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Submitted to **Call for evidence - local authority public health prescribed activity**
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Introduction

What is your name?

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Organisation:
Institute of Health Visiting

Call for evidence

Principles for prescribed functions

What is your view on the principles of prescribed activity? Are they still the right ones? Is there evidence to support your view?

Answer:
The Institute of Health Visiting (iHV) supports the view that the Healthy Child Programme (HCP) (DH/DfCSF, 2009) of which the five health and development reviews 'mandated' or prescribed are a part, is right to be prescribed and provided in a standardised way. It is delivered on the basis of 'proportionate universalism' as propounded by Sir Michael Marmot (2010) which reflects the evidence that the health and development issues identified through these reviews are widely distributed throughout the population and not confined to children or families with known risks. It is recognised that 'targeted' interventions of known risk can be guaranteed to fail to identify the bulk of risk and health need in the population; and that universal primary preventative services form the bedrock of a systematic approach to reducing heath inequalities in terms of health and wider outcomes in childhood and beyond. While there is variation in the number of reviews in the UK four nations, the five prescribed in England is the lowest, and therefore should be regarded as a minimum, not a maximum. (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).

Beyond this principle, there is evidence that the continuation of the prescribed status of these reviews is, to a limited extent, a protective factor in mitigating unwarranted variations in practice across England. However, while the prescribed status of these reviews may be necessary for this purpose, the iHV's survey evidence indicates that it is by no means sufficient to assure that the service is, in fact, made available to all – see responses to question 2, below.

Answer:
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Development of prescribed functions

What evidence are you aware of on the impact of the prescribing activity so far? Is there evidence to suggest the impact of the regulations varies between people or groups? This could relate, for example, to people of different gender, age, ethnicity or sexual orientation.

Answer:
In response to this question, the iHV offers evidence from three sources:
1. The report on Review of mandation for the universal health visiting service carried out for Public Health England (PHE) in 2016
2. The findings of the iHV's survey of its members in November 2017
3. Responses to a confidential request to iHV Facebook followers regarding the current status of local reductions and other restructuring of health visiting services in England, March 2018.

The PHE consultation on which the review of mandation was based yielded a very high number and quality of submissions with an overwhelming consensus in favour of the continuation of mandation. The review was forward looking in that it identified early evidence of trends emerging following the transfer of commissioning of heath visiting services to local authorities in October 2015. Moreover, it also canvassed commissioning intentions of local authorities. These indicated that the redesign of services and cost reduction in the context of tendering for services was a reality across the sector. The report also highlighted that the forthcoming change to LA funding to 100% retention of the local business rate was 'a fundamental change to in the way in which the operations of local government are financed, including the responsibility for local public health. How this will impact on these services is not yet known'.
Evaluating the impact of this and related changes is hampered by the reduced quality and consistency of data available since the end of the investment that came with the Health Visiting Implementation Plan, 2011-2015 (DH, 2011). However, the review anticipated this as follows:
'The intention of the mandation was to secure the drive for universal coverage and to maintain the momentum of the health visiting programme [the Call to Action &HV Implementation Plan]. Whilst this has, so far, been achieved at a national level and in the majority of local areas, some local authorities maybe struggling to either maintain the levels of service coverage which they inherited or to assure the quality of the data which they are using for management reporting… [In]

addition, and bearing in mind the challenges with data quality, some local areas are reporting almost universal levels of coverage for the health visitor reviews while some local areas are reporting levels which indicate that a very reduced service is available'. P18

It is worth noting that the data returns do not differentiate whether the reviews have been carried out by health visitors or by other workers of whatever level of training. In Scotland, Wales and Northern Ireland it is required that the reviews are carried out by health visitors.

The evidence that the iHV has collated since the review of mandation was carried out and suggests that the above trends and concerns have continued and intensified in their impact i.e. reduction in a universal approach to a more targeted focus. Whilst recognising the different levels of data returned and the status of that data i.e. statutory requirements through PHE, the survey of our membership on the State of Health Visiting in the autumn of each year from 2012-2017 provides additional evidence over a period of time that presents a picture of how service delivery is changing during the period of change being considered in this public health activity review. This has included questions about the delivery of the five mandated reviews as well as the HCP of which health visitors lead and deliver in line with other services. The most recent survey yielded over 1300 returns, almost all from within England.

