Institute of Health Visiting
Excellence in Practice

State of Health Visiting in England

"We need more health visitors!"

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Contents

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 everyone who took the time to complete our survey this year – we surpassed our target with 1,291 responses. Your feedback, as the 'eyes and ears' of the community, helped us gain a true picture of the realities that health visitors are facing in practice, with workforce challenges and escalating levels of population need - without a universal health visiting service, much of this need would be hidden from sight. This report has been prepared by the iHV professional team. We would like to give special thanks to Georgina Mayes, Lisa Jacobs and Julie Cooper for handling its data collection, evidence synthesis, distribution and publication.

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Executive Summary

Our 8th annual health visiting survey was completed by 1,291 practitioners from across the UK during October and early November 2021. The survey is conducted the same way every year, with some topics and questions changing from year to year. This year we achieved a large sample size, providing a significant weight of evidence on the changing needs of families with babies and young children and the current state of health visiting. The results provide a rich time trend, adding a depth and context to the findings that no other measure of health visiting services provides.

This year, 1,186 survey respondents were from across England – we achieved good geographical spread across all regions. Where country specific data is presented, we have indicated where this is 'England only' or where we have presented data from the devolved nations as a comparison for interest (although due to the small sample size from the devolved nations, we recognise that data from our survey alone is not representative of these countries).

We publish at a time of unprecedented crisis for health services, the economy and society as we seek to rebuild in the wake of the COVID-19 pandemic. The findings from our survey tell the story of escalating levels of population need and vulnerability experienced by families with babies and young children, and a 'postcode lottery' of health visiting support.

The pandemic is not over – what is clear is that its impact on families has been significant. The findings from this survey present health visitors' unique view into the lives of babies, young children and their parents/ carers who are often hidden behind front doors and invisible to other services. Health visitors reported soaring rates of domestic abuse, mental health problems, child behaviour problems, poverty, and child safeguarding.

The pandemic hit the profession at a time when it had the least capacity to meet these rising levels of need. Following years of cuts, there is now a national shortage of 5,000 health visitors. Against this backdrop, health visitors did not stop, they have risen to the challenges and demonstrated that they are a modern, innovative, and responsive workforce[1] which has continued to support families as far as possible through the most difficult circumstances.

However, despite health visitors' best efforts, in many areas, services are so stretched that they can only reach the 'tip of the iceberg' of need due to reduced workforce capacity to meet these needs. There are stark and unwarranted variations in the level of support provided by the best and worst performing areas in England and compared to the much more comprehensive level of support provided by health visitors in the devolved nations.

The resounding headline message to policy makers is captured in this report's sub-title which is a direct quote repeated hundreds of times throughout the survey responses...

"We need more health visitors".

Headline findings

- **Babies, young children, and families' needs are increasing:**

  Over the last twelve months health visitors have seen widening health inequalities with an increase in vulnerability and safeguarding risks:

  - 81% of health visitors reported an increase in perinatal mental health problems
  - 80% an increase in domestic abuse
  - 71% an increase in child safeguarding.

  Alongside this:

  - 86% of health visitors reported an increase in speech, language, and communication problems
  - 80% an increase in child behavioural problems
  - 72% an increase in poverty affecting children and families.

- **Not enough health visitors to meet the rising levels of need:**
  - 42% of health visitors worry that they "***can't do enough to safeguard babies and children***"
  - Only 4% of health visitors in England are **always able** to offer **continuity of carer** which families value
  - Only 3% of health visitors in England report being able to provide an '***excellent***' service.

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Cuts to health visitor workforce numbers in recent years have left the remaining health visitors with unmanageable workloads:

- **Only 9% of health visitors** in England work with the recommended ratio of 250 children aged 0-5, or less, per full time equivalent health visitor (FTE HV); compared to around two-thirds of health visitors in Scotland and Wales
- **In Scotland, only 3%** of health visitors are accountable for **over 500 children** per FTE HV, compared to **49% of health visitors in England**
- Worryingly, **more than 1 in 4 health visitors in England** are accountable for **over 750 children** (in Scotland and Wales, no health visitors have caseloads of this size).

- **A 'postcode lottery' of support:**

As the cuts to health visiting have not been applied equally across local authorities, families face the brunt of this with a 'postcode lottery' of support. Services are so stretched in some areas of England that many families are not receiving their mandated Healthy Child Programme universal contacts with a qualified health visitor:

- 85% of health visitors in England still complete all new birth visits; the remaining 15% of health visitors reported that, for some families, this key assessment contact is now completed by practitioners who are not health visitors
- Only 21% of health visitors report that they are able to offer all families the antenatal contact
- Only 21% of health visitors are able to offer all families a two-year review
- Only 6% of health visitors in England reported that they had sufficient capacity to adequately supervise and support non-health visiting staff completing delegated work – compared to 73% in Scotland.

- **Innovation – video-enabled contacts:**

Health visitors have led the way in developing new ways of working to reach as many families as possible. Video-enabled contacts have brought some welcome benefits. Our survey findings highlight that video contacts cannot be simplistically evaluated in a binary way – as either 'good' or 'bad' – their effectiveness depends on when, where, and how they are used.

