Lords Select Committee: Integration of Primary and Community Care
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The Institute of Health Visiting (iHV) is an independent charity, professional body and centre of excellence, established to strengthen the quality and consistency of health visiting for the benefit of all children, families and communities. Our Vision for Health Visiting provides an evidence-driven blueprint for services within an integrated health and care system. We provide evidence to the Committee in response to the questions that relate to health visiting and its key contributions across multiple clinical pathways for child and adult health.

1. What are the main challenges facing primary and community health services?

Too many babies, young children and families are currently being failed by fragmented health policies that fail to meet the scale of need. The key challenges are:

- **Increased population need with widening health inequalities:** More children experience poor health and are being harmed by conditions that are almost entirely preventable:
  - We have some of the worst child health outcomes compared to other similar nations, with widening health inequalities[1].
  - More young children are falling behind with their development, the number of children with clinical or safeguarding vulnerability is increasing and the poorest children have the worst outcomes[2] [3]. This situation predates the pandemic but has been exacerbated by it[4].
  - The growing number of 'invisible vulnerable children' is a national concern, with 2.3 million children in England living in vulnerable family circumstances - more than a third are not known to services and less than a fifth are supported by children's social care[5].
  - Overall, as a nation, we are becoming less healthy[6]. Lives are being cut short and more people are living with multiple, co-existing conditions and disadvantage that take root in early childhood and have both a human and financial cost. Laying strong foundations for health at the start of life will be an important part of the solution.
- **Lack of prioritisation of public health:** Public health has a long history of being poorly understood and gets easily squeezed from healthcare spending under the guise of making savings in the short-term – this is short sighted and will prove much more costly in the long run[7] [8]. It seems that every generation needs to repeat the mistakes of the one before and learn the lessons of the value of prevention and early intervention again for themselves. This needs to change as the greatest threats to our nation's health are almost entirely preventable[9] and require a public health response.
- **Cuts to public health funding**: Health policy is often driven by the electoral cycle, whereby interventions that are likely to have a short-term impact are more likely to be commissioned[10]. The public health grant has been cut by 26%, or more than £1bn, on a real terms per person basis since 2015/16[11]. These siloed cuts overlook the fact that the benefits of an effective health visiting service

[1] Royal College of Paediatrics and Child Health (2020) State of Child Health https://stateofchildhealth.rcpch.ac.uk/key-priorities/reduce-health-inequalities/
[2] Institute of Health Visiting (2023) State of Health visiting report 2022. https://bit.ly/3IHXNGB
[3] OHID (2023) Child development outcomes at 2 to 2 ½ years: annual data 2021 to 2022. https://www.gov.uk/government/statistics/child-development-outcomes-at-2-to-2-and-a-half-years-annual-data-2021-to-2022
[4] Hogg, S. & Mayes. G. (2022) Casting Long Shadows: The ongoing impact of the COVID-19 pandemic on babies, their families and the services that support them. First 1001 Days Movement and Institute of Health Visiting. https://bit.ly/3iiacGw
[5] Children's Commissioner for England (2019) Childhood vulnerability in England 2019 https://bit.ly/3QnJsAR
[6] Department of Health and Social Care (2023) The Hewitt Review https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1148568/the-hewitt-review.pdf
[7] Early Intervention Foundation (2017) The cost of late intervention https://www.eif.org.uk/report/the-cost-of-late-intervention-eif-analysis-2016
[8] Royal Foundation Centre for Early Childhood (2021) Big change starts small. https://centreforearlychildhood.org/report/
[9] Department of Health and Social Care (2023) The Hewitt Review. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1148568/the-hewitt-review.pdf
[10] Vodden A., et.al., (2023) Evaluation of the national governmental efforts between 1997 and 2010 in reducing health inequalities in England. Public Health, Volume 218. https://www.sciencedirect.com/science/article/pii/S0033350623000811
[11] The Health Foundation (2023) Public health grant: what it is and why greater investment is needed. https://www.health.org.uk/news-and-comment/charts-and-infographics/public-health-grant-what-it-is-and-why-greater-investment-is-needed

accrue to the NHS, primary care, education and children's social care. A greater acceptance of a shared long-term vision for 'health', with sufficient resource across the integrated system, is needed to ensure inequalities amongst conditions and risk factors with a longer "time to impact" are not neglected.