Behind aggregate data, qualitative returns also confirm that not only is there a substantial and widening gap between the level of service offered in England and the other three UK nations, but there is substantial unwarranted variation between the 152 English local authorities being implemented through rolling tendering for service contracts shaping services in 152 different ways, with impact on staff numbers, reduction in professional skills available to children and families accessing the service and the universal service becoming a targeted one. None of this can be accounted for by the appeal to sound evidence or best practice. Separate analysis of survey returns from London in indicate that the trends identified across England are particularly acute in the capital which has its own health challenges in terms of inequality, population mobility, ethnic diversity and housing pressures.

The most directly relevant responses from our November 2017 survey are as follows:

i) Delivering and leading the HCP
The HCP is a national programme of health prevention and health promotion. At its heart is a schedule of health and development reviews that should be provided to all families with children under five. This forms the basis for searching for and identifying health needs.

Our survey responses indicate that health visitors' capacity to deliver all of the five mandated health and development reviews of the HCP in England is seriously reduced. These reviews are the minimum required by the HCP in England (there are more in the rest of the UK), yet they are being increasingly delegated to less qualified practitioners and / or not carried out.

We asked:
'Thinking about the HCP/Universal Provision, are you or a team member able to deliver each of the following mandatory (in England) five assessments and the recommended 3-4 month assessment 'service offer' to all families on your caseload, either personally or by delegating to a team colleague?'
• >90% New Birth Visit are delivered to all families; 75% 6-8 week assessment – otherwise reviews are provided on a 'targeted' basis by health visitors
• 41% Antenatal visit to all families; around 50% of families receive formal health visitor contacts at 9-12 months but only about a third after that with over half to targeted families
• Only 12% can offer ¾ month MH assessment advised by NICE to all families
• Only 15% are always able to offer listening visits to mothers identified as experiencing postnatal depression with 36% offering them mostly and 27% some of the time

We also asked about caseload sizes.
21% of health visitors said they are now again working with caseloads of over 500 children – the funding transferred from NHS to local government in 2015 was set at a recommended 'minimum floor' of one whole time equivalent health visitor for 300 children.

The survey shows there is great variation in how caseloads are calculated and defined as local arrangements proliferate, departing from national norms. These reflect more targeting of work away from a universal primary preventative service, more delegation to less qualified staff, combined with increasing use of 'corporate caseloads'.

The survey results indicate that health visitors are increasingly focused on the most vulnerable children and families at the expense of the five reviews and that the HCP is being implemented in an increasingly 'targeted' manner, against its fundamental design principles.

The result is that health visitors cannot be confident that they are identifying needs or providing early primary prevention. 60% state their ability to make a difference is hampered by 'focusing only on those most at risk [that] dilutes universal service'; rather, they are managing risk with children and families with known needs.

ii) Reality of health visitors working with the most vulnerable and a 'targeted' service
Health visiting is based on international evidence that the long-term return on investment in health outcomes is greatest when focused on early childhood preventative care based on 'proportionate universalism': that is, inclusive of all children and families, providing access to graded levels of additional support, early intervention or help, and where necessary, safeguarding and child protection.

We asked: Do you deal with any of the following vulnerable groups in your work? The responses indicate how successful health visitors are at engaging with children and families who are most vulnerable and often least confident to access support.
[PLEASE SEE SEPARATELY UPLOADED VERSION OF THIS DOCUMENT FOR DATA]

We do not have evidence that suggests that there should be a change to the regulations that prescribe the mandated reviews of the HCP. Rather our evidence suggests that although meeting the mandated requirements is a significant challenge, it nevertheless prioritises action to attempt universal coverage. However, we do have evidence that although mandation may be necessary, it is not sufficient to ensure effective delivery of the HCP. Indeed, we have evidence that the translation of the mandation into Key Performance Indicators (KPIs) as measures of service performance can have distorting effects that can subvert the intentions of the HCP.

Key issues include the following:

Key issue #1: Threat to continuity and quality of health visitor-client relationships due to increased caseloads / reductions in health visitors
Survey questions and responses of relevance to this include

Have you been restructured to reduce the number of health visitors since local authorities took over the commissioning of health visiting in October 2015?

50% replied 'Yes' and 15% replied No, but we have a reduced-size skill-mix team. Overwhelmingly, the many additional qualitative comments referred to loss of posts, under-recruitment and lower level skill-mix.