After more than 20 months' experience of using virtual contacts:

- 88.6% of frontline practitioners 'agree' or 'strongly agree' that they can be used effectively to provide families with quick access to advice for straightforward concerns between universal contacts.
- However, the majority of practitioners reported that video contacts **could not** safely or effectively replace face-to-face universal assessments; their use also introduced safety-critical risks for health visitors' work with vulnerable families:
- 93.8% of practitioners 'disagree' or 'strongly disagree' that video contacts are as effective as face-to-face contacts for identifying needs or enabling disclosure of risk factors in vulnerable families
- Only 16% of practitioners thought there was enough evidence to safely roll out video-enabled contacts in health visiting.

- **Health visitor workforce crisis: "We need more health visitors"**

Health visiting in England is now facing the biggest workforce challenge in living memory with an estimated shortfall of 5,000 health visitors[2]. Our survey shows that:

- 52% of health visitors in England are aged between 50-65
- In England, only 28% of respondents reported that they were training enough **student health visitors** to maintain health visiting workforce supply needs (in contrast, in Scotland, 54% of health visitors said that they were training enough).

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

Working effectively during a pandemic has come at a personal cost to all staff working in health visiting teams. Health visitors reported increased levels of work-related stress due to unmanageable caseloads and rising levels of vulnerability within families:

- 68% of health visitors report that they are working longer hours
- 39% that they are experiencing low mood because of the stress of the job
- 13% that they have had sickness absence due to work-related stress.

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Our call to action:

As the country looks to 'Build Back Better' for all its citizens, we call on the Government to make good their pledge to 'rebuild health visiting'. Health visitors provide a vital infrastructure of support for all families, and a crucial safety-net identifying vulnerable babies and young children who are often otherwise invisible to services.

The findings presented in this report are reinforced by those reported by other organisations working with families[3]. Collectively, they provide important evidence for policy makers to inform their learning on the impact of the pandemic on families and frontline health visitors. We urge the Government to consider the implications of these findings on their plans to deliver the Start for Life vision[4] to support families in giving their baby the best start in life.

We call on the Government to make good their pledge to 'rebuild health visiting' with 3 specific policy calls:
1. **Funding** - We are calling for a £500 million ring-fenced uplift in the Public Health Grant over the next three years to reverse years of cuts, deliver the Government's pledge to 'rebuild health visiting', and ensure sufficient resource to deliver the full breadth of the Healthy Child Programme of prevention and early intervention to all families. A ring-fenced grant would provide protection from political cycles of disinvestment.
2. **Workforce** - We need 5,000 more health visitors in England with the specialist community public health nursing skills to support families through prevention and early intervention, and address a multitude of physical and mental health needs, child development priorities, social issues and safeguarding concerns which can impact on outcomes for babies and young children. Workforce forecasting, training, recruitment, and retention plans are needed to address current capacity issues and predicted losses, build leadership capability, and support succession planning.
3. **Quality** - An end to the 'postcode lottery' of health visitor support. Real, meaningful accountability in public service delivery is needed to ensure that families receive personalised and effective support to improve child outcomes and reduce inequalities wherever they live. The iHV is concerned that the Budget outcome metrics for the "Start for Life" plans all relate to 'education' and that 'health' has been overlooked. History has shown us that 'you get what you measure' and, without effective levers to assure the quality of health visiting services, this will lead to further erosion of preventative public health and weaken the health visiting contribution to multiple health pathways.

A frontline health visitor speaks for many:

> *I love my job, when I have time and resources to do what families need me to do, if not it feels like we are all constantly chasing our tails and overwhelmed with the fall out of cuts to services in other areas and the impact of poverty continues relentlessly…*
>
> *Our team is stretched so thin we dread new vulnerable families being added to our caseload, thinking where on earth are we going to get the time to support them?*
>
> *But we do, we make it happen, we turn up every day and keep going, our families would never know we feel this way if you asked them. I am so proud of my colleagues, we do more than any system, or Key Performance Indicator could capture, but unfortunately it feels like no one will understand that until we are gone!*

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1.0 Introduction

Our 8th annual health visiting survey report captures the experiences of frontline health visiting practitioners working across the United Kingdom in 2021, at a time when the COVID-19 pandemic continued to impact on the lives of babies, young children, and their families. Over the past year, health visitors have supported thousands and thousands of families every week through the third national lockdown between January and March 2021, and subsequently through numerous local lockdowns and changes in national and local policy. Throughout this time, health visitors did not stop in their efforts to support families in the best way that they could. They demonstrated their breadth of skills as Specialist Community Public Health Nurses, as well as leaders and innovators, quickly developing and embedding new ways of working to ensure that as many families as possible were supported.

The iHV 'State of Health Visiting' survey was completed by 1,291 practitioners from across the UK during October and early November 2021. Our survey is conducted the same way every year, with some topics and questions changing from year to year. This year we achieved a large sample size, providing a significant weight of evidence on the changing needs of families with babies and young children, and the current state of health visiting. The results provide a rich time trend, adding a depth and context to the findings that no other measure of health visiting services provides.

This year, 1,186 survey respondents were from across England– we achieved good geographical spread across all regions. Where country specific data is presented, we have indicated where this is 'England only' or where we have presented data from the devolved nations as a comparison for interest (although due to the small sample size from the devolved nations, we recognise that data from our survey alone is not representative of these countries).

We publish at a time of unprecedented crisis for health services, the economy and society as we seek to rebuild in the wake of the COVID-19 pandemic. The findings from our survey tell the story of escalating levels of population need and vulnerability, and a 'postcode lottery' of health visiting support. The pandemic is not over – what is clear is that its impact on babies, young children and families has been significant. The findings from this survey present the health visiting service's unique view into the lives of families, often hidden behind front doors and invisible to other services, with reports of soaring rates of domestic abuse, mental health problems, child behaviour problems, poverty, and child safeguarding.