- **Workforce shortages:** Eight years of cuts to health visiting have led to a 40% reduction in England's workforce, and in an estimated shortfall of 5,000 health visitors[12]. As a result, there aren't enough health visitors to deliver the Healthy Child Programme as intended and meet the scale of rising need.
- **Loss of focus on 'health' in the delivery of the Healthy Child Programme (HCP):** Cuts to the public health grant and pressures in children's social care have meant that many cash-strapped local authorities have prioritised their statutory responsibilities for safeguarding and education over the 'health' elements in the HCP. This has led to the erosion of health visitors' work across multiple clinical pathways for adult and child health, and physical and mental health. For example, the closure of numerous health visitor clinics has limited their ability to support parents to manage minor illnesses and identify child development problems, clinical conditions and vulnerability. There is less capacity to address key priorities including falling immunisation rates, rising demand on urgent care, deteriorating oral health, responding to findings from maternity and postnatal care reviews, and tackling the rise in non-communicable diseases that have their origins in early childhood. This has knock-on consequences across many other health services that are also stretched (including primary care, urgent care and children's therapies)[13] and will have cumulative impacts for years to come.
- **Inequity - National/ Local accountability**: Regional variation has left families in England with an unjustifiable postcode lottery of health visiting support[14]. The health of our nation's children is too important to be left to chance, or solely to local decision making. Whilst local areas understand the health of their communities best, the narrowing focus of national targets cannot come at the expense of improving the health of all children in England - the most pressing public health priorities do not vary substantially between local authority areas.

Key messages:

- **What happens in the first years of life matters –** we have more evidence than any other generation that the building blocks of future health and lifetime success are laid in the earliest years of life. Early childhood is the period when children learn to manage emotions and build relationships, develop resilience against adversity and trust in others. There is also strong evidence that exposure to certain environmental influences during critical periods of development and growth (preconception, pregnancy and the earliest years) can have significant consequences on an individual's short- and long-term health, increasing the risk of disease in later life.
- **Change is possible.** We need to take a long-term view when rebuilding services to provide a sustainable solution. If we get the early years right, we can avoid so much harm later in life. Health inequalities are not inevitable. Preventing, identifying and treating problems before they reach crisis point is not only much cheaper, it's also much kinder than cure.
- **The cost of 'getting it wrong' is soaring out of control.** Late intervention in childhood costs more than £23 billion per year[15]. This estimate does not include the longer-term societal costs and burden of non-communicable diseases[16] that pose the greatest threats to our nation's health and are the

[12] Conti G & Dow A (2021) Rebuilding the health visiting workforce: costing policy. https://bit.ly/3XdvWIw
[13] Parent Infant Foundation (2022) Why health visitors matter. https://parentinfantfoundation.org.uk/wp-content/uploads/2022/05/Why-Health-Visitors-Matter.pdf
[14] Office of Health Improvement and Disparities (2022) Health visitor service delivery metrics experimental statistics: annual data 2021 to 2022 https://bit.ly/3QmWOgR
[15] Independent Review of Children's Social Care Debate between Tim Loughton and Wera Hobhouse Thursday 24th November 2022 https://www.parallelparliament.co.uk/mp/tim-loughton/vs/wera-hobhouse
[16] World Health Organisation (2022) Noncommunicable diseases https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases

biggest cause of preventable illness, disability and lives cut short. Not tackling this problem is short-sighted and will prove much more costly in the long run.

- **When families are supported, babies thrive and all of society benefits.** Prevention and early intervention can make a big difference to children's health, development, and the reduction of inequalities. This is not just good news for babies and children, it also brings wider societal benefits, reducing the need for costly late intervention across multiple government departments.

