

Designing a public services workforce fit for the future

The House of Lords Select Committee on Public Services, February 2022

Introduction:

This response has been developed by The Institute of Health visiting (iHV), a Centre of Excellence for health visiting. We support the Committee's 'principles for public services reform' and are in agreement that the valuable contributions of charities, community groups, volunteers and the private sector deserve greater recognition as part of a comprehensive integrated system of support for families. Other agencies will advocate on behalf of this sector and, due to word limitations, our response will focus on the vital contribution of an effective health visiting service working with these partners. Ahead of the Spending Review 2021, 700 leading children's sector organisations were united in their call for investment for 3,000 more health visitors over the next three years. These organisations, who understand how this sector works and know the considerable challenges that families are facing, recognise the importance of strengthening the health visiting (HV) service which provides a vital public sector infrastructure of support for babies, young children, and their families. Our response is focused on the numbered questions below:

Recruiting, retaining, and training the public services workforce

1.0 A national plan for child health is needed to inform a national workforce plan. This should include:

- 1.1. **Updating the Healthy Child Programme (HCP)** to provide clarity on its scope and intended outcomes. The current plethora of piecemeal child health policy needs to be pulled together within a national plan for children and families' preventative public health to ensure equity of provision across England.
- 1.2. **National service specifications for individual integrated clinical pathways across the full breadth of the HCP are needed** with clear objectives, a plan and investment to deliver this. This needs to extend beyond the Start for Life objectives which are focused on education outcomes and should also include the HCP health outcomes (iHV Vision¹ sets out 15 High Impact Areas as priority clinical pathways for children and families' public health).
- 1.3. A tiered approach is needed for:
 - Describing children and their needs
 - Describing interventions
 - Describing the skills and competence of the workforce needed to deliver the integrated pathways. This is well described in Public Health England's Integrated Speech and Language pathway².
- 1.4. **Accurate workforce datasets** for all public sector posts are needed to provide a national benchmarking and monitoring system, and to support workforce planning, quality assurance, equity across England and to offer accountability. Action is needed to address the estimated shortfall of 5,000 health visitors (HV) in England³.
- 1.5. **Workforce modelling to calculate the workforce and budget needed to deliver the integrated clinical pathways based on population need**, taking account of:
 - Proportionate universalism – *'Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently; indeed, it may stigmatise those most affected while missing the opportunity to reduce the social gradient across the whole population who are all negatively impacted to a greater or lesser extent'*⁴. A robust service is therefore needed in all areas, with increased investment in areas of high deprivation and correlated with local epidemiological data.
 - Workforce skills needed to deliver the full HCP. The HCP includes significant 'health' functions – it is a safety critical requirement that these elements are provided by a regulated 'health' workforce with the capabilities to assess, plan, coordinate and deliver healthcare – with recognition that some interventions can be safely delegated with good supervision and training in place. The HCP includes HVs' mandated and statutory Public Health Grant functions as well as targeted, specialist and wider system support functions across a multitude of NHS and social care pathways which are often overlooked. For example,

¹ Institute of Health Visiting (2019) Health Visiting in England: A Vision for the Future. <https://bit.ly/3HnDpGd>

² Public Health England (2020) Best start in speech language and communication. <https://www.gov.uk/government/publications/best-start-in-speech-language-and-communication>

³ Conti G & Dow A (2021) Rebuilding the health visiting workforce: costing policy. <https://bit.ly/3DSD8KE>

⁴ Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M et al. (2010) Fair Society, Healthy Lives: The Marmot Review. Strategic review of health inequalities in England post-2010. London: Marmot Review; 2010. <https://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf>

support for childhood illnesses to reduce A&E attendances, Newborn genome screening, immunisation uptake and the identification of clinical and safeguarding vulnerability (See Appendix 1).

- **Training and clinical supervision** requirements should be factored into workforce modelling.
- National guidance on the safe and effective use of skill mix in 0-19 public health services is needed, including a risk assessment of its impact on quality of care and outcomes.