We asked about the impact of these changes on the quality of services as received by children and their families
• 73% of health visitors say that they are not confident that health visitors will be able to contribute fully to the care of pre-school children in the future
• 73% report seeing a rise in poverty affecting families they visit in the past 2 years, which increases the need for health visiting support to mitigate the potential harm to pre-school children
• 34% say that their service is so stretched that they foresee a safeguarding tragedy in their area at some point soon
• 46% describe their service as contact driven with 41% describing it as outcome driven.

It is not surprising that health visitors report that they can no longer offer continuity of relationships to their families – which is what families most value from the service according to research evidence (Donetto, et al, 2013) and as highlighted in PHE (2018) commissioning guidance.
The biggest barriers to 'making a difference' to families include:
• 'Lack of time' at appointments 44%
• Lack of continuity/ chance to get to know the family 49%
• Focusing only on those most at risk 62%

Research shows that what clients value most about health visitors is a trusted relationship over time that can provide authoritative support and advice in a way that is tailored to their family circumstances. It is especially valued by those who find group and centre-based services stigmatizing (Scottish Government, 2015).
• 42% can only offer continuity of care to vulnerable/child protection

Many respondents chose to highlight the pressure to meet KPIs, with particular mention of completing the New Birth visit by 14 days, even when this would require the visit to be undertaken by another team member, who was not the health visitor who undertook the antenatal visit: for example, when the latter works part-time and would not be available until day 15. Thus, health visitors are forced to prioritise meeting the KPI over continuity of care and the establishment of a trusted relationship. Given that many families are not seen again by their health visitor beyond the 6-8 week check (owing to delegation to the skill-mix team), this undermines this crucial feature of service quality and effectiveness.

Overall, these responses indicate that with increased case-loads, unmet need, and high thresholds for 'early help', health visitors are struggling to deliver their commitment to universal coverage of the mandatory reviews included in the HCP while also meeting needs within their caseloads. Increasingly, productivity is measured by the number of visits undertake rather than what takes place within them.

Key issue #2: Dilution of skill-base for delivering the HCP
Survey responses provide evidence of enforced delegation to less well-trained and qualified staff that are determined by staffing levels and increased use of skill-mix without evidence to justify this (while health visitors are deemed by the Regulations to be professionally accountable for such delegation).
We asked about which of the mandated reviews (plus the NICE recommended visit to review perinatal mental health) were delegated and to whom.

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The responses are indicative of the attempt to focus on the transition to parenthood and early weeks for the skills of the qualified health visitor and the provision of continuity of care where possible. The most common member of staff to whom reviews were delegated are community nursery nurses and staff nurses.

However, in addition, a further request to members to provide feedback on the impact of the reduction of health visiting posts indicates implementation of skill and grade-mix for which there is no evidence base in relation to skill, competency or effectiveness. This has been highlighted as a gap in the otherwise substantial body of health visiting research reviewed by Cowley et al (2013), synthesising 25years of research evidence. In the last year, the iHV has led multi-stakeholder review of curricula for the education and training of health visitors and school nurses in the UK. There is no nationally agreed competency framework either for health visitors or skill-mix roles to deliver the HCP. On the other hand, the rationale for the increase in the number of qualified health visitors was based on the recommendations of Lord Laming's challenge to government:
'to develop the health visiting workforce further, to provide leadership and expert practice for the HCP, and to use health visitors' specialist skills in supporting vulnerable families and making their contribution to safeguarding. He called for immediate action to increase the numbers, confidence and competence of health visiting staff' (DCF&S, 2009: 22).

Our evidence suggests that reductions in staffing and increased delegation are having precisely the opposite effect. The intention of Lord Laming's recommendations was not for health visiting to become a child protection service – a direction of travel strongly resisted by our colleagues who are Named Healthcare Professionals for safeguarding and child protection. Nevertheless, our survey responses indicate a distortion of the service model to one that is stretched between delivering the mandated reviews and holding risk for safeguarding cases while servicing the requirements of safeguarding procedures (e.g. case conference reports, on behalf of 'health' as a proxy for the wider healthcare system); and, as a corollary of this is, our responses indicate lack of opportunity to respond to unmet need (universal-plus level of service) identified through the mandated reviews and follow-ups. Rather, our survey results indicate that health visitors are increasingly focused on the most vulnerable children and families at the expense of full implementation of the five reviews and that the HCP is being implemented in an increasingly 'targeted' manner, against its fundamental design principles.