1.1 What are the solutions within the current framework?

Working together to improve health in the earliest years of life is an essential part of the solution (see iHV Hewitt Review submission). A coherent integrated *preventive child healthcare team* is needed in local areas where services have become fragmented or severely understaffed. This will take collaboration at all levels to ensure best use of resources and partnerships between people who agree on the prioritisation of the needs of babies and young children in terms of long-term life course trajectories. A typical *preventive care team* would involve GPs, paediatricians, health visitors, therapists, midwives, local authority public health and early years staff, local nurseries, community champions, charities, and local pharmacists. This is not a new concept but one that needs strengthening if the Marmot Review and Hewitt report are to be taken seriously.

How does investing in health visiting improve health, support the long-term management of complex conditions and reduce inequalities?

- **Health visitors are integral to the delivery of the Healthy Child Programme** (HCP), providing services covering pregnancy up to the age of five years, to ensure that 'every child has the best start in life' and 'no child is left behind', regardless of where they live. When sufficiently resourced, health visitors can play a crucial role in ensuring that families get good, joined-up support – ***preventing, identifying and treating problems before they reach crisis point***. A health visitor can, for example:
  - **provide clinical intervention** to a depressed mother struggling with a new baby;
  - equip parents with the knowledge, skills and confidence to manage common childhood illnesses, thereby taking the pressure off overstretched A&E and primary care;
  - **identify a child with an undiagnosed complex condition** or developmental delay – early identification and treatment can significantly improve child outcomes. Conversely, delayed diagnosis can have life-changing and catastrophic consequences for some children;
  - **reach and support the multitude of families** who want to provide a healthy home environment for their children, but rising levels of poverty, health inequalities and poor health literacy are significant barriers to achieving this;
  - and **work with families and communities, through prevention and early intervention,** to address the biggest threats to our nation's health, including smoking, unhealthy diets, insufficient physical activity, excess alcohol/ addictions, and mental illness – (see iHV infographic, Who are health visitors and what do they do and short film Health Visiting in your community).
- **Focus on health creation:** Effective intervention requires practitioners to have the skills to work in partnership with families to achieve change through the complex process of 'helping' in the messy real world. This includes helping families find solutions that work for them (not a 'one size fits all'). The health visiting workforce is equipped to work with babies, children, adults and communities; with physical and mental health needs; social needs; child development; and safeguarding concerns.
- **Health visitors provide a vital safety net** to protect our most vulnerable babies and young children who are largely invisible to other services unless their parents reach out for help:

- The health visiting service is unique in its universal reach to all families, it is non-stigmatising and is still the most trusted source of advice for parents with high levels of acceptability (health visitors have a legitimate reason to work with families through their health functions)[17] [18] [19].
- Through their **systematic review** of all children and application of a breadth of knowledge of public health to assess families in context and spot deviations from the norm, they can identify problems early. This is vital for spotting clinical vulnerability and child safeguarding[20] [21].
- Health visitors are trained to manage sensitive conversations and work with families who do not have the agency to seek support when needed. Vulnerable families are often the least likely to reach out for help and most likely to disengage.

****Important point that is often overlooked:** Early intervention is predicated on early identification of babies and young children at risk of poor outcomes – without an acceptable mechanism of identifying these children who are often invisible to services, all preventative public health strategies will struggle to reach those who are currently underserved by health services. A strengthened health visiting service provides an important part of a system-wide approach to address the issue of invisible vulnerable babies and children[22].

Rebuilding the health visiting service in England requires:

- **Demand-driven workforce modelling, with sustainable funding** to give confidence when planning services for the longer term, deliver the Healthy Child Programme in full, and end the postcode lottery. An urgent uplift to the public health grant is needed now, with a national workforce plan.
- **Shift towards prevention and early intervention** (including the first 1001 days) with front-loaded spending[23] to support all people to lead healthy lives, thereby preventing costly ill health in later life.
- **Workforce development:** Investing in workforce training, education, and development programmes can build workforce capacity and improve retention and the quality of care.
- **Systems thinking:** the benefits of an effective health visiting service accrue to numerous government departments and across a person's lifetime. Complex systems' principles need to be applied across all aspects of health and care delivery, including workforce, funding, service design and the development of measures that capture input and impact across the system.

