Written evidence from the Institute of Health Visiting to the parliamentary Health and Social Care Committee inquiry into the First 1000 Days of Life

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The Institute of Health Visiting

The Institute of Health Visiting was established in 2012 as an academic and professional body to strengthen the quality and consistency of health visitor services.

Question 1. National strategy

1 We welcome the initiation by Sir Simon Stevens, Chief Executive of NHS England, of a new NHS 10-year plan to be published later in the year. In particular we welcome inclusion of new priorities notably: *"a renewed focus on children's services, and prevention and inequality as they affect children",* as well as the prioritising of mental health. We believe that evidence supports a specific priority of *prevention and inequality as they affect children* the first 1000 days of life owing to their high level of significance for future health and development. We specifically propose this should:

> **1.1 Build on the Marmot principle of proportionate universalism to tackle inequalities and shift the curve of demand on services**; and
>
> **1.2 Support the key leadership role of health visitors to deliver the Healthy Child Programme (HCP) – with strengthened joint governance mandated within a national quality framework for systems-based practice for child and family public health.**

1.1 Prevention and proportionate universalism

1.1.1 Sir Michel Marmot (2010) has demonstrated the health gains at population level to be achieved through improving health and reducing inequalities in the earliest years of life; and Heckman has depicted graphically the return on investment and the costs of failure (see Figure 1). Moreover WAVE (2013) has demonstrated that 'early years' interventions are a rare opportunity to spend money in a way that delivers social and economic benefits at the same time' (p.101).

1.1.2 The 'prevention paradox', as outlined initially by Geoffrey Rose (2008), explains that the greatest impact will be achieved by addressing needs across the population as a whole in order to improve health. This is as well as by reducing the severity and number of cases with the greatest needs that make the greatest demands on public services over the long term. This requires 'proportionate universalism' in the first 1000 days or the 'foundation years' (Field, 2010) for which health visiting is a core component.

1.1.3 There is consensus that early years services should adopt evidence-based practice and programmes. It needs to be remembered that this applies not only to specific interventions such as manualised parenting programmes, but also the overall shape of the service offered. According to the Harvard Center on the Developing Child 'Decades of brain science and developmental research suggest a three-tiered approach to ensure the health and well-being of young children' to which, in the Health Visitor Implementation Plan (Department of Health, 2011), the community level of service delivery is added to strengthen community capacity. These four levels (community, universal, universal plus, and universal partnership plus) are based on sound epidemiological analysis of health inequalities and 'proportionate universalism' (Marmot, 2010).

1.1.4 The Healthy Child Programme, the evidence for which has recently been reviewed (PHE, 2015a; EIF, 2018), includes **five** child health and development reviews mandated by the commissioning of 0-5 services by local authorities. Unfortunately, even this minimal service is not able to be delivered universally by health visitors due to reductions to resourcing.

1.1.5 The six high impact areas for public health outcomes in the early years are a selection of those for which there is evidence of sensitivity to health visiting interventions and for which the health

visiting workforce is well equipped to deliver. The four levels of service delivery, five mandated reviews and six high impact areas combine to form the 4/5/6 service model of health visiting.

1.1.6 The WAVE Trust (2015) states that '1001-days' strategies should be based on *primary preventive principles* applied universally, with particular emphasis on fostering mental/emotional wellbeing and secure attachment, and preventing child maltreatment. The term 'universal services' has come to be understood in somewhat different ways within local authorities in contrast to the NHS and health visiting. This is more than a semantic difference which is of importance because, while Local Authorities have a legal duty to promote the health and wellbeing of their populations, statutory provision of Children's Services focuses on secondary preventative programmes and duties to safeguard and protect children at risk of significant harm. Shifting the curve of health need at population level requires an inclusive, universal reach which is embodied in the health visiting mode of practice and the Healthy Child Programme. This is summed up by Cowley et al, (2018) as follows:

> Universal health visiting takes a particular format. It moves beyond 'availability' in the sense of being there if wanted into actually delivering a specified service to all families, which enables primary prevention and health promotion. It provides a 'safety net' that is accessible without stigma and, while the service is universal, it is not uniform. The mandated provision is a base from which to vary the service according to the assessed health needs of families. By using this core service 'offer' to tailor information specific to each family's individual needs, health visitors can draw on particularist principles (Carey and Crammond, 2017), provide differentiated help at the level of each family, acknowledging health, cultural and social situations to achieve a service that is proportionate to need (Carey et al, 2015). This enables health visitors to work towards reducing the social gradient of health inequalities by delivering services based on 'proportionate universalism', which is argued to be the key to reducing health inequalities (Marmot, 2010).
>
> (Cowley, et al, p358).

