Results of the State of Health Visiting Survey 2016

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State of Health Visiting Report, December 2016

The Institute of Health Visiting survey of the state of health visiting shows a radical downgrading of this public health workforce and the work it does, which focuses on the most formative period of children's lives. This is despite recent significant investment in the health of young children and families 2011-15, which transformed the health visiting service, but which now looks set to be overturned.

Introduction

In November 2016, the iHV surveyed its associates, yielding over 1220 responses from front-line health visitors. This is the fourth annual survey covering the high-water mark in 2015 of the last government's Health Visitor Implementation Plan: A Call to Action (Department of Health, 2011) and what has happened since. That Plan aimed to grow the workforce in England by 4,200 to modernise the workforce; and to transform the service in readiness for local authority commissioning and integration with other local children's services.

Analysis of our survey data revealed the following **ten themes**:

1. Effectiveness of Health Visiting

Health visitors provide a universal service to every family in the country with a child under the age of five. Of health visitors responding to the survey, 75% considered they make a positive difference to the families they see although, of these, 25% would like the opportunity to do more. The remaining 25% report that their time is spread too thinly to be able to make much of a difference.

Beyond the 'inability to change basic circumstances e.g. housing, poverty, education of parents,' barriers to effectiveness include: 'focusing only on those most at risk dilutes the universal service' (55%); 'lack of time/ resources to set up support groups (e.g. for teen mums)' (69%); 'lack of continuity/chance to get to know the family' (43%); and 'lack of freedom to follow up those in need' (43%).

The transformed health visiting service is founded on the evidence-based principle of proportionate universalism. Sir Michael Marmot (2010) states:

> *Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.*

Also, health visiting research evidence (Cowley, et al, 2014) and the Brookings Institute (Daro and Dodge, 2010) agree that preventative universal programmes are most effective when based on an in-depth professional assessment of need, effective trusting relationships and tailoring needs to other services within the community. Thus, our survey indicates the criticality of health visitors being able to have the time to develop continuity of trusting relationships with parents, to work flexibly, and to have effective pathways of responsive care with wider community and other resources.

2. Coverage of Five Mandated Child Health Reviews

In England, the Healthy Child Programme (HCP) includes five child health reviews from the antenatal period to 2-2.5 years with a recommended additional contact at 3-4 months. In the rest of the UK an enhanced provision is supported. The mandation of these reviews in England expires in April 2017.

Of these visits, the 'new birth visit' is completed by virtually 100% of health visitors responding to our survey. Only around 70% of these respondents are able to complete the '6-8 week', 'one year' and '2-2.5 year' reviews for all families. There is some evidence of prioritisation of families with greatest known need, with only 30% of health visitors providing the 'antenatal visit' to all families, with other health visitors exercising considerable selectivity to prioritise known need.

There is concern that departure from universal coverage leaves needs unrecognised antenatally and at subsequent developmentally critical periods for young children. Postnatal depression screening at 3-4 months is recommended by NICE but not mandated, and this visit is reported as being completed by only 15% for all families. This suggests mandation is a powerful instrument to help maintain and improve coverage. Epidemiological evidence indicates that the bulk of need within the population is just below the highest threshold of need that attracts targeted interventions. Therefore, successful demand management requires the system to retain universal primary prevention through systematic health surveillance as part of the delivery system for the HCP.

3. Continuity of Care / Relationships with Families

Evidence from surveys of parents indicates that health visitors are the most frequent and trusted sources of advice on child health and parenting issues. (Early Intervention Foundation, 2015; Scottish Government, 2015), especially from those mothers who experience multiple disadvantage and who are least likely to access group or centre-based programmes, even when they are available. Linking families to such services is a critical function of relationship-based practice through home visiting (Daro and Dodge, 2010).

Our survey clearly indicates that health visitors prize relationship formation and continuity, but only 55% of respondents are able to offer continuity of care to families most of the time and 5% 'always', while 31% are able to provide this only to families already identified as vulnerable or where there is a child protection plan. While this demonstrates that health visitors practise proportionate intensity of engagement, the universality of population cover is clearly less than parents would prefer and diminishes confidence in effective recognition and response to unidentified need.

