

**Health
Visiting
in England:
A Vision for
the Future**



October 2019

The Institute of Health Visiting is a Centre of Excellence:

- Supporting the development of universally high quality health visiting practice;
- so that health visitors can effectively respond to the health needs of all children, families and communities;
- enabling them to achieve their optimum level of health, thereby reducing health inequalities.

Foreword

“The Government’s decision to cut public health grants four years ago has led to a steady disinvestment in health visiting services, with significant negative impact on their work with families. Today there are almost a third fewer health visitors in England which, when coupled with the inconsistencies in the health visiting services being delivered across the country, will affect the future of many babies, children and families.

This needs to change, and fast, as already the country is facing the consequences of this short-sighted policy. Through the Institute’s new Vision, we highlight how we believe the health visiting service urgently needs to be organised across England to allow every baby to reach their optimum level of health and to address health inequalities.

Yes this requires investment: initially we suggest it requires returning to the level of investment in the service in 2015. This needs to be followed by rigorous economic modeling of the revised Healthy Child Programme and a commitment from the Government to support its delivery in full. In return we believe the primary beneficiaries will be children and families, with wider positive impact felt across the health and social care system. We have highlighted how the health visiting service is ideally placed to provide an important part of the solution to a number of key government priorities. These include reducing pressure on GPs, paediatricians and A&E, and ultimately late intervention services like mental health and safeguarding, and improving immunisation rates. The evidence for these outcomes is clear and included in this document.

May I take this opportunity to thank the many individuals and organisations who have helped in the preparation of our new Vision - you know who you are, and many are represented throughout the document. May I also thank our Director of Policy, Alison Morton, who has overseen its production, no small task, as well as our Executive Director, Dr Cheryll Adams CBE, who has involved so many health visiting supporters and our wonderful designer, Lisa Jacobs.

Action is urgently needed and families need your help”.

**Pamela Goldberg OBE, Chair
Institute of Health Visiting**



Acknowledgements

This report has been developed by the Institute of Health Visiting in collaboration with experts in the field of health visiting including - health visiting and local authority public health leaders, practising health visitors, academics, researchers and the views of more than 1000 parents. This report is intended to support the government’s plans to refresh the health visiting model for England through the provision of independent evidence-based recommendations for practice.

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Context

- The Department of Health and Social Care has announced welcome plans to update the Healthy Child Programme and the 4,5,6 health visiting model for England¹.
- This document sets out the Institute of Health Visiting's own vision for the health visiting service in England, our reasoning behind why such a vision is urgently needed and recommendations for the next steps to achieving it.
- We are privileged to live in a time when we have more evidence than any other generation before us on the importance of the first years of life as a foundation for future health and wellbeing. We need to use this opportunity to make a difference to the lives of infants, children and their families.
- We now know more about why early intervention matters. Disadvantage starts early in life, the effects are cumulative, can impact across the life course and transmit from one generation to the next, if not addressed.
- Inequalities are not inevitable. We know enough about the interventions that make a difference and we need to take action now to build a fairer society.
- The cost of failing to intervene early is enormous. This is felt in human suffering and lost potential, as well as placing a burden on the Treasury to cover the increased costs of late intervention and associated issues like knife crime, substance misuse and worklessness.
- Health visitors lead the delivery of the Healthy Child Programme and are a highly skilled workforce who are equipped to work in partnership with parents and communities to address a multitude of key government priorities for children and their families.
- The health visiting service does not discriminate. It is offered universally to an undifferentiated population and supports both primary prevention and early identification of children and families who would benefit from additional support².
- There is widespread concern about the current state of health visiting in England and the impact that this has on children and families.
- It is time for action to create a world-class health visiting service that is based on evidence and relationships. A service that can improve the lives of every baby, child and parent and build the foundations for a better future.

"Health visitors are an essential part of the country's support structure for young children and their parents – especially those who are struggling to cope. But they can only do this if they have the time and capacity to develop good, trusting relationships with families. I am very concerned that the huge pressure on health visitor services is making it harder for them to do this, meaning some vulnerable children are in danger of falling through the gaps. I will be carrying out research this year into services for children in the early years, including health visitors, to understand what can be done to make sure no child goes without help."

Anne Longfield, Children's Commissioner for England



Our vision

- **Our vision for health visiting** sets out an “upstream” public health response with action based on the principles of proportionate universalism. It seeks to address some of the limitations of the current 4,5,6 model, balancing the need for a **population approach alongside a more personalised individual response**.
- Currently all parents should be offered five mandated contacts and these focus on six high impact areas where health visitors can make the greatest difference to infant, children and families’ outcomes. In many areas the service is now predominantly focused on the five mandated contacts and safeguarding. However, as leaders of the Healthy Child Programme, health visitors should work in partnership with families to understand their needs and then where necessary arrange a programme of more intensive universal plus or universal partnership plus support as needed.
- The health visiting service of the future needs to be built more closely around the needs of infants, children and their families. We recommend **eight key elements** to ensure the service is: evidence-driven, accessible, responsive, personalised, collaborative, fairer and effective (see Figure 1). This will only be achieved with greater professional autonomy and a recognition of the importance of relationships at the heart of everything we do.
- We make the pragmatic case for **eight universal contacts** and additional tailored support where needed, aligned primarily to **fifteen High Impact Areas**.
- A radical shift in service outcome measures is needed - moving away from the current emphasis on process outcomes, to a streamlined approach which measures impact over time, drives quality improvement and supports integrated working³.
- **National leadership** will be essential to set ambitious and binding national goals to reduce health inequalities for children in key public health priority areas.
- Political leadership - and action to make the difference - is essential to ensure a long-term solution for health visiting services in England.
- **Sustainable funding for health visiting services and their crucial preventative work requires sufficient resourcing as a core activity rather than as an optional extra to be undertaken if resources allow⁴.**
- National and local accountability for improving health and reducing inequalities that arise in childhood is unclear and should be clarified and shared collectively across the health and social care system.

School nursing

- Although the vision focuses on the health visiting service in England, senior school nursing leaders confirm that many of the key messages and recommendations are equally applicable to the school nursing service.

“Health visitors act as a frontline defence against multiple child health problems – from providing advice to parents on breastfeeding and nutrition, to supporting parents with information about immunisations and safe sleeping practices. They also play a crucial role in the early identification of mental ill health, allowing those struggling to access support at the earliest opportunity. This can be life saving. Health visitors are an important cog in the wheel that allows the child health service to effectively function. However, thanks to sharp public health spending cuts, numbers are falling dramatically and this is having a detrimental impact on infants and children. The proportion of 6-8 week reviews completed for new born children ranges from 90% in some areas to 10% in others for example.

In its recent spending review, the Government agreed in real terms, to increase the Public Health Grant which is warmly received. In order to ensure all infants, children and their families receive the same high level service no matter where they live in the country, the Government must reinstate the budget in full”.

Prof. Russell Viner, President of the Royal College of Paediatrics and Child Health (RCPCH)

Figure 1: Key elements of an effective family-centred health visiting service



Section 1. Introduction

This document sets out the Institute of Health Visiting's vision for the health visiting service in England, our reasoning behind why such a vision is urgently needed and recommendations for the next steps to achieving it.

Our Vision requires health visiting to play its fullest part within an integrated system to reduce health inequalities that arise in childhood and for England to achieve health outcomes on a par with the best in the world.

This will be achieved by providing an effective health visiting service that works in partnership with parents and carers, "working with, not doing to", and as part of a broader approach with others to ensure every child has the best start in life.

Principles:

- To provide an accessible, evidence-based service for all children and their families based on proportionate universalism supporting the Government's ambition for it to be, "universal in reach and personalised in response"⁵.
- To value everyone as an individual and provide personalised, responsive support through partnership working and strengths-based practice.
- To co-produce services with the people who use them based on the best evidence of what works.
- To focus on priorities at both an individual and community level to make the biggest difference to improve health and reduce health inequalities.
- To work within a whole systems approach to children and families' health and social care that is across government departments and integrated at a national and local level.
- To continually listen, learn and improve to ensure services are effective and fairer. Strong health visiting leadership is needed to drive quality improvement which should be rooted in data on access, experience and outcomes, and collaborative working with others to reduce inequalities.
- To strengthen the health visiting workforce and professional autonomy.
- To meet the standards for professional practice laid down by the NMC.

"We are privileged to live in a time when we have more evidence on the importance of the first years of life and the effectiveness of early intervention than any other generation before us - now is the time to translate this evidence and policy rhetoric into practice.

The current status of health visiting is not serving families well, based as it is on universally delivered process outcomes which risk "ticking the box, but missing the point". To ensure every child really does have the "best start in life", the health visiting service of the future needs a shift of emphasis - services need to be built more closely around the needs of infants, children and their families, be evidence-driven, accessible, responsive, personalised, collaborative, fairer and effective. This will only be achieved with greater professional autonomy and a recognition of the importance of relationships at the heart of everything we do".

**Dr Cheryl Adams CBE, Executive Director
Institute of Health Visiting**

*"What you [health visitor] offered me was more profound and complex than what could be summarised on a monitoring form. Because what you offered me was **hope**. You offered me a safe space to share my mental pain and distress. You contained my distress and allowed me to feel heard and valued... you fought for me. When I had no strength to fight for my own care. You spoke up for me, for my needs. You were the voice for our family. Alone in this struggle, we would have no voice. We did not know what to say. **But you did...** Thank you for believing that things would change".*

Jane Fisher, Parent expert by experience

“Getting the very best start to life is of crucial importance for babies in Britain today. It determines their trajectories throughout life and is the basis for intellectual and emotional resilience and their abilities to become productive adults and parents themselves in due course. Health visitors play a key role in supporting them and their families, especially those living in disadvantage or with disabilities, and it is time we recognised their contributions. The new vision for the profession is sorely needed and has my support”.

Professor Sir Al Aynsley-Green, former first Children’s Commissioner for England and author of ‘The British Betrayal of Childhood’

“Health visitors working in local government play a pivotal role in tackling health inequalities and helping ensure all children get the best possible start in life. The impact of the early support they provide cannot be underestimated, it builds resilience, encourages healthy lifestyles and aids social and emotional development. Giving children the best start in life is one of the most important jobs councils do and we have already seen benefits of closer links between health visiting, housing, social care and early years education. However, if we are to truly improve outcomes for children – we need a more joined up approach across the child’s life-course and across organisational divides. A properly resourced and sustainable workforce plan to support children’s wellbeing is key to achieving this.”

Councillor Ian Hudspeth, Chair, Community Wellbeing Board Local Government Association

“Public health nurses, especially health visitors and school nurses are a hugely important part of any approach to helping children and families start and develop in good health. They are a prudent and essential investment in our country’s future. National policy on early childhood remains fragmented and lacking investment. Cuts by government to services for children, families and young people is to the detriment of our children and our future. It’s time we invested again in joined up services for children. Public Health nursing including health visitors and school nurses must be a core part of that investment”.

Prof. Jim McManus, Vice President, Association of Directors of Public Health (ADPH)

“After the birth it is so important that mothers and their babies get the care and support they need. Initially midwives provide this and then hand on the care to our health visitor colleagues. Both professions are facing significant shortages and we know this is having an impact on the care health visitors and midwives are able to give. It is imperative that mothers get the continuity of care they need throughout and beyond pregnancy. This means good communication between both professions and the time to do this effectively, a situation that is most certainly challenged by the ongoing shortages. This is a vital period for the health of the mother and child and we need to see more investment in it and in health visitors”.

Gill Walton, Chief Executive, Royal College of Midwives

“The School and Public Health Nurses Association (SAPHNA) welcome this forward-looking vision from our iHV colleagues and support the proposals for a refreshed and revitalised Health visiting model. Investment in early years and early help that continues across a child’s life-course, is essential if we are to turn the tide on the worsening health and well-being outcomes of our children, young people and families. This, in turn, will allow Health Visitors and School Nurses to work upstream in what we do best!”

Sharon White OBE, CEO SAPHNA (School and Public Health Nurses Association)

“Over the last decade, pressures on families have increased dramatically, so skilled, evidence-based care is needed more than ever. Yet over this same time period, the number of health visitors – highly trained and trusted professionals with the ability to support and enable health improvements in families with pre-school children - has fallen dramatically. These children and families deserve better. A universal health visiting service with the expertise and capacity to increase support in proportion to need will pay great dividends in the long term. I commend this vision from the Institute of Health Visiting, which sets out the form of provision needed and clear evidence to show the benefits to children and their families, along with the potential savings to be made in the long term”.

Prof. Dame Sarah Cowley DBE, Emeritus Professor King’s College London



“Children and our society need the expertise that a Health Visitor brings in helping families to navigate the challenges of parenting. The effects of cuts to the health visiting service is evidenced by inappropriate and costly GP and emergency care support. Successive governments have committed to improving childhood outcomes; whilst on the one hand setting out a need for growth, have very quickly implemented commissioning strategies that are now seeing the demise of the health visiting workforce. There needs to be a reinvestment in health visiting services to enable babies, children and families to have the upstream support they need and deserve”.

**Dame Donna Kinnair, Chief Executive
Royal College of Nursing**

“It was a huge success of the coalition Government that we recruited almost the 4,200 target for health visitors that was set back in 2010. We have lost as many as 30% of those now... given the cash constraints on local authorities, health visitors have turned out to be a soft target. That is a hugely false economy and certainly needs to be revisited as a priority. The lifelong impact of early attachment should not be underestimated... Not getting it right during the conception to age two period will have an impact on many children for their childhood years, for too many, continuing into the adult years too”.

**Tim Loughton MP, Chair All Party Parliamentary Group for
Conception to Age 2 (first 1001 days)**

“The challenge of giving every child the best start in life begins before conception and continues throughout childhood. The first 1000 days of a child’s life represent a critical phase of heightened vulnerability, but also a window of enormous opportunity... By devoting resources to interventions during this early period of a child’s life the Government can improve the health, wellbeing and life chances of future generations”.

**Health and Social Care
Committee. First 1000 days of
life, 2019⁶**

*“In my experience, GP colleagues are advising on more infant weaning and feeding problems, and more on infants who are constipated. GPs are also spending more time reassuring parents regarding immunisation and managing parental anxiety, than we did years ago, when **these issues would have been largely managed by our expert health visitors, whose numbers are in rapid decline**”.*

**Dr Helena McKeown
GP and Chief Officer
British Medical Association**



“After an impressive period of investment in health visiting, that groundwork is slipping away with rising caseloads and reduced numbers of health visitors. We know that relationships really do matter, especially in building parental confidence. Parents tell us that their child’s earliest years can be challenging - we need more Health Visitors not less. With fewer Health Visitors than ever we are taking strides, not just steps, backwards. Too many children are missing out on their needs being identified early enough”.

**Annamarie Hassall MBE
Director, National Children’s Bureau**

“The Healthy Child Programme delivers a universal service to all children, and an enhanced service to families in need. The identification of families in need requires expert, holistic assessment- this is one of the most important roles of the health visitor”.

**Prof. Alan Emond, Emeritus Professor of Child
Health, University of Bristol**

“The Health Visiting service in the UK is the envy of the world. The provision of a robust Health Visiting service that supports the health and wellbeing of the most vulnerable in our society is an indication of how seriously we take the health of our children and families. It is critical that we continue to invest in the Health Visiting service to secure the best possible health outcomes for future generations”.

**Dr Crystal Oldman CBE, Chief Executive
The Queen’s Nursing Institute**



“CPHVA members are very concerned about the future of health visiting as a vital public health service. We believe there should be commitment to maintain health visiting standards and maintain registration of the specialist practice on the NMC register. This ensures promotion of professional practice and safeguards children and young people”.

**Obi Amadi, Lead Professional Officer
UNITE the Union (includes the Community Practitioners’
and Health Visitors’ Association)**

Section 2. Setting out the case: the population's health and the challenges ahead

The case for investment in the earliest years of life

Investing in the earliest years saves money in the long run⁷ and, more importantly, ensures that every child is supported to achieve the best start in life with foundations for good health throughout the life-course. The evidence that supported the case for the Health Visiting Implementation Plan (DH, 2010- 2015)⁸ still stands, with more recent evidence further supporting this case^{9 10}.

The current state of child health and wellbeing in England

Despite overall improvements in child health¹¹, England lags behind other countries on many key health outcomes; infant mortality reductions have stalled, our breastfeeding and obesity rates are amongst the worst in Europe and health inequalities are seen across all indicators¹².

In recent years there has been a continuing shift in the burden of disease from mortality to morbidity¹³. People are living longer, however years of life lost to disability are increasing, placing additional burden on the health and social care system.

Much of this burden is preventable¹⁴, with the foundations for virtually every aspect of human development including physical, intellectual and emotional wellbeing being established in the first years of life¹⁵. Effective intervention, particularly in the first 1001 days has the potential to break intergenerational cycles of transmission of Adverse Childhood Experiences and disadvantage¹⁶.

The Children's Commissioner¹⁷ estimates that in total 2.3 million children are living with risk because of a vulnerable family background. Within this group more than a third are "invisible" (i.e. not known to services) and therefore not getting any support. At the most extreme end of the spectrum, as in previous years, currently the highest rate of homicide for any age group is in babies under the age of 1¹⁸.

The current context of persistent inequalities

There is a persistent, and in some cases, widening social gradient in outcomes for children¹⁹. The effects of these early inequalities are cumulative and can last a lifetime if not addressed.

These inequalities result in poorer physical and mental health, academic achievement and employment prospects at every stage of life, as well as having financial consequences across government.

Increased investment is needed to address existing gaps in provision and emerging priorities, including:

- Falling immunisation rates and recent loss of WHO measles elimination status in 2019²⁰;
- Poor oral health;
- Inequalities in speech, language and communication and other causes of developmental delay to support school readiness;
- Increasing infant and child mental health problems;
- Increasing rates of childhood obesity and low breastfeeding rates;
- Rising Emergency Department attendances by children 0-5 years;
- Increasing pressure on primary care services from families who would have once consulted a health visitor;
- The impact of couple conflict;
- Reducing smoking in pregnancy;
- Support for children living with alcohol and substance dependent parents;
- Support for perinatal mental illness;
- Improving sleep to mitigate the risks of serious health conditions associated with sleep deprivation.

A shift in emphasis towards preventing illness and supporting good physical and mental health is needed²¹. This requires a whole system response to ensure every child has the best start in life and individuals are supported **through a population response and personalised support to lead healthier lives**²².

Funding for the health visiting service

This is the responsibility of the Department of Health and Social Care, although **the benefits of an effective health visiting service accrue to numerous government departments with shared priorities for children.**

Since 2015, local authorities were expected to secure continuous improvement in the health visiting service. At the heart of the plan was improved access, experience and outcomes for all families with a level of flexibility to ensure that services were responsive to local needs. Yet year on year reductions to the public health grant have resulted in cuts to the service and considerable variation in the quality of support that families receive dependent on where they live, rather than their level of need. Unfortunately, the current national system-levers and quality assurance mechanisms have not adequately addressed or mitigated these unwarranted local variations.

When evaluating the cost effectiveness of recent service cuts, consideration needs to be given to costs incurred elsewhere in the system as a direct result of these cuts²³; for example increasing demand on GPs for concerns for which parents would previously have sought advice from a health visitor; alongside the considerable cost of late intervention²⁴ and preventable conditions. "Turning off the tap is more effective than mopping the floor"²⁵.

Health visiting provision in England is locally commissioned (in contrast to the devolved nations), leaving vital decisions to local government members. Whilst there have been some examples of good commissioning in recent years, even senior Directors of Public Health recognise that commissioning in some areas is not as good as it could be.

Reduction in health visiting numbers

The numbers of health visitors working in England shows a continued steady decline, with numbers reverting to pre-Call to Action figures. The way that health visiting numbers are calculated in England is not straightforward. Currently data is collected in two ways nationally:

- [NHS Workforce Statistics](#) - includes staff working in NHS organisations, but not staff working in local authorities or other provider organisations.
- [Independent Health Care Provider Workforce Statistics, England](#). These statistics are collected biannually and are published as experimental statistics as they have only been collected from September 2015.

There has been a 31.8% reduction in health visitors in England's NHS, from 10,309 FTE in October 2015 to 7,026 FTE in June 2019²⁶. The most recent published data from the Independent Health Care Provider Workforce Statistics shows a reduction of 13.5% from 1,240 at its peak in 2017 to 1,073 in the latest data reported for March 2019. This presents a worrying trend for health visiting inside and outside NHS community employment.

Any action to address this significant reduction in health visiting workforce numbers has not mitigated this worrying trend for health visiting inside and outside NHS employment. This is a concern to the Institute as action needs to be taken now to reverse this trend and ensure every child and their family has access to an effective health visiting service.

Reduction in student health visiting training places

The closure of the Health Visiting Implementation Plan led to an immediate fall in student health visitor training places. The number of entrants for training in England has significantly reduced from 2787 in 2013-14 to 448 in 2017-18²⁷. An economic analysis of early years prevention concludes that:

'The essence of quality in early childhood services is embodied in the expertise, skills, and relationship-building capacities of their staff. Substantial investments in training, recruiting, compensating, and retaining a high-quality workforce must be a top priority for society'²⁸.

"Ticking the box, but missing the point"

To be effective, all areas need to provide a continuum of support for a continuum of need. This requires both universal and targeted services. Mandating the five universal reviews has skewed prioritisation of resources to achieving targets for numbers of universal contacts achieved at the expense of personalised support for families with identified needs, or with any regard to quality.

What gets measured gets done - A focus on process outcome measures, often mean the delivery of statutory and mandatory functions are protected to the detriment of early intervention and prevention services.

The complexities of measuring impact in a complex adaptive system are widely recognised:

'This form of performance measurement [process measurement] actually encourages people to game the system. At best, they focus on the numbers that allow them to tick the box they are responsible for, with the result that it becomes harder to work across services or to take into account the variable and interrelated factors that affect outcomes on the ground'²⁹.

Approaches that appear to be cost saving at face value may inadvertently disadvantage children and families with the greatest needs and as a result prove to be more costly in the long term due to the impact of unrecognised needs which drive widening inequalities. For example, completing health reviews by sending Ages and Stages (ASQ-3™) developmental review questionnaires through the post might achieve a performance target (ticking the box). **However**, the most vulnerable families are known to find it difficult to focus on their child's needs and are often less motivated to seek out and use support services³⁰³¹³², resulting in "invisible children". In addition, the ASQ is not an effective tool for this task; it is a population measure and not a screening tool and was introduced to be used as part of a holistic assessment which relies on professional judgement and interpretation (missing the point)³³.

Often funding and outcomes for health visiting services are short-term in nature, leaving them vulnerable to cuts if results aren't seen quickly. Outcome measures need to be developed to support longer term outcomes with a greater level of personalisation and professional autonomy, recognising the complexities associated with measuring interventions in a complex system.

Many families who have inter-generational poor health and social outcomes may fall below statutory thresholds but need more support than universal services can provide. Therefore, greater attention needs to be given to what services are not providing and who is being missed to ensure equity of access. The universal health visiting assessment provides an important means to capture this information.



What does it feel like to be a parent and receive a high-quality health visiting service? (Quotes from Channel Mum Survey, April 2019)

"Being a new mum, even the second time round, it is SO important to have support around. I felt safe and reassured having the visits, and to have them at the end of the phone if needed. Sometimes, even if you think you're doing right, or have a 'silly' question it's nice to have backup and advice".

"Gave me a lot of information on development and helped get us the move we so urgently need for our daughter to have the space she needs to develop - so, so very grateful".

"I felt she was very patient and understanding when I admitted I had been feeling low. She had a lot of time for me and I didn't feel rushed. I felt that none of my questions were silly and she made me feel comfortable and more confident".

"Excellent support through the health difficulties of my eldest as a baby and with my own postnatal depression second time round. Very individualised support and help."

"Being able to ask what felt like stupid questions and not feeling judged".

"I got a lot of information on weaning my little girl on to solid food with a severe milk protein allergy".

"Made me feel supported and more confident to deal with a very difficult situation and gave advice to help my daughters to feel safe and secure while they were with me and helped me to have the strength to be keep going".



What does it feel like to be a parent who lives in an area where an effective level of health visiting support is NOT available?

"My mum died when my baby was 8 weeks old. I told my health visitor and she wrote in my book that I was to be offered additional support, but I wasn't actually offered anything, it was just a paper exercise. She promises to phone me but doesn't".

"Different health visitors all the time. No extra support for having twins with reflux. Felt she was ticking boxes rather than actually looking at us".

"First visit after baby from a health visitor that wasn't my usual health visitor – this made me upset as I felt I couldn't talk to her. Was like a tick box exercise. My usual health visitor is very good".

"I haven't seen or heard from them since my son was 4 months old".

"I was meant to have a visit. I tried to contact my HV but she never got back to me, so I didn't have more visits. Only 1".

"Couldn't get hold of the team; Phone always off. Not able to answer emergencies- Sessions always rushed".

"Barely saw her after my twins came out of hospital she came to visit once when they were in hospital".



What do parents want from a health visiting service?

The findings from a survey of 1000 mothers of children aged 0-23 months completed by Channel Mum for the Institute of Health Visiting in April 2019 highlighted a mixed picture of health visiting nationally with many mothers valuing the service, however some reported a poor experience and difficulties accessing the service.

Mothers valued being treated as an individual, with continuity of health visitor, a non-judgemental strengths-based approach and easy access to expert, up to date advice. Yet 22% of mothers reported that the health visiting service felt like a “tick box exercise”. The main drivers for dissatisfaction were lack of continuity of health visitor, the appointments feeling rushed, too little time spent on emotional transition to parenthood, difficulties accessing the service when needed and conflicting advice.

Service user engagement and research has identified that the following components of health visiting practice matter to parents^{34 35 36}:

Evidence driven and effective: Parents value health visitors’ knowledge of parenting and childcare issues, their capacity to offer reassurance and support with specific issues such as postnatal depression.

Accessible and responsive: Parents value both evidence-based factual information and advice that is both timely and tailored to suit their needs.

Personalised with relational continuity: Building and nurturing the parent-health visitor relationship is important for underpinning the delivery of functional aspects of care and for a sense of continuity - “knowing and being known personally by a health visitor”. Health visitors should strive to meet parents in an interaction that role models attunement. As health visitors attune to the parent, they are modelling high reflective function which forms the foundation of secure attachments between the baby and its parents³⁷.

Collaborative/ Being involved: Parents value health visitors as a point of contact (and referral to other health professionals). A reciprocal relationship (involvement) and good communication is crucial.



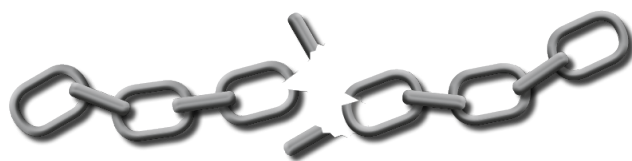
Section 3. Health visiting within an integrated health and care system

Health visitors lead delivery of the Healthy Child Programme (HCP), which is a universal prevention, health promotion and early intervention programme available to all families. Health visiting is non-stigmatising and has high levels of acceptability to the public.

Health visiting: an important link in the chain

Ensuring every child has the “best start in life”³⁸ and reducing inequalities requires a whole system, integrated approach as prevention and intervention cut across a range of stakeholders working with children and their families³⁹. No one organisation or professional group provides the complete solution – effective strategic system-wide approaches require organisations to work together within integrated clinical pathways to:

- Support all children and their families to reduce inequalities in key priority areas;
- Identify children at risk of poor outcomes;
- Provide a continuum of support for a continuum of need, to address the key priorities set out predominantly in the High Impact Areas.



Tackling key government priorities for children:

The health visiting service should provide an important part of the solution to numerous current national priorities including:

- Improving early language development and the home learning environment; identifying and supporting families with children with Special Educational Needs or Disabilities (SEND); and safeguarding children from abuse and neglect (**Department for Education (DfE)**);
- Supporting Troubled Families (**Ministry of Housing, Communities and Local Government**);
- Reducing parental conflict (**Department for Work and Pensions**);
- Improving parental health literacy to reduce unnecessary A&E attendance in children; improving immunisation uptake; supporting families at risk of, or experiencing, infant and perinatal mental health problems; reducing childhood obesity and poor oral health; and early identification and support for families with children with developmental delay and/or complex health needs (**NHS England/ Department of Health and Social Care (DHSC)**);
- Support to help children living with alcohol-dependent parents (**DHSC**);
- Improving uptake of child benefit (**HMRC**), Healthy Start benefits (**DHSC**) and free education and childcare for two year olds (**DfE**) by eligible families;
- Early support to reduce demand on general practitioners by parents with everyday parenting concerns such as feeding difficulties (**DHSC**).

A strengthened health visiting service is integral to an effective collaborative system and improved outcomes for infants, children and their families. Conversely, a weak health visiting service increases the likelihood that children and families will be “missed”, and the extra system burden associated with late identification and intervention.

For example, the recent investment in NHS Specialist Perinatal Mental Health and Maternity services⁴⁰ will go some way to supporting women with the most severe form of perinatal mental illness; yet hundreds of thousands of women every year will not reach the criteria for these services⁴¹ and will fall within the remit of the health visiting service which provides a crucial role in early identification and treatment. Urgent investment is needed to strengthen this link in the chain.

Similarly, whilst direct causation of recent reductions in uptake of the measles vaccination cannot be directly attributed to reductions in the health visiting workforce over the same time period, it is widely recognised that health visitors are seen as one of the most trusted sources of information by parents⁴² and provide an important role in supporting parents with vaccine hesitancy.

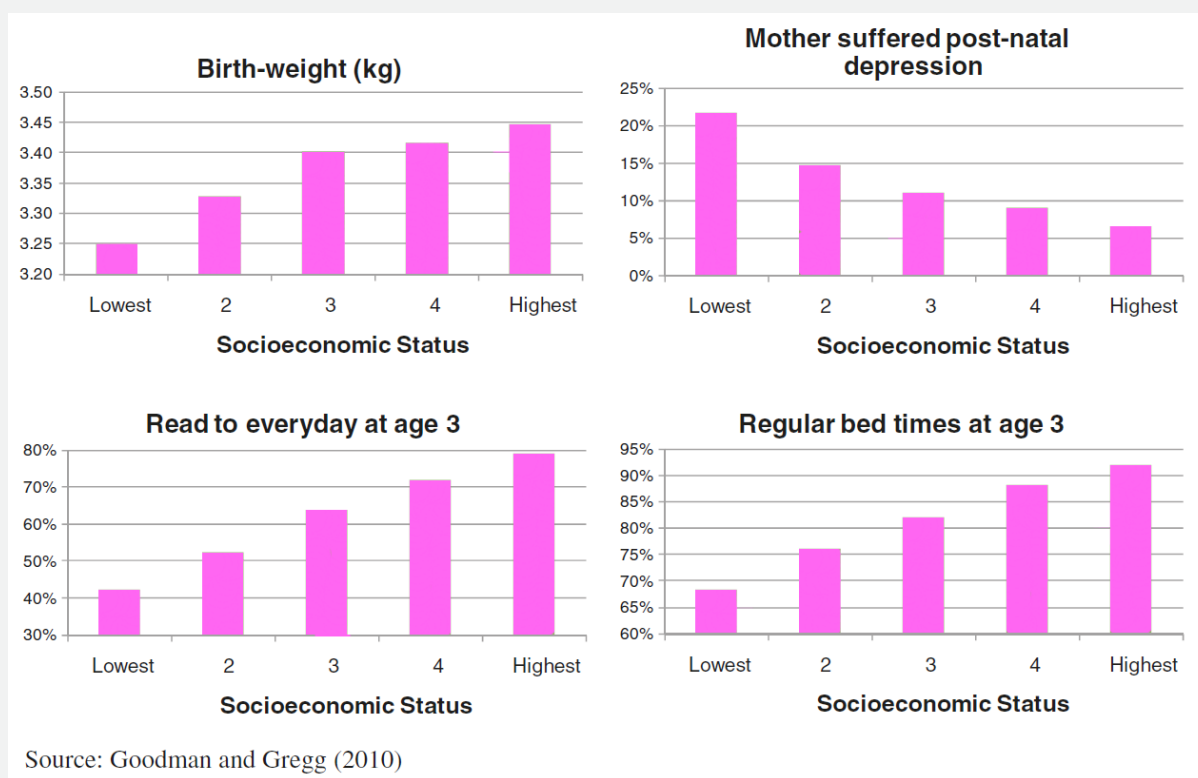


Section 4. Overview of a new vision for health visiting in England

Fairer – working to narrow the health gap

Inequalities in health begin early in life and are not inevitable and are reflected across the whole population. There is a significant body of evidence to support the case that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently^{43 44}; 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. Instead actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage⁴⁵.

Figure 2: Factors Affecting Child Development^{46 47}

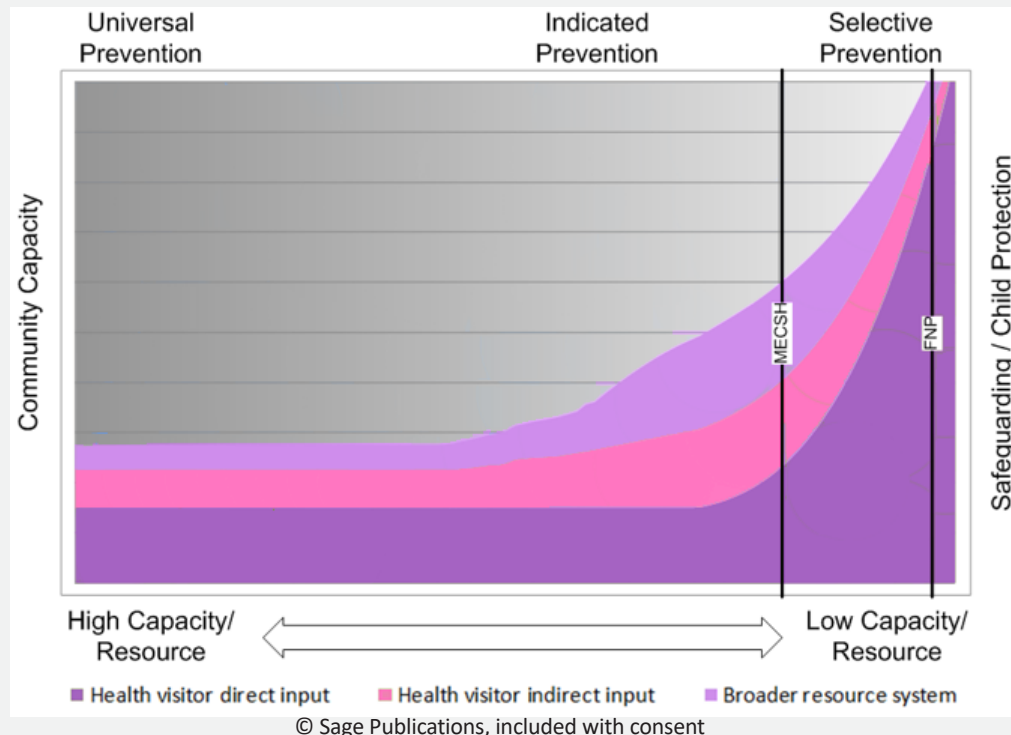


Taking an asset-based approach:

“In practice, the immediate and long-term impact of risk or resilience factors, as well as their interaction, are complex and difficult to predict. Factors intrinsic to the child and in their immediate environment, particularly their parents or carers, are likely to have the most significant effect on child outcomes. The sum impact of significant social risk factors may be ameliorated by child characteristics and the care and nurture they receive from their parents and carers. Practice that builds on people’s strengths is demonstrably more effective than approaches that emphasise problems, risks and the expertise of professionals”⁴⁸.

Figure 2 highlights a range of problems and risk factors, which are important for needs assessment and to inform targeted provision, yet their negative focus can distract from people’s individual assets⁴⁹ and the many resources upon which families can call. Figure 3, places families with the highest capacity at one end of a continuum, and those with the lowest at the other.

Figure 3: Matching programmes and services to family resource/capacity⁵⁰



Key:

- **Universal prevention** interventions for a whole population group.
- **Indicated prevention** targets high-risk people who are identified as having minimal but detectable signs or symptoms indicating predisposition for a disorder.
- **Selective prevention** targets individuals or subgroups of the population whose risk of developing a disorder is significantly higher than average. These families need more sustained or intensive support.
- **Health visitor direct input** - provision delivered by the health visitor.
- **Health visitor indirect input** - provision arranged by or through the health visitors, e.g. by delegating to team members or referring to colleagues in the wider multi-disciplinary team.
- **The broader resource system** includes formal and informal provision through health, local government and third sector (non-governmental organisations), etc.
- **Personal capacity and resources** include emotional, cognitive, practical/physical and social resources available to the individual/family, indicating strengths, capacity or resilience.

The Prevention Paradox⁵¹ asserts that a large number of people at small risk may give rise to more cases of disease than a small number of people at high risk. High risk groups make up a relatively small proportion of the population. Interventions are therefore needed to reduce inequalities across the whole of society, not only for the worst off⁵².

Yet a balance needs to be found to avoid the documented risks of focusing solely on a population approach which has been criticised for overlooking the individual and “medicalising” normal life – the assumption behind the paradox is that the whole of society is “sick” and needs treating⁵³. Shifting of the distribution curve in a favourable direction therefore requires action at both an individual and population level as complementary approaches to improve outcomes in public health.

To address all of these factors, we have sought to develop a vision that brings greater recognition of the individual within a complex adaptive system, whilst applying the principles of proportionate universalism, thereby incorporating both a population and an individual/ more personalised approach with a greater level of professional autonomy.

What this means in practice is that:

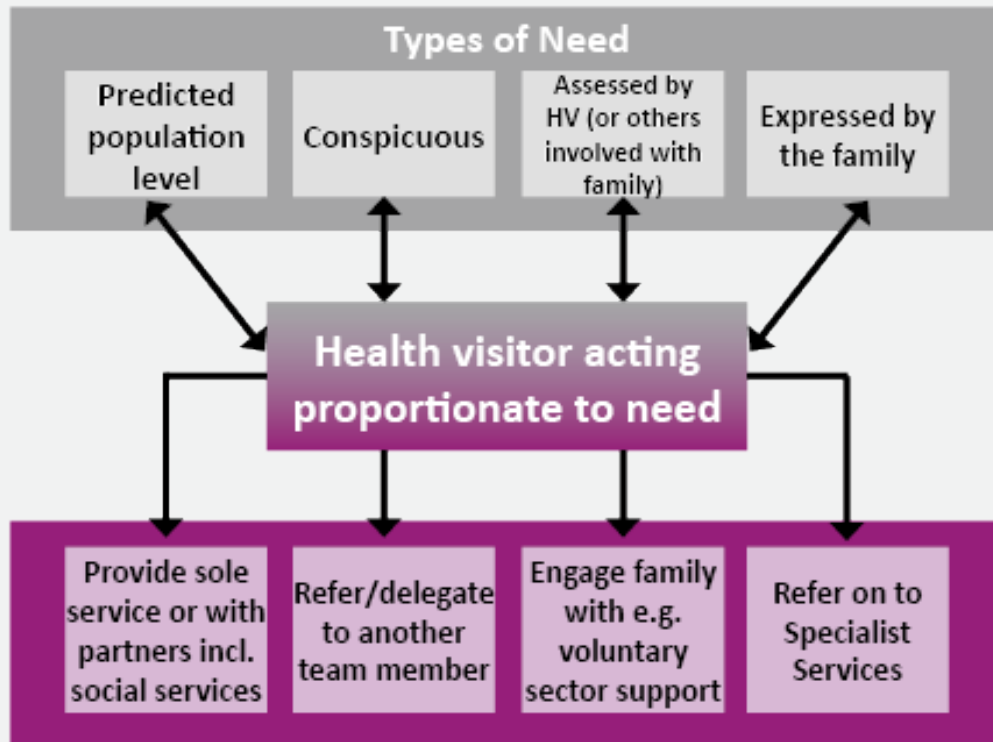
- All families get a level of support (population approach).
- Resources can be targeted to those who are most disadvantaged: the level of support can be “dialled up or down” according to need. Health visitors work in partnership with families to negotiate a programme of more intensive universal plus or universal partnership plus support (personalised/ individual tailoring).

This approach has been introduced into the Family Nurse Partnership Programme ADAPT with good results⁵⁴ - families are reviewed at 12 months and services “dialled up or down” depending on need.

Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need:

- Services are universally available. Provision of additional interventions should be developed according to an assessment of need at two levels: at an area/population level, and at an individual/family level. Assessment of need at a population level provides information about workforce requirements, taking account of the local context and community assets. There is not a “one size fits all” approach – what works in Sheffield, may not work in Cornwall.
- Assessment of individual/family strengths and needs provides clinical information about the type of service to be delivered in that instance.
- Assessment should be completed over time and avoid a “tick box” approach. The aim is to gain a clear understanding of the individual family situation, assets and capabilities as well as their problems and difficulties within the wider personal, family and social context. This is a highly skilled activity that aims to elicit needs that may not always be conspicuous or readily disclosed. As such, all holistic health needs assessments and plans for support should be led by a health visitor and in partnership with parents.
- The aim is to achieve equity of outcome, not equal input. The overriding ambition to ensure every child has the best start in life must drive decisions based on individual need; this is important to avoid the level of flexibility within the vision being misapplied to justify cuts to services or make assumptions about the needs of certain groups.
- Increased support is provided to those with the greatest need, which may not be conspicuous (Figure 4). The service should aim to always reach every child at risk of poor outcomes, rather than rationing support based on capacity within current services. Information on levels of unmet need and waiting lists should be collated to inform future service planning.

Figure 4: Types of need and health visitor responses
(reproduced with permission from Viv Bennett – Chief Nurse PHE)



Key elements of our vision for health visiting

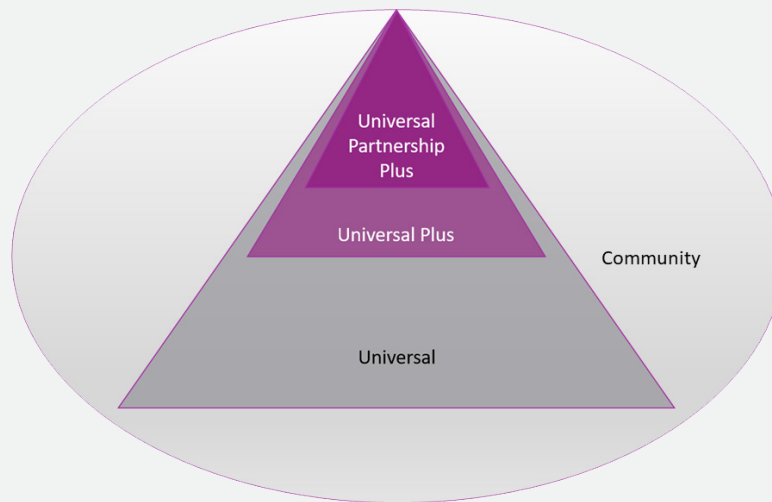
Drawing on the evidence of “what works” we have identified eight key elements of an effective health visiting service:

- **Personalised:** To be effective, services need to be built around the needs of infants, children and their families, with relationships at the core of all health visiting provision⁵⁵. Continuity and collaboration are essential elements of team working.
- **Fairer:** Achieving the primary ambitions of improved outcomes and a fairer society with reduced health inequalities requires a preventative focus. This approach is not primarily concerned with mitigating health and social problems but with **creating health (salutogenesis)** with an ‘upstream’ focus on the ‘cause of the causes’ of health inequalities⁵⁶. In areas of higher deprivation, more families would need more support based on the principles of proportionate universalism. This would need to be factored into the baseline with smaller caseload sizes in those areas. This allows on-the-ground flexibility, whilst providing a clear specification for a funding model.
- **Evidence-driven** provision should be available to provide a continuum of support for a continuum of need. Families will have varying needs and may benefit from interventions, tailored to their needs, at different levels simultaneously.
- **Responsive:** Movement between levels of support needs to be fluid as needs change over time and may emerge throughout the early years. Easy access to health visiting support is crucial to ensure that the service is responsive to need as and when it arises. Parents value drop-in clinics and groups that are both accessible and flexible to meet their needs⁵⁷, as well as services augmented with new technologies providing personalised advice like “ChatHealth™”⁵⁸.
- **Accessible:** Services should ensure they are accessible to all groups, particularly those individuals and groups who do not currently experience easy access to services (for example the Gypsy/ Traveller community, asylum-seekers and individuals who are not registered with a GP)⁵⁹, and consequently do not experience the same health outcomes as the rest of the population.
- **Effective:** The focus of outcome measures needs to shift from the current position which measure the provision of “services” and work towards longer term goals⁶⁰ which value health assets, with cross sector shared ambitions that matter to a community and recognise collaborative working.
- **Collaborative:** Health visitors and their teams work collaboratively with local communities and key partners like GPs to respond to local priorities, mobilise assets within communities, promote equity and increase people’s control over their health and lives.
- **Professional autonomy** is essential for enabling health visitors to provide a flexible service, tailored to individual need.



Our vision balances a structured programme of universal reviews, with the flexibility for personalised support proportionate to the level of need.

Figure 5: Personalised support with 4 different levels of intervention proportionate to need:



- **Community:** Health visitors work collaboratively with others to facilitate a place-based response to local need.
- **Universal:** Eight universal health visiting reviews provide a service for all and a safety net for children and families who might be “invisible” without this provision. Non stigmatising and acts as a gateway to other levels of support.
- **Universal Plus:** A swift response when families require specific expert help. To reflect the breadth of the health visiting contribution, we have based this particularly on 15 High Impact Areas.
- **Universal Partnership Plus:** Support for families with multiple or long-term, complex needs requiring a multi-agency coordinated response, working together and with families.
- **Safeguarding is a thread that runs through all levels of health visiting.** The health visiting service is recognised as important to both safeguarding and child protection “because it **safeguards all children**”⁶¹.



Eight universal contacts - Fifteen High Impact Areas

“The first priority should be for every child to receive all the five mandated visits, in a manner that does not compromise the quality of these visits...the Government [should] set out proposals for increasing the number of routine visits. We recommend that all checks should be carried out by a health visitor, and that a minimum number of contacts should include a home visit... We recommend that an additional mandated visit at 3–3½ years should be included in the Healthy Child Programme, to ensure that potential problems that may inhibit the ability of children to be ready to start school are identified and addressed”.

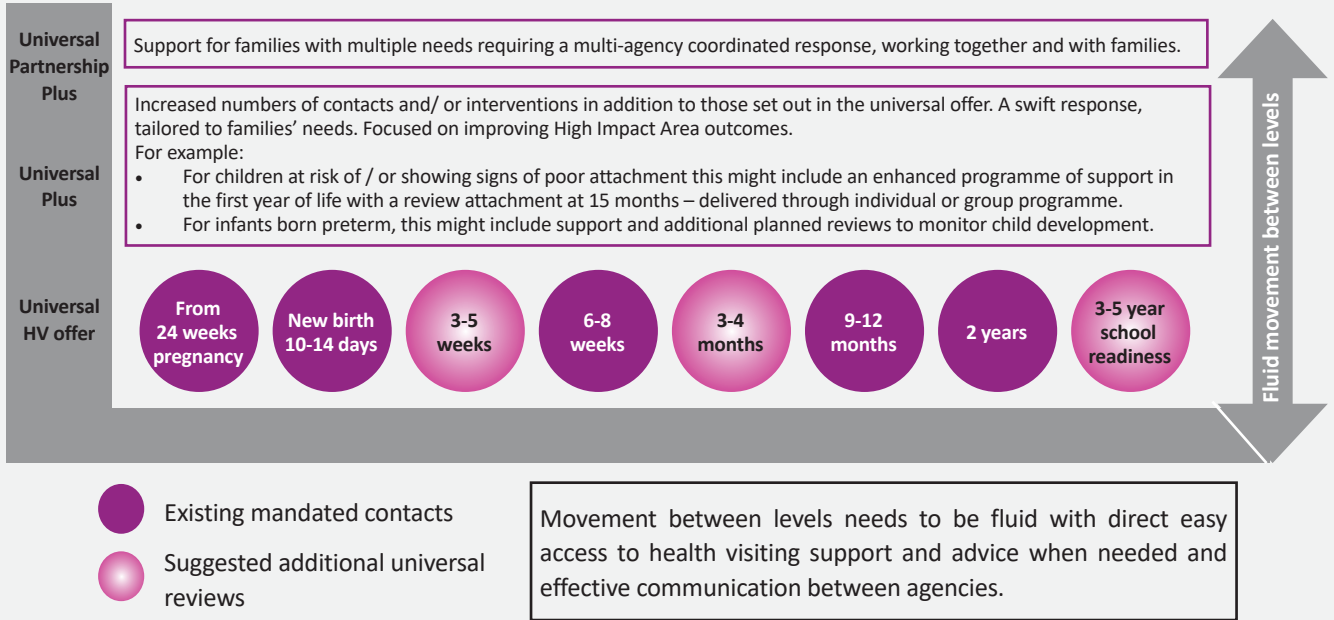
Health and Social Care Committee, First 1000 Days of Life, 2019⁶²

Health visitors are Specialist Community Public Health Nurses, as well as being nurses or midwives, and have extensive clinical skills. The health visiting contributions to integrated clinical pathways are aligned to the High Impact Areas (HIA) where they can make the biggest difference.

To ensure the full scope of the health visiting contribution is recognised and maximised, the existing HIA have been extended to include evidence driven recommendations in “Health for all Children – fifth edition” (2019)⁶³.

- 1 Transition to parenthood, including preconception care
- 2 Breastfeeding
- 3 Perinatal mental health (mothers, fathers and partners)
- 4 Infant and child mental health
- 5 Healthy nutrition, physical activity and healthy weight
- 6 Managing minor illnesses, building health literacy and prevention of Sudden Infant Death Syndrome (SIDS)
- 7 Reducing unintentional injuries
- 8 The uptake of immunisations
- 9 Primary prevention and health promotion in oral health
- 10 Child development 0-5 years, including speech, language and communication and school readiness
- 11 Sleep
- 12 Children with developmental disorders, disabilities and complex health needs
- 13 Tobacco, alcohol and substance misuse in the perinatal period
- 14 Healthy couple relationships
- 15 Teenage parenthood

Figure 6: A flexible health visiting service tailored to individual need



“It is essential to treat young children’s mental health problems within the context of their families, homes, and communities. The emotional well-being of young children is directly tied to the functioning of their caregivers and the families in which they live. When these relationships are abusive, threatening, chronically neglectful, or otherwise psychologically harmful, they are a potent risk factor for the development of early mental health problems. In contrast, when relationships are reliably responsive and supportive, they can actually buffer young children from the adverse effects of other stressors... These findings underscore the importance of prevention and timely intervention in circumstances that put children at serious psychological risk”.

Center on the Developing Child, Harvard University⁶⁴



Section 5. Evidence to support the High Impact Areas

The evidence that supported the case for the current six High Impact Areas for health visiting still stands⁶⁵. There is also a case for increased investment to improve and join up services for families with a strengthening of the health visiting contribution in a further nine key priority areas, creating fifteen in all.

1. Transition to parenthood, including preconception care

The role of the health visitor in supporting transition to parenthood is well established⁶⁶. Health visitors are still the preferred source of evidence-based advice for most parents⁶⁷. Health visitors work with families to complete a holistic assessment of health and wellbeing needs during their transition to parenthood and throughout the period from pregnancy to school entry. The Healthy Child Programme states that assessments should avoid a “tick box” approach. Care that is not personalised may satisfy auditors; however, it has been shown to be more costly in the long run as it fails to identify need⁶⁸. During this period of transition, the health visitor will seek to establish a positive relationship with the family. The notion of “being known” is recognised as an important part of the helping process⁶⁹.

Health visitors use a strengths-based approach that supports parents to build on their personal and community assets. When difficulties or problems arise, rather than automatically referring all children to an “expert” to get fixed, the health visitor will work to bring expertise within the context in which the child lives. Most importantly this includes supporting parents and those closest to the child to develop the “expert” skills needed to support their child’s health and developmental needs.

Support for transition to parenthood now also includes an additional focus on preconception care. Poor preconception health limits women’s choices and impacts on the safety of pregnancy and childbirth for both mothers and babies, with potentially long-term consequences on child health⁷⁰. 45% of pregnancies are unplanned or associated with feelings of ambivalence. Even amongst those who do plan their pregnancy, a relatively small proportion of women currently modify behaviours pre-pregnancy. Maternal weight, smoking, alcohol/substance misuse, folic acid intake, immunisations, long-term physical and mental health conditions, previous pregnancy complications, maternal age, consanguineous relationships, pregnancy spacing and domestic violence all influence these outcomes. Planning pregnancy, promoting healthy behaviours and reducing or managing risk factors are important for improving pregnancy outcomes.

Health visitors have been recognised by Public Health England as being ideally placed to support preconception care and transition to parenthood for all families with children under 5, including otherwise hidden populations, through the universal reach of the Healthy Child Programme (HCP), with increased support targeted to children and families at high risk of poor outcomes.



“When I recall the stress and uncertainty that followed my babies’ births, my abiding memory is of the reassurance and real difference that [health visitor] provided to me, an inexperienced first-time 44 year old father, through her words and exceptional actions. Always a cheery and caring voice providing support and advice in person, and over the phone when that was more convenient. Her approach dispelled in an instant all the myths I had heard before the birth about ‘Health Visitors’. Every interaction I have ever had with [HV] has been exemplary, beneficial and informative, conducted with respect and with a high and reassuring degree of professionalism. Even now, two years later, I know that [HV] is only a call away. Recently, she came to the house (which helped us significantly) with a student she has been mentoring, to run through the two year old checks for [my children]. Going forward, we will meet six monthly at TAC meetings for my son, who has cerebral palsy. Needless to say, [HV] has provided very useful guidance on focus areas both now and as we look to the future. [HV] is particularly pro-active and many of our TAC related queries are moved on a stage or two by the time of the TAC meeting through [HV] involvement, which I believe is a service both to us (we are primary beneficiaries) and the other professionals / local health authority involved. In many ways, I think of [HV] as the facilitator and leader of those sessions. It is no exaggeration to say that the outcome my children find themselves in now is significantly improved thanks mainly to [HV] her drive, energy, knowledge and support inspires me to push myself and, in a sense, the kids, to celebrate and live life to the max. We have come such a long way since my first meeting with [HV]”.

A father’s feedback on health visiting support with transition to parenthood

2. Breastfeeding

Breastfeeding and the provision of human milk is widely recognised to be one of the most accessible and cost-effective actions to improve public health. Breastfeeding is known to reduce the prevalence of a range of infectious diseases such as gastro-enteritis and otitis media, and non-communicable diseases (NCDs), specifically childhood obesity, type 2 diabetes and maternal breast cancer⁷¹. The World Health Organisation (WHO) recommend exclusive breastfeeding for around the first 6 months of life, thereafter infants should receive complementary foods with continued breastfeeding up to 2 years of age or beyond⁷². The UK has one of the lowest breastfeeding rates in the world; 81% of babies are breastfed at birth, only 1% are exclusively breastfed by 6 months⁷³. Breastfeeding rates are lower among less educated mothers and those living in areas of higher deprivation⁷⁴, exacerbating health inequalities.

Improving support to women to increase and sustain breastfeeding would deliver significant cost savings to the NHS and to the local authority. Reducing the incidence of just five illnesses, protected by breastfeeding, would translate into cost savings for the NHS of at least £48 million and tens of thousands fewer hospital admissions and GP consultations⁷⁵. Premature infants who do not receive breastmilk are much more likely to suffer infections, sepsis and necrotising enterocolitis (NEC).

Health visitors also support the wider remit of infant feeding, which includes supporting families to use infant formula safely and providing evidence-based support for families with infant feeding difficulties including allergies and intolerances.

“Improving the UK’s breastfeeding rates would have a profoundly positive impact on child health. Increasing the number of babies who are breastfed could cut the incidence of common childhood illnesses such as ear, chest and gut infections and save the NHS up to £50 million each year. Breastfeeding rates in comparable European countries, with similar population sizes and demographics, show that it is possible to increase rates with a supportive breastfeeding culture and the political will to do so. A key aspect of improving breastfeeding rates is the provision of face-to-face, ongoing, predictable support to families across all public services, and social support in the local community. The Baby Friendly Initiative enables mothers to receive this help within healthcare services, delivering a holistic, child-rights based pathway for improving care”.

UNICEF United Kingdom: The Baby Friendly Initiative

3. Perinatal mental health (mothers, fathers and partners)

It is estimated that 1 in 4 women are affected by perinatal mental health (PMH) problems⁷⁶, with suicide continuing to be a leading cause of maternal deaths in the UK⁷⁷. Mental illness is the most common serious health problem that a woman can experience in the perinatal period. While depression and anxiety disorders are the most common illnesses, other conditions exist including eating disorders, psychosis, bipolar disorder and schizophrenia⁷⁸. Taken together, perinatal depression, anxiety and psychosis carry a total long-term cost to society of about £8.1bn for each one-year cohort of births in the UK⁷⁹. Nearly three quarters (72%) of this cost relates to adverse impacts on the child rather than the mother.

“Not every woman experiencing mental distress during pregnancy will come into contact with specialist mental health services, but it is expected that the vast majority will access midwifery, obstetric and health visiting services during pregnancy and in the postnatal period. Through their contacts with mothers to be and new mothers, these services can play a significant role in the early identification of perinatal mental health services and signpost women on to other services including specialist secondary mental health services as required”.

NHS Benchmarking Network: Perinatal Mental Health Steering Group (2017)⁸⁰

To ensure every child has the best start in life, it is important that perinatal mental health strategies incorporate a range of interventions and approaches to address maternal mental health and also consider the role of fathers and partners and the impact of perinatal mental illness on them. It is estimated that at least 1 in 20 fathers suffer with PMH problems, with some studies citing a prevalence of 1 in 10 or higher^{81 82}. Treating these conditions is important as children of mothers, fathers and partners who have experienced mental health problems have an increased risk of adverse cognitive, behavioural, social and emotional developmental outcomes^{83 84 85 86 87} with even greater risk when both parents have mental health problems⁸⁸.

Whilst there is now improved provision for women experiencing the most severe and complex mental health conditions⁸⁹, most mothers and fathers/partners will be seen and supported in universal services^{90 91}. Based on the number of live births per year in England and Wales⁹², it is estimated that for every annual birth cohort, 32,854 women will be referred to specialist mental health services and 98,561 will be primarily supported by universal services, including health visitors. Perinatal mental health services are provided throughout pregnancy and the first two years of a child's life which means that services need to be in place to support this level of demand for all birth cohorts within this range.

Addressing perinatal mental health problems at scale requires a whole system, integrated approach⁹³. No one organisation or professional group provides the complete solution – effective strategic system-wide approaches to PMH require organisations to work together. Health visitors play an important role within local integrated perinatal mental health pathways; through their universal reach and holistic family-centred approach, health visitors are ideally placed to support mothers', fathers' and partners' mental health and in turn, empower parents to provide the very best foundation for good mental health across the life-course for their children. Health visitors can provide anticipatory guidance, identify risks and signs of mental health problems, manage mild to moderate perinatal mental illness and refer on to more specialist care according to the level of need.

Women value speaking to their health visitor and there is evidence that they would disclose mental health problems more to health visitors if: they understood the role and knew they were registered nurses⁹⁴, saw the same health visitor, and were confident that health visitors had the time, motivation, confidence and competence to help⁹⁵.



“I was terrified when I first became pregnant. I learnt to manage my mental well-being as an adult, with the help of medication but when I found out I was pregnant my anxiety kind of ramped up a gear.

It is crucial that you don't have to have that awful scenario of having to explain your case again, each time you see a health visitor. It is really difficult to ask for help in the first instance but especially if you have to repeat that over and over again”.

Quote from NSPCC, Fight For a Fair Start⁹⁶

Therapeutic interventions delivered by health visitors (often referred to as listening visits) have been shown to be effective as a treatment for depression in mothers⁹⁷, and the provision of psychologically orientated sessions by health visitors with additional training have been shown to be effective not only in treating postnatal depression but also in preventing it in some women^{98 99}. Health visitor training has also been found to be highly cost-effective in preventing symptoms of postnatal depression in a population of lower-risk women, thereby reducing overall treatment costs over a 6-month period¹⁰⁰. Given the importance of good PMH it is essential that all health visitors are trained and have access to advanced/specialist lead health visitors at every local level as recommended by national bodies^{101 102 103}.

4. Infant and child mental health

Infant mental health is a complex concept which begins before birth and can be defined as *“the young child’s capacity to experience, regulate and express emotions, form close relationships and explore the environment and learn. All of these capacities will be best accomplished within the context of the caregiving environment that includes parents, family, community and cultural expectations. Developing these capacities is synonymous with healthy social and emotional development”*¹⁰⁴.

Health visitors provide a crucial role within an integrated system of support which promotes positive infant mental health and parent/carer and infant relationships¹⁰⁵. This begins in the antenatal period and continues at every further contact. Offering NICE concordant interventions^{106 107}, health visitors use a strengths-based approach to promote sensitive, consistent, responsive, nurturing relationships between parents and infants in the first few years of life. These are essential for: enabling secure infant attachment, healthy brain development and building strong foundations for the development of future social and emotional health and wellbeing¹⁰⁸.

Data on population risk factors provides an indication of how many children are at risk of poor social and emotional development and wellbeing. Parents living with high levels of ongoing stress, mental health difficulties and attachment insecurity in their own childhood are more likely to find it more challenging to engage sensitively and positively with their child. Other risk factors include parental drug and alcohol use, young parents, looked after children, child maltreatment and homelessness¹⁰⁹. Health visitors are ideally placed to identify early risks, protective factors and understand the multifactorial context of relationships, families and communities. A significant minority of parents struggle to respond sensitively to their child’s needs, contributing to an insecure or disorganised attachment relationship. A disorganised attachment is associated with insensitive and harmful parenting, including child maltreatment¹¹⁰. It is estimated that around 10-25% of children have a disorganised attachment with their primary care giver, although prevalence is much higher in vulnerable groups.

Health visitors work in partnership with families to discuss professional and/or parental concerns, consider further evidence-based interventions to enhance the parent infant relationship or ensure timely referral to specialist parent infant services where needed. This includes skills in the assessment of the parent/ infant relationship, maintaining “an infant health frame of mind”¹¹¹ using observation and reflection to understand the perspective of both parent and infant.

The provision of evidence-based assessment and treatment at an enhanced level to meet the needs of families requiring more specialist care can be delivered by lead health visitors operating at an advanced level of practice as advocated by Health Education England. “Specialist” health visitors can deliver direct evidence-based interventions

using psychoanalytic, attachment and behavioural theories. Attachment-based interventions supporting maternal sensitivity and attunement delivered as part of an intensive home visiting programme have been shown to be effective in improving the sensitivity of highly vulnerable parents^{112 113 114}. Specialist health visitors also support the skills development of the wider team through delivering training, offering consultation and supervision as well as joint home visiting¹¹⁵.

“Although babies are not able to communicate their needs using words, they have a wonderful capacity to communicate them via a range of cues, to which they rely on the adults around them to understand and respond. We now know that having these cues understood and their needs met in a timely and appropriate manner, is one of the most important aspects of an infant’s early life because of the impact of such sensitive caregiving on their ability for socioemotional regulation and their rapidly developing brain. Pregnancy and the first two years of life are very important if we want to equalize the life-chances of all children to enable them to realize their full potential. Specialist Health Visitors in perinatal and infant mental health are absolutely fundamental if we are to achieve these goals”.

**Jane Barlow, President Association for Infant Mental Health (UK)
Professor of Public Health in the Early Years, Warwick Medical School**

5. Healthy nutrition, physical activity and healthy weight

Good nutrition is absolutely central to future health. The World Health Organisation (WHO) Report on Ending Childhood Obesity¹¹⁶ emphasized the need for “coordinated cross-sectoral action and a strong focus on actions in pregnancy and early life”. Obesity is a major public health priority and a key area for government action with a plan for reducing childhood obesity by 50% by 2030¹¹⁷. The high rates of overweight and obese children cannot be overlooked due to the associated risk of poor health outcomes; it remains a significant health inequality with greater rates witnessed amongst children in disadvantaged areas and some ethnic groups. Latest data from the National Child Measurement Programme¹¹⁸ suggests that 22.9% boys and 21.8% girls are overweight or obese in reception year. This trend continues with 36.4% boys and 32.2% of girls being overweight or obese in year six.

Family nutrition and weight is a highly sensitive area that requires skilful and sensitive intervention¹¹⁹; the traditional approach of offering nutritional advice has little impact alone. Health visitors through their contacts with families as part of the Healthy Child programme are ideally placed to work effectively alongside families and for parents to be empowered to make healthy choices around nutrition and activity levels. To support the government’s strategy to tackle childhood obesity, health visitors are able to: identify children above a healthy weight; sensitively discuss weight with families; signpost families to support to make positive lifestyle changes; refer families to tier 2 and tier 3 weight management services to prevent ill-health.

Through their unique universal reach into all families, health visitors are in an ideal position to provide individuals and communities with information on the type and amount of physical activity that they should undertake to improve their health.

“In children and young people, regular physical activity is associated with improved learning and attainment, better mental health and cardiovascular fitness, also contributing to healthy weight status.... The benefits of physical activity during pregnancy [include] reduction in hypertensive disorders; improved cardiorespiratory fitness; lower gestational weight gain; and reduction in risk of gestational diabetes. The benefits of physical activity in the postpartum period (up to one year) were identified as a reduction in depression; improved emotional wellbeing; improved physical conditioning; and reduction in postpartum weight gain and a faster return to pre-pregnancy weight. If physical activity were a drug, we would refer to it as a miracle cure, due to the great many illnesses it can prevent and help treat”.

UK Chief Medical Officer, 2019¹²⁰

6. Managing minor illnesses, building health literacy and prevention of SIDS

2 million children aged 0-5 years attend A&E every year with rates increasing by 24% in the last six years¹²¹ despite a falling birth rate and improvements in overall child health¹²². All regions have shown an increase during this 6-year period. Analysis shows many of these presentations are avoidable or preventable and will be for relatively minor or self-limiting illnesses and unintentional injuries.

The economy: The cost of A&E attendances in 2016/17 by under-5s, is approximately £300 million (assuming an average cost of £148 per attendanceⁱ). The South West has the lowest rates of A&E attendance in under-5s. If all regions could lower their rates to match that of the South West, over 400,000 fewer under-5s would attend A&E.

Prevalence: Much of the increase in A&E attendance rates is associated with minor illnesses¹²³. Six high volume conditions account for half of all emergency and urgent care admissions for children¹²⁴. The severity of many of these presentations will be relatively minor or self-limiting and treatment elsewhere or self-care may be more appropriate¹²⁵. The reasons for this increase are complex and likely to be down to a number of factors including the availability of services outside the hospital¹²⁶ and changes in parental expectations and health literacy/ confidence to manage minor illnesses. **These visits tell us that parents are worried and are either unable or unsure how to access the reassurance or advice they need in other ways.**

The Keogh review¹²⁷ made recommendations for reducing increasing demand on A&E services, including interventions to promote self-management, however much of the emphasis was on frail elderly patients and those with long-term conditions. The NHS has developed and tested some solutions in local systems with evidence that A&E attendance by children can be reduced but these have not been widely tested or implemented at scale¹²⁸.

The evidence from a well-established integrated programme involving health visitors in Wessex¹²⁹ has demonstrated that when parents receive consistent, explicit safety-netting advice, they are less likely to re-attend. There is also Randomised Control Trial evidence^{130 131} that health visitor home visiting can lead to better use of services (A&E, GP). Health visitors are also well placed to support initiatives to tackle antimicrobial resistance, which is recognised as one of the most pressing global challenges we face this century¹³².

Because of the significant social inequalities, increasing health visiting provision and maximising their reach into all families to address this High Impact Area will impact positively in improving health and other outcomes for the poorest families.

“My health visiting team were amazing. Looking back there were many indicators that [my child] was poorly but I didn’t really think much of it. As a team they supported me to get [my child] tested and through everything that followed, I would have been lost without them”.

“I took my daughter to get weighed at the clinic and the health visitor there noticed she was still jaundiced at 4 weeks old so asked me to go straight over to the doctors for an appointment. The doctor looked at her, said she was fine. A week later I took her to be weighed again, my health visitor wasn’t happy so told me to take her back to the doctors. I saw another doctor who referred us to hospital for tests and then it all went mad from there and got diagnosed in Leeds”.

Service user quotes provided by the Children’s Liver Disease Foundation (2019)

i Average unit cost 2016/17, A&E attendances by patients of all ages. https://improvement.nhs.uk/documents/1972/1 - Reference_costs_publication_VSnAQ5x.pdf

7. Reducing unintentional injuries (UI)

Unintentional injuries (UI) are a leading cause of preventable death, ill health and disability for children¹³³. Emergency hospital admission rate for UI among the under-fives is 38% higher for children from the most deprived areas compared with children from the least deprived (for some injury types e.g. burns, this inequality may be much larger). Each year an average of 55 children under 5yrs died due to an UI; 370,000 children attended A&E and 40,000 children were admitted to hospital.

Cost: The NHS cost of an admission for ≤1 day is from £700–£1000. The short-term average healthcare cost of an individual injury (all types) is £2,494; the wider costs of a serious UI are £33,200. This does not include costs for NHS or social care for longer term follow-up of more severely injured children. The estimated lifetime cost for a 3yr old child who suffers a severe traumatic brain injury is estimated to be £4.89m.

A recent programme of evaluation on unintentional injuries demonstrated a significant association with modifiable risk factors for falls from furniture and on stairs, poisoning and scalds in children aged 0-4 year, with evidence of the effectiveness of home safety interventions, including economic evaluations¹³⁴.

As leaders of the HCP, health visitors provide a universal service to all families and there is a strong economic case for preventing unintentional injuries. The existing Early Years High Impact Area 5¹³⁵ sets out the key contribution of health visitors to reduce accidents to improve outcomes for all children.

“Health visitors are vital partners in our work to stop children dying or suffering serious injury in preventable accidents. I am increasingly worried by the cuts to the health visiting service in England and the loss of experienced health visitors. Parents need expert, up-to-date advice on how to keep young children safe, from professionals who understand the links between childhood accidents and the links to child development.

Reducing health visitor numbers puts at risk the recent reductions in A&E visits for unintentional injuries in the home, particularly for children from deprived areas whose parents are most in need of help and support”.

Katrina Phillips, Chief Executive of the Child Accident Prevention Trust

8. The uptake of immunisations

Immunisations are one of the most cost-effective health interventions, producing substantial health gains and reducing pressure on the NHS. Although overall immunisation rates in the UK are high, pockets of lower coverage and social



inequalities in uptake persist. More than 500,000 children in the UK are unvaccinated against measles, with uptake of the 2nd dose of MMR at 87.2% which falls below the 95% needed for herd immunity¹³⁶. Sustaining and improving uptake rates remain a high priority. NHS England is responsible for the routine commissioning of national screening and immunisation programmes under the terms of the Section 7a agreement (S7a). Most childhood immunisations for children 0-5 years are provided by General Practices and administered by General Practice Nurses. However, health visitors are ideally placed to contribute to a “whole system” approach to improving immunisation uptake, through the universal

reach of the Healthy Child Programme. Health visitors can provide tailored information on maternity and childhood immunisation to all families, with an opportunity for parents to discuss any questions that they may have, and by reminding them when their child has overdue immunisations at universal contacts.

“The World Health Organisation (WHO) has identified vaccine hesitancy as one of the top ten threats to global health in 2019 (<https://www.who.int/emergencies/ten-threats-to-global-health-in-2019>). Falling MMR rates have been responsible for the resurgence in measles, with over 82,500 measles cases occurring in Europe in 2018, three times as many as in 2017, and 15 times as many as in 2016. In the first quarter of 2019, there were 231 confirmed cases of measles in England. Access to health visiting services plays a crucial role in counteracting the impact of online anti-vaccine messages; through the provision of accurate information provided by health visitors and public health nurses, we can increase vaccine uptake rates and protect children from unnecessarily contracting vaccine preventable infections. Reductions in health visitor numbers risks a further decline in vaccine uptake rates”.

Dr Sanjay Patel, Consultant in Paediatric Infectious Diseases and Immunology, Southampton Children’s Hospital; Wessex Strategic Clinical Network Regional Project Lead

9. Primary prevention and health promotion in oral health

Tooth decay is largely preventable, yet it remains a serious problem. Findings from Public Health England’s 2017 national dental epidemiological survey of 5-year-old children¹³⁷ showed that, in England, 23.3% of children experienced obvious dental decay. While dental decay levels are reducing, and there are signs that inequalities are beginning to reduce, the inequalities gap remains unacceptably high with children from deprived backgrounds experiencing higher levels of decay than those from the least deprived (33.7% for the most deprived and 13.6% for the least deprived).

Dental decay in children is often left untreated and leads to pain, distress, sleepless nights for children and parents, and time off school and work. Tooth extraction is the sixth most common procedure in hospital for children under 5 years of age. The average cost of a tooth extraction in hospital for a child aged 5 and under is £836 and in the financial year 2015-2016 £7.8m was spent on tooth extractions among the under 5s¹³⁸.

Health visitors have an important role in providing advice and support as part of the Healthy Child Programme in promoting good oral health and preventing dental caries. This includes providing consistent evidence-based information on: infant feeding, nutrition, oral health advice, including brushing advice as soon as teeth erupt in the mouth, signposting to dental services, encouraging dental attendance around 6 months of age (Dental Check by One (DCby1)¹³⁹) and identifying families that need additional support^{140 141}.

NICE Guidance (PH55)¹⁴² recommends the distribution of free tooth brushing packs by health visitors to families in groups at high risk of poor oral health. Distribution of packs should be combined with information on tooth brushing and local dental services. These programmes not only demonstrate evidence of effectively reducing tooth decay, they also demonstrate significant return on investment. For each £1 spent on targeted provision of tooth brushing packs by health visitors the return on investment is £4.89 after five years and £7.34 after ten years.

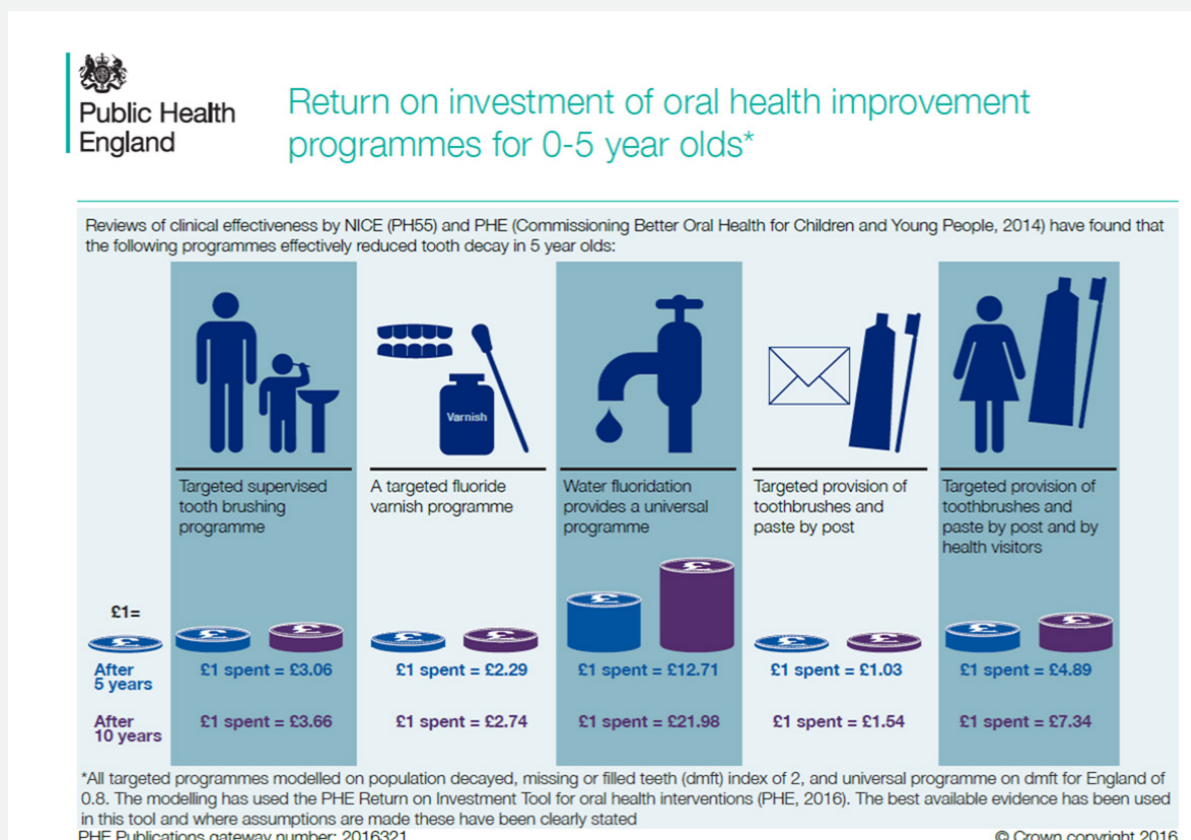


“Whilst tooth decay is largely preventable it remains the most common oral disease affecting children and a serious public health problem. Extraction of teeth due to tooth decay is the most common reason for hospital admission for children aged six to ten years-old. In 2017, almost a quarter of five-year-olds started school with tooth decay. Whilst oral health has improved in this age group, significant inequalities persist with almost half (47%) of five-year olds in Rochdale having tooth decay in comparison with 13% in Cambridgeshire. In the most deprived areas in England, over a third of children have tooth decay (36.3%), compared to just 12.5% in the least deprived areas. Tooth decay starts early in life, the first survey of three-year olds in 2014 found that 12% had visible tooth decay, with on average three teeth affected.

Health visitors have a key role to support oral health improvement. They intervene early, as part of the Healthy Child Programme, with evidence-based advice and support regarding infant feeding and commencing toothbrushing. Evidence shows that health visitors’ interventions are not only effective but cost effective, as illustrated in the PHE return on investment infographic”.

**Dr Jenny Godson, Chair Child Oral Health Improvement Programme Board
National Lead Child Oral Health Improvement, Public Health England**

Figure 7: Return on investment of oral health improvement programmes for 0-5 year olds



10. Child development 0-5 years: speech, language and communication and school readiness

Children's development is strongly determined by genetic factors, yet it is also very sensitive to social factors with wide disparities between the least and most disadvantaged children already present at school entry. Child development is a good measure of wellbeing more generally¹⁴³. There is also a significant body of evidence to support the case for early language as a primary indicator of child wellbeing¹⁴⁴ which has driven the current policy priority to focus on this area to improve social mobility^{145 146}.

Enabling all children to achieve their full potential and be physically and emotionally healthy provides the foundation for a healthy and productive adulthood¹⁴⁷. Promoting child development, health and wellbeing also makes economic sense as delayed or abnormal development can have substantial policy implications for health, social and educational services¹⁴⁸. Supporting every child to achieve the best start in life with optimal child development is a central part of the health visitor's role; health visitors work in partnership with parents to promote child development, assess needs and identify problems or issues at the earliest opportunity, including signposting to specialist support if needed. Health visitors are also in a unique position to promote learning in the home environment from antenatal through to school entry, building on the strengths within families and providing support and guidance when required.

“Early language is hugely important... this is an area that health visitors can make an important difference to. Parents see health visitors as a trusted professional and every parent has a health visitor. This avoids any stigma from being singled out in some way, which can be a stumbling block to asking for help”.

**Nadhim Zahawi MP, whilst Parliamentary Under Secretary of State for Children
Young People and Families, UK Parliament.**

(Institute of Health Visiting Conference – keynote address, May 2019)

11. Sleep

Sleep deprivation is identified in the Prevention Green Paper¹⁴⁹ as a neglected public health issue. Poor sleep is increasingly common in children, and associations between short sleep duration in early childhood and obesity¹⁵⁰, children's learning and behaviour¹⁵¹ are consistently found. 40% of children and young people in England and Wales are affected by sleep issues at some point in their childhood¹⁵². Poor sleep patterns and crying often co-exist, this is costly to manage and associated with adverse outcomes including postnatal depression symptoms, early weaning from breast milk, and later child behaviour problems. There is also an increased risk of Shaken Baby Syndrome¹⁵³ due to excessive crying and associated parental lack of sleep. The management of infant crying (for infants under 3 months old) and associated poor sleep has been estimated to cost the NHS over £65 million in professional salaries alone¹⁵⁴.

Sleep deprivation is a mental health issue and can affect maternal mental health and cause fatigue and affect mood¹⁵⁵. Sleep deprivation affects employees and work productivity, with higher risks for health and safety, car accidents¹⁵⁶, mental health, and domestic abuse and violence. Health visitors are well placed to advise parents on how to create healthy sleep routines for their children to reduce the negative impacts of sleep deprivation on the infant and its parents.

Health visitors also play an important role in the dissemination of Safer Sleep guidance to all families. There are approximately 216 unexplained deaths of infants every year in the UK. Research has shown that several parent and infant care factors are associated with an increased risk of death from Sudden Infant Death Syndrome (SIDS)¹⁵⁷. There is no advice that guarantees the prevention of SIDS but following safer sleep advice can significantly lower the chance of this tragedy occurring. Health visitors can support parents make safe decisions on baby care, for example about where to sleep with their new baby and what bedding to buy, at different times. Health visitors can reinforce these messages and check understanding at universal contacts during the antenatal and postnatal period, and during additional targeted support for high risk groups (for example parents with learning disabilities and smokers).

“Health visitors are ideally placed to support parents to understand normal sleep and prevent sleep and settling issues occurring. By working in partnership with parents, they can increase confidence and competence in this. Promoting safe sleeping using the NICE Guidance and a compassionate approach, health visitors can support parents who are facing sleep and settling issues and can also recognise when onwards referral to more specialist support is needed”.

Maggie Fisher – a sleep specialist health visitor

12. Children with developmental disorders, disabilities and complex health needs

Health visitors play a crucial role in the early identification of children with atypical or disordered patterns of development or with significant impairments likely to result in disability. Health visitors are often the first point of contact for families who have concerns about the way that their child is developing and are therefore ideally placed to facilitate effective support and provide information about local and national services.

Early identification of developmental disorders and disabilities is important to support prompt diagnosis and tailored interventions and support¹⁵⁸, including supporting parents through the process of adjustment when they receive “different news”¹⁵⁹. This includes supporting transition to parenthood for families who receive a diagnosis following antenatal screening as well as those whose conditions are recognised in the early years. Children born prematurely are at particular risk of developmental delay and often show atypical patterns of development.

NICE (2019)¹⁶⁰ state that “Disabled children and young people are entitled to the same access to health and social care as other children and young people. They may have severe and complex needs that require health and social care support from a range of providers. This requires a joint, integrated, inter-agency approach at the point of delivery of both health and social care”.

Supporting children and young people with complex health needs, disabilities, and special educational needs is an important part of the universal prevention and early intervention programme provided by health visitors. NHS England and DfE (2015)¹⁶¹ highlight the need for coordination of care for these families; health visitors are a skilled workforce who can support parents to navigate the complex systems of support. It is widely recognised that parents of children with complex health needs are at increased risk of experiencing additional stress; parenting a disabled child goes beyond ‘ordinary’ parenting. It is not surprising, therefore, that parents of disabled children are more likely to require support than parents of non-disabled children. 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 outcomes¹⁶². Services need to be flexible and promote individualised care which requires that joint working is coordinated between the family and all practitioners involved. Health visitors also play a crucial role in supporting effective transition to school and the school nursing service.

“Our HV was amazing – she came and saw me every day for the first week, then came every few days for the next few weeks. Not just to check on Amos and I, but also to make sure that my husband and children were all coping too. She supported me with getting Amos to breastfeed (which took a long 12 weeks) and took me to the local baby café, where we received expert help. She made me tea and told me my baby was perfect and beautiful. It was just what I needed and without her I think we would have found it all much more daunting. She was an absolute lifeline”.

Emma, mum to a boy who happens to have Down’s syndrome, as well as a cheeky smile and an infectious laugh

13. Tobacco, alcohol and substance misuse in the perinatal period

Health for All Children – fifth edition (HfAC5)¹⁶³ makes a strong case for action to prevent exposure to teratogenic substances such as tobacco, alcohol or substances during pregnancy which can affect the unborn and newborn infant, with long term consequences on the later development of the child. One of the four key ambitions of the [Tobacco Control Plan](#) (2017) is to reduce smoking in pregnancy. Smoking is estimated to cause up to 2,200 premature births, 5,000 miscarriages & 300 perinatal deaths per year¹⁶⁴. It also increases the risk of developing a number of health conditions. Although rates have fallen gradually over recent years, over 65,000 infants are born to smoking mothers each year. Treating mothers and their babies (0-12 months) with problems caused by smoking during pregnancy is estimated to cost the NHS between £20 million and £87.5 million each year¹⁶⁵. Interventions to help women quit smoking have been shown to be cost-effective.

Over 75% of all pregnant mothers report drinking at least one alcoholic beverage per week and 11% engage in risky drinking behaviours during the first trimester¹⁶⁶. Heavier consumption in pregnancy is consistently associated with a greater likelihood of birth complications, including foetal alcohol spectrum disorders.

Health visitors have a crucial role in providing universal and targeted interventions to pregnant women and those planning a subsequent pregnancy. There is strong evidence to support the practice of advising pregnant women to stop smoking, with information on the risks to the child, including the hazards of exposure to second-hand smoke, and referring them to NHS Stop Smoking Services if appropriate¹⁶⁷. In addition, health visitors have a role in the identification and referral of women engaged in harmful or dependent drug or alcohol misuse in pregnancy or throughout the early years to a specialist substance misuse service. HfAC5 also recommends referring pregnant women, if they do not wish to reduce their harmful alcohol or substance misuse, to children’s social care due to the risk of significant harm – health visitors play a crucial role in advocating for the “voice of the child” in these cases.

“Health visitors are ideally placed to support families to be smokefree. Newborn babies are acutely susceptible to secondhand smoke, which significantly increases the risk of sudden infant death syndrome as well as middle ear disease, chest infections, asthma and meningitis. Children growing up in households where their parents smoke are also much more likely to become smokers themselves. By delivering very brief advice to families on quitting smoking, and making referrals to specialist stop smoking services, health visitors can help ensure children grow-up free from the harms caused by exposure to tobacco smoke”.

Deborah Arnott, Chief Executive, ASH

14. Healthy couple relationships

The quality of the couple and family relationship has been linked to outcomes in key public health priority areas including cardiovascular disease, child poverty, alcohol and substance misuse, mental health, childhood obesity, children’s mental health, cognitive development and infant attachment¹⁶⁸. Health visitors are in a unique position to offer early preventative relationship support and promote family and relationship stability^{169 170}. Family breakdown is estimated to cost the public purse £51 billion annually¹⁷¹. Family breakdown has been described as a public health emergency and health visitors can play a key role at a crucial time in parents’ lives to prevent relationship breakdown.

The transition to parenthood is recognised as a time when the couple relationship can deteriorate leading to increased relationship stress which can negatively impact on the outcomes of babies, children and families. Where conflict between parents is frequent, intense and poorly resolved, it can harm children’s outcomes – regardless of whether parents are together or separated. This includes family contexts not usually regarded as ‘high-risk’ and not just where parents have separated or divorced or where there is domestic violence¹⁷².

Health visitors are uniquely placed to offer preventative support at this pivotal time during the transition to parenthood with evidence of the effectiveness of brief interventions to improve outcomes^{173 174 175}.

Domestic violence and abuse is defined as:

'Any incident or pattern of incidents, of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 years or over who are or have been intimate partners or family members, regardless of gender or sexuality. This can encompass, but is not limited to, psychological, physical, sexual, financial or emotional abuse.'
(Home Office, 2013)¹⁷⁶

Domestic violence and abuse (DVA) has a considerable impact on communities and society as a whole. There are costs associated with a loss of quality of life for victims and their families as well as the financial costs of providing services to victims and their families. Estimating the costs of domestic violence and abuse is complex - largely because it does not present as a single incident and costs are incurred in both the short and long term. Based upon findings from the Crime Survey for England and Wales, a recent Home Office report has estimated that for year ending 31 March 2017 the costs of domestic abuse in England and Wales were at least £66 billion¹⁷⁷. Children and young people may suffer from a range of short and longer term physical, emotional, behavioural, developmental and social difficulties linked with experiencing domestic abuse. Babies and pre-school age children are particularly vulnerable to the impact of domestic abuse. This may be due both to cumulative exposure to DVA and very young children's limited capacity either to escape or manage it because of their developmental, intellectual or verbal ability. Exposure to domestic abuse in the critical first 1001 days of life can disrupt early attachment and foetal neurodevelopment; these can affect later emotional, social and behavioural outcomes¹⁷⁸.

Health visitors are ideally placed to identify and support families experiencing DVA. This can sometimes be a very difficult issue to recognise - but central to this is the health visitor's ability to develop relationships with clients and undertake skilled assessment using evidence-based tools and professional judgement.

DVA may not always present - or even be happening at the time of the primary contact with a client. Moreover clients' journeys through services - particularly due to their mobility (meaning they may access different health visiting teams if they move geographically) or changes in intimate relationships (new/different partner or a developing relationship) - means that health visitors must always have DVA in mind during every client contact. Central to good practice is a dynamic process of professional assessment - which includes being aware of DVA signs and indicators - and when appropriate addressing the issues directly through routine or targeted enquiry.

"It is now well established that a strong inter-parental relationship provides the emotional bedrock for the healthy development of babies and children. Yet, for many couples becoming parents and adapting to family life can be challenging and stressful. Up to two thirds of new parents experience a dip in relationship satisfaction, increased relationship distress and conflict.

This is a significant public health issue, often leading to more complex and serious issues for families later down the line. Health Visitors are ideally placed to pick up relationship issues and can offer effective support to reduce inter-parental conflict and prevent family breakdown".

Penny Mansfield, Director, One Plus One

15. Teenage parenthood

In many ways teenage parents are not a specific high impact area but instead, in the same way as safeguarding practice, support to address their needs is threaded through every level of practice and each HIA. Teenage parents, like all parents' benefit from a personalised approach to their care and support. We have also made the case in this paper for a much broader approach to targeted intensive support to address the needs of the much larger group of the population at the greatest risk of poor outcomes, of which teenage parents form an important part.

However, to avoid the needs of teenage parents being subsumed, and possibly overlooked within a much larger group, we make the case for a specific HIA for teenage parenthood. Teenage pregnancy is both a cause and consequence of health and education inequalities, including higher rates of infant mortality, low birthweight and poor maternal mental health¹⁷⁹. 12% of births to women aged under 20 are to young women who are already mothers. In 2016 babies born to mothers under 20 years had a 24% higher rate of stillbirth and a 56% higher rate of infant mortality¹⁸⁰. Young mothers are less likely to complete education and may be further economically disadvantaged by a failure to enter employment. Younger mothers are also more likely to smoke during pregnancy than older mothers. Young people who are looked after are 3 times more likely to be a parent by 18.

“Young parents and their children benefit across the life course from having access to universal services which are personalised to their needs and support for them and their babies to reach their potential. Working together within integrated local systems health visitors and Family Nurses can reduce inequalities within this population”.

**Ailsa Swarbrick, Director, FNP National Unit
Lynne Reed, Head of Clinical Quality Improvement, FNP National Unit**

The rate of [teenage conceptions](#) (females aged less than 18 years) has fallen from 34.2 per 1,000 in 2010 to 17.9 per 1,000 in 2017. This has been achieved through a long-term evidence-based teenage pregnancy strategy, including an important contribution from health visiting teams, alongside the Family Nurse Partnership Programme. Health visitors work within an integrated system providing coordinated support for young parents and their children, which is crucial for improving their outcomes and reducing inequalities¹⁸¹. There is significant variation in the level of support available dependent on where young parents live as service configuration is subject to local decision making. The most effective examples include evidence-driven teenage parent pathways, with health visitors or Family Nurses working with a shared vision to help support a common and consistent approach across a local workforce.

We have set out a recommendation for further work to support the development and testing of targeted support approaches to address the needs of children and their families in severely challenging situations and this should include a framework of support for teenage parenthood. This work should be evidence driven and include early years programmes (pregnancy to age 5 years) that work best for this target group and the incorporation of the key elements of these programmes within the wider work of health visitors with families outside the scope of licensed programmes.

Other high impact areas

It is important that the work of the health visitor is responsive to the needs of children and their families and, as such, other high impact areas may be priorities from time to time but we have decided to focus on those above in the first instance as some of the most generalisable. However, that doesn't mean that other issues shouldn't receive health visiting interventions when they are found to be impacting negatively on the infant or wider family. For example, supporting the mother postnatally to manage on-going physical consequences of giving birth such as incontinence, supporting the family of a child who has a chronic and worrying health issue such as asthma, supporting families through a bereavement or working with a marginalised group and their particular health needs. All these circumstances and others, if not supported early, can provide longer term negative consequences and should remain an important part of the health visiting role.



Section 6. Evidence for levels of health visiting support

Community:

Health visitors work collaboratively with others to facilitate a place-based response to local need.

The principles of working collaboratively within communities are deeply rooted in health visiting and remain as relevant to health visiting practice today as when first developed.

“The professional practice of health visiting is aimed at improving the physical, mental, emotional and social health and wellbeing of the population, preventing disease and reducing inequalities in health. Its overall purpose is to improve health and social wellbeing through identifying health needs, raising awareness of health and social wellbeing, influencing the broader context that affects health and social wellbeing, and enabling and empowering people to improve their own health, [which] takes account of the different dynamics and needs of individuals, families and groups and the community as a whole”.

The Principles of Health Visiting, 1977 (updated 2010)¹⁸²

The community aspect of the health visiting role has been eroded in recent years as the focus has shifted to a more prescriptive offer based largely on the needs of the individual. To secure better outcomes for communities, health visiting services need to work closely together within the local authority and with the NHS and community organisations to maximise their contribution within the local integrated health and care system and Primary Care Networks.

Examples of the community work of health visitors to improve health include community action to build community capacity and influence local policies, initiating “Breastfeeding Welcome” schemes¹⁸³ and coordinating “Ready Steady Mums”¹⁸⁴ walking groups to reduce social isolation and improve physical activity and emotional wellbeing.

Universal – a service for all families:

Universal provision is non-stigmatising, it is offered to an undifferentiated population and supports primary prevention and early identification of children and families who would benefit from additional support¹⁸⁵.

The universal service acts as a gateway to other levels of health visiting provision, promoting, supporting and safeguarding the wellbeing of children.

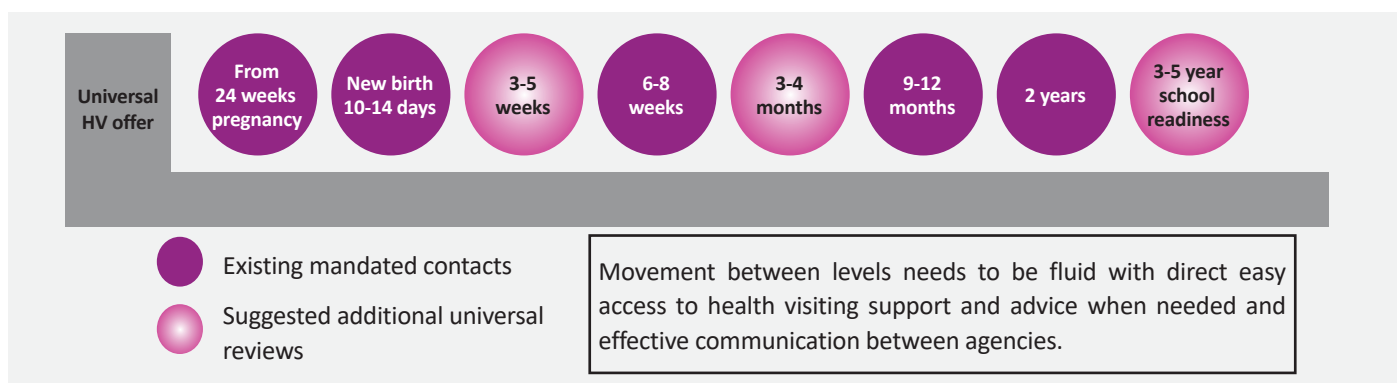
Based on the evidence¹⁸⁶, we recommend that the universal offer in England includes three additional service reviews, increasing the offer to eight contacts (see Figure 6):

- Evidence indicates that to be effective, home visiting programmes need to have at least 6-10 visits and last for at least a year^{187 188}. It is important that the service offer is personalised and that health visitors have the professional autonomy to work with families to agree the right level of support.
- The recommendation for eight universal contacts should focus on improving “outcomes” rather than risk perpetuating the existing culture of equating success with delivering X number of contacts.
- The universal contacts are not end points in themselves but auditing their successful delivery has been recognised as a useful process measure of family support¹⁸⁹. Service uptake also provides a proxy measure of service user satisfaction as parents are less likely to engage with a service that does not meet their needs.

- Health visitors are still the preferred source of evidence-based advice for most parents¹⁹⁰. Families need to be appropriately supported but also enabled to have the confidence to be effective in meeting their own and their children’s needs.
- Services should aim to provide continuity of practitioner and personalised care in line with the ambitions of the Maternity Transformation Programme¹⁹¹ and Select Committee recommendations¹⁹². This needs to be carefully balanced with the current workforce pressures and opportunities afforded by an appropriately trained, and supervised, skill-mixed team and wider community resources. Workforce modelling should inform this process with a shift away from “task allocation” to workload redistribution to maximise the skills of all staff.

NOTE: Universal assessment of strengths and needs within an undifferentiated population requires a high level of practitioner skill and should be delivered by a health visitor.¹⁹³

Enhancing the existing five mandated universal contacts with three additional universal reviews



The evidence¹⁹⁴ suggests that by increasing the number of universal contacts, families would:

- Develop trusting relationships with health visitors, which can lead to greater awareness of needs and timely support.
- Home visits offer health visitors a holistic perspective of the home environment and can facilitate early identification of need.
- A universal pathway offers systems and structures that standardise practice throughout the country and ensure that the health visitors’ role is well defined and clear to families and wider agencies.

All the High Impact Areas (HIA) apply across all the universal contacts. The following HIA are particularly pertinent to the suggested additional universal review points. Whilst these contacts are recommended for all families, a level of flexibility and professional judgment is needed; for example a health visitor may reach out to a multiparous mother who is confident with introducing solid food and has no signs of perinatal mental health problems who may decide not to take up the offer of a 3-4 month additional review. Decisions on personalised care should be driven by the needs of infants, children and their parents/ carers, rather than misused as a vehicle to justify service cuts and a reduced offer of support.

We recommend that the health visiting antenatal contact is completed from 24 weeks of pregnancy (rather than 28 weeks). The evidence¹⁹⁵ supports the case for meeting parents at an earlier point in pregnancy as this enables them to focus more fully on the wide range of topics. A contact at a later point in pregnancy coincides with parents understandable preoccupation with labour and birth when they are less receptive to new information. Late antenatal contacts also miss pre-term births and limit the time that families can benefit from actions to improve outcomes in key areas like smoking in pregnancy, healthy weight and perinatal and infant mental health. Similarly, the 2-2.5 year review should be completed at 24 months to reduce the gap between this contact and the last universal contact at 9-12 months; this will support earlier identification and intervention to address developmental concerns, particularly early language delay.

**3-5
weeks**

- Transition to parenthood - support strengths and needs assessment over time; advice on contraception and pregnancy spacing
- Healthy couple relationships
- Perinatal mental health (mothers, fathers and partners)
- Promoting infant mental health
- Breastfeeding
- Managing minor illnesses, building health literacy and the prevention of SIDS
- Encouraging the uptake of immunisations

**3-4
month**

- Transition to parenthood - strengths and needs assessment over time; advice on contraception and pregnancy spacing
- Healthy couple relationships
- Perinatal mental health (mothers, fathers and partners)
- Infant and child mental health
- Breastfeeding
- Promoting healthy nutrition - preparation for introducing solid food
- Managing minor illnesses, building health literacy and the prevention of SIDS
- Encouraging the uptake of immunisations
- Reducing unintentional injuries
- Promoting child development 0-5 years, including speech, language and communication
- Sleep

**3-5 year
school
readiness**

- Healthy couple relationships
- Child development 0-5 years, including review of speech, language and communication (outcome measure) and supporting school readiness (social, emotional and communication development; and physical development like using the toilet independently)
- Sleep
- Immunisations – particularly promoting MMR uptake
- Promoting healthy nutrition and physical activity
- Supporting children with developmental disorders, disabilities and complex health needs – including preparation for transition to school/ school nursing service
- Review of holistic family health needs assessment – including parental risk factors (e.g. mental health, substance misuse, domestic violence and abuse etc...)

“Secure, responsive relationships between babies and their parents are a vital ingredient in healthy brain development... Achieving this requires a whole system of services and support to be available, ranging from universal support for all families, to targeted and specialist services for those who need extra help. These services must be working together as part of care pathways, which ensure that families receive the right support at the right time”.

**Sally Hogg, Head of Policy and Campaigning
Parent Infant Partnership UK, 2019**



Universal Plus: A service for some families

- The Universal Plus (UP) service provides a swift response when families require specific expert help for an identified public health need that usually align with one of the High Impact Areas. The health visitor will work alongside families to negotiate and agree client-led goals and a plan of support.
- To reflect the breadth of the health visiting contribution, we have based this on 15 High Impact Areas where health visitors can make the greatest difference.
- Universal Plus support tends to be:
 - Time-limited i.e. at the end of the intervention families will revert to universal level of support.
 - Typically “indicated prevention”, for example for early signs of developmental delay.
 - Generally requires only one agency, in contrast to universal partnership plus support with its multi-agency intensive support.
 - Most cases will fall below the threshold for “high risk” groups, yet the impact on outcomes for children is considerable
- An increased number of contacts will be provided in addition to those set out in the universal offer, providing a swift response, tailored to families’ needs. For example:
 - For children at risk of / or showing signs of poor attachment this might include an enhanced programme of support in the first year of life with a review of parent-infant interaction at 15 months¹⁹⁶.
 - For infants born preterm, this might include support and additional planned reviews to monitor child development.
- Easy access to health visiting support is crucial to ensure that the service is responsive to need as and when it arises (for example open access child health clinics are highly valued by service users yet this form of accessible support is under threat due to cuts to public health budgets).
- This additional universal plus support may be as apparently simple as providing additional contacts to support successful breastfeeding, helping a sleep deprived family to get more sleep, or allowing time for a mother to disclose her fears about her relationship with her baby, and then providing additional support – yet the costs of not intervening are not insignificant.

The Prevention Green Paper *“is not about nannying, but empowering people to make the decisions that are right for them. It’s about providing everyone with the chance to live happy, healthy lives... Children are also affected by the wellbeing of their parent or primary carer. Because these challenges occur from birth onwards, it’s vital that families and their children who need extra support are identified early and receive tailored support. That way, we can prevent problems from arising in the first place, rather than dealing with the consequences”¹⁹⁷.*

- Health visitors also support numerous clinical pathways that are predominantly led by the NHS but require health visiting interventions. These include pathways for: prolonged jaundice and children’s liver disease; developmental delay including additional support for high risk groups like preterm infants; managing minor illnesses and chronic conditions like eczema; allergies and nutritional support for growth problems; and perinatal and infant mental health.
- In some cases, the health visiting offer can be strengthened by input from specialist health visitors within health visiting teams. For example, intervention by specialist health visitors has been found to strengthen bonding and attachment between parents and their babies and young children¹⁹⁸ which could achieve longer term savings on child and adult mental health services, social care and criminal justice budgets as well as having wider public health benefits and reducing health inequalities.

The Children’s Liver Disease Foundation (CLDF) supports the excellent work health visitors undertake, particularly, their key role in spotting the signs of liver disease in newborns. Many families that we support share experiences of diagnosis and how their health visitor was vital in picking up the initial signs of liver disease and referring them for further investigation. It is crucial that liver disease is identified and treated as early as possible to give the best chance of survival and reduce the likelihood that the child will require a liver transplant. We are strongly opposed to the cuts already undertaken to health visitor services and staffing levels as well as any future reductions. Health visitors are integral to early referral and contribute to better outcomes for those diagnosed with a liver condition.

Universal Partnership Plus: A service for a few families

The Universal Partnership Plus (UPP) level of health visiting provides support for families with multiple needs requiring a personalised, multi-agency, coordinated response, working together and with families.

Childhood adversity is frequently determined by the co-existence of multiple risk factors at the level of the child, family, community and society¹⁹⁹. Health visitors play an important role within a comprehensive prevention ‘system’ of support which is needed to reduce the occurrence and impact of this adversity – this includes working as part of the government’s “Troubled Families” programme to provide “joined up” support to build resilient families²⁰⁰.

“Individual differences in resilience and vulnerability among children facing significant adversity present important unmet challenges for intervention programs that have been developed as a “one size fits all” model for service delivery. Drawing on new insights from 21st-century medicine, molecular biology, and genetics, as well as advances in the social sciences, researchers are beginning to identify interesting patterns of differential impact and new ways of measuring the variable effects of adversity that can strengthen our ability to match specific interventions to the distinctive resources and needs of different subgroups of children and families”²⁰¹.

Center on the Developing Child, Harvard University, 2015

A personalised evidence-based response: Health visiting is in an ideal position to provide targeted personalised support through its unique reach across the whole population.

The contribution that the health visiting service makes at the Universal Partnership Plus level is complex and the impact is often not explicit. As a result, it is not well captured within current national outcome measures and difficult to articulate to commissioners which places the service at risk of cuts to release perceived efficiencies. Whilst recognising the value of emerging evidence-based targeted interventions, it is important that these are developed alongside a comprehensive universal health visiting service. This builds on the principle of proportionate universalism and a whole system approach to early intervention.

A recent review of the evidence to support the Healthy Child Programme²⁰² identified that, whilst knowledge of what does and does not work continues to grow at a rapid pace, notable gaps in the evidence base remain. There is good evidence underpinning many of the activities already delivered through the Healthy Child Programme, with recognition that the majority of the interventions and practices could be successfully delivered by health visitors. A culture of quality improvement is needed to support the translation of this evidence into practice and further development of the health visiting universal partnership plus offer.

The health visiting service is universal and works at four levels, but it also works alongside some licensed intensive home visiting programmes. And in some instances, health visitors will lead the delivery of these programmes²⁰³. Intensive and targeted programmes have been shown to be effective for specified target groups^{204 205 206} and can achieve good outcomes for eligible families working within local systems (see Appendix 1 for overview health visiting alongside intensive home visiting programmes in England).

However, it is important that effective tailored support is available to **all** families at high risk of poor outcomes. Targeted interventions, by definition, leave many high-risk families ineligible for their services. **Families who are not eligible for such programmes fall within the remit of health visiting’s universal partnership plus offer which is ideally placed to provide a range of personalised support and broker a multi-disciplinary response to complex needs.**

Drawing on the evidence of “what works” we have identified eight key elements of an effective health visiting approach, which should be centred on the individual needs of children and their families and take account of the importance of relationships. The following key elements are integral to an effective service, which should be: evidence-driven, accessible, responsive, personalised, collaborative, fairer and effective. Professional autonomy is a necessary requirement, which enables health visitors to use their skills and knowledge of families to provide a flexible service²⁰⁷ which incorporates all of these key elements.

Value added is provided to the UPP health visiting offer in local areas who invest in specialist health visitors to support target groups or priority areas, such as, the homeless, and infant and perinatal mental health²⁰⁸.

Safeguarding is a thread that runs through all levels of health visiting, contributing to multi-disciplinary, multi-agency networks to protect children (and in some instances their parents) from abuse and exploitation and to safeguard their health and wellbeing. The Health Visiting Benefits Realisation review (2017)²⁰⁹ concluded that the universal health visiting service was important to both safeguarding and child protection “because it **safeguards all children**”.

Health visitors play a crucial role in identifying children at risk and provide a vital “voice” for infants and young children, who often have no voice. The Children’s Commissioner²¹⁰ estimates that more than a third of children who are living with risk because of a vulnerable family background are “invisible” (i.e. not known to services) and therefore not getting any support. It is important that these children are not forgotten – a strengthened health visiting service provides an important part of a system-wide approach to address this issue.

However, health visitors should not be regarded as substitute social workers; recent “role drift” in some areas has eroded the primary prevention and early intervention role of the health visitor in favour of more reactive “safeguarding” work. This is short-sighted and will ultimately lead to increased costs of intervention at a later date – prevention and early intervention are more effective and more cost-effective in the long run.



Section 7. Demonstrating effectiveness

It is widely recognised²¹¹ that reducing inequalities requires a whole-system, integrated approach as prevention and intervention cut across a range of stakeholders working with children and their families. This is also affected by wider determinants of health like poverty, housing and government policy.

Integrated local systems

Health visiting is part of a “system” – we maximise the impact of the service by working collaboratively with partners. Clear leadership for children and families’ public health is essential to ensure plans are in place which are co-ordinated across the area and across those responsible for the wider determinants of health.

Including health visitors in such planning will support the desired outcomes as they hold important intelligence on the needs of local families and effective levers for health improvement.

Greater clarity on and stronger accountability for shared outcomes for children and their families is also needed, with close alignment to national goals.

Shared responsibility for children’s outcomes across all High Impact Areas:

Local stakeholders, including Clinical Commissioning Groups (CCG) or Sustainability and Transformation Partnership (STP)/ Integrated Care System (ICS)/ Primary Care Networks (PCN) where these are in place, local authority public health, children and education services should work together to set out local pathways for the High Impact Areas (using the national models as a benchmark). Ensure all stakeholders understand what is required of them with clear, agreed roles, responsibilities, governance and identified funding through integrated commissioning or memorandums of understanding between key partner organisations.

Quality assurance and sector-led improvement approaches should be used to support organisational learning and a continuous cycle of service improvement, testing and learning.

Quality assurance in a preventative service^{212 213}:

Required concepts for high quality health visiting services:

- **Time** - Is a valuable resource for the service user, health visitor and organisation and needs to be considered “well spent” by all as a measure of quality²¹⁴; Insufficient time is a constraint.
- **Knowledge** - Including a high level of practitioner knowledge and skills; and service users’ and other services’ knowledge of the role of the health visitor and support available.
- **Communication/ relationships** – Relationships are central to the health visiting process, which is purposeful for:
 - identification of need;
 - delivery of evidence-based interventions;

“A respectful, negotiated way of working that enables choice, participation and equity, within an honest, trusting relationship that is based in empathy, support and reciprocity. It is best established within a model of health visiting that recognises partnership as a central notion. It requires a high level of interpersonal qualities and communication skills in staff, who are themselves supported through a system of clinical supervision that operates within the same framework of partnership”²¹⁵.

- **Environment** - Taking account of the context of the environment – the home context is seen as a crucial element of building an effective relationship between the health visitor and the client, particularly at the first contact;

- **Orientation to practice** – Health visiting practice is health creating (salutogenic), rather than problem / deficit focused. For example, this means that the practice aims to promote resilience and self-efficacy through strengths-based practice.

“Every patient has a story. To work alongside patients who have complex and challenging lives we need to understand that story. We need to look beyond the face that sits opposite us in a consulting room and listen with respectful curiosity, understanding that their priorities today and tomorrow may not be ours”

Fair Health, 2019²¹⁶

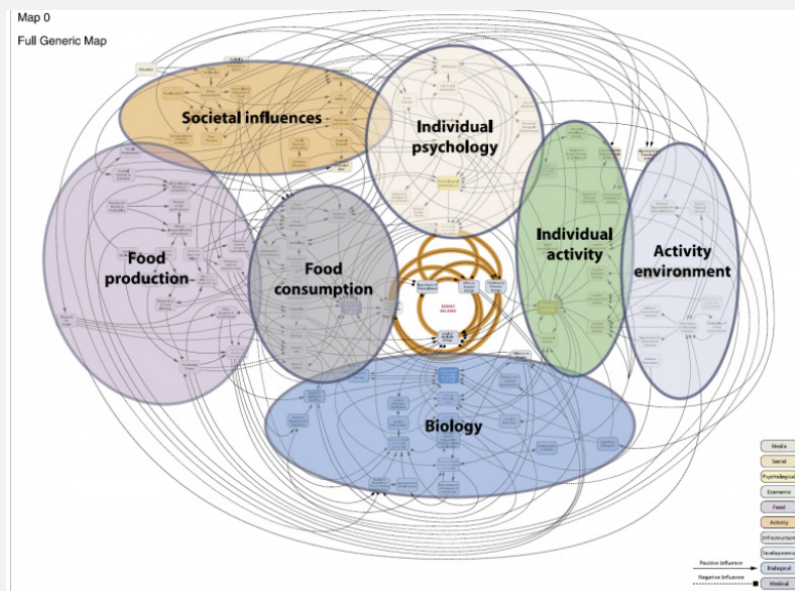
Demonstrating impact in a complex system:

Health visiting is not unique in facing difficulties articulating causal impact within a complex adaptive system in which the factors that impact outcomes are varied and messy²¹⁷. Figure 8 highlights the complex relationships between the main factors influencing levels of obesity and their relative importance

Simple reductive approaches for demonstrating impact within complex systems have been widely criticised for providing limited and misleading conclusions, with a call for changes to the way outcomes are measured in order to allow for meaningful accountability in service delivery²¹⁸.

Measurement for learning within complex adaptive systems relies on relationships, trust and autonomy²¹⁹. Abstracted and simplified data from performance measurement should be considered alongside practitioners’ own experience, qualitative feedback from other sources, including service user experience, to produce learning that can be used to adapt and improve practice.

Figure 8: The full obesity system map with thematic clusters, from the Tackling Obesity: Future Choices Report²²⁰



“Allowing people on the frontline a degree of autonomy is essential. Working effectively requires the ability to adapt and change in response to the dynamic nature of the environment, because the context which enables interventions to ‘work’ is constantly changing, so our interventions need to constantly adapt and change. If we want better outcomes, we need to help the people and organisations in these systems to collaborate and coordinate more effectively. In other words, healthy systems produce good outcomes”

Lowe, 2019²²¹

Access:

- Services should aim to address the needs of those who do not currently experience easy access to services. Reducing health inequalities should be regarded as a key test of effectiveness for every health visiting service model in England.
- The entry points to the health visiting service need to be widely accessible to the local population and support engagement as and when needs arise.
- ‘One size doesn’t fit all’. Using co-production, services should identify potential barriers to service uptake and alternative solutions to reduce the number of “invisible children”²²² who are often those with the greatest needs. The number of “missed children” provides a useful proxy measure of quality of service.

Experience:

Health visiting services should be committed to listening and hearing the views of the people who use their services to provide quality assurance and inform a continuous cycle of service improvement. Co-production quality improvement methods should be used, which should also include the views of experienced/ expert professionals in the field.

Excerpts from a letter by Jane Fisher (2019)

TO MY HEALTH VISITOR...

Thank-you doesn't quite do it justice. It seems too empty and overused. Unoriginal and clichéd. What I feel is deep gratitude that transcends the platitudes on a greetings card.

Unlike other mums' experiences, you were my health visitor for all my children. And, for this, I thank divine intervention! Continuity is a sacred rarity, yet common sense labels it a logical idea. Why not send the health visitor you've already met?

You had already proved your professionalism, evidence-based knowledge and reliability. We trusted you. This made what was to come more bearable.

What was to come was a deep descent into mental illness. Symptoms too many to list. A depression that was blacker than the sky at night. Anxiety which crippled and paralysed me, incapable of moving. And a brush with psychosis. Making logical and rational thoughts, for a time, extinct. Racing, intrusive, terrifying thoughts flooding through my mind...

Over the next 12 months I would see health professionals of all disciplines, come and go.... But you remained. The universal service that didn't make me feel different, marginalized or stigmatised. Everyone has a health visitor!

Thank you for noticing those early signs of mental ill-health. Thank you for the simple question of 'and how are YOU?' You didn't need a specialist perinatal mental health qualification to ask me this. **You needed to put down your paperwork, look me in the eyes and ask 'and how are YOU'.** This paved the way for open and honest conversations in the months and years to come...

When you listened, and I mean really listened, I felt heard. I felt seen, in a world that was all about my three small humans who took up every minute of the day and night. When you listened, your silence told me I was important. I mattered. The message you conveyed was 'I see you.' I see past the red books, the scales, the growth chart, the checklists. And I see you.

Thank you for making the time to visit. I appreciate how busy professional life is. I know the pressures you were under. Targets, financial cuts, the infamous 'service redesign.' I know my listening visits were not easily quantified or justified in terms of simple, measurable outcomes. I was not a straightforward tick box. But then who is?

What you offered me was more profound and complex than what could be summarised on a monitoring form. Because what you offered me was hope. You offered me a safe space to share my mental pain and distress. You contained my distress and allowed me to feel heard and valued...

Words cannot describe the deep sense of relief and gratitude when you answered your phone at 9.15am on Friday 26th September 2015. I finally knew I had come to the end of my ability to keep myself safe. And I needed you to get me more help.

Then you fought for me. When I had no strength to fight for my own care. You fought for every mental health referral and every appointment. You spoke up for me, for my needs. You were the voice for our family. Alone in this struggle, we would have no voice. We did not know what to say. **But you did.**

And that brings us to hope. Thank you for believing that things would change. When I could see no way out, no future, no hope this would ever end, **you saw hope.**

I gave up on myself daily, if not hourly. But you never gave up on me. And that is the most powerful, permanent gift you gave to us. **Hope.** And it is for that, we say thank you, and we remember you.

Jane's full letter is available to read at <https://ihv.org.uk/news-and-views/voices/to-my-health-visitor/>

Outcomes:

- The current national outcome measures for health visiting are largely process measures designed to prove compliance to external bodies. They have been criticised for only measuring a very small proportion of the scope of the health visitor's role and workload. They also provide very limited information on service quality, nor any information on the children and families who have not accessed the service.
- Local Authority data on health visiting is published on:
 - PHE Early Years and Child Health Profiles: <https://fingertips.phe.org.uk/profile/child-health-profiles> and
 - NHS Digital: Maternity statistics 2017/18: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2017-18>.
- The focus of outcome measures needs to shift from the current position which measure the provision of "services" and work towards longer term goals²²³ which value health assets, with cross-sector shared ambitions that matter to a community.
- To take account of the extent of inequalities we recommend that progress in all outcome measures should be based on the percentage in the worst-performing Index of Multiple Deprivation (IMD).
- To reduce the provider burden of excessive process Key Performance Indicators and ensure measures are in place to drive quality improvement, the government should develop and set high level goals for children's population health with a clear line of accountability between national goals, ambitions or targets and regional systems (see Blackpool²²⁴ example of three overarching outcomes: social and emotional development; communication and language; diet and nutrition).
- Measure the impact of health visiting intervention on demand for other services and prevention of specific illnesses to determine wider system cost savings. For example, fewer A&E attendances and hospital admissions from increased breastfeeding and improved parental health literacy and reduced infectious illness from vaccine uptake.

- The lack of hard system levers to drive quality in local authorities has in many ways led to the current unwarranted variation in service provision. Legislation of local authority functions to drive improvement is seen by many as punitive; instead, change needs to be driven by working across traditional organisational boundaries and silo working, creating a culture and working relationships built on partnership and trust to achieve shared aims.
- Meaningful measures of improved integration of local services need to be developed which should include a service user perspective on whether support is effective and integrated. Integrated health, care and support is defined as, *“person-centred, co-ordinated and tailored to the needs and preferences of the individual, their carer and family”*²²⁵. There is a significant gap in available measures to address this question, although we are aware of some local measures that would benefit from further evaluation and modification to be implemented at scale.

“Health Visitors are vital in supporting parents to develop their children’s early language skills. Early language at age three is a key measure in a composite of ‘brain health’ that can predict which individuals are more likely to be of very high cost to society 35 years later – in unemployment benefits, criminal convictions, hospitalisations and prescriptions. But what I’m hearing is that health visitors are now so thin on the ground that they are only able to focus on safeguarding and have no time to work with families where children’s development is not on track. This is just short-sighted in policy terms”.

Jean Gross CBE, former government Communication Champion for Children



“Health visitors can play an important role in promoting parent-infant relationships as they have the opportunity to work with every family. Unfortunately, many health visiting services are unable to offer additional parent-infant relationship support to families... Sadly, many health visiting services can barely deliver the core health visiting service to families, let alone specialist work to support parent-infant relationships, despite the clear value of this work”.

PIP UK “Rare Jewels” (2019)²²⁶



Section 8. Workforce

Model of service delivery for skill-mixed teams²²⁷:

“The wide range of competencies needed means that different practitioners can deliver different components of the child health programme.

It is not cost effective to have all the tasks in the programme undertaken by practitioners who have the level of competencies needed for assessment of risk and need, and for delivering targeted interventions.

However, it is also not wise to skill mix to the point that staff do not have the knowledge, skills and attitudes needed to undertake holistic assessments and risks are ignored and needs are missed.

Having practitioners with the capacity to undertake needs assessments is essential to the concept of proportionate universalism – to identify children and families who need an enhanced or targeted service, or who need referral to specialists.”

Health for All Children – fifth edition (2019)²²⁸

Services need to be built around the needs of infants, children and their families, to ensure easy access to the right support at the right time. It is important that thresholds between levels of service do not act as barriers to access and support from a health visitor.

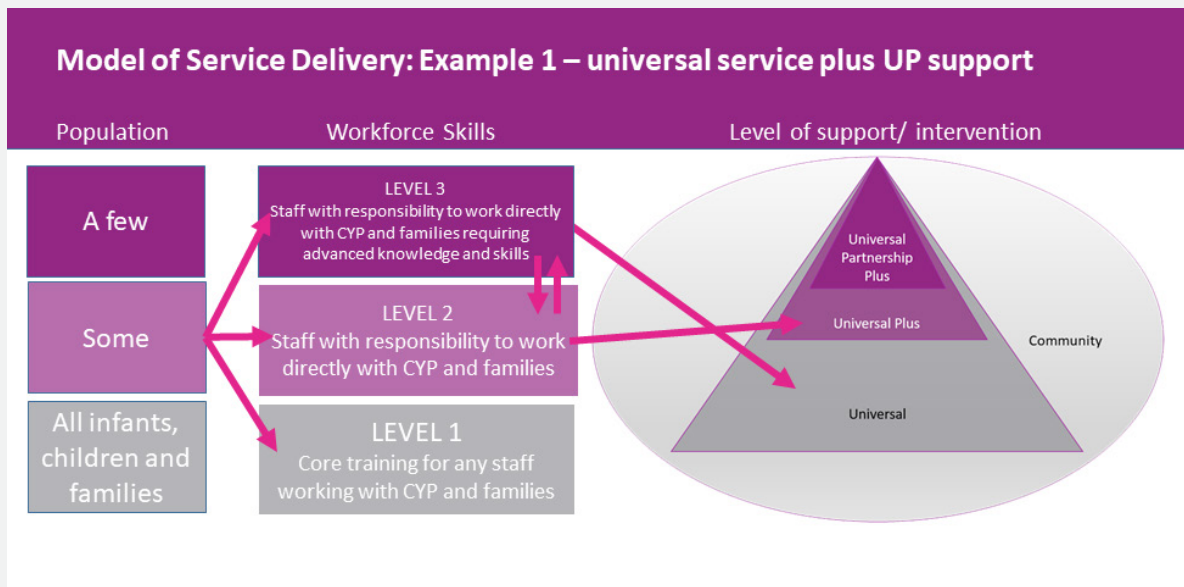
From a commissioning perspective it is important to have a clear understanding of the distinction between:

- A tiered approach to describing children and their needs;
- A tiered approach to describing interventions;
- A tiered approach to describing the skills and competence of the workforce.

It is important that services are not built on the misguided assumption that universal services require a minimal level of practitioner skill.

NOTE: Universal assessment within an undifferentiated population requires a high level of practitioner skill and should be delivered by a health visitor²²⁹: The effectiveness of this holistic health needs assessment is dependent on a highly trained health visitor to facilitate a style of practice that is based on parents’ strengths, is family centred, is community centred, promotes psycho-social wellbeing and skilfully manages negotiations to broker engagement, elicit needs, agree goals and plan personalised support.

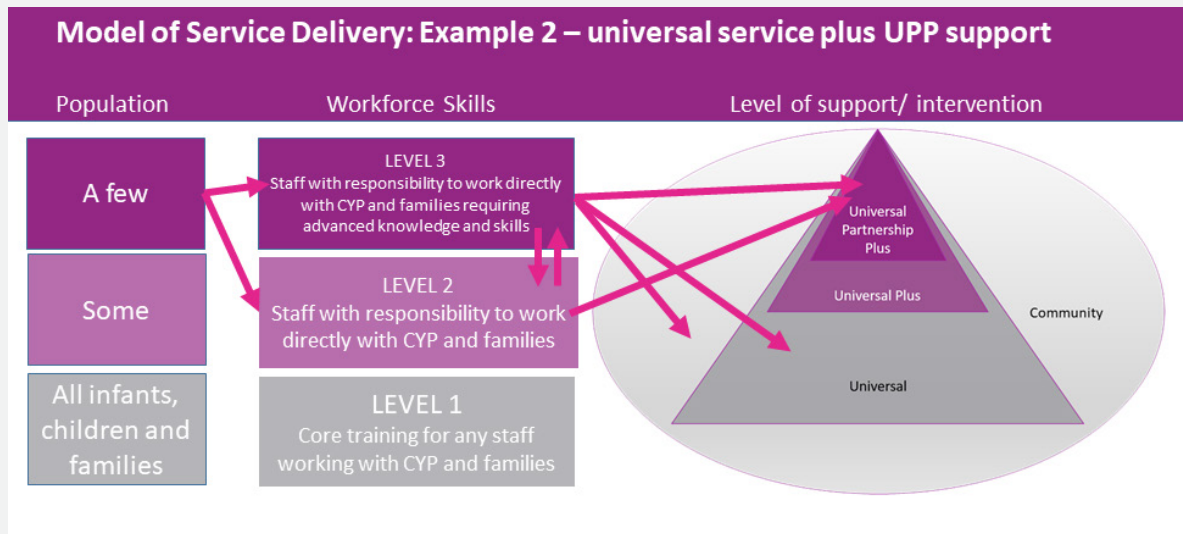
Health visitors are professionally accountable for any delegated activity undertaken within skill-mixed teams. In accordance with the NMC Code²³⁰, the health visitor must make sure that everyone they delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care. Accountability may be compromised if there are blanket protocols in place (e.g. all follow-up visits carried out by nursery nurses or community staff nurses), because they remove authority from the accountable health visitor.



Example 1: A mother of a 3-week infant experiencing difficulties with breastfeeding who recently moved into the area during pregnancy is supported by different members of the health visiting team:

- The health visitor (level 3) completes a holistic assessment of need and the antenatal, new birth contact, 3-5 week and 6-8 week contact.
- The community nursery nurse (level 2) trained to UNICEF Baby Friendly standards – leads the breastfeeding support group and additional 1:1 support for breastfeeding as needed. Is supported and supervised by the health visitor.
- The health visiting team administrator (level 1) signposts parents to community resources and oversees administration of “Ready Steady Mums” walking group.

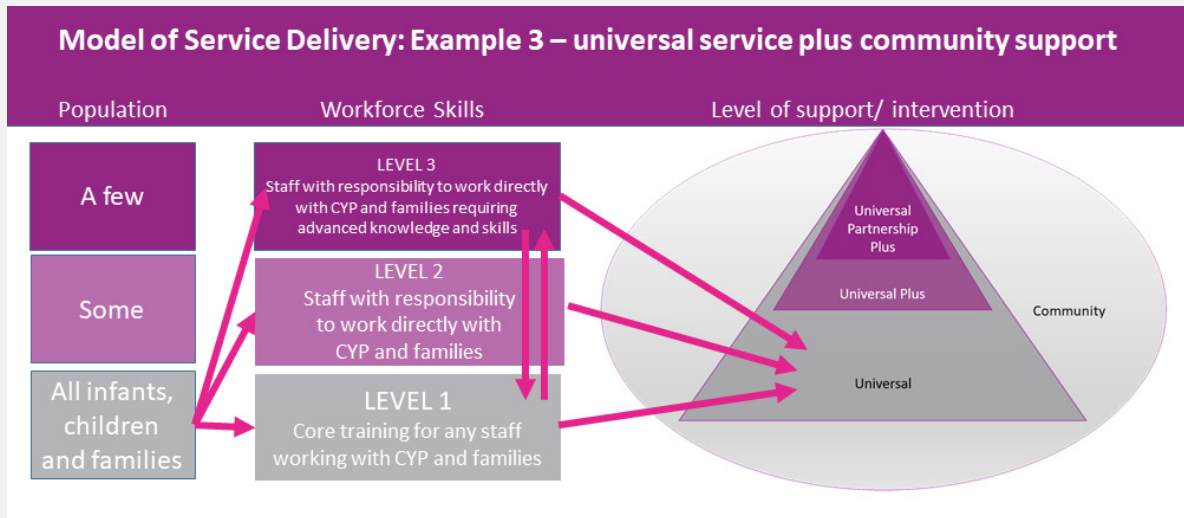




Example 2: A mother of a 3 ½ -year-old child with cerebral palsy is supported by different members of the health visiting team:

- The health visitor (level 3) completes:
 - universal contacts to ensure continuity of practitioner and regular re-assessment of need.
 - universal partnership plus: co-ordinates HV team support and liaises with other members of the multi-disciplinary team as part of a collaborative package of support; initiates support for transition to school and liaison with school nursing service.
 - community – liaises with the housing department to support a case for re-housing as the family are living in unsuitable housing for a child with a physical disability and signposts the family to a local charity providing housing advocacy support.
- The community nursery nurse (level 2) trained to manage sleep difficulties provides 1:1 support for the child’s disrupted sleep patterns. The community nursery nurse practises within their scope of competence - supported and supervised by the health visitor.





Example 3: A mother of a 10-week infant with no additional health needs identified is supported by different members of the health visiting team:

- The health visitor (level 3) completes:
 - universal assessment contacts (antenatal, new-birth, 3-5 week and 6-8 weeks) to ensure continuity of practitioner and regular re-assessment of need
- The community nursery nurse (level 2) invites parents to a workshop prior to introducing solid food to promote healthy eating and physical activity
- The health visiting support worker (level 1) – works with the health visitor to welcome families at the child health clinic, complete administrative functions and supports families to access information on “what’s on” in the local area.

Safer staffing

- A ‘health visiting service’ should be one that is delivered and led by health visitors who are trained and qualified to the level of Registered Specialist Community Public Health Nurse and who work autonomously within a local service framework. An increased focus on continuity of care is also needed to ensure that as far as possible a family sees the same health visitor.
- It is important that we avoid a system that is “health visitor led” in name only. Health visitors are professionally accountable for any delegated activity undertaken within skill-mixed teams.
- Health visiting practice is not simply skills to be learnt or tasks to be completed but encompasses a philosophy and way of working that makes health visiting a distinct profession (see Appendix 2). Health visitors are trained to support the child within the context of their family and wider community, taking an ecological approach to enable parents to focus on the needs and priorities of their baby and family²³¹.

“We need highly skilled relationship-based practice using motivational approaches to have real impact= the ability to have “difficult conversations” based on trust and relational working – what we call “high support high challenge”.

Member of iHV Expert Collaborator Group (Health Visiting Service Lead)

- Health visitors are professionally accountable for the assessments of health and care for all families on their caseload. With the recent cuts, health visitors in some areas are now accountable for caseloads of over 750 children. In contrast, NHS services are monitored against “Safer Staffing”²³² levels, yet health services devolved to local government do not have this level of clinical governance. It goes without saying that it is impossible for a single practitioner to be safely accountable for the assessment and care of 750 children and their families.
- The Department of Health recommended a ‘minimum floor’ standard of funding for one whole time equivalent health visitor for 300 children under five. This informed the independent Advisory Committee on Resource Allocation (ACRA)²³³ formula for 2016-17. **The iHV recommends a maximum caseload of 250 children, and less in areas of high need.** These ratios have been adopted by the devolved administrations for their current reinvestment in health visiting.
- Health visiting faces similar challenges to those experienced by other advanced specialist nurses in terms of demonstrating the breadth and complexity of health visitors’ workload to support “Safer staffing” and optimum caseloads (a recent review of District Nurses estimates that only 15% of their work is recognised)²³⁴. This presents challenges to those who commission and manage these services and requires robust workforce modelling to ensure that the added value of employing advanced specialist practitioners is not overlooked (**there is a substantial body of evidence which indicates that advanced specialist nurses provide care at reduced cost and increase efficiency across the wider health and social care system in the long-run**)²³⁵.
- Revised workforce modelling will be needed to establish workforce requirements to deliver the refreshed Healthy Child Programme and all levels of the health visiting service offer. This should include current work demands, including essential and desirable work that is currently not completed. Due to the lack of capacity within the current workforce, a workforce plan will be needed to build capacity to implement the recommendations in full.
- Health visitors play an important role in supporting nursing students and nursing associate students whilst on their community placements. We have received feedback that some health visitors are finding it increasingly difficult to provide student nurses with the breadth of practice and learning opportunities to sign off their nursing placement “learning competencies”. This is due to the recent narrowing of the scope of health visiting practice to safeguarding and mandated reviews in some areas. Student placements provide an important part of the “pipeline” into the health visiting profession. It is therefore vital that the full breadth of the health visiting role in supporting physical, emotional and social wellbeing is reinstated to enable students to have a rich learning environment and exposure to the health visiting profession as a possible career option.

Supervision and leadership:

“Aside from the additional resources to fund this vision, its success hinges on the quality of leadership and supervision of practice and its importance to drive quality improvement. This will require a sustained approach to guiding, supporting and supervising staff to ensure implementation in practice and avoid the inexorable drift back to what are considered the essentials for delivery of the service - meeting KPIs etc”.

Martin Smith, Consultant in Public Health, Liverpool City Council

In common with the experiences of other practitioners working in the NHS, health visiting faces the leadership challenges of implementing new service models which requires greater system collaboration. Systems-based, cross-sector, skilled professional leadership will be essential for health visiting to play its full part within integrated place-based healthcare.

Health visiting leadership development is integral to health visitor training and should continue throughout professional careers to enable career progression and support retention. The iHV with government support piloted the creation of 150 Fellows of the Institute 5 years ago and these Fellows, all senior health visitors, have again and again demonstrated their clinical leadership capacity in driving positive change for the profession.

Section 9. Recommendations

Funding and accountability:

1. A radical shift in government policy is needed to provide sustainable funding for prevention and early intervention services for children in England. All government departments who accrue the benefits of an effective health visiting service should collectively commit to support immediate investment back into public health with pooled ring-fenced budgets for high quality health visiting services with protection into the future.
2. New investment is needed to support implementation of effective early intervention and improve outcomes for the most disadvantaged infants and children (to support an effective universal partnership plus offer). The Early Intervention Foundation is clear that there are, “Few magic bullets or quick wins”. The majority of effective interventions are relatively intensive. While these interventions are typically more expensive than care as usual, their costs need to be considered against their cost-effectiveness in the long run, with increased benefits for parents and children.
3. To improve joined up services for families, national and local government should work together with key stakeholders to set out model integrated system pathways (including gaps) for key public health priority areas, with the necessary system support in place to implement these in full. Information on levels of unmet need and waiting lists should be collated to inform future service planning.
4. Government should develop and set high level goals for children’s population health and an outcome measure for integrated care, with a clear line of accountability between national goals, ambitions or targets and regional and local systems. To drive quality improvement and reduce unwarranted variation, this requires a shift away from the current emphasis on process outcome measurement and benchmarking against a historical baseline at point of transfer in 2015. Services need to be focused on the outcomes that matter to the people who use the health visiting service which should be easy to access, based on best evidence, and built around the needs of children and their families.
5. The Government’s ambition to ensure continuity of practitioner and personalised care within maternity services should be extended to include health visiting and the midwifery-health visitor transfer.
6. Government should develop an extension to the early language measure being developed by PHE/DfE to include an additional review at 3.5 years for those children identified with speech, language and communication delay at 2-2.5 years. This will provide a measure of progress, an indication of the effectiveness of early intervention and identify those children who may require more specialist support.
7. An innovation fund is needed to develop, test, and scale new ways of individualizing health visiting universal partnership plus services for children and their families in severely challenging situations and mechanisms to demonstrate their impact. This programme of work should consider “health visiting” within complex adaptive systems and make use of rapid-cycle system change methods to establish user needs, develop and test solutions and drive implementation at scale. To support integrated working this should include the health visiting contribution within the wider system (for example the health visiting contribution to the Troubled Families Programme and Early Help).
8. The re-establishment of closer ties with other NHS services, especially Midwifery and General Practice, to enhance the flow of information between these other essential universal services that support and protect babies and their families.

Workforce and leadership:

9. Urgent action is needed to reverse the current decline in the health visiting workforce. As we await the refreshed Healthy Child Programme, as an interim measure, the proposed metric should be a floor of 12,000 WTE to restore the workforce to the target figure calculated for the Health Visiting Implementation Plan, 2011-2015.
10. The planned review of the Healthy Child Programme should include workforce modelling to secure national implementation of its recommendations in full, including addressing current unmet need. This should include guidance for delivering “safer staffing”, in line with the ambitions for staff working within the NHS^{236 237}.
11. The ambitions of the NHS People Plan should be applied to the health visiting workforce with a national health visiting workforce strategy to strengthen leadership, provide opportunities for career progression and address high levels of sickness, recruitment and retention difficulties. A plan for health visitor training, which takes account of the proposed new standards being developed by the NMC is needed. This should include: a review of the risk assessment for the implementation of the Apprenticeship Standard and training funded via the Apprenticeship Levy; and a review of the risk assessment for the removal of the Practice Teacher function to support high quality learning in practice.
12. To consolidate and improve the quality of centrally held data on health visiting workforce numbers. This should include all publicly funded health visitors, student health visitors and members of the skill-mixed health visiting team (differentiated by grade and qualification) employed in NHS and non-NHS organisations, including local authorities.
13. Data should be collected from all local authorities to determine the ratio of health visitors to the 0-5 population for which services are commissioned using metrics including Indices of Multiple Deprivation (IMD) and other factors such as rurality. The ACRA (2015) proposed formula for 0-5 children’s public health should be refreshed and applied to funding.
14. To address current workforce gaps, career paths towards and beyond registration as a SCPHN (health visitor) should be prepared and promoted including Apprenticeship, preceptorship and further post-qualifying professional learning and development. More rapid graduate entry to end-point qualification as a nurse / SCPHN-HV should be developed as an attractive career option. Safe and effective practice should be underpinned by an entitlement to skilled professional supervision with a restorative function.
15. New National Standards for health visiting are needed to support consistency within the profession. The title ‘health visitor’ should be protected and restored to statute.
16. Ensure plans are in place to develop leadership capabilities within the health visiting workforce. This should include a robust strategy for supervision and nationally recognised leadership development programmes to support clinical leadership and career progression within health visiting e.g. to Chartered Status (Willis Report). To strengthen health visiting leadership we believe that new health visitors should undergo a [two-year preceptorship](#) period supervised and mentored by senior health visitors who might be Fellows of the iHV. On completion they could be given the status of ‘chartered’ health visitor or similar, in line with many other professions.
17. A Healthy Child Programme oversight function at national and local level should be established which includes workforce standards, training and development of staff at all levels. Establishing best practice in delegation and supervision of skill-mixed staff is needed to support delivery of the HCP, including the role of the Nursing Associate.
18. Employer standards for health visitors and health visiting teams should be reviewed and refreshed within new clinical governance structures; integrated within Sector-Led improvement.

Appendix 1. Health visiting alongside intensive home visiting programmes in England

The health visiting service is universal and works at four levels, but it also works alongside some licensed intensive home visiting programmes. These have been introduced in some areas of the country and have been shown to be effective for specified target groups^{238 239 240}. However, at a population level, the reach of these programmes is small when considered against the context of the total number of children experiencing risks and vulnerabilities. The Children's Commissioner estimates that 2.3 million children are living with risk because of a vulnerable family background²⁴¹. The health visiting service plays an important role in identifying and supporting all vulnerable families in all areas.

A small number of local authorities deliver the Maternal Early Childhood Sustained Home-visiting programme (MECSH) which is embedded within their existing health visiting teams. About half of all local authorities provide intensive support for young parents through provision of the Family Nurse Programme (FNP)²⁴².

MECSH is designed to be delivered at whole population scale (by every health visitor for the vulnerable families on their caseload; families can enrol on the programme at any time up to six weeks after the birth). Much of the evidence for MECSH is based on non-UK studies and has been found to be effective in improving child and maternal outcomes, and the developmental quality of the home environment.

MECSH provides intensive nurse (health visitor)-led home visiting for parents experiencing a wide range of needs. This programme identifies families for extra contact from within the existing health visiting service²⁴³. MECSH is gaining in popularity for this reason and is embedded within some existing health visiting service delivery systems in England. While not all families that need this level of service may take up this offer, the programme has been found to have 'spill-over' effects producing positive outcomes for the whole community and the way in which health visitors support all families²⁴⁴. The MECSH programme is undergoing further research to demonstrate transferability to the UK. The full findings of a mixed methods impact study in the UK are due to be published in 2020.

FNP is a preventive programme for first time young mothers (under 20 years, although a recent ADAPT trial has increased this to age 24 in some sites). It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until the child is two. It is a licensed programme originating in the USA and much of the supporting evidence for FNP is based on non-UK trials. FNP has the highest level of evidence rating from the Early Intervention Foundation, although it is also rated as high cost^{245 246 247}. There is only one trial on the effectiveness of FNP in England²⁴⁸, published in 2015. This evaluated short term impact (to age 2) and did not find evidence of improved effectiveness in the four primary maternal outcomes tested when compared to a control group receiving the health visiting service. The trial did observe significant between group differences favoring FNP for some secondary outcomes including maternal self-efficacy, intention to breastfeed and child cognitive and language development. We await the outcomes of the FNP ADAPT development strategy and the findings from a study which evaluates the longitudinal outcomes from the first trial in England.

The FNP ADAPT Programme (FNP)²⁴⁹ has been developed to rapidly adapt, test and improve the Family Nurse Partnership programme in England. ADAPT harnesses the strength of research and the pragmatism of improvement approaches to adapt, test and learn about the FNP programme, while respecting its strong evidence base. It aims to identify adaptations that will enable FNP to better meet the needs of families and respond to ongoing change in the local and national context. It has also enabled the development and documentation of a method for rapid cycle adaptation and testing.

As well as supporting individual families for more than a decade, FNP has helped build a better understanding of how to:

- Translate high quality evidence and policy into practice in the real world, implementing a nurse-led public health programme with fidelity at pace and at scale;
- Adapt an evidence-based programme to better fit client need and local context, using co-design and data-driven methods;
- Understand the value and importance of different types of evidence, providing a valuable case study example of the implementation of intensive home-visiting in England.

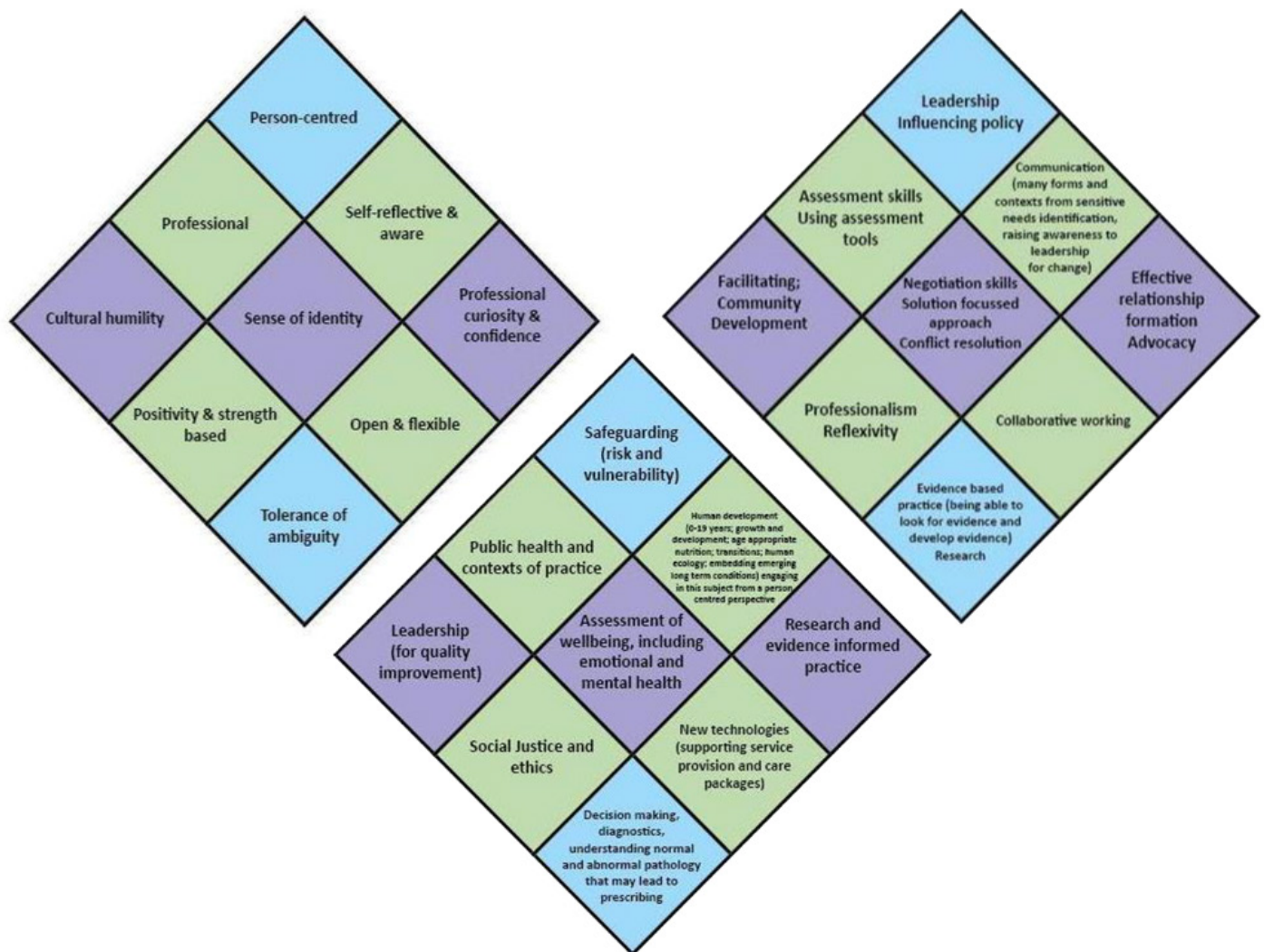
However, it is important that effective tailored support is available to all families at high risk of poor outcomes. Meta-analyses of intensive home visiting programmes^{250 251 252} have identified that targeted interventions, by definition, may leave many high-risk families ineligible for their services.

Limitations may include:

- Gaps in programme reach - in England the decision on whether intensive home visiting programmes are provided rests with each local authority. For example, the Family Nurse Partnership Programme is only commissioned in approximately half of all local authorities in England and is only available for young parents.
- Populations with the greatest risk of maltreatment, such as parents with mental health or substance misuse problems are known to have relatively low rate of enrolment in voluntary programmes²⁵³. These parents often find it difficult to focus on their child's needs and are often less motivated to seek out and use support services^{254 255 256} and high levels of attrition from programmes has been reported in some groups²⁵⁷.
- Targeted programmes, which require that families be identified as having certain economic or personal deficits can be stigmatizing. The very families one hopes to engage in such efforts may refuse participation for fear of being labelled as being inadequate parents.
- Risks may emerge after the enrolment period (the most popular programmes have enrolment "cut off" points that range from pre-birth to up to six weeks postnatally) and to those in ineligible group. Maltreatment and poor parenting skills are not limited to low-income families, or those in a particular age range and can surface in families across the income spectrum and at any time in response to the dynamic changes that occur in each family during pregnancy and early childhood.
- Current risk assessment tools lack the required level of sensitivity and specificity for use as screening tools. The accuracy of the process of identifying families at risk of poor outcomes has been shown to be improved using highly skilled staff, with sufficient time to establish a trusting relationship that supports disclosure of need over a period of time, rather than a single "snapshot"^{258 259}.

Appendix 2. Health visiting workforce – Attributes, knowledge and skills of successful health visitor recruits:

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