1.6. **Workforce surveys to inform workforce forecasting** and identify workforce challenges are needed. Our survey highlighted that: 52% of HVs are aged 50-65 years; 61% of HVs intend to leave in the next 5 years; and only 28% reported sufficient training places to maintain HV workforce supply needs⁵.

2.0 Training to maximise the number of public services professionals and improve their skills

2.1 The **challenges within conventional approaches to training need addressing**. A significant reduction in HV training places, delays in announcing the annual HV training budget from Health Education England and uncertainties around the future of health visiting due to year-on-year cuts since 2015 have been key drivers for the workforce challenges in health visiting that cannot be overlooked.

2.2 Recognition of the **unique specialist skills** of certain roles, with practitioners who are bound by the standards of regulatory bodies. For example, HVs are legally bound by the nursing and midwifery council (NMC) which protects the public through registered practitioners with a regulatory training and competencies framework.

2.3 Each professional group should have a career progression plan from career entry through to senior leadership roles, supported by national bodies. This should include:

- **Retention initiatives** to improve job satisfaction, support practitioner wellbeing and reduce attrition. Looking after 'our people' should apply across the whole healthcare system – with a particular focus on rebuilding workforce wellbeing and post-COVID recovery.
- **Career pipeline for skill mix workforce**
 - Bespoke **Nursing Associate** programme for public health and HCP.
 - **Staff nurse** developmental posts – with progression on to health visiting training. Ensure that all skill mix staff are safely supervised by health visitors.
 - **Increase HV training places** – Modelling by UCL calculated that 5000⁶ health visitors need to be trained over the next 5 years to offset the current national shortage and forecasted attrition rates.
 - **Fast-track HV training for graduates**⁷ – shortened Registered Nurse training followed by HV training.
 - **Rekindle return to practice incentives** – currently programmes are hard to find.
- **Career progression opportunities to retain experienced staff** – Including the creation of specialist posts, leadership development programmes and clinical academic posts to increase research capacity.
- **Clear commitment to health visiting** as a profession from the Government to provide career stability. There is a lot of uncertainty within the profession about its long-term viability in England which is driving retention issues as HVs seek job security elsewhere. This is not experienced in the devolved nations.
- **Continuous Professional Development (CPD)**.

3.0 What are the hurdles to joint training between services?

3.1 **Lack of clearly defined integrated multi-agency pathways** setting out workforce requirements and associated training needs analysis.

3.2 **Shared training for CPD and areas of role overlap are beneficial**. Role-specific training is often still needed to avoid specialist skills dilution through a 'homogenous' workforce/training which risks becoming a 'lowest common denominator' in an attempt to achieve relevance for all audiences. Future proofing is needed to ensure sufficient 'subject-expert' teacher and assessor capacity within the workforce.

3.3 Core qualification/ registered training is distinct from CPD and needs to be considered separately. In particular, the safety critical requirement to equip practitioners with the regulated core 'health' qualifications needed to assess, plan and deliver clinical care, which is central to the HCP, should not be overlooked.

3.4 Skill mix to provide targeted support for a specific public health priority will provide a welcomed additional resource and there are some good practice examples. This needs to be within a tiered approach with recognition that families with multiple co-existing and complex needs require access to more specialist support

⁵ iHV (2021) State of Health Visiting in England Report: <https://bit.ly/3HRg6q1>

⁶ Conti G & Dow A (2021) Rebuilding the health visiting workforce: policy costing proposals <https://bit.ly/3DSD8KE>

⁷ iHV (2021) 'Pathways to Health Visitor Qualification': <https://bit.ly/3hmmQQH>

from a HV practitioner with the skills to plan and oversee a package of support for physical and mental health needs (children and adults), child development and social needs/ safeguarding – this is essential to coordinate care.

3.5 How might better data sharing improve joint training?

- Ensuring key government department priorities are mirrored by a joined-up, fully-funded workforce plan.
- Pooled budgets to support better integration through Integrated Care Systems (for example Section 75 agreements)⁸ are intended to support joint planning for ‘one workforce’ with a shared vision.

