evidence, we now know that many children are being harmed by the secondary impact of the pandemic and we cannot knowingly overlook their needs again, as we live with the virus for the foreseeable future.** It is encouraging to hear words of support for children from the Government in recent months. These words must now be translated into the action, investment and policy directives that are required to strengthen support for families and make the much-needed difference.

Health visitors provide a universal "safety-net" for babies and young children and their services are needed now, more than ever. **Finding vulnerable families with babies and young children is problematic without the universal health visiting service** which also coordinates support and works in partnership with others within an integrated "whole system" approach for the earliest years of life.

The findings from our survey cannot be ignored if we are to sustain a health visiting service that is fit for the future and able to support the Government's ambition to "level up" society, which starts in the critical earliest years of life. The pandemic has exposed significant flaws in the way this nationally-funded health visiting service is prioritised and delivered locally. The evidence for health visiting has never been stronger, as well as the importance of getting it right in the very early years to strengthen the whole health economy over time. Historically, health visiting has co-evolved with the emerging health needs of society from the earliest days of Florence Nightingale's vision of 'health nursing'<sup>27</sup> and it continues to innovate. We need to capture this learning to strengthen and fully restore the health visiting service.

Our survey indicates that health visiting is at a make or break point in England, lacking consistency and struggling with insufficient resources to deliver the Healthy Child Programme in the way it was intended. The iHV has set out a positive Vision for Health Visiting<sup>28</sup>, based on the best evidence of "what works" and the views of parents<sup>29</sup>, alongside published case studies<sup>30</sup> of how the profession continues to innovate despite the pressures of the COVID-19 pandemic<sup>31</sup>. However, service quality and the health visiting workforce requires urgent reinvestment and leadership at both national and local levels. We, alongside others, made representations<sup>32</sup> to the recent Treasury Spending Review seeking reinvestment in the health visiting service to ensure that it not only survives, but thrives, thus realising the prospects of the nation's children and families to do the same. Unfortunately, as yet our representations have not been responded to.

## 5.0 Key policy recommendations

Government needs to find a way to protect this vital workforce **into the long term** so that its activities are no-longer at risk from policy changes by subsequent governments. In our submission to the planned Comprehensive Spending Review in the autumn, we set out our recommendations to the Government:

1. Government funding for health visiting should be increased by £206m<sup>33</sup> a year to increase the number of health visiting substantive posts in England by 5000 to 13,000<sup>34 35</sup>. This will reverse the 31% reduction in health visitors since 2015, with a further increase to ensure an average recommended caseload size of 250 children aged 0-5 years per WTE health visitor<sup>36</sup>. The benefits of an effective health visiting service accrue to numerous government departments through its contribution to many key national priorities, which if unaddressed carry a significant fiscal burden, and by providing a vital safety net for vulnerable babies and young children who are often hidden from other statutory services. Increasing the health visiting workforce will ensure families receive additional universal and targeted support as recommended by the Health and Social Care Committee<sup>37</sup>.
2. Additional government funding of £218m<sup>38</sup> is needed to train 6000 health visitors over the next four years to offset the current national shortage of health visitors and projected 20% shortfall in the future due to retirements and attrition.
3. To strengthen health visiting leadership capability, an additional expenditure of £4m is required to provide a leadership development programme for health visitors to help transform models of care in the way that the Government is due to outline within its existing commitment to refresh the health visiting model for England and the Healthy Child Programme.

In light of our survey findings on the impact of working in a pandemic on the wellbeing of health visitors, we set out the following additional recommendation:

4. A clear plan of support is needed for all publicly-funded health visitors, regardless of whether they work in the NHS or not, to restore and maintain staff wellbeing during the ongoing pandemic and recovery phase.

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