60% state their ability to make a difference is hampered by 'focusing only on those most at risk [that] dilutes universal service'; rather, they are managing risk with

children and families with known needs. The result is that health visitors cannot be confident that they are identifying needs or providing early primary prevention.

Answer:
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Public Health Outcomes Framework

How, if at all, does the evidence suggest that we could change the regulations prescribing activities to support better public health outcomes -for example, as expressed through the objectives of PHOF to increase healthy life expectancy and reduce differences in life expectancy?

Answer:
We do not believe that the evidence supports a change to the regulations as applied to health visiting. They are necessary but by no means sufficient to support better outcomes for children and families. However, the lack of consistent action on other requirements to adequately resource the service means that the regulations have perverse effects which must be addressed to achieve the intended outcomes.

There is a strong case to be made for additionally prescribing a 3-4 month review as recommended by NICE to assess and support maternal mental health as well as a support continued breast feeding and delay of weaning until 6 months, issues that relate to oral health and prevention of obesity as current public health priorities. However, this would also exacerbate the strain on capacity, given the rapidly diminishing workforce available.

Finally, we include here minimally redacted responses to a confidential request to iHV Facebook followers re the current status of local reductions and other restructuring of health visitor services in England, March 2018.

Responses cover a variety of forms of service providers; rural and urban; and all parts of the country. They have been minimally redacted for clarity and to ensure anonymity. Examples have been selected that make direct reference to the mandated reviews.
This qualitative data supplies context to the impact of structural changes upon the shape of services, the capacity to deliver services to families and the lived experiences of a diminishing workforce of health visitors at varied stages in their careers. They speak powerfully for themselves.

1. The zone I am in is currently 10 fte health visitors down, this doesn't include those on maternity leave or long-term sick (a lot is due to the stress). The service provider are currently trialling health visiting being a 0-8 service and school nursing 8-19, the rationale and reasoning behind this has not been forthcoming. Health visitors are behind on all 6-week checks, under one-year reviews and two-year checks. Health visiting jobs are continually out to advert but when people start lots continue to leave. Discussion has been made to train children centre staff to complete assessments however due to the limited number of staff this has been difficult to complete. Health visitors are required to attend all safeguarding meetings and the pressure is relentless.

2. Y Trust cut 40 WTE posts last February. As HVs leave they are replacing them with nursery nurses and saying they can do all the development checks and telling HVs not to do follow up visits. Please do not share my details as I am fearful of reprisals.

3. … currently we are in consultation... The aim is to save money around 11%. As a small team we have lost six HV already with no replacement. It is proposed that when we join with two other teams we need to lose five health visitors. around four admin [posts] and two clinical leads. This is just one borough. The home visits are to be stopped only to do a new birth at home. Clinics are proposed as self-weigh. Developmental checks are proposed to be completed by nursery nurses. Antenatals will get a letter unless universal plus. The whole service is being changed and slimmed down… The impact of this short term we don't know what is happening and unable to plan for example baby massages courses as we do not know where we at. The stress level is high. All team members … have a consultation paper but it is private and confidential. We need to lose five more. In our borough there are 15 WTE now. They looking to have just 10 WTE by June...
I have just been told that Children's Centres are closing down. And we use them for Clinics. Feels like the whole service is dissolving.

4. HV Cuts: Myself and 1 other HV both full time have been running a caseload of 1950 children since January! We are delivering New Birth Visits, Clinics and Safeguarding only. I trained as part of call to action and when I started in my team (2014) there were 6 HVs working the same caseload many posts appear to have 'disappeared' as we apparently now only have 2 vacancies currently?! Thanks

5. We are unable to deliver antenatal contacts. We visit at the New Birth Visit at home. 6-8 week contacts are now in clinics which families have to travel 20+ minutes in a car to attend. All of our visits are monitored, and we are unable to deliver additional packages of care without having to argue our reasoning. We are all worried about our NMC registration and missing something due to the demanding work load and no time to reflect on our daily work. It is all target driven and achieving KPI's. We do have 3 monthly safeguarding supervision, however this is not sufficient and does not allow time to get peer support regarding families of concern at the time. We can access safeguarding supervision via the telephone 9-5, however there is not time to personally reflect and not time in the working day to do this, as we have to achieve a minimum of 4-5 visits a day, with travel times between visits being so long.

Answer:
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Funding of local authority public health responsibilities

Summary and questions

What is your view on the principles of prescribed activity? Are they still the right ones? Is there evidence to support your view?

Answer:

Answer:
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