4.0 How might the public sector become more attractive as an employer (recruitment/ retention)?

- 4.1 One of the top reasons for people leaving is that they do not receive the development and career progression that they need⁹. Believing that your work makes a difference to service users¹⁰ is the most important reason why people stay. HV recruitment and retention¹¹ motivations are precisely aligned with what families most value from the service: connecting with families and communities, working in collaboration, using skills and experience and professional autonomy to respond appropriately.
- 4.2 The current reality of practice is often a shock to newly qualified staff (staffing issues, high workload/ vulnerability, erosion of autonomy), which drives workforce attrition. Bridging this gap between education and practice is important to prevent staff burnout and provide job satisfaction.

Transforming workforce effectiveness

7.0 What role can digital tools play in increasing the accessibility of public services

- 7.1 HVs have led the way in using digital and virtual methods to reach as many families as possible, with good practice case studies¹². Digital self-serve functions can empower users to independently resolve issues through text messaging or web-based resources. This can help to reduce demand for more expensive services.
- 7.2 Our survey findings¹³ highlight that video/ digital contacts cannot be simplistically evaluated in a binary way – as either ‘good’ or ‘bad’ – their effectiveness depends on when, where, and how they are used. After more than 20 months’ experience of using virtual contacts:
 - 88.6% of frontline practitioners ‘agree’ or ‘strongly agree’ that they can be used effectively to provide families with quick access to advice for straightforward concerns between universal contacts.
 - 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.
 - Research highlighted concerns that virtual methods render vulnerable babies and young children invisible as they are not seen¹⁴. By default, they also rely on one parent (normally the mother) advocating on behalf of the family which will undermine ‘father-inclusive’ services and the clinical assessment/ observation of children. We have a longstanding problem in England with 2.3 million vulnerable children, and of these, 1/3 are invisible to services and not receiving the support they need. Babies and young children are the most at risk group. The highest proportion of serious incident notifications continues to be for **children under one**¹⁵ who also have the **highest rate of homicide**.¹⁶
- 7.3 Digital methods for delivery of the HCP are currently untested. An evaluation of the use of non-face-to-face methods is urgently needed to determine their effectiveness for identification of vulnerabilities and risks, impact on child and family outcomes, and reducing inequalities, to inform future digital change.

8.0 How can digital technologies be used most effectively for training?

⁸ Social care institute for excellence in collaboration with Integration and Better Care Fund (August 2019): Pooling budgets and agreeing risk share to develop coordinated care <https://www.scie.org.uk/integrated-care/better-care/guides/bring-budgets-together/pooling>

⁹ NHS (2019) NHS Long Term Plan. <https://www.longtermplan.nhs.uk/online-version/chapter-4-nhs-staff-will-get-the-backing-they-need/5-supporting-our-current-nhs-staff/>

¹⁰ Lowe T (2021) How health visiting creates positive outcomes <https://ihv.org.uk/news-and-views/voices/how-health-visiting-creates-positive-outcomes/>

¹¹ Whittaker, K., et al. (2013) *Start and Stay: The Recruitment and Retention of Health Visitors*. National Nursing Research Unit, London.

<https://www.kcl.ac.uk/nmpc/research/nrru/publications/reports/start-and-stay-report-final.pdf>

¹² Institute of Health Visiting (2020a). Making history: Health visiting during Covid-19. <https://bit.ly/3nSp0LX>

¹³ IHV (2021) State of Health Visiting in England Report: <https://bit.ly/3HRg6q1>

¹⁴ Barlow J, et al (2020b) 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 - Stage 2 findings. https://www.ucl.ac.uk/children-policy-research/sites/children_policy_research/files/the_impact_of_the_covid-19_pandemic_on_services_from_pregnancy_through_age_5_years_final_report_101120.pdf

¹⁵ DfE. (2021). Serious incident notifications. GOV.UK. Available from: <https://explore-education-statistics.service.gov.uk/find-statistics/serious-incident-notifications>

¹⁶ ONS (2021) Homicide in England and Wales: Year ending 2021

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2021>

- 8.1 Reduce barriers/ costs created by travel and venue - enable a wider audience for training events. Particularly national events which then attract delegates from across the UK to improve sharing of best practice.
- 8.2 Use online tools – like digital toolkits/ interactive workbooks to track progress and with a blended learning approach with Global classroom to support participation, social learning and supervision.