1.1 <u>What steps should be taken to improve support for the long-term management of complex conditions in the community, and respond to the needs of patients and communities?</u>

- **Give greater attention to the first 1001 days** (as above).
- **Maximise opportunities to prevent SEND** (for example, by preventing the avoidable harms caused by alcohol and smoking in pregnancy and maximising genomics).
- **Improve the identification of babies and young children with SEND** at the earliest opportunity. Health visitors have a key role to play through the reach of their work with all families.
- **Personalised support for babies/ young children with SEND** and their families should be in place as soon as the early signs are detected. The period before diagnosis is often highly stressful for families and should not be overlooked.

[17] Institute of Health Visiting (2019) Health Visiting in England A Vision for the Future https://bit.ly/3HnDpGd
[18] Institute of Health Visiting (2020) What do parents what from a health visiting service https://bit.ly/3JZECp5
[19] Public Health England (2021) Guidance Early years high impact area 5: Improving health literacy, managing minor illnesses and reducing accidents https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/early-years-high-impact-area-5-improving-health-literacy-managing-minor-illnesses-and-reducing-accidents
[20] Child Safeguarding Practice Review Panel (2022) National review into the murders of Arthur Labinjo-Hughes and Star Hobson https://www.gov.uk/government/publications/national-review-into-the-murders-of-arthur-labinjo-hughes-and-star-hobson
[21] MacAlister J (2022) The Independent Review of Children's Social Care: Final report. https://bit.ly/3ippA3L
[22] Children's Commissioner for England (2019) Childhood vulnerability in England 2019https://www.childrenscommissioner.gov.uk/resource/childhood-vulnerability-in-england-2019/
[23] Vodden A., et.al., (2023) Evaluation of the national governmental efforts between 1997 and 2010 in reducing health inequalities in England. Public Health, Volume 218. https://www.sciencedirect.com/science/article/pii/S0033350623000811

- **Improve access to early intervention** which can significantly improve outcomes. The consequences of delayed treatment are costly and can be life-limiting and life-changing.
- **Policy join-up** is needed across all child health policies.
- **A national 'statutory offer' for SEND** is needed across health and education whilst also maximising the opportunities of responsive integrated place-based approaches within ICSs.
- **National standards should be co-produced** with people with lived experience and practitioners to raise the bar from the current legislative standards.
- **Demand-driven workforce modelling with adequate funding** to implement the HCP in full, in all areas.

2. What are the key barriers preventing improved integration?

There are several key barriers preventing improved integration of health services, including:

- **Poorly joined-up child health policies that are often focused on short-term goals[24] to align with a single political cycle:** Policies that relate to child and family health, early years and child safeguarding emanate from multiple government departments that still largely operate in silos. This lack of integration in the heart of government makes it more difficult for health services to integrate at a local level as they have different funding streams and objectives, leading to different services and providers operating independently. For example, the Government's Best Start for Life programme duplicates some of the elements of the Healthy Child Programme, but not all of them, and does not sit clearly with other programmes across government or the NHS.
- **Translating evidence into practice:** We have more evidence than any other generation on 'what works'; The Healthy Child Programme provides a robust evidence-based blueprint for our national universal prevention and early intervention programme for child health. The main challenges relate to the translation of this evidence into practice due to the factors listed in this section.
- **Fragmented governance structures and lines of accountability across different parts of the system:** The Special Educational Needs and Disabilities (SEND) and Alternative Provision (AP) Improvement Plan, Best Start for Life, the Healthy Child Programme and Supporting Families originate from different government departments and largely operate independently with no shared accountability.
- **Insufficient and fragmented funding streams:** There is no obvious coordination between funding for early years, family hubs, children's social care, public health and community child health services. Insufficient funding and a lack of demand-driven financial modelling is a well-documented problem.
- **Professional silos and leadership:** Different professional cultures and silos can create barriers to collaboration. Strong leadership that is committed and equipped to support integration is essential to success.
- **Information sharing:** Concerns around privacy, data security, different IT systems, limited inter-operability and the absence of a unique 'child identifier', make it difficult to share information across health, education, police and social care services. The inquiries into the deaths of Arthur Labinjo-Hughes and Star Hobson highlighted how improvements are needed in this area[25].