2.0 Results of the State of Health Visiting Survey 2020

2.1 The secondary impact of the COVID-19 pandemic on babies, children, and families

Health visitors are a unique, specialist 'health' workforce with the skills and experience to support babies, young children, and adults across numerous clinical pathways for physical health, and mental health, as well as social needs, child development and safeguarding concerns. Health visitors reach out to families and build relationships with them, preventing problems happening in the first place, spotting problems early and providing a vital safety net for babies and young children who are invisible to other services and can easily fall through the gaps between services.

England is lagging behind other countries on many key child health outcomes: infant mortality reductions have stalled; breastfeeding and obesity rates are amongst the worst in Europe; and health inequalities have widened across all indicators[5]. The recent MBBRACE UK[6] report highlights widening inequalities for pregnant women, with gaps in mortality rates between women from deprived and affluent areas, women of different ages, and women from different ethnic groups. Our survey findings mirror the evidence of widening health inequalities, with health visitors seeing an increase in safeguarding risks and health and social care needs across many clinical pathways.

COVID-19 is still having a significant impact on pregnant women, babies, children, and their families as well as the health visiting services which support them. Health visitors are reporting soaring rates of mental health problems, domestic abuse and child safeguarding concerns. It is evident that the majority of frontline health visitors have witnessed increasing needs across several health and social care pathways in the last twelve months (see Table One) .

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Table One: Percentage of health visitors reporting increased need across a range of indicators:

Speech, language and communication difficulties	86%
Perinatal mental health problems	81%
Child behaviour concerns	80%
Domestic abuse	80%
The use of food banks	72%
Poverty affecting babies, children, and families	72%
Child safeguarding	71%
Sleep problems	60%
Autism	56%
Breastfeeding difficulties	48%
Child development concerns	45%
Substance misuse	41%
Homelessness	39%
Attention deficit hyperactivity disorder	38%
Childhood obesity	37%
Growth concerns (including faltering growth)	36%
Managing childhood illnesses	24%
Long-term conditions/disabilities	5%
Asthma	4%

Health visitors are the 'eyes and ears' of the community. Working with all families, behind 'front doors', they act as an 'early warning system' of the impact on the pandemic on expectant parents and families with babies and young children.

What health visitors said about increasing need and vulnerability:

> *COVID-19 has had a massive impact on child development, perinatal mental illness, domestic abuse, child behaviour problems, child safeguarding, sleep problems, breastfeeding problems etc… because parents haven't had the face-to-face support they needed.*

> *I am worried about how we will manage when the refugees arrive as they will come with needs and trauma and, as far as I am aware, no budget has been given to us to help support these families*

> *Health visiting is at crisis point in my area. Shortages of health visitors and an increasingly complex picture of health and inequalities is emerging. Lack of universal services has been exacerbated by systems trying to recover from the COVID pandemic… families are slipping through the cracks and are not getting the support, information and referrals they need to thrive*

> *COVID has increased parental pressures in childcare, and adapting to home working…. Parents have identified delays in developing child's socialisation, increased separation anxiety and adverse behavioural issues.*

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2.2 Health visiting capacity to meet increasing need

Health visiting in England faces the biggest workforce challenge in living memory with an estimated shortfall of 5,000 health visitors, representing a loss of around one-third of all health visitors since 2015[7]. Our survey shows that the workload of health visitors has increased over the last year with 45% of health visitors highlighting increasing needs of the population as one of the top reasons for this. Prioritisation has a human cost; the combination of increased need with reduced health visiting capacity has left health visitors in a position where they need to prioritise one family over another. These difficult decisions are captured in the quote of one health visitor who stated that they can only do the "***urgent work but not the important work***". This is not the service that parents deserve or one that health visitors want to provide.

In the last year, we have seen escalating rates of child protection, with almost 200 cases of serious harm or death of a child under the age of one reported in national data; this represents a 31% rise compared to the previous year[8], and **babies under the age of one remain at the highest rate of homicide for any age group**[9]. Health visitors told us that they are deeply concerned about the rising numbers of child safeguarding cases:

- 39% of health visitors **feel so stretched** that they "***worry there may be a tragedy in their area***" and
- 42% of health visitors worry that they "***can't do enough to safeguard babies and children***".

> *I am being forced to prioritise only the most important tasks which makes me feel that I am not delivering a quality service and potentially missing things.*

> *I still love my job, however the last year has been stressful beyond belief. I live in fear of missing something*

> *Children social care (CSC) criteria for referral is so high now, we have on our caseloads families that in the past would be having input from CSC.*

> *Staffing levels are unsafe and, in our area, we are heading for a tragedy. We are unable to recruit as we have had a service redesign that is failing spectacularly. Clients no longer have continuity of care and are moved from Universal to Enhanced [caseloads] continuously. Staff have no job satisfaction as it has become a task and tick exercise*

3.0 Quality

3.1 Coverage of the mandated Healthy Child Programme reviews

The revised Health Visiting Model for England[10] which was updated by Public Health England (PHE) in March 2021 is designed to be 'universal in reach and personalised in response' and recommends an additional two contacts at 3-4 months of age and 6 months of age, alongside the five mandated assessments. With countless health visiting services running at critical staffing levels, despite health visitors' best efforts, many families no longer receive the basic service of five mandated contacts, let alone these recommended additional contacts.