9.0 How might such services be embedded within any public services workforce strategy?

- 9.1 A **whole systems approach** is required to enable public services to respond to user need¹⁷. Risk assessments and evaluations of new integrated arrangements are needed to ensure that services are built around safety and effectiveness. Packages of support need to be responsive to families’ multiple and changing needs, with clinical supervision and data sharing mechanisms in place, and clear lines of accountability.
- 9.2 All parts of the system are mutually dependent upon each other for success. Integrating resources, responsibilities and control is intended to improve collaborative working through shared objectives, and accountability for improving outcomes.
- 9.3 Health visiting should be an integral part of any preventative/ early intervention public health workforce strategy. HVs are highly skilled specialist community public health nurses who work to address public health needs in communities and across adult and child clinical care pathways (see Appendix 1).
- 9.4 Health visiting is not a task, or an intervention, but an infrastructure of support – to be effective it needs to be built with the key ingredients to deliver the intended outcomes (relationships and knowledge of families’ changing needs over time is at the heart of effective care)¹⁸.
- 9.5 Health visiting is a profession of vigilance – through HVs’ clinical acumen, reasoning, and application of a breadth of knowledge of public health, they are trained to assess families in context, spot nuance and deviations from the norm, in order to identify problems early. HVs 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 have high rates of attrition from interventions.
- 9.6 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 the so-called ‘hard to reach’. The HV service is unique in its universal reach into all families and is still the most trusted source of advice for parents with high levels of acceptability (HV’s have a legitimate reason to work with families through their health functions). It therefore provides a unique and vital safety net and infrastructure for vulnerable babies and young children.

10.0 What have been the effects of the COVID-19 pandemic and Brexit on the public services workforce?

- 10.1 The impacts of the pandemic have been wide ranging and disproportionately affected the most disadvantaged families, exacerbating factors that can lead to poorer outcomes and increasing demand for health visiting support. The HV’s ability to respond was compromised due to national policy decisions to partially stop the service and variations in local implementation including the redeployment of HVs (with up to 63% of the workforce redeployed in some areas)¹⁹, pre-existing workforce capacity issues and the effectiveness of innovations to identify and support vulnerable families²⁰.
- 10.2 HVs have reported **soaring rates of increased need for babies, children, and families** across all indicators:²¹
 - 86% have seen an increase in speech, language, and communication difficulties
 - 81% have seen an increase in perinatal and mental health problems
 - 80% have seen an increase in domestic abuse
 - 71% have seen an increase in child safeguarding
- 10.3 Despite rising levels of need, health visiting has not been included in any Covid recovery plan like the NHS. The profession has faced ongoing cuts, resulting in unmanageable caseloads. One in four HVs now work with an average ratio of over 750 children per FTE HV,²² with high levels of reported work-related stress²³.

¹⁷ Skills for Care (2021) The Principles of workforce integration: <https://www.skillsforcare.org.uk/Documents/Leadership-and-management/Workforce-integration/The-principles-of-workforce-integration.pdf>

¹⁸ Lowe T (2021) How health visiting creates positive outcomes. <https://ihv.org.uk/news-and-views/voices/how-health-visiting-creates-positive-outcomes/>

¹⁹ Conti, G; Dow, A. (2020). “The impacts of COVID-19 on Health Visiting in England: FOI Evidence for the First Wave”. Unpublished manuscript. Available at: <https://dl.orangedox.com/HEALTHVISITINGFOINEW>

²⁰ Morton A., Adams C., (2022) Health visiting in England: the impact of the Covid-19 pandemic. Journal of Public Health Nursing. <https://onlinelibrary.wiley.com/doi/full/10.1111/phn.13053>

²¹ iHV (2021) State of Health Visiting in England Report: <https://bit.ly/3HRg6q1>

²² iHV (2021) State of Health Visiting in England Report: <https://bit.ly/3HRg6q1>

²³ Conti, G; Dow, A. (2020). “The impacts of COVID-19 on Health Visiting in England: FOI Evidence for the First Wave”. Unpublished manuscript. Available at: <https://dl.orangedox.com/HEALTHVISITINGFOINEW>

10.4 The pandemic also brought some benefits, with new opportunities for collaborative working between partner agencies with a shared responsibility for children's health and wellbeing across the local health and social care system²⁴. The extent of this collaborative working varied between local areas²⁵. Effective case study examples have been published^{26 27}.