2.1 How might these barriers be overcome?

- **A shared vision and national plan for children to improve health and reduce inequalities is needed with ambitious goals** for the most pressing health priorities (across NHS, public health and social care). The Core20Plus5 ambitions for children and young people are an important first step, but they

[24] Vodden A., et.al., (2023) Evaluation of the national governmental efforts between 1997 and 2010 in reducing health inequalities in England. Public Health, Volume 218. https://www.sciencedirect.com/science/article/pii/S0033350623000811

[25] The Child Safeguarding Practice Review Panel (2022) Child Protection in England: National review into the murders of Star Hobson and Arthur Labinjo-Hughes. https://bit.ly/3QoyUBs

do not go far enough as they only focus on the role of NHS providers, overlooking vital services like health visiting and school nursing that are funded through local authorities.

- **Leadership:** Strong leadership is needed to represent children's health nationally and within ICSs.
- **Clear governance and funding structures that support integration** are needed between the NHS, primary and community care, including local authority funded public health services.
- **National accountability:** The narrowing of the focus of national targets cannot come at the expense of improving child health and reducing inequalities across England - the most pressing public health priorities do not vary substantially between local authority areas. It is misleading of the government to state that current failings are solely due to 'local decision making' when this is the operating environment that the national government has created through its cuts to the public health grant and dearth of workforce planning.
- **Robust system levers and incentives are needed to hold each part of the local integrated system to account** for their inputs and contributions to achieving national goals, including the delivery of the Healthy Child Programme in full, in all ICSs.
- **Demand-driven workforce modelling, with sustainable funding is needed** to give confidence when planning services for the longer term.
- **Improved information sharing:** Integrated electronic records, or inter-operability between systems, can facilitate information sharing and coordination of care. A unique child identifier would help to overcome some of the challenges of consolidating information about children from multiple sources.
- **Integrated care pathways** need to be mapped across primary, community, secondary and tertiary care to ensure early identification of all children at risk of poor outcomes, with effective support and treatment proportionate to need. Ensuring there is coordination between different levels of government and healthcare providers in the NHS and local authority will avoid fragmentation, maximise efforts, and improve seamless support. If one part of the pathway is weak, or missing, the whole pathway is impacted by the consequences.
- **Workforce education and training** to enhance skills in working effectively in an integrated system is needed, with shared learning across organisations, including system leadership. This will help to break down silos and recognise the unique contribution of different partners towards the shared national goals for child health.
- **Developing collaborative partnerships** between primary and community health services, patients, families, and community organisations can help identify and address the root causes of health inequalities.
- **Co-production/ mechanisms to capture and respond to children's 'voices':** Engaging stakeholders, including families, and community organisations in co-production can improve health and care services. Lessons from research and inquiries, alongside 'frontline practitioner intelligence', should inform decision making, particularly for babies/ children who cannot speak for themselves.

2.2 Could you provide examples of successful or innovative models of integration between primary and community care, either in the UK or internationally?

There are good examples of local integrated programmes with health visitors to address key priority areas, including: childhood obesity, perinatal and infant mental health, oral health, immunisations, unintentional injuries and, as well as advanced 'whole system' plans for better integration in some areas. The ,osr successful examples of integration are seen in areas with strong local leadership, a ''whole system' approach' approach and an integrated response between agencies to ensure all stakeholders understand what is required of them with agreed roles, responsibilities, governance and funding.