Families face the brunt of years of underfunding and workforce cuts with a "postcode lottery" of support. Recent Health Visitor Service delivery metrics (Office for Health Improvement and Disparities, Nov 2021)[11] lay bare the unacceptable and unwarranted variation in the quality of the health visiting service in England. Table Two highlights that, apart from the new birth visit, metrics for all the other mandated reviews are worse than the previous year and indicate that the health visiting service is struggling to deliver the Healthy Child Programme as intended and has not been fully restored.

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Table Two: Uptake of the universal mandated health visitor reviews by local authority area:

Percentage uptake of the universal health visitor reviews by local authority area: range of uptake between worst and best performing local authorities (LA)		
Type of mandated contact	**Percentage uptake in lowest performing LA**	**Percentage uptake in highest performing LA**
New Birth Visit by 14 days	27.9%	99.9%
6-week review by 8 weeks	6.1%	99.6%
12-month review by 12 months	2.1%	99.1%
2-2½ year review by 2½ years	5%	99.4%

In our survey, we asked frontline health visitors which of the five mandated reviews they were able to provide themselves to all families. In recent years there has been a drift towards ever increasing reliance on practitioners who are not qualified health visitors to deliver these universal contacts.

Table Three: Delivery of the universal mandated health assessments by a qualified health visitor:

Healthy Child Programme Mandated Assessment	Percentage of health visitors who report that contacts are always completed by a qualified health visitor
Antenatal	21%
New Birth Visit	85%
6-8 week postnatal contact	71%
9-12 month review	30%
2-2½ year review	21%

What health visitors say about the quality of service they are able to offer to families:

> *The KPIs are met but that is not indicative of a good quality service*

> *Too much emphasis on processing children/families as a tick-box exercise instead of looking at what individual families need*

> *Staffing is down by 70%. We are providing minimal contacts only, the service we are offering our families is extremely poor*

> *We cannot provide a good service anymore, health visitors are only doing safeguarding and new births, not the job I trained for*

> *The look on parents faces when I say that they will probably not see me again as I leave.... No wonder parents feel let down*

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3.2 The impact of high caseloads

To provide a national benchmark, we asked survey respondents to calculate the ratio of full-time equivalent health visitors against the number of children aged 0-5 in their local population. We are aware that some areas are using different descriptors for health visitors' 'caseloads'. However, as the health visitor remains accountable for all children within a designated area, and for delegated work, this provided the fairest comparison between areas.

As health visiting is a preventative public health service, it is important that the caseload size includes all families based on the principles of proportionate universalism which is widely accepted as the most effective means to reduce inequality[12]. There is a significant body of evidence to support the case that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently, instead it may stigmatise those most affected while missing the opportunity to reduce the social gradient across the whole population who are all negatively impacted to a greater or lesser extent[13]. Actions must therefore be universal, but with a scale and intensity that is proportionate to the level of disadvantage. Health visitors working in areas of high vulnerability will require smaller caseloads to offset increased need.

Cuts to health visitor workforce numbers in recent years have left the remaining health visitors with unmanageable workloads:

- **Only 9% of health visitors** in England work with the recommended ratio of 250 children aged 0-5, or less, per full-time equivalent health visitor (FTE HV); compared to around two-thirds of health visitors in Scotland and Wales. (This is **three-times greater** than the maximum caseload size recommended by modelling developed by the UK Public Health Association[14], which immediately preceded and informed the 'Health Visitor Implementation Plan 2011-2015: A Call to Action'[15-16]).
- **In Scotland, only 3%** of health visitors are accountable for **over 500 children** per FTE HV, compared to **49% of health visitors in England**.
- Worryingly, **more than 1 in 4 health visitors in England** are accountable for **over 750 children** (in Scotland and Wales, **no** health visitors have caseloads of this size).
- In comparison, Scotland and Wales do not practise with caseloads of these sizes. Safer staffing levels are needed to ensure that all health visitors have a manageable caseload. It goes without saying that it is impossible for a single practitioner to be safely accountable for the assessment and care of over 750 children and their families at any one time.

Health visitors with large caseloads have to spread their time more thinly, resulting in less time available to support individual families. As a result, practitioners reported the following concerns:

- Families' needs, vulnerabilities and risk factors will be missed
- Late identification of babies and young children with health conditions and signs of disability – in some cases, this delay has a significant or catastrophic impact on prognosis
- Children at risk of poor outcomes and those with developmental delay will remain invisible and not receive the support they need to be ready to learn and ready for school.

Respondents with unmanageable workloads reported its negative impact on their job satisfaction. Many practitioners in this situation reported work-related stress and burnout:

> *I really like my job, I just want to be able to do it better, to give the families more with a reduced caseload so I can share my knowledge and expertise with the families. It's no good having the training and expertise that I do if I don't have the time to share it.*

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> *I have a huge caseload and don't have the hours in the day to give fully to all of these families*

> *I have not managed to complete my day in less than 11 hours for 18 months, I get paid for 8 hours. I am asked to do management, my specialist role and teach the workforce - it is not doable and although I love it, it is exhausting, and I have decided to retire at 55 rather than 60 as I cannot carry on like this.*

3.3 Innovative workforce, embracing new technology

During the pandemic, health visitors have demonstrated that they are a modern, innovative and responsive workforce[17] which has continued to support families through the most challenging times. Video-enabled contacts have brought some welcome benefits. Our survey findings highlight that video contacts cannot be simplistically evaluated in a binary way - as either 'good' or 'bad' – their effectiveness depends on when, where, and how they are used. After more than 20 months' experience of using virtual contacts:

- 88.6% of health visitors 'agree' or 'strongly agree' that video/ virtual contacts can be used effectively to provide families with **quick access to advice for straightforward concerns** between universal contacts.