4. Safeguarding Children and Working with Vulnerable Groups

Within the continuum of need, safeguarding and child protection constitutes one area of prioritisation, along with others, such as emerging developmental difficulties, complex health conditions, mental health issues, behavioural issues and so on. Health visitors are the only part of the children's workforce for under 5s whose caseloads include every child that is or was subject to a child protection plan. Moreover, those children, for whom there are concerns that fall below thresholds of recognised concern for local authority children's safeguarding interventions, are more numerous than those with Child Protection Plans. So, health visitors bear significant responsibility for preventative work with these families to mitigate risk and prevent escalation through home visiting in largely unpredictable and unsupported environments. Our respondents clearly recognise the importance of this responsibility, with 27% agreeing that 'You can never eliminate risk, but I am confident we are doing our best', whilst 72% feel 'I do sometimes worry that we can't quite do enough' or 'I feel that we are stretched and there may be a tragedy in our area at some point.'

In the past two years, 75-80% of the health visitors report witnessing an increase in domestic violence and abuse and perinatal depression or anxiety. These are 'toxic' for early childhood development and behavioural outcomes, especially when combined with substance abuse and also poverty that 68% health visitor respondents report has increased.

5. Perinatal and Infant Mental Health

Perinatal mental illness due to depression or anxiety disorders before or after the birth of a baby affect up to 20% of families and are frequently under reported. This burden of suffering in families accounts for over £7billion (Bauer, et al, 2014) of preventable costs each year in the formative '1001 critical days' of early childhood development (WAVE, 2013). This early period lays the foundation for healthy infant attachment to an adult care giver, cognitive skills and the social emotional development needed for readiness for school and longer term outcomes including the major long-term health conditions of adult life that presently overstrain health and social care services.

25% of health visitors in our survey cannot access any specialist perinatal or infant mental health services for their families. The availability of these services is highly variable, according to our survey, with any generalist Child & Adolescent Mental Health Service (CAMHS) or specialist infant mental health service reported by 20% or less.

6. Obesity

Half of health visitors surveyed reported that obesity / excessive weight gain has increased as an issue for families in their caseloads over the last two years. This is reflective of obesity as a national public health crisis (HM Government, 2016) and its importance is reflected in being one of the six High Impact Areas (Department of Health, 2014) in the early years, which are amenable to health visitor interventions.

When their coverage is universal it means that health visitors are the members of the children's workforce able to directly promote and support the duration of breastfeeding beyond initiation, and transition to appropriate family foods beyond 6 months with all families.

7. Using the Public Health Outcomes Framework (PHOF) and 6 High Impact Areas to Measure Outcomes

Our survey suggests that data collection by health visitors on the PHOF is highly variable. Some of the outcome data are recorded by other professional groups (for example, tooth decay), which means that the potential link with health visitors' inputs to these issues may be inadequately accounted for. The six High Impact Areas are more consistently reported in health visitor data, although over 50% of health visitors do not collect data on healthy weight and healthy nutrition outcomes, or on managing minor illness and reducing accidents; and 60% of health visitors do not report data on 'transition to parenthood'.

These survey findings suggest that urgent attention needs to be given to ensuring that services use data to 'measure what matters' (Roberts, Donkin and Pillas, 2013), in order to better capture the effectiveness of needs assessment and the impact on outcomes across the multiagency system.

8. Workload Demands

Of the health visitors surveyed, 85% report their workload has increased over the last 2 years, with 40% of the increase in workload attributed to a reduction in the number of health visitors during this time. This is remarkable in view of the increase of the numbers of health visitors in post by almost 50% from 2011-2015. Increased workload is attributed to increased needs in the population (more unemployment, financial pressure, housing needs etc.) by 28% of the respondent health visitors, and 8% to increased birth-rate. Increase in workload is also affected by reductions in other services including children's centres, social services, CAMHS and speech & language therapy.

As might be expected, there is variability in the size of caseload, but 63% have caseloads of 300 families or more, with 20% over 400 and 16% caseloads of between 500-1000 children, whereas nationally it is recommended the caseload average should be 250 children for safe and effective practice.