3. How would you assess the current state of community care, in particular the integration between both areas? The current state of health visiting in England is captured in our recently published annual State of health visiting survey report: a vital safety net under pressure[26] that highlights:

- **Hundreds of thousands of children are missing out on vital health visitor reviews** that provide an opportunity to identify babies, young children and families in need, or at risk of poor outcomes:
  - On the nationally mandated five health visitor health and development reviews, a total of 458,454 reviews were missed in 2021–22[27]. Overall, 1 in 5 children in England have missed these reviews; and 1 in 4 children missed the 2-2½ year review.
  - Some regions fair significantly better than others – just 8% of reviews were missed in the North East, while 30.5% were missed in the East of England and 25% in London[28].
  - Regional data mask even greater variation between local authority areas – the uptake of the 12-month review varies from 2.1% in the lowest performing local authority, to 99.6% in the highest[29]. Children's needs do not vary this significantly to justify this variation.
- **Lack of capacity within services to meet the scale of need.**
  - Only 7% of health visitors[30] were confident that 'all or most' families would get the support or treatment that they needed when a need was identified by a health visitor.
  - 86% reported that there is not enough capacity in other services to pick up onward referrals (including, children's therapy, community paediatrics and early support).
  - Health visitors reported concerns that child protection or child safeguarding cases are not being detected due to practitioners' reduced contact with families. Social workers' caseloads are capped to a maximum number of children which masks rising levels of need. Health visitors are reporting that the thresholds for children's social care are now much higher.
- **Unmanageable workloads are a source of increased work-related stress**[31].

4. What are the implications of the Government's long-term workforce plan for the NHS on primary and community care staffing? We are still awaiting a health visitor workforce plan as health visiting sits outside the NHS and is funded by the public health grant. A demand-driven, well-resourced, national workforce strategy is needed to ensure that there are sufficient health visitors to deliver the Healthy Child Programme as intended, support improved integrated working across primary and community care, and address current and forecasted losses, improve retention, job satisfaction and career progression for experienced staff.

9. To what extent have ICSs been able to deliver the aims they were set up to achieve?
ICSs are being developed in deeply challenging times, with increased levels of need and widening inequalities, alongside political and economic instability and varied levels of healthcare performance. Whilst ICSs are in their infancy and their success awaits evaluation, there are good examples of local integrated programmes with health visitors to address key priority areas (see section 2.2).

10. Could you provide examples of how primary and community care have contributed to tackling health inequalities, including international comparisons?
When adequately resourced, health visitors provide **a systematic way to reach all families** with babies and young children to improve health and reduce inequalities across a breadth of physical and mental health needs, child development, social needs and safeguarding. They contribute to reducing demand on primary

[26] Institute of Health Visiting (2023) State of Health visiting report 2022. https://bit.ly/3IHXNGB
[27] Office of Health Improvement and Disparities (2022) Health visitor service delivery metrics experimental statistics: annual data 2021 to 2022 https://bit.ly/3QmWOgR
[28] Office of Health Improvement and Disparities (2022) Health visitor service delivery metrics experimental statistics: annual data 2021 to 2022 https://bit.ly/3QmWOgR
[29] Office of Health Improvement and Disparities (2023) Health visitor service delivery metrics. https://www.gov.uk/government/statistics/health-visitor-service-delivery-metrics-experimental-statistics-quarterly-data-for-2022-to-2023
[30] Institute of Health Visiting (2023) State of Health visiting report 2022. https://bit.ly/3IHXNGB
[31] Institute of Health Visiting (2023) State of Health visiting report 2022. https://bit.ly/3IHXNGB

and urgent care and 'whole system' outcomes by **preventing, identifying and treating problems before they reach crisis point**. Alongside the evidence below, we have listed some examples in our response to Q2.2:

- **Evidence for the health visiting service and intensive home visiting (alongside evidence in Our Vision[32] for Health Visiting)**:
  - **England:** Review of Mandation for the universal health visiting service[33] showed "statistically significant improvement observed in many relevant outcomes over the lifetime of the National Health Visiting Programme".
  - **Scotland:** Universal Health Visiting Pathway evaluation[34] found that coverage increased and was largely equitable across all socio-economic groups. The additional reviews identified new concerns for children without previous concerns flagged. Parents reported a positive and trusting relationship with their health visitor and were better able to ask for and accept the support on offer.
  - **Review of intensive home visiting programmes across the world[35]** reported, "Overall, home-visiting programmes had a positive effect on reducing child maltreatment. This is based on the high strength of the evidence which indicates that strong confidence can be placed on the conclusions drawn" (18 studies reviewed, 16 used randomised control trials).