However, the findings from the iHV survey of frontline health visitors, after 20 months' experience of using virtual methods more universally for Healthy Child Programme contacts, reported:

- 93.8% disagree or strongly disagree that video contacts are as effective as face-to-face contacts for identifying needs or enabling disclosure of risk factors in vulnerable families
- Only 16 % of practitioners agree that there is enough evidence to safely roll out video-enabled contacts in health visiting.

There is emerging evidence from COVID-19 research that a virtual contact can "***significantly hinder the practitioner's ability to safeguard vulnerable children due to its limitations in terms of actually seeing and assessing the children in person***", and concerns that they make it more difficult for practitioners to pick up on risk factors like bruising or evidence of substance misuse or domestic abuse[18]. More evidence is needed to inform when virtual contacts can be used safely and without negatively impacting on service quality. The assessment of families using virtual platforms excludes families who are experiencing digital poverty and disproportionately affects children who are 'clinically vulnerable' because they cannot be clinically assessed for symptoms like prolonged jaundice, faltering growth or poor muscle tone.

The second **Babies in Lockdown** report[19] by the Parent Infant Foundation, Best Beginnings and Home-Start highlighted that, whilst many areas have restored face-to-face contacts, 28% of parents are still having health visitor appointments via the telephone or online in their area and explained how this left them feeling "***unsupported***" and "***alone***".

Despite lacking evidence of safety or effectiveness of virtual contacts, on 16 September 2021, Public Health England extended their interim guidance that virtual contacts would continue to be counted as a valid method of recording health visitor service delivery metrics until the end of 2022[20]. In October 2021, the Institute of Health Visiting formally escalated its concerns to the Office for Health Improvement and Disparities that, without sufficient evidence to confirm the safety of virtual contacts for delivery of the mandated health reviews, this decision would be seen to endorse their use and would place babies, young children and families at increased risk of harm.

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What health visitors say about video/ virtual contacts:

> *Growing sense that HV are one of very few professionals that have seen children during COVID*

> *I would like more time to visit families and support. Face-to-face contacts are the best, and most effective, for the vulnerable group I work with, but not always possible*

> *Face-to-face contacts are crucial for relationship building*

> *Our job is so stressful now. Not supposed to see face-to-face at 6-week review unless 'known concerns' but most of us still do…. I feel totally not ok... How can we properly assess for mental health over video link that often freezes, delays, no privacy etc etc..?*

> *I cannot stress the value of skills and expertise of HVs and the importance of autonomy and face-to-face contacts for full assessment of needs /review. Services need to be delivered in a trauma-informed way, with a clear focus on attachment and the importance of early recognition of these difficulties.*

What parents say about video/ virtual contacts:

> *…But as a first-time mom in a pandemic with no other support, how would I know if something was going wrong?…*

> *"We've not seen anyone, we had a Zoom call at the 12-month check-up. Of all my friends, I was the only one that actually got a video call which was shocking. They didn't even get a phone call."*
>
> *"…when you're ringing health visitors, and they can't actually see your child, it's really difficult…"*

(Parent Infant Foundation, Best Beginnings and Home-Start, 2021)[21]

3.4 What are the biggest barriers to making a difference?

While 15% of health visitors reported feeling that they were able to 'make a difference' to children and families, a further 45% believed that they were able to make a difference but would like the opportunities to do more. However, 40% 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 in Table Four. Many of these reflect the reductions in health visiting and other services resulting in less time and fewer resources available to health visitors. As a result:

- **Only 4%** of health visitors reported that they are **always able** to offer **continuity of carer**
- **42%** of health visitors said they could offer continuity of health visitor "most of the time", a fall from 45% last year and 65% in 2015

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- **39%** of health visitors reported that they are only able to offer continuity of support to vulnerable families or those on child protection plans, rather than all families – a fall from 44% last year
- Only **3%** of health visitors reported being able to provide an '***excellent service***'.

Table Four: Biggest reported barriers to 'making a difference'

Lack of time to deliver groups and initiatives	74%
Inability to change basic circumstances	69%
Lack of capacity to follow up families with needs	66%
Focusing solely on those who are most at risk	61%
Families who are hard to engage or seldom reached	49%
Lack of continuity	49%
Too few appointment slots to cover workload	45%
Lack of understanding of HV role	42%
Lack of admin support	39%
Inefficient processes	34%
Lack of professional autonomy	30%
Appointment times are too short	19%
Cultural barriers (lack of interpreter)	16%
Lack of skills to confidently address some priority areas	14%
I don't see any barriers	0.5%

3.5 Outcome measures which improve outcomes

With rising caseload numbers, and a shift in recent years towards more prescribed ways of working, many health visitors reported that their ability to work as autonomous practitioners was being eroded. They expressed concerns that these changes were driven by perverse system incentives to achieve superficial process outcome measures (Key performance Indicators (KPIs)) which failed to capture service quality or the actual impact on child or families' experiences or health outcomes, describing this as "ticking the box but missing the point". Process outcome measures were deemed to be misleading as they produce good looking data but leave families and health visitors dissatisfied and mask the following:

- Unwarranted variation in health visitor support across England, with some families reporting that they hadn't seen a health visitor face-to-face for over a year[22]
- Lack of continuity of carer and relationships with families which correspond precisely to what we know parents most value about the service[23] and the Government recognises as central to effective outcomes[24]
- To cut costs, some areas are now completing the important health visitor mandated reviews with a postal or telephone contact despite evidence warning that this practice is unreliable and introduces unacceptable risks as the child is not seen.