1.1.7 According to Public Health England (PHE, 2015b) 'early childhood experiences have been found to have a lasting impact upon a child's mental wellbeing. Initiating improvements in the mental wellbeing of this age group may thus deliver tangible improvement across their whole life course.' (PHE, 2015b: 4) and significantly help NHS expenditure.

1.1.8 Adverse childhood experiences (ACEs) embed social disadvantage biologically due to the impact on the developing brain of 'toxic stress', for example due to exposure to domestic violence; while sensitive and responsive care from primary care-givers, parents & others within the family circle, shape a sturdy architecture of brain development and secure attachment. **However, targeting only conspicuous needs can be guaranteed to miss the majority of need and fail to reduce demand on specialist services at the cost of children's subsequent health, development, educational attainment and longer-term health outcomes.**

1.1.9 Based on this understanding, we advocate that the NHS and Local Authorities can support effective work against inequalities in child health by underwriting this mode of practice within a commissioning environment that rebalances the terms of integration with children's social services, early years provision and the range of child health services commissioned and provided by the NHS.

1.2 Support the key leadership role of health visitors to deliver the Healthy Child Programme (HCP) – with strengthened joint governance mandated within a national quality framework for systems-based practice for child and family public health.

The Healthy Child Programme (HCP)

1.2.1 Across UK, parents are offered a series of regular planned universal health visitor reviews of the health and development of each child in dialogue with their parents and family, often in the home. In England, this is the spine of the HCP (Department of Health, 2009), led by health visitors. Families can expect different patterns of service delivery depending on where they live in the UK: in Wales there are 9 reviews; N Ireland, 7, with planned increase to 9; in Scotland there are 11, all carried out by qualified health visitors. Both Scotland and Wales specify which reviews are to be carried out by a qualified health visitor, rather than a team member, which helps to ensure the quality of their programmes. The minimum in England is *five key child development reviews*.

- antenatal health visit;
- new baby review;
- 6 to 8-week assessment;
- one-year assessment;
- the 2 to 2½ year review.

1.2.2 These, together with health promotion, parenting support, screening and immunisation programmes (PHE, 2015a) comprise the HCP led by health visitors for the 0-5 population. The Department of Health (2015) states:

> It is also important to note the *aggregated public health benefits* of the range of family assessments and delivery of public health messages at key points during the first five years of a child's life when they can make the greatest difference. The assessments undertaken by health visitors go *beyond the[se] specific activities* … [T]he '*return*' on such activity is that issues are tackled before they become more serious, impacting on families and/or impinging on costlier services. (Para 2.11).

Health visitor skills to lead the HCP

1.2.3 The Department of Health (2015) also states:

> It is recommended that professional health visitors with specialist public health knowledge and clinical skills are used to deliver the 0 to 5's HCP. (para. 2.3)

Only the five health reviews, rather than the whole service model are mandated by regulation and the regulation does not specify which professional must carry them out. Regulation holds health visitors accountable for delegation of reviews although in practice they often have little choice or control over who undertakes many of these reviews. This stands in contrast to specifications in the other UK countries, which recognise the need for the particular skills of a qualified health visitor to carry out all health reviews.

1.2.4 A randomised controlled trial (RCT) in North Carolina demonstrated the preventive impact of universal home visiting by nurses similar to UK health visitors, specifically reducing the amount of emergency medical care through early assessment, identifying individual family needs, intervening briefly or connecting the family with targeted community resources (Dodge et al, 2013). PHE's review of the evidence for the HCP in England also identified a number of 'cross-cutting issues' including: the identification of families with additional needs; matching needs and services; reaching

the ‘hard-to-reach’; working with families, and family readiness to change; practitioner motivation and readiness to change; adopting evidence-based approaches with fidelity; and developing others within the workforce development. These characterise the core practices and service orientation of health visitors for which they are very well equipped to lead provided that they are adequately trained, supported staffed to do so.

1.2.5 Health visitors have highly developed skills in home visiting and formation of trusting relationships critical to engagement with families in the first 1000 days. They have in-depth applied knowledge of attachment and a repertoire of skilled approaches such the Solihull Approach the Family Partnership Model and increasingly use tools such as Newborn Behavioural Observation (NBO) to promote parental sensitivity and secure infant attachment. Perinatal mental health of parents is intimately connected to infant mental health and health visitors are equipped to both identify and support parents with mental health needs so that they can be responsive to the needs and capabilities of their young children, especially in the home and before they are likely to have accessed centre-based activities.