- **Reduced burden on emergency departments**: Health visitors can improve health literacy, manage minor illnesses and reduce accidents (high impact area 5). Action is needed to tackle the root causes of increases in children's A&E attendance[36]. Most of these additional attendances do not lead to an increase in admissions, but they tell us that parents are worried about their unwell baby or child and are unable to get the help that they need elsewhere. It is perfectly normal to worry when your child is unwell – in the past, many parents would have sought support for a range of common childhood illnesses, feeding difficulties and infant's distress from their health visitor. There is good evidence that when parents received consistent, explicit, safety-netting advice from a health visitor they felt more confident and were less likely to re-attend[37]. Health visitors support for related issues like infant feeding[38], infant crying[39] and perinatal and infant mental health[40] [41] are also well evidenced.

11. In what way could the existing infrastructure be enhanced to improve the use of health technologies, and what are the possible benefits for patients?

The benefits for patients of improved use of health technologies are numerous, including:

- **Improved access to care:** Health visitors have been innovative in using technology to reach as many families as possible and this accelerated during the COVID-19 pandemic. Video-enabled contacts have brought some welcome benefits, but their effectiveness depends on when, where, and how they are used. 88.6% of frontline practitioners 'agree' or 'strongly agree' that video-enabled contacts can be used effectively to provide families with quick access to advice for straightforward concerns between universal contacts[42], some follow up meetings or targeted interventions.

[32] Institute of Health Visiting (2019) Health visiting in England: A vision for the future. https://ihv.org.uk/wp-content/uploads/2019/11/7.11.19-Health-Visiting-in-England-Vision-FINAL-VERSION.pdf
[33] Public Health England (2016) Review of Mandation for the universal health visiting service. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592893/Review_of_mandation_universal_health_visiting_service.pdf
[34] Scottish Government (2021) Universal Health Visiting Pathway evaluation - phase 1: main report - primary research with health visitors and parents and case note review. https://www.gov.scot/publications/evaluation-universal-health-visiting-pathway-scotland-phase-1-main-report-primary-research-health-visitors-parents-case-note-review/pages/2/
[35] What works for Early Intervention and Children's social care: https://whatworks-csc.org.uk/evidence/evidence-store/intervention/home-visit-programmes/#:~:text=Overall%2C%20home%2Dvisiting%20programmes%20had,16%20used%20randomised%20control%20trials.
[36] NHS 75 England A&E Attendances and Emergency Admissions 2022-23 https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-andemergency-admissions-2022-23/
[37] Healthier Together website https://www.what0-18.nhs.uk/about-us
38 Chambers A., et.al., (2023) Emotional and informational social support from health visitors and breastfeeding outcomes in the UK. https://internationalbreastfeedingjournal.biomedcentral.com/articles/10.1186/s13006-023-00551-7
[39] Nottingham Trent University (2023) Support for parents of babies who cry excessively to be trialled nationally https://www.ntu.ac.uk/about-us/news/news-articles/2022/12/programme-to-support-parents-of-babies-who-cry-excessively-to-be-trialled-nationally
[40] Homonchuk, O. and Barlow, J. (2022) Specialist Health Visitors in Perintal and Infant Mental Health. Department of Social Policy and Intervention, University of Oxford. https://spi.web.ox.ac.uk/sites/default/files/spi/documents/media/specialist_health_visitors_in_perinatal_and_infant_mental_health_-_january_2022.pdf
[41] Institute of Health Visiting (2023) Supporting high quality perinatal mental health care: what does good look like? https://mcusercontent.com/6d0ffa0c0970ad395fc6324ad/files/11c33e19-f4f8-d56a-bc58-bb8f64316151/Making_all_care_count_Evidence_review_FINAL_VERSION_03.03.23.pdf
[42] Chat Health Evidence: https://chathealth.nhs.uk/evidence/