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What health visitors said about measuring what matters:

> *We need a focus away from ticking the box of KPIs and on to asking the question 'Are we effective in our practice and is our practice delivering positive outcomes to reduce health inequalities?' We need the focus to be on best practice and giving every child the best start in life*

> *KPIs are important but senior management get too focused on them due to commissioning cycle and reducing budgets. 'Trying to make a silk purse out of a sow's ear' - you can only do some much with reducing resources*

> *Change the focus back to practitioners being able to use our skills to assess and provide support to families instead of worrying re ticking boxes… We need less focus on extensive reports for safeguarding families and more focus on health*

> *Sadly, health visiting in the way I trained 30 years ago is dead. It's now a tick box, KPI-driven service and I have no idea what it is achieving to be honest. I feel very sad about this for current and future parents and ultimately children*

4.0 Workforce

4.1 Health visitor workforce crisis: "*We need more health visitors*"

England has seen a loss of around a third of its health visitor workforce since 2015[25-26]. This is the biggest health visitor workforce challenge in living memory with an estimated shortfall of 5,000 health visitors[27]. The findings from our survey highlight that:

- 84% of practitioners in England have seen a decrease in the number of health visitors in the last year
- A small number of local authority areas are now investing in health visitors with 7% of respondents reporting an increase in health visitors in the last year
- 6% were 'unsure' of workforce numbers
- 3% had seen no change.

Our survey shows that:

- 52% of health visitors in England are aged between 50-65
- In England, only 28% of respondents reported that they were training enough **student health visitors** to maintain health visiting workforce supply needs (in contrast, in Scotland, 54% of health visitors said that they were training enough)
- Staff are still being redeployed from the profession to support other parts of the healthcare system like COVID-19 vaccinations.

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What health visitors said about workforce:

> *We need more health visitors*

> *Many health visitors and other team members are seconded out to the 12-15 immunisation team (thus more work left for us)*

> *There is less staff and more work… We are haemorrhaging health visitors*

4.2 Innovative workforce models - skill mix teams

Skill mix is not a new concept, and our survey results show that innovative service design has been implemented in many areas across the country to manage health visiting budget cuts. Our survey shows there is wide variation with skill mix across the country, showing both an increase and decrease in various roles. There is evidence of much less skill mix in Scotland, with health visitors completing all the 12 mandated health assessments as well as targeted interventions and safeguarding work[28].

In England, 43% of practitioners reported an increase in Registered Nurses working in health visiting teams. Decisions are driven by efforts to reduce costs as well as manage reported difficulties in recruiting qualified health visitors. It is worth noting that there is not much financial gain through using this model (with only £772 annual pay difference between a newly qualified health visitor and a Registered Nurse paid at the top of Agenda for Change Band 5[29]). However, there is a significant difference in the expertise and responsibilities of Specialist Community Public Health Nurses who are trained to work through prevention, assessment and early intervention with babies, young children, adults and communities, and across a breadth of public health priorities and clinical pathways for physical health, mental health and social needs, as well as child development and safeguarding.

Survey respondents valued skill mix team members and gave examples of areas where this was working well, utilising their skills as Registered Nurses qualified within a specific branch of nursing (adult, child, mental health or learning disability) and often on a career development pathway into health visiting.

Caution was expressed by some respondents from areas that had 'tried and tested' skill mix within health visiting teams and encountered significant problems and increased serious incidents due to the dilution of Specialist Community Public Health Nursing skills within the workforce, and practitioners working beyond the scope of their clinical competencies and skills.

> *Due to budget cuts – our organisation replaced health visitors who left with lower grade staff. In the two years which followed, we saw an increase in high-risk incidents where 'red flags' had been missed, the complexity of cases increased and there were not enough HVs to support the most vulnerable families. We have learnt from this, and we are now investing back into health visiting locally and creating more specialist posts*

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What health visitors said about skill mix teams:

Our HV caseloads get bigger by the month and skill mix are employed to plug the gaps but don't have the overall responsibility for the more complex cases

Whilst a move to skill mix within teams is positive, the role of an experienced HV to assess, plan deliver and evaluate care should not be lost in the effort to manage service costs

We are extremely short of health visitors. Our continuity plan involves delegating to a staff nurse far too early in my opinion, but there really is no other option - if we didn't delegate, the family wouldn't be seen

Universal contacts, such as the 1- and 2-year checks, are now being undertaken by community nursery nurses - so they may initiate targeted work in response to these assessments without any assessment by a Health Visitor

Community Nursery Nurses report they feel overwhelmed and unsupported. Feel they're taking on too much of the HV role.

I am a band 4 worker and I have taken on more and more of the health visitor's role, but I don't get paid anywhere near the same

The 'legal bits' to consider when delegating work

The Nursing and Midwifery Council (NMC)[30] and Royal College of Nursing[31] set out expectations of registered nurses when they delegate work to others. Health visitors are bound by the NMC code. The NMC[32] states that registered nurses need to make sure that everyone they delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care. The registered nurse needs to confirm that the outcome of any delegated task meets the required standard.

» Only 6% of health visitors in England reported that they had sufficient capacity to adequately supervise and support non-health visiting staff completing delegated work – compared to 73% in Scotland.