9. Organisation of Care and Support and Supervision

Barriers to making a difference to families reported by health visitors are highly variable and include, in descending order:

- Lack of time/ resources to set up support groups (e.g. for teen mums)
- Inability to change basic circumstances e.g. housing, poverty, education of parents
- Lack of time at appointments
- Focusing only on those most at risk dilutes universal service
- Too few appointment slots to cover workload
- Lack of continuity/chance to get to know the family
- Lack of freedom to follow up those in need

The introduction of new technologies has had varied impact, with different perceptions from our respondents, which possibly reflect different approaches to their use. For example, 31% of respondents reported that the use of electronic recording systems has strengthened their practice, whereas 47% felt they weakened practice because they take health visitors away from time in direct contact with families. Surprisingly, 30% of health visitors have to share a computer to record their work and 17% still use paper-based systems, which may account for some of these differences.

There is strong evidence for supervision being key to clinical effectiveness, safe decision-making and practitioner resilience (Department of Education, 2011). Health visitors gain support from a variety of sources, with over 80% valuing informal support from peers. Supervision (be it 'clinical', 'child protection' or 'restorative') is widely accessed, although 47% report it is not always possible to find time for scheduled sessions.

10. Workforce and Student Commissions

In England, a period of steady decline in workforce numbers followed by a five-year period of rapid expansion of the health visiting workforce, as part of the Health Visiting Implementation Plan, means an established workforce, mature in age, is joined by over half of health visitors qualified for five years or less, with many coming straight from their initial nurse training. Uncertainty about the future commissioning of health visiting services, due to its transfer from the NHS to local authorities, leaves the profession vulnerable to rapid loss of recent investment while local authorities are under severe fiscal constraint. Since the end of the Call to Action, health visitor numbers are no longer counted nationally, but a distinctive 'hour-glass' profile describes a workforce with the most and least mature members of the profession being over represented. NHS data[1] suggest a *decline of over 900 posts* in the past 18 months in England, being a loss of almost 25% of the investment made by the HV Implementation Plan. 80% of health visitors believe the transfer of commissioning is placing health visiting in a difficult position for funding; and, while a third believe it makes sense to be integrated with other public health services, 40% find it is challenging because

[1] It is hard to compare these data to the official workforce data from NHS Digital, because the Health Visitor Minimum Data Set (HVMDS), which was collated specifically to support the Implementation Plan, ceased collection in September 2015. The standard workforce data at that time reported that there were 11,377 whole time equivalent (WTE) health visitors employed in the NHS, as reported through the Electronic Staff Record (ESR), with another 500 or so employed outside the NHS. The standard workforce data from NHS Digital recorded 10,236 WTE health visitors through the ESR in September 2015 – one month before commissioning shifted to local government – and 9,311 WTE in August 2016, the most recent available data. It is not clear why there is such a large difference between the standard workforce data from NHS Digital and the former HVMDS, but it is clear that the number of health visitors is falling fast and this is reflected in the responses to our survey.

of different cultures, and 40% report that it is reducing contact with GPs/primary care, and 27% that it is adversely affecting liaison with NHS services e.g. midwives, CAMHS.

While health visitors indicate a positive attitude to integration with public health, children's services and a 0-19 child health service, the realisation of potential benefits is seen as highly challenging due to disinvestment in health visiting at a local level.

After rapid expansion of training, 62% of health visitors surveyed report there are insufficient training places commissioned now; and 20% report that training places are unfilled. Hence, it seems that the expansion of the workforce is being reversed and is not sustainable. In 2018, it is intended that an apprenticeship training model will be introduced for health visiting with training organised and funded by employers from the apprenticeship levy. This is immensely worrying, as knowledge of this new system appears scant amongst employers and the profession is already so vulnerable to decommissioning.

The State of Health Visiting 2016: A Cause for Concern

This survey lays bare the risks to children and families from a decommissioning of health visitor posts which it seems is just about to accelerate, especially if the five mandated contacts with children are lost. Indeed, a survey by the Association of Directors for Public Health identified that 56% of their members expect health visitor posts to be decommissioned where they work in 2017/18. Our survey shows the extent to which the universal service and necessary follow-up provision appears to be reducing already, and further disinvestments will increase the risk to the most vulnerable families, as well as prevention overall. Urgent reinvestment into public health is essential to prevent further cuts to health visiting posts and with it all the consequences for children and families and the social, mental and physical health and economic consequences for the country.

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