- **Reduced costs:** Technologies can help reduce costs, for example by reducing administration[43].
- **Empowerment:** Health technologies, such as Healthier Together and Family Assist, The NHS Website can enable families to take more control and manage their conditions themselves.
- **Safety considerations:** There is a growing body of evidence that highlights the risks of non-face-to-face contacts, particularly their use by health visitors for universal mandated assessment contacts and work with vulnerable families. Despite this evidence, mandated contacts are still counted as face-to-face contacts, even when they are delivered using virtual platforms. Virtual contacts 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 signs of substance misuse or domestic abuse[44]. Their use excludes families in 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. 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[45]. More evidence is needed to inform when virtual contacts can be used safely and without negatively impacting on service quality.

11.1 What are the main barriers to increasing the sharing of information and data?

In partnership with The Health Foundation, the iHV completed a review of data and analytical capability in health visiting, "Moving Beyond Bean Counting"[46]. The following barriers were highlighted:

- **Legal and regulatory barriers:** The impact and different interpretation of data privacy, GDPR and safeguarding requirements. Particularly recording information about parental vulnerability on a child's record.
- **Technical barriers:** Variation in operating systems/electronic patient records. Locally devolved decisions on IT systems and interoperability. Slow and old IT equipment. Lack of consistency in data collection and coding. No unique child identifier across all systems. Varying thresholds and definitions of vulnerability does not enable comparisons between areas.
- **User capability and skills:** Lack of time and training, poor data quality – information not fit for purpose and not trusted as timely or accurate.
- **Cultural and organisational barriers:** Different health services may have different cultures and priorities which can make it challenging to build trust and collaboration around data sharing.

12. Could you please outline one key change or recommendation?

Investment in the workforce with demand-driven workforce modelling and sufficient funding for substantive posts to meet the increased demand and a growing backlog of unmet need[47] [48]. Workforce shortages were the single biggest challenge facing the NHS and the wider health and care system well before COVID-19[49]. England now faces the biggest health visitor workforce crisis in living memory[50].

[43] Kene.Partners 2022 How can technology reduce healthcare costs? https://kene.partners/insights/how-can-technology-reduce-healthcare-costs/
[44] Barlow J, Bach-Mortensen A, Homonchuk O, Woodman J (2020a) The impact of the COVID-19 pandemic on services from pregnancy through age 5 years for families who are high risk of poor outcomes or who have complex social needs – Interim findings. Department of Social Policy and Intervention, University of Oxford, UCL Institute of Education on behalf of the NIHR Children and Families Policy Research Unit (CPRU). https://bit.ly/314G4Wa
[45] Institute of Health Visiting (2021) State of Health-Visiting in England "We need more health visitors" http://bit.ly/43v8Yu7
[46] Insititute of Health Visiting (2021) Moving beyond bean counting. http://bit.ly/3KWPJlZ
[47] NHS Confederation (2022) Hidden waits: The lasting impact of the pandemic on children's services in the community https://bit.ly/3GNk6t1
[48] Murray R, (2022) 'The health and care system is in crisis: what should (and shouldn't) be done?' The Kings Fund. https://bit.ly/3IALg7Q
[49] Shembavnekar N, et.al., (2022) REAL Centre projections: NHS workforce projections 2022. The Health Foundation. https://bit.ly/3GO5c5O
[50] The total health visitor workforce numbers come from 2 published national datasets: There are 5,653 HVs employed in the NHS in England (latest data published on 6th April: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/december-2022). There are 998 health visitors employed in non-NHS providers (last updated February 2023): https://digital.nhs.uk/data-and-information/publications/statistical/independent-healthcare-provider-workforce-statistics/september-2022-experimental Current total health visitor workforce in England = 6,651FTE, representing a loss of 40% since 2015 (peak 11,193FTE). Previous government modelling calculated that a HV workforce of 12,292 FTE was needed (DH, 2011)