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What health visitors said about delegating work and their NMC registration (which enables them to safely practise as a nurse and health visitor):

> *[health visiting] is just too risky now. I worry about my pin (NMC registration) every single day. The workloads are huge, and no one is happy*

> *That's why I left, no health visitors left. I was bullied out of the service by management. All they cared about was meeting targets... I am now out the service but there will be something really awful that will happen.*

> *The caseloads are too large. There is no time to follow up any work delegated unless those delegated to bring back concerns*

4.3 Workforce wellbeing: The impact of work-related stress

The COVID-19 pandemic has changed the way in which health visiting services are delivered in the UK. Health visitors are now working more remotely, with 40% of practitioners working from home. Virtual delivery methods for service delivery have become the norm in some areas, as well as using Personal Protective Equipment (PPE) for face-to-face contacts. All of these changes have resulted in many health visiting staff reporting that they are working under greater levels of pressure, feeling isolated, anxious and unsettled.

Research by Conti & Dow (2020)[33] showed that health visiting staff:

- express feelings of panic and anxiety
- feel overwhelmed and exhausted
- report extremely low morale and find the job demoralising.
- feel undervalued by managers and their employer

Our survey findings mirror some of Conti & Dow (2020) findings, with respondents reporting that:

68% are working longer hours	**57%** feel worried, tense and anxious	**46%** feel demotivated
46% state their sleep has been affected	**36%** are experiencing low mood because of stress	**35%** the stress from work is impacting on their role as a parent and partner
34% state they would leave health visiting if they could	**32%** report that their physical health has been affected	**23%** struggle to concentrate at work
22% are managing stress in negative ways such as drinking more alcohol or comfort eating		**21%** have accessed service support for their mental health as a direct result of stress at work
11% say they manage their stress through having more sickness/time off		**9%** report that their stress levels have not increased

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What health visitors are telling us about their wellbeing:

> *I worry about the health of my colleagues. We all want to be the best health visitors we can be for our families and communities, however staff are overwhelmed and burnout*

> *I can't even write about it, it's so upsetting*

> *I find that remote working has significantly impacted on my emotional wellbeing as I have no peer support in the same way as working from an office*

> *We have been managing high risk situations during COVID, visiting families in their homes when most other services had stopped. We have been on the front line having to manage these issues: domestic abuse; mental health; non-accidental injuries. I have been diagnosed with PTSD as a result of some of my experiences - a manager commented that they didn't think that community-based staff would experience PTSD?*

> *Poor management...*
>
> *...Senior managers have no idea of the stresses and just expect more and more...*
>
> *...Bullying*

4.4 Wellbeing support

There is a well-evidenced link between staff wellbeing and quality of care delivery. The importance of focusing on the health and wellbeing of health visitors and those working in health visiting teams, alongside supporting them in their work, is therefore fundamental to ensuring the best outcomes for the babies, young children, and families they support[34].

Our survey showed that health visiting staff are seeking support with their wellbeing:

- 60% seek support from family and friends
- 52% from colleagues sharing an office
- 50% from clinical supervision
- 46% from child protection supervision
- 40% from their manager/team leader.

Health visiting staff also reported seeking support for work-related stress from other sources including through their faith or religion, GP, counselling, occupational health services/ employee assist programmes and social media.

4.5 Supervision

Although practitioners have described supervision as a way of seeking support for their wellbeing, our survey has shown a mixed picture of supervision across the country. When practitioners were asked, is it always possible to make time to attend scheduled clinical supervision sessions?

- 48% said yes
- 52% said no

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> *At times of greater demands, it is easy to put off supervision - but this is the time I need it most. To have time to consider a different way of doing things and being able to think about what I do well. I have never put off supervision as many times as I have in the past year.*

In response to whether they felt supervision support was sufficient in terms of quality and frequency:

- 49% said yes
- 51% said no

Some health visitors have reported supervision as a "tick-box exercise" and that it "doesn't help"

> *Feel it is a paper exercise… Problems are recognised but no solutions are ever achieved due to budgets and commissioning*

> *Support in work is not sufficient. Daily exposure to trauma in work, monthly supervision is not sufficient to protect from secondary trauma which is evidenced in physical and mental health sickness rates in the team. Other services have weekly supervision and are exposed to the same client base. My friend who is an OT for the elderly has weekly caseload supervision and she isn't exposed to half the trauma that I am as a health visitor*

4.6 Reflections on the current state of health visiting

Many health visitors took the opportunity to say how proud they were to be a 'health visitor', and that they 'loved their work with families'. However, practitioners from across the UK reported rising levels of need amongst families and reduced capacity within the service to meet these needs.

