Institute of Health Visiting
Excellence in Practice

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?

EXECUTIVE SUMARY

December 2020

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Executive Summary

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 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" 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***.

- **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.

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."

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.

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 a year to increase the number of health visiting substantive posts in England by 5000 to 13,000 . 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. 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.

2. Additional government funding of £218m 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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