1.2.6 Health visitors are pioneers of universal perinatal mental health services and are critical to the implementation of pathways to specialist services. In accordance with recent developments health visitors not only seek out unrecognised postnatal depression and offer listening visits but increasingly identify both anxiety and depression in mothers and fathers antenatally and postnatally and develop trusting relationships to support families directly or through referral pathways (NICE, 2014). **Recent research (in press) provides evidence that HV training was highly cost-effective in preventing symptoms of postnatal depression in a population of lower-risk women and cost-reducing over 6 months.**

Fragmentation of services

1.2.7 While we focus on the contribution of health visiting to the First 1000 Days, this is not in isolation from other services and agencies. On the contrary, we advocate that successful strategy needs to join up several additional components notably:

- seamless working with good antenatal maternity services, general practice;
- good specialised perinatal and infant mental health services;
- universal assessment and support for good attunement between parent and baby; and
- skilled linkage of families to resources and services supportive of their needs, identified through assessment in the context of a trusting relationship with a skilled health visitor.

1.2.8 The HCP is a sound, evidence-based delivery vehicle for improving child health at individual and population levels. However, fragmentation of services for families and children between local government, the NHS and other arms of the public services since the implementation of the Health and Social Care Act (2012) and, in particular, **the transfer of commissioning of health visiting in 2015 has weakened the governance that supports the HCP,** which depends on a number of strands being effectively coordinated. The Maternity Transformation Programme, General Practice Forward View and STPs have little to say about health visiting and preventative child health, but all are critical to the continued vitality of a child health strategy that works against the persistent challenges of health inequalities and the unequalled return on investment in the health of the earliest years of childhood.

1.2.9 At the operational level, the health visiting service model has been rebased from GP attachment to be population/community based, better aligned with local authority Children’s Centre services but often at the expense of links to the wider health system. According to the National Children’s Bureau (2012):

> Collaboration of health visiting services with Children's Centres would enable them to shift the curve of disadvantage and poor attainment by concentrating 'specifically on pregnancy to three year olds, with an emphasis on language development for very young children and paths to employment for mothers and fathers [without which] [the risk is that without the light touch support and community capacity building that centres are particularly good at, more and more families will fall into the tail end of the curve, creating huge and costly problems for families and communities in the future.
> (NCB, 2012: 8).

1.2.10 Recent reviews of children centre services (NCB, 2012) advocate greater emphasis on outreach. Integration of health visiting with early years services offers new opportunities. Health visiting is more than an 'outreach' service *from* Children's Centres or other health or educational facilities: it reaches across boundaries determined by services and settings to engage with children and families where they live. Home visiting is a core element of health visiting alongside needs assessment and a positive orientation to health. Home visiting is associated with improvements in parenting and cognitive development, reduction in child behavioural problems and accidental injury, and improved detection and management of postnatal depression according to a recent review of evidence (PHE, 2015a).

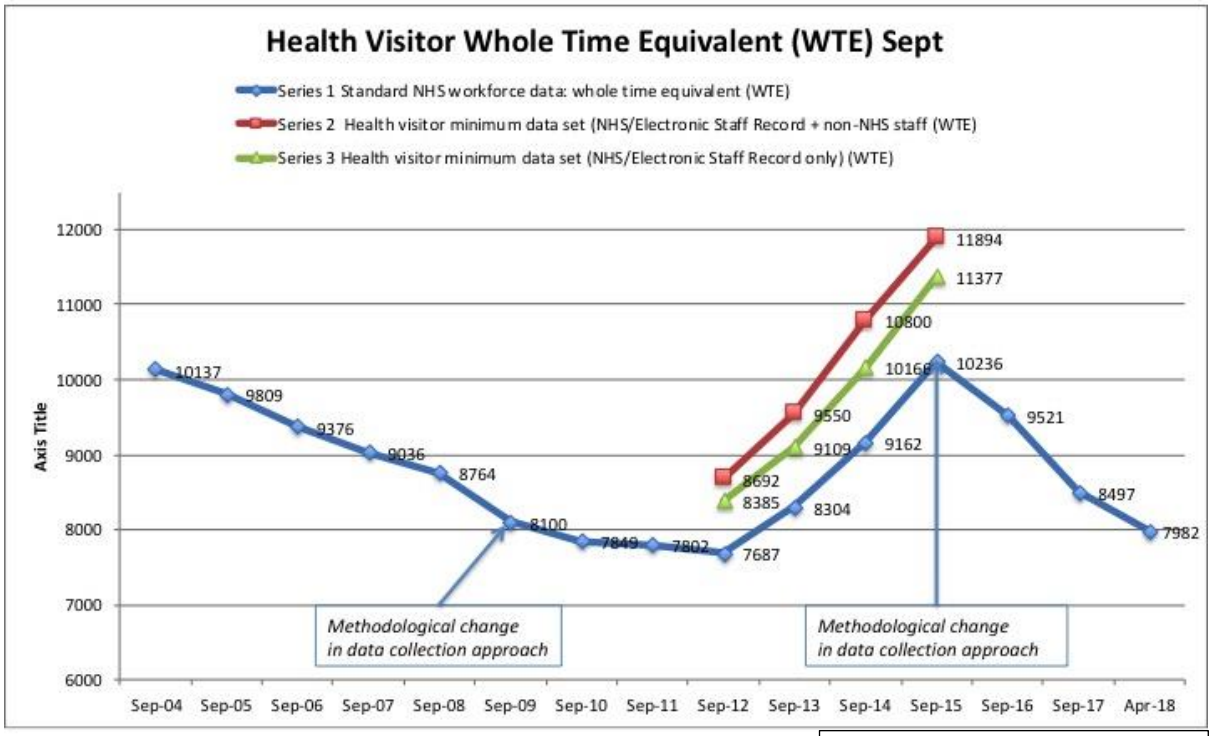
1.2.11 We propose that the NHS should act with others to strengthen the governance of the HCP across all partners through joint commissioning within a national quality framework for systems-based practice for child and family public health to realise the benefits of closer working with both NHS child health services and primary care *and* local authority services such as children's centres. In such a context, health visitors are well equipped to fulfil more realistically their long-recognised mandate to both deliver in practice and to lead the HCP at system level.