Changes needed to the structure of the workforce, particularly to enable better integration

11.0 What would be the outcomes of better integration between public services workforces?

11.1 Improved access, experience and outcomes²⁸ for babies, children and families, with reduced inequalities should remain the ambition of the HCP. Key performance indicators which extend beyond process output measures are needed for health visiting. Validated health status measures are readily available, however, a substantial shift in practices is required before their use becomes commonplace²⁹.

15.0 Public services workforce planning

15.1 A national HV workforce plan is needed; leaving this to local decision making has not served the profession well with a significant decline in HVs since 2015³⁰. The benefits of an effective health visiting service accrue to multiple government departments, likewise, the cuts to the HV service have been felt in other parts of the system and an overburdened NHS. Greater join up of pathways across government and the NHS is needed to ensure that the wider contributions of health visiting are not overlooked. There are lots of opportunities to maximise this in the ambitions within the Health and Care Bill if the role and functions of the HV is included within the plans.

Creating user-centred public services

16.0 What workforce barriers need to be overcome to bring about a more user-focused approach?

16.1 The iHV's Vision for Health Visiting was built on the best evidence of 'what works' and an in-depth review of service user needs³¹: *'Services which are accessible and offer a partnership approach where parents are involved in decision making result in improved parent satisfaction, decreased parental stress, and an improvement in child outcomes. Services need to be flexible and promote individualised care which requires that joint working is coordinated between the family and all practitioners involved'*³².

16.2 There are numerous models to support co-production of services, including Experience Based Co-Design. A continuous cycle of quality improvement, drawing on data from a variety of sources, is needed to support 'joined up' system learning (e.g., complaints, compliments, child death enquiries, serious case reviews and patient feedback for example). However, practitioners are often not trained in their use and systems are often not in place to synthesise feedback and data from multiple sources. This is a gap that needs addressing.

Appendix 1

An infographic called: 'Who are health visitors and what do they do?' describes the role of the health visitor. The infographic can be found by clicking this link: <https://bit.ly/3K1uqfL>

²⁴ Morton A Adams C, (2022) Health visiting in England: the impact of the Covid-19 pandemic. Journal of Public Health Nursing. <https://onlinelibrary.wiley.com/doi/full/10.1111/phn.13053>

²⁵ Institute of Health Visiting (2020). State of health visiting in England. <https://bit.ly/3BZYvcD>

²⁶ Institute of Health Visiting (2020a). Making history: Health visiting during Covid-19. <https://bit.ly/3nSp0LX>

²⁷ Local Government Association (2020). Healthy Child Programme during COVID-19. <https://www.local.gov.uk/case-studies/healthy-child-programme-during-covid-19>

²⁸ Local Government Association (2017) Improving outcomes for children and families in the early years. <https://www.local.gov.uk/sites/default/files/documents/improving-outcomes-childr-bf1.pdf>

²⁹ Crocker, H., Kelly, L., Harlock, J. *et al.* Measuring the benefits of the integration of health and social care: qualitative interviews with professional stakeholders and patient representatives. *BMC Health Serv Res* **20**, 515 (2020) <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-020-05374-4>

³⁰ Latest figures can be obtained from the NHS workforce [data](#) (last updated 3 Feb 2022 recorded Oct 2021 as 6275 FTE). The Independent healthcare workforce [statistics](#) (last updated 21 Feb 2021 – recorded Sept 2020 as 1133 FTE). Total combined published HV workforce data (Feb 2022) = 7408 FTE.

³¹ Institute of Health Visiting (2020) What do parents want from a health visiting service? <https://bit.ly/3l8ZRKX>

³² Institute of Health Visiting (2019) Health Visiting in England: A Vision for the Future. <https://bit.ly/3HnDpGd>