"**Who are health visitors and what do they do?**" Survey respondents from across the UK wanted better recognition of health visitors' skills, experience and vital contribution to child and family outcomes as Specialist Community Public Health Nurses. Health visitors reported that a lack of awareness of the breadth of the health visitor's role made the profession vulnerable to redeployment during the pandemic and cuts due to the whims of successive governments. Interestingly, even health visitors in the devolved nations expressed concerns about the fragility of preventative public health services – this theme is captured in the following quotes:

> *Need nationally ring-fenced funding - can't 'level up' or improve lives of children and their future adult selves without properly implementing the Healthy Child Programme. Bring back Sure Start centres everywhere! Stop targeted services being default - proportionate universalism please - raise everyone up.*
>
> *So fed up with years being wasted and millions spent on initiatives that cannot succeed because of lack of properly allocated money and people to implement.*
>
> *Nothing has changed since Marmot… yet preference is to keep relaunching Early Years as if 'new' discoveries being made by each new government. And as if health visitors and allied professionals are not already trying to effect change... it's insulting.*
>
> *Relaunch of Health Visiting this year - great! And overdue. But highlighting issues that have been known for decades is so frustrating...*
>
> **Health visitor in England**

> *There needs to be a guarantee from government that HV training will be sustained and the HV service is seen as a priority and appropriately funded as early intervention is key*
>
> **Health visitor from Scotland**

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When health visitors were asked if there was one thing that they could change about the future of health visiting, what would it be:

Top responses included:

- More health visitors
- Increased funding
- To be able to give better care
- To see more families, face-to-face
- Increased recognition of health visitor's role
- To have more specialist roles within HV
- To reduce the 'tick-box' KPI culture

What practitioners had to say about 'funding and more health visitors':

> *As far as I can see, we can do little when our workforce is staffed at a level that is basically firefighting*

> *Government to realise that preventative work is key and to actually invest LONG TERM, rather than paying lip service i.e. Implementation plan - as soon as it ended, we started cutting HV numbers*

> *Desperate need for more health visitors*

What practitioners said about being able to give better care:

> *Vulnerable families need to be at the top of the agenda*

> *More visits, more health visitors. Continuity of care is essential*

> *That we do all contacts face-to-face. That we are able to have clinics back up and running, and groups for communities to build community capacity*

What practitioners said about increasing the recognition of HV role:

> *We need to raise awareness of our role, everyone knows what a midwife is from a young age, so many people don't know we exist until they have a child and even then, they usually have no idea what our role is. If we can push health visiting as a career to aspire to and raise awareness of the role, we might hear 'when I grow up, I want to be a health visitor, or even better, more nurses/ midwives coming to work with us!!*

> *More clarity on the role of the health visitor as it feels like it is more social care than health care*

> *To make it feel like a valuable role for all again. Make it an attractive job prospect and feel valued again by our non-health partners and be commissioned by health*

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5.0 Conclusion

Our survey findings this year paint a picture of a health visiting service under pressure due to the impacts of the pandemic which are ongoing and have been wide ranging and disproportionately affect the most disadvantaged families, increasing demand for health visiting support. Health visitors' abilities to respond were compromised due to variations in local health visitor delivery models, the extent of pre-existing workforce capacity issues and the effectiveness of innovations to identify and support vulnerable families including video/ virtual contacts. Families have faced the brunt of this with a 'postcode lottery' of support.

In England, the pandemic hit the profession at a time when it had the least capacity to meet families' rising levels of need. Following years of cuts, there is now a national shortage of 5,000 health visitors. Against this backdrop, health visitors did not stop, they have risen to the challenges and demonstrated that they are a modern, innovative, and responsive workforce[35] which has continued to support families as far as possible through the most difficult circumstances.

However, in many areas, despite health visitors' best efforts, health visitors report that services are so stretched that they can only reach the 'tip of the iceberg' of need. The resounding headline message to policy makers is captured in this report's sub-title which is a direct quote repeated hundreds of times throughout the survey responses,

"We need more health visitors"

This survey provided health visitors with the opportunity to 'tell their story' – this is important as others are keen to tell it for them and they will tell it wrong. Health visitors are the 'eyes and ears' of the community - through their universal reach into all families, they know more than most, the realities of families' struggles behind closed doors.

The urgent need for more health visitors is supported by a phenomenal groundswell of support from more than 700 leading organisations[36] working with children. These organisations understand how this sector works and the struggles that families are facing – they came together with 'one voice' and supported our call for investment to rebuild health visiting in the recent Spending Review. Our message to the Government was clear, don't just take our word for it, these organisations can't all be wrong!!

6.0 Key policy recommendations

We call on the Government to make good their pledge to 'rebuild health visiting' with 3 specific policy calls:

1. **Funding** - We are calling for a £500 million ring-fenced uplift in the Public Health Grant over the next three years to reverse years of cuts, deliver the Government's pledge to 'rebuild health visiting', and ensure sufficient resource to deliver the full breadth of the Healthy Child Programme of prevention and early intervention to all families. A ring-fenced grant would provide protection from political cycles of disinvestment.
2. **Workforce** - We need 5,000 more health visitors in England with the specialist community public health nursing skills to support families through prevention and early intervention, and address a multitude of physical and mental health needs, child development priorities, social issues and safeguarding concerns which can impact on outcomes for babies and young children. Workforce forecasting, training, recruitment, and retention plans are needed to address current capacity issues and predicted losses, build leadership capability, and support succession planning.
3. **Quality** - An end to the 'postcode lottery' of health visitor support. Real, meaningful accountability in public service delivery is needed to ensure that families receive personalised and effective support to improve child outcomes and reduce inequalities wherever they live. The iHV is concerned that the Budget outcome metrics for the "Start for Life" plans all relate to 'education', and that 'health' has been overlooked. History has shown us that 'you get what you measure' and, without effective levers to assure the quality of health visiting services, this will lead to further erosion of preventative public health and weaken the health visiting contribution to multiple health pathways.

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Institute of Health Visiting
A Registered Charity Number 1149745
c/o Royal Society for Public Health, John Snow House, 59 Mansell Street, London E1 8AN
Telephone: +44 (0) 207 265 7352 | Email: info@ihv.org.uk
www.ihv.org.uk