Question 2. Current spending and barriers to investment

Recent reductions in funding and workforce

2.1 We cannot provide evidence of direct spending, but we can evidence impact of reductions in the resourcing of health visiting. A key achievement of the Health Visiting Implementation Plan of the Coalition Government (DH, 2011) was development and recording of a 'Health Visitor Minimum Data Set' by NHS Digital. This was discontinued in October 2015, since when only the number of health visitors *employed* by NHS organisations and those returning workforce data through the Electronic Staff Record (ESR) have been published, which increasingly gives a very partial picture. The lack of accurate figures makes workforce planning extremely difficult, which is discussed further below. Despite its deficiencies, the NHS Digital dataset shows that the number of health visitors employed has fallen by over 20% since service commissioning transferred from NHS England to Local Government in Oct 2015 until April 2018 taking the numbers down below what we would consider to be safe levels of coverage.

2.3 The national workforce figures offer one illustration of how deeply the public health funding cuts have affected health visiting (see Figure 1). The vast majority of our interactions with members are about concerns around service cuts and re-tendering exercises. These contacts mirror the experience of health visitors and service managers, who spend huge amounts of time in competing for contracts.



Source: NHS Digital

NB. Provisional figure for April 2018

Figure 1: Health Visitor Workforce 2004-2018

The number of health visitors employed outwith the NHS is not routinely published. The lack of accurate figures makes workforce planning extremely difficult.

2.4 In October 2015, sufficient funding was transferred on a 'lift and shift' basis to Local Government to cover a flat 'minimum floor' of one full time equivalent (FTE) health visitor to 300 pre-school children. The Advisory Commission on Resource Allocation (ACRA) was engaged to advise about how to deal best with higher need and vulnerable first-time mothers. They recommended children in low income households receive a weight per head of four times higher than children not in low income households (PHPSU, 2015).

2.5 We recommend that caseload size should not exceed 250 children per FTE health visitor or a maximum ratio of 1:100 in more deprived areas.

Question 3: What a high-quality evidence-based approach to service provision would look like for the First 1000 Days of life.

We propose the following as success factors:

- Marmot principles based in proportionate universalism adopted systemically and culturally across commissioners and service providers.
- National quality framework for systems-based practice for child and family public health that links with wider agendas including Maternity Transformation Plans, STPs, General Practice Forward View, Best Start in Life.

- Healthy Child Programme is underpinned by shared governance mandated by local commissioners working to national quality framework
- An indicative clinical governance framework is developed to provide assurances that information and interventions offered to the public are evidence-based and appropriate for intended beneficiaries, balancing criteria of fidelity to evidence with acceptability.
- System performance is evaluated at system level to assure full scope of HCP i.e. HCP is not only measured by KPIs tied to 5 mandated reviews
- Mandated 5 reviews are increased to 9 and seen as minimum floor, not an aspiration
- Resources are matched to need by building on current modelling in Scotland and Wales and recent work in England for the HV implementation plan
- The workforce is stabilised and strengthened by taking remedial action consequent upon an urgent impact assessment of the introduction of the Apprenticeship funding route for entrants to the profession.
- Work towards caseload size not exceeding 250 children per FTE health visitor or a maximum ratio of 1:100 in more deprived areas.
- An additional 'dual qualification' route to registration as a nurse and health visitor is developed and trialled as attractive career route for graduates wishing to have an impact on the life-chances of future generations.
- Research is commissioned to identify the merits of optimal skill-mix and appropriate education, training and support for health visiting teams.
- Specific clinical leadership roles are developed, resourced and evaluated to support service development and good practice at service level, beginning with perinatal and